STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525264	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook at Appleton	1335 S Oneida St Appleton, WI 54915

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on staff and resident interview and record review, the facility did not ensure 1 resident (R) (R25) of 14 sampled residents was offered the opportunity to create or obtain Power of Attorney for Health Care (POAHC) paperwork. R25 was admitted to the facility on [DATE]. The facility did not obtain R25's POAHC document or offer R25 the chance to fill out a new document prior to 5/7/24. Findings include: The facility's Advanced Directive policy and procedure, dated October 2020, indicates: The resident has a right to accept or refuse medical or surgical treatment and to formulate an advance directive in accordance with state and federal law .Purpose: To help ensure a resident's right to formulate an advanced directive . Procedure: .2. The facility will inquire at the time of admission whether the resident has previously executed an advance directive. 3. If a resident has executed an advance directive, the facility must obtain a copy from the resident or the legal representative which is stored in the resident's medical record. Nursing notifies the physician of the resident's or the legal representative's wishes, obtains orders as appropriate, and enters the information in the electronic health record. On 5/6/24, Surveyor reviewed R25's medical record. R25 was admitted to the facility on [DATE]. R25's medical record did not contain POAHC documentation. On 5/7/24, Surveyor reviewed a POAHC refusal document, dated 4/12/24, that indicated R25 did not wish to complete paperwork at that time. On 5/7/24 at 10:15 AM, Surveyor interviewed R25 who stated Social Services Director (SSD)-D was just in R25's room and requested R25's POAHC document. R25 indicated R25 had a POAHC document from 2004 in R25's safe at home and did not wish to fill out another one. When Surveyor asked R25 to review the refusal document provided by the facility, R25 stated the document was filled out and signed on 5/7/24 approximately 10 minutes prior to the interview. On 5/7/24 at 10:40 AM, Surveyor interviewed Social Services Assistant (SSA)-C who stated SSA-C didn't have R25 sign the refusal document, however, SSA-C was asked to sign and date the document 4/12/24 by SSD-D after SSD-D obtained R25's signature on the document on 5/7/24. (continued on next page)

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
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at 10:37 AM, Surveyor interviewed SSD-D who verified R25 signed the POAHC refusal document on 5/7/24.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not notify a Power of Attorney for Healthcare (POAHC) for when 1 resident (R) (R34) of 14 sampled residents experienced a change in condition. The facility did not notify R34's POAHC following a fall on 5/1/24. Findings include: The facility's Fall Management policy, dated July 2020, indicates when a fall occurs, it is the responsibility of the nurse to communicate the fall to the attending physician and the resident's representative, and document the notification on the Interdisciplinary Post Fall Review report. The nurse will discuss recommended interventions to reduce or prevent further falls with the resident and/or the resident representative. 1. From 5/6/24 to 5/8/24, Surveyor reviewed R34's medical record. R34 was admitted to the facility on [DATE] with diagnoses including Parkinsonism, muscle wasting and atrophy, unspecified severe protein-calorie malnutrition, and altered mental status. R34's Minimum Data Set (MDS) assessment, dated 4/20/24, indicated R34 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R34 had severe cognitive impairment. A care plan, initiated on 9/21/23, indicated R34 was at high risk for falls related to confusion. R34 had an activated POAHC. On 5/6/24 at 2:03 PM, Surveyor interviewed POAHC-R who stated R34 had a recent fall and POAHC-R was not notified until POAHC-R visited R34 and was informed of the fall by R34. POAHC-R stated POAHC-R asked staff who verified R34 had a fall. On 5/7/24, Surveyor reviewed a fall incident report, dated 5/1/24, that stated R34 had an unwitnessed fall in R34's room. The fall report indicated R34's physician and Director of Nursing (DON)-B were notified. The fall report did not indicate POAHC-R was notified. On 5/8/24 at 1:20 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed POAHC-R was not notified of R34's fall on 5/1/24. NHA-A stated the nurse responsible for the notification confirmed to NHA-A that POAHC-R was not notified following the fall. NHA-A stated education was provided to the nurse. NHA-A confirmed NHA-A expects staff to update a resident's representative following a fall. NHA-A stated NHA-A called POAHC-R on 5/8/24 and notified POAHC-R of R34's fall.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not ensure 2 residents (R) (R145 and R32) of 2 residents reviewed for hospitalization received a transfer notice that included the date of the transfer, the reason for the transfer, the location of the transfer, and appeal rights. R145 was transferred to the hospital on 4/18/24 and was not provided with a written transfer notice. R32 was transferred to the hospital on 3/10/24. R32 and/or R32's legal representative were not provided with a written transfer notice. Findings include: The facility's Bedhold Notification policy, dated March 2021, includes a sample letter Notice of Transfer that states the reason for the resident's transfer and their right to appeal. 1. From 5/6/24 to 5/8/24, Surveyor reviewed R145's medical record. R145's latest admission to the facility was on 4/25/24. R145 had diagnoses including heart failure, morbid obesity with alveolar hypoventilation (a condition where the lungs do not get enough air which causes high levels of carbon dioxide in the blood and decreased oxygen), and obstructive sleep apnea. R145's Minimum Data Set (MDS) assessment, dated 1/6/24, contained a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R145 had intact cognition. R145's medical record indicated R145 fell on [DATE]. After staff transferred R145 to bed, R145 was hard to arouse and no injuries were noted. R145 was sent to the hospital for evaluation and returned to the facility on [DATE]. R145's medical record did not indicate a written transfer notice was provided to R145. On 5/8/24 at 10:33 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E and LPN-F. LPN-E indicated LPN-E verbally informs residents of the reason for the transfer and was not aware the facility has a transfer notice form. LPN-E and LPN-F indicated they were unaware a written transfer notice is required when a resident is transferred. On 5/8/24 at 10:54 AM, Surveyor interviewed Director of Nursing (DON)-B who verified R145 did not receive a written transfer notice when R145 was transferred to the hospital on 4/18/24. DON-B indicated R145 should have received a written transfer notice. 48794 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. From 5/6/24 to 5/8/24, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] with diagnoses including neoplasm of uncertain behavior of brain, moderate persistent asthma with (acute) exacerbation, acute respiratory failure with hypoxia, and acute on chronic diastolic (congestive) heart failure. R32's MDS assessment, dated 4/7/24, contained a BIMS score of 15 out of 15 which indicated R32 had intact cognition. R32 had an activated Power of Attorney for Healthcare (POAHC). R32's medical record indicated R32 was hospitalized on [DATE] with diagnoses of exacerbation of asthma, acute on chronic diastolic congestive heart failure, acute exacerbation of moderate persistent asthma, and acute hypoxic respiratory failure. A progress note, dated 3/10/24, indicated nursing staff called R32's POAHC to notify them of the transfer. R32 returned to the facility on [DATE]. On 5/8/24 at 10:33 AM, Surveyor interviewed LPN-E and LPN-F. LPN-E indicated LPN-E verbally informs residents of the reason for the transfer and was not aware the facility has a transfer notice form. LPN-E and LPN-F indicated they were unaware a written transfer notice is required when a resident is transferred. On 5/8/24 at 1:20 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated the facility did not have documentation that a written transfer notice was provided to R32 or R32's POAHC. NHA-A stated a written transfer notice should have been provided.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not ensure 2 residents (R) (R145 and R32) of 2 residents reviewed for hospitalization received notification of the facility's bed hold policy when they were transferred to the hospital. R145 was transferred to the hospital following a fall on 4/18/24. R145 was not provided written notice of the facility's bed hold policy. R32 was transferred to the hospital on 3/10/24. R32 was not provided written notice of the facility's bed hold policy. Findings include: The facility's Bedhold Notification policy, dated March 2021, states when a resident is transferred to the hospital, the facility will provide written notice to the resident and/or resident's representative regarding the resident's bed hold rights and the facility's bed hold policy. 1. From 5/6/24 to 5/8/24, Surveyor reviewed R145's medical record. R145's latest admission to the facility was on 4/25/24. R145 had diagnoses including heart failure, morbid obesity with alveolar hypoventilation (a condition where the lungs do not get enough air which causes high levels of carbon dioxide in the blood and decreased oxygen), and obstructive sleep apnea. R145's Minimum Data Set (MDS) assessment, dated 1/6/24, contained a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R145 had intact cognition. R145's medical record indicated R145 fell on [DATE]. After staff transferred R145 to bed, R145 was hard to arouse and no injuries were noted. R145 was sent to the hospital for evaluation and returned to the facility on [DATE]. R145's medical record did not indicate a copy of the facility's bed hold policy was provided to R145. On 5/8/24 at 10:33 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E and LPN-F. LPN-E indicated LPN-E verbally informs residents or their representatives of the bed hold policy. When Surveyor asked LPN-E if LPN-E follows up with a written bed hold policy to ensure a signature, LPN-E indicated the Social Worker has the resident sign. LPN-F stated LPN-F was unsure of the facility's bed hold process. On 5/8/24 at 10:54 AM, Surveyor interviewed Director of Nursing (DON)-B who verified R145 did not receive a copy of the facility's bed hold policy when R145 was transferred to the hospital on 4/18/24. DON-B indicated R145 should have been given a copy of the bed hold policy. 48794 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. From 5/6/24 to 5/8/24, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] with diagnoses including neoplasm of uncertain behavior of brain, moderate persistent asthma with (acute) exacerbation, acute respiratory failure with hypoxia, and acute on chronic diastolic (congestive) heart failure. R32's MDS assessment, dated 4/7/24, contained a BIMS score of 15 out of 15 which indicated R32 had intact cognition. R32 had an activated Power of Attorney for Healthcare (POAHC). R32's medical record indicated R32 was hospitalized on [DATE] with diagnoses of exacerbation of asthma, acute on chronic diastolic congestive heart failure, acute exacerbation of moderate persistent asthma, and acute hypoxic respiratory failure. R32 was readmitted to the facility on [DATE] following an acute hospital stay. On 5/8/24 at 1:20 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated the facility did not have documentation that a copy of the bed hold policy was provided or reviewed with R32 or R32's POAHC. NHA-A stated R32 should have received a copy of the facility's bed hold policy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on staff interview and record review, the facility did not ensure a comprehensive assessment was completed after a significant change in condition for 1 resident (R) (R8) of 14 sampled residents. R8 started Hospice services on 3/13/24. The facility did not complete comprehensive assessment for a significant change in condition. Findings include: The Centers for Medicare & Medicaid Service's (CMS's) Resident Assessment Instrument (RAI) Version 3.0 Manual, dated October 2023, indicates: OBRA-required comprehensive assessments include the completion of both the Minimum Data Set (MDS) and the Care Area Assessment (CAA) process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required . On 5/6/24, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] with diagnoses including dementia, diabetes, and coronary heart disease. On 5/6/24 at 2:26 PM, Surveyor interviewed Power of Attorney for Healthcare (POAHC)-Q via telephone who stated R8 started Hospice services in March of 2024. Surveyor noted R8's medical record did not contain a comprehensive MDS assessment for a significant change of condition when R8 started Hospice services. On 5/8/24 at 10:15 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified that facility did not complete a significant change assessment for R8 but should have.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not develop a baseline care plan that included the minimum healthcare information necessary to properly care for 1 resident (R) (R149) of 14 sampled residents. R149's baseline care plan did not include information related to R149's dialysis, diet, and smoking status. Findings include: The facility's Baseline Care Plan (BCP) policy, revised February 2021, indicates: Each resident will have a baseline care plan developed within 48 hours of admission that addresses identified risk areas and the resident's initial individual needs .The BCP documents and communicates the resident's initial needs until the comprehensive care plan is finalized .Procedure: 1) The admitting nurse will perform an initial nursing assessment of the resident and gather specific information from the following sources: physician orders, diet, therapy, medications, activity limitations, treatments, and social services .4) The BCP includes the following key elements: Initial goals based on admission orders .dietary orders .6) A summary of the BCP will be provided to and discussed with the resident .The summary .should include .c) services, treatments and interventions to be administered by the facility . The facility's Safe Smoking/Tobacco Use policy, revised October 2020, indicates: The interdisciplinary team (IDT) determine if a resident may safely use tobacco products or e-cigarettes before the resident is permitted the privilege to do so .Safe Smoking/Tobacco Use Determination: An evaluation is conducted for all residents who use tobacco products or e-cigarettes in order to .observe the resident's ability to smoke/use tobacco in a safe manner. The resident's care plan reflects: That the resident smokes .the degree of supervision that is necessary, if the resident is to wear a protective smoking/vest/apron .Procedure: .3) A resident who smokes .is evaluated to determine whether the resident is safe or unsafe to use tobacco products or e-cigarettes using the following forms a) Upon admission or readmission, if the nursing admission data collection identifies that the resident uses tobacco .evaluation is completed .Residents who are determined to be unsafe while smoking are required to wear a protective smoking vest/apron and are supervised at all times while smoking . From 5/6/24 to 5/8/24, Surveyor reviewed R149's medical record. R149 was admitted to the facility on [DATE] with diagnoses including severe protein-calorie malnutrition, end stage renal disease, renal dialysis, nicotine dependence, and dysphagia (difficulty swallowing). R149's Minimum Data Set (MDS) assessment, dated 4/23/24, stated R149 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R149 had intact cognition. R149's medical record indicated the following: ~R149 was prescribed a low potassium diet with a mechanical soft texture and thin liquids. ~R149 had an order for dialysis on Tuesdays, Thursdays, and Saturdays. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~A smoking assessment indicated R149 required assistance to smoke. A baseline care plan, initiated 4/19/24, did not include information related to R149's dialysis, diet, and smoking status. On 5/8/24 at 10:04 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who indicated R149 could smoke independently. On 5/8/24 at 10:11 AM, Surveyor interviewed LPN-E who indicated R149 was an independent smoker. On 5/8/24 at 11:04 AM, Surveyor interviewed Director of Nursing (DON)-B who verified R149 did not have a care plan for smoking. DON-B confirmed a smoking assessment was completed and indicated R149 required assistance when smoking. DON-B indicated DON-B had not seen R149 smoke and did not think R149 smoked. DON-B indicated an intervention for assistance when smoking should have been included in R149's BCP. On 5/8/24 at 11:11 AM, Surveyor interviewed DON-B who verified R149's diet and dialysis were not included in R145's BCP but indicated both should have been included in R149's BCP.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on staff interview and record review, the facility did not ensure a comprehensive care plan was developed and implemented for 1 resident (R) (R8) of 14 sampled residents. R8 started Hospice services on 3/13/24. The facility did not develop a care plan to address R8's Hospice care. In addition, R8 did not have an order for Hospice prior to 5/8/24 Findings include: On 5/6/24, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] with diagnoses including dementia, diabetes, and coronary heart disease. R8 began Hospice care on 3/13/24. On 5/6/24 at 2:26 PM, Surveyor interviewed Power of Attorney for Healthcare (POAHC)-Q via telephone who stated R8 started Hospice care in March of 2024. On 5/7/24, Surveyor reviewed R8's medical record and noted R8 did not have a care plan for Hospice or an order for Hospice care. On 5/8/24 at 10:19 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff should obtain a referral from the Hospice provider, obtain an order from the resident's physician, and implement a care plan when a resident starts Hospice care. DON-B verified R8 did not have an order or a comprehensive care plan for Hospice services. On 5/8/24 at 10:34 AM, Surveyor interviewed Regional Consultant (RC)-M who indicated R8 did not have a Hospice care plan prior to 5/8/24 when RC-M initiated a Hospice care plan for R8. On 5/8/24 at 10:51 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who provided Surveyor with a copy of R8's MD order for Hospice care. NHA-A verified the Hospice order was entered in R8's medical record on 5/8/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47248 Based on observation, staff interview, and record review, the facility did not ensure 2 residents (R) (R33 and R4) of 2 residents reviewed for pressure injuries received the necessary care and services to promote healing. R33 had an order to remove R33's wound vac on 3/13/24 and reapply the wound vac on 3/20/24. On 3/20/24, the order was changed to reapply the wound vac on 3/27/24. The facility did not reorder wound vac supplies in a timely manner and the wound vac was not reapplied until 4/10/24. R4 had a pressure injury on the coccyx and an order to cleanse the wound with Vanshe wound cleanser. During an observation of wound care on 5/8/24, staff did not use Vanshe cleanser during R4's dressing change and stated the facility was out of the cleanser. Findings include: The facility's Dressing Change policy, with a revision date of 3/2020, indicates staff should prevent wound contamination and promote healing and complete dressing changes per physician orders. 1. On 5/6/24, Surveyor reviewed R33's medical record. R33 had diagnoses including pressure ulcer of right buttock, stage 4 right ischial tuberosity, blister of left thigh, and lumbar spina bifida with hydrocephalus. R33's Minimum Data Set (MDS) assessment, dated 4/16/24, indicated R33 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R33 had intact cognition. R33 was R33's own decision maker. On 5/6/24 at 8:35 AM, Surveyor interviewed R33 who stated a wound vac previously applied to R33's right ischium was taken off on 3/13/24 and was to be reapplied on 3/20/24. On 3/20/24, an order indicated the wound vac should remain off for another week and be reapplied on 3/27/24. R33 stated the wound vac was not reapplied on 3/27/24 because the facility did not order wound vac supplies which caused R33's wound vac to remain off until 4/10/24. R33 indicated staff did not inform R33 the supplies were not ordered prior to 4/8/24. R33 stated R33 asked nursing staff and Registered Nurse (RN)-H when the wound vac would be reapplied and was told the supplies were ordered but had not been received. R33 stated nursing staff told R33 on 4/8/24 that the supplies would arrive the following day and the wound vac would be reapplied. R33 stated this concerned R33 because the wound vac remained off longer than intended. R33's medical record contained the following information regarding R33's wound vac: ~Wound vac removed from 3/13/24-3/20/24 to assist with peri-wound healing. Daily dressing changes ordered. ~Wound vac to remain off one more week to aide in peri-wound healing. Wound vac to be reapplied on 3/27/24. (continued on next page)

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Meadowbrook at Appleton	1335 S Oneida St Appleton, WI 54915

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~R33 was seen on 3/27/24 by Wound Clinic Advance Practice Nurse Practitioner (WCAPNP)-U. A note indicated the wound vac was on hold for one more week because the facility did not have wound vac supplies. -R33 was seen again on 4/8/24 and were still were no wound vac supplies. The supplies were then ordered and the wound vac was reapplied on 4/10/24. On 5/6/24 at 11:12 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who indicated the supplies needed to reapply R33's wound vac were not ordered timely. LPN-E indicated the supplies were received on 4/10/24 and the wound vac was reapplied. RN-E indicated the former Director of Nursing (DON) was responsible for ordering the supplies. On 5/6/24 at 1:03 PM, Surveyor interviewed DON-B and Nursing Home Administrator (NHA)-A regarding R33's wound vac. NHA-A indicated the original order for wound vac supplies should have been placed by the previous DON who was no longer employed by the facility. NHA-A indicated there was a miscommunication after the previous DON left employment as well as a lack of communication regarding follow up to ensure the supply order was placed. DON-B stated DON-B has a note on DON-B's calendar to review orders to ensure they are submitted every Friday. 50467 2. On 5/7/24 and 5/8/24, Surveyor reviewed R4's medical record. R4 was readmitted to the facility on [DATE] following a hospitalization and had diagnoses including pressure injury of sacral region stage 4, quadriplegia unspecified, unspecified severe protein-calorie malnutrition, and osteomyelitis (bone infection) unspecified sites. R4's Quarterly Minimum Data Set (MDS) assessment, 4/14/24, contained a Brief Interview for Mental Status (BIMS) assessment that indicated R4 was rarely/never understood. R4's spouse was R4's legal guardian. A wound care treatment order on R4's medication administration record (MAR) indicated: Stage 4 pressure injury to coccyx: cleanse wound with Vashe cleanser. Ten minute soak. Apply Cavilon Advance to peri-wound. Place Prisma collagen to wound bed. Pack with Hydrofera Classic. Cover with bordered foam. Once daily every 2 days for stage 4 pressure wound and every 1 hour as needed (dated 4/18/24 at 2:45 PM). On 5/8/24 at 11:13 AM, Surveyor observed RN-H complete wound care for R4. RN-H stated RN-H would do the 10 minute soak, but the facility was out of Vanshe. When Surveyor asked how long the facility was out of Vanshe and if Vanshe was reordered, RN-H stated RN-H didn't know but indicated Vanshe was used when R4 was treated during wound rounds on 5/1/24. RN-H was unsure if Vanshe was used for three dressing changes between 5/1/24 and 5/8/24. On 5/8/24 at 1:20 PM, Surveyor interviewed DON-B who indicated RN-H would have ordered the wound care supplies. On 5/8/24 at 1:23 PM, Surveyor interviewed RN-H who provided Surveyor with an email of RN-H's request to DON-B on 4/26/24 to reorder Vashe. RN-H confirmed DON-B orders supplies. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 at 2:01 PM, Surveyor interviewed DON-B who indicated DON-B left two messages with the wound clinic but they didn't return the call. DON-B indicated DON-B should have continued to call the wound clinic to clarify the order. DON-B did not have documentation of the calls to the wound clinic. On 5/8/24 at 3:16 PM, Surveyor interviewed staff at Wound Care Clinic (WCC)-L who confirmed via encounter notes, a paper chart, and email that the wound clinic did not receive communication from DON-B or the facility related to R4's treatment from 4/26/24 to 5/8/24.

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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** 48794 Based on staff interview and record review, the facility did not provide adequate monitoring post fall for 1 resident (R) (R34) of 2 residents reviewed for falls. The facility did not complete neurological checks per their policy after R34's unwitnessed falls on 9/21/23 and 10/21/23. Findings include: The facility's Fall Management policy, dated July 2020, indicates: In the event a resident has a fall and it is determined that they hit their head, or it cannot be determined if they hit their head, such as an unwitnessed fall, the nurse initiates neurological checks (an assessment used to monitor and detect possibility of head injury), and documents the checks. The facility's Neuro Check Assessment Form, copyright 2023, indicates nurses should complete neurochecks every 15 minutes for the first hour following the fall, then every 30 minutes for an hour, every hour for 4 hours, every 4 hours for 24 hours and then once per shift until 72 hours post fall. Neurochecks should include the resident's vital signs, level of consciousness, movement in all four extremities, hand grasps, speech, pupil reaction, and bilateral pupil size. From 5/6/24 to 5/8/24 Surveyor reviewed R34's medical record. R34 was admitted to the facility on [DATE] with diagnoses including Parkinsonism, muscle wasting and atrophy, unspecified severe protein-calorie malnutrition, and altered mental status. R34's Minimum Data Set (MDS) assessment, dated 4/20/24, indicated R34 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R34 had severely impaired cognition. A care plan, initiated on 9/21/23, indicated R34 was at high risk for falls related to confusion. R34 had an activated Power of Attorney for Healthcare (POAHC). Surveyor reviewed R34's fall on 9/21/23. A Fall Incident Report indicated R34 was found on the floor next to R34's bed. R34 stated R34 was trying to catapult R34's self under the wheelchair. A Neurological Flow Sheet indicated an initial neurocheck was completed as well as every 15 minutes for the first hour and every 30 minutes for the next hour. No additional neurochecks were completed. Surveyor reviewed R34's fall on 10/21/23. A Fall Incident Report indicated R34 was found on the floor of R34's room in a sitting position with R34's back to the wall. R34 stated R34 hit R34's head. Neurochecks were completed for twenty four hours post-fall. No additional neurochecks were completed. On 5/8/24 at 11:22 AM, Surveyor interviewed Director of Nursing (DON)-B who stated DON-B expects staff to follow the facility's policy for completion of neurochecks which DON-B confirmed should be every 15 minutes for the first hour, every 30 minutes for the next hour, every hour for 4 hours, and then every shift for 72 hours. DON-B verified neurochecks were not appropriately completed following R34's falls on 9/21/23 and 10/21/23.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on observation, record review, and staff interview, the facility did not ensure respiratory equipment was routinely cleaned for 2 residents (R) (R145 and R156) of 2 sampled residents. Staff did not clean R145 and R156's continuous positive airway pressure (CPAP) equipment and did not change R145 and R156's oxygen tubing per the facility's policy. Findings include: The facility's CPAP-BiPAP (Bilevel Positive Airway Pressure) Use policy, dated October 2020, indicates: Residents using CPAP/BiPAP will require a physician order to include approved order setting, duration of use, use of humidifier, if necessary, and a supporting diagnosis .6) The CPAP/BiPAP mask, tubing, and humidifiers shall be cleaned weekly with soap and water and rinsed thoroughly, unless otherwise specified by the physician or respiratory therapist. 7) If a humidifier is in use, the water will be discarded and replaced daily with fresh distilled water. The facility's Liquid Oxygen Use policy, dated October 2020, indicates: 3) Cleaning the unit: a) Wipe down outside of the unit with a clean damp cloth, b) Discard and replace the oxygen mask or cannula weekly and as necessary per facility policy. 1. From 5/6/24 to 5/8/24, Surveyor reviewed R145's medical record. R145's latest admission to the facility was on 4/25/24. R145 had diagnoses including heart failure, morbid obesity with alveolar hypoventilation (a condition where the lungs do not get enough air which causes high levels of carbon dioxide in the blood and decreased oxygen), and obstructive sleep apnea. R145's Minimum Data Set (MDS) assessment, dated 1/6/24, contained a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R145 had intact cognition. R145 had a physician order to change R145's oxygen tubing every week on Friday night (NOC). R145's medical record did not contain an order or care plan for CPAP cleaning. R145's Treatment Administration Record (TAR) also did not contain an order for CPAP cleaning. On 5/6/24 at 12:12 PM, Surveyor observed R145 use 3 liters per minute (LPM) of oxygen via nasal cannula. Surveyor noted R145's oxygen tubing did not indicate when the tubing was last changed. On 5/6/24 at 12:13 PM, Surveyor interviewed R145 who stated staff had not cleaned R145's CPAP equipment. On 5/8/24 at 10:17 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who indicated R145 had an order to change R145's oxygen tubing weekly which was completed by NOC shift staff. LPN-E indicated R145's CPAP equipment should be rinsed daily. LPN-E indicated LPN-E was unsure the last time R145's CPAP was cleaned. LPN-E confirmed R145's medical record did not contain an order to clean R145's CPAP or oxygen equipment. Per LPN-E, orders should have been entered for CPAP and oxygen cleaning. LPN-E also indicated staff should label oxygen tubing when the tubing is changed. On 5/8/24 at 10:19 AM, LPN-F indicated CPAP and oxygen tubing change orders should be listed on a resident's TAR. LPN-F verified R145's TAR did not contain orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 at 10:25 AM, LPN-F verified R145's green oxygen extender tubing was dated 3/10/24 and R145's clear oxygen tubing did not contain a date. 2. From 5/6/24 to 5/8/24, Surveyor reviewed R156's medical record. R156 was admitted to the facility on [DATE] and had diagnoses including heart failure, chronic obstructive pulmonary disease, dependence on supplemental oxygen, and chronic respiratory failure with hypoxia. R156's MDS assessment, dated 4/26/24, contained a BIMS score of 13 out of 15 which indicated R156 had intact cognition. R156 had an order to change R156's oxygen tubing every Friday NOC. R156's medical record and did not contain an order or care plan intervention to clean R156's CPAP equipment. On 5/6/24 at 10:35 AM, Surveyor interviewed R156 who indicated R156's CPAP equipment was not cleaned since R156 was admitted to the facility. R156 stated R156 cleaned R156's CPAP equipment weekly at home. R156 stated R156 noticed the CPAP reservoir was cloudy approximately two to three nights ago. Surveyor did not observe cloudiness in the reservoir. R156 also indicated R156's oxygen tubing was not changed since admission. Surveyor noted R156's oxygen tubing did not indicate when it was last changed. R156 received 1 LPM of oxygen via nasal cannula. On 5/8/24 at 10:27 AM, Surveyor interviewed LPN-E and LPN-F who verified R156's oxygen tubing was not dated. LPN-E indicated R156's oxygen tubing would have been changed if R156 notified staff that the tubing was not changed for three weeks. On 5/8/24 at 10:29 AM, LPN-E stated R156's medical record contained an order for CPAP cleaning, however, the order was placed on 5/6/24 and revised on 5/7/24. LPN-E indicated a CPAP cleaning order should have been entered and care planned upon admission. On 5/8/24 at 10:31 AM, Surveyor interviewed LPN-F who verified R156's TAR and care plan did not contain an order to change/clean R156's oxygen tubing. LPN-F indicated the order should have been entered upon admission. On 5/8/24 at 11:00 AM, Surveyor interviewed Director of Nursing (DON)-B who verified R145 and R156's medical records did not contain orders for CPAP or oxygen tubing cleaning/changes. DON-B indicated R156's medical record contained an order to rinse R156's CPAP equipment weekly, however, the order was entered on 5/6/24 and revised on 5/7/24. DON-B indicated scheduled cleanings should have been care planned upon admission. DON-B stated residents' oxygen tubing/extenders should be labeled with the date they were last changed. DON-B also indicated CPAP equipment should be cleaned weekly and oxygen tubing should be changed weekly.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on staff interview and record review, the facility did not ensure ongoing communication and collaboration with the dialysis center for 1 resident (R) (R17) of 2 resident reviewed for dialysis services. R17 received peritoneal dialysis daily at the facility and had an order for daily weights. R17's daily weight was not obtained on 8 out of 38 days. In addition, R17's physician orders were not clarified and the physician was not notified of weight increases above the specified parameters. Findings include: The facility's Peritoneal Dialysis policy dated March 2023, indicates: .15. Before, during and after receiving peritoneal dialysis, facility staff must, based on the physician's orders and professional standards of practice, do the following: a. Obtain vital signs, weights, assess the resident's stability, level of consciousness, and comfort or distress; b. Monitor for post-dialysis complications and symptoms such as, but not limited to dizziness, nausea, fatigue, or hypotension; . On 5/8/24, Surveyor reviewed R17's medical record. R17 was admitted to the facility on [DATE] with diagnoses including end-stage renal disease (ESRD) requiring daily peritoneal dialysis, diabetes mellitus, obesity, and congestive heart failure. R17's Quarterly Minimum Data Set (MDS) assessment, dated 4/12/24, contained a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R17 had intact cognition. R17 had an order from Dialysis Medical Doctor (DMD)-N, dated 10/13/23, to call the dialysis center or on-call dialysis nurse if R17's blood pressure is less than 90 and symptomatic (lightheaded, dizziness) or greater than 190 and symptomatic (headache, blurred vision, nausea/vomiting), pulse rate is less than 50 or greater than 110, temperature is greater than 100 degrees, dry weight is greater than 89 kg (kilograms), or weight is 5 pounds less than or greater than dry weight. R17 had an order from MD-O, dated 2/11/24, for daily weights and to obtain a dry weight after discontinuing dialysis (ESD 89 kg). The order indicated to call the clinic if R17's weight is more than 5 pounds below or above the estimated dry weight (EDW). Surveyor reviewed R17's weight documentation and noted R17's weight wasn't obtained on 8 (5/6/24, 5/4/24, 4/30/24, 4/27/24, 4/22/24, 4/14/24, 4/8/24, and 4/1/24) of 38 days. Surveyor reviewed R17's weight parameters as prescribed above and noted R17's dry weight was based on 89 kg which equaled 195.8 lbs. Surveyor noted R17's weights measured between 200 and 213.5 pounds between 3/31/24 and 5/7/24. R17's medical record did not indicate the physician or dialysis center was notified that R17's weight was above the specified parameters. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note written by Registered Dietitian (RD)-P, dated 4/12/24, indicated: R17's weight was 213.5 pounds on 4/12/24 and body mass index (BMI) was 33.9 (obesity). R17 had a significant weight change in 30 and 90 days: 3/12/24: 197 pounds (gain of 16.5 pounds, 8.4%); 1/12/24: 184.5 pounds (gain of 29 pounds, 15.7%). 10/11/23: 196 pounds (gain of 17.5 pounds, 8.9%) not significant. R17's Ideal body weight (IBW) was 132.5 pounds +/- 10%. On 5/8/24 at 12:01 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R17 can connect and disconnect R17's peritoneal dialysis bags every morning and night. DON- B stated staff empty the bags and record the numbers from the peritoneal machine daily and send them to the dialysis clinic weekly. DON-B indicated R17 is weighed daily and that determines the bags and dialysis settings used for the day. When Surveyor asked about R17's missing weights and weight gains, DON-B found a message to a Nurse Practitioner (NP) regarding a 4.5 pound weight gain. DON-B indicated there was no other documented communication to the dialysis clinic. On 5/8/24 at 1:35 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who indicated nurses are trained in peritoneal dialysis and obtain daily weights. LPN-E stated sometimes R17 likes to stay in bed until lunch and will let staff know when R17 is ready. LPN-E indicated weights are written on a renal document. If the unit flow is over, staff contact the dialysis clinic. LPN-E stated the nurses were not sure what EDW meant and just discussed it. LPN-E stated LPN-E did not know the facility's dietitian and had no communication regarding weight gain. LPN-E indicated staff might have forgotten to document R17's missing weights. LPN-E indicated R17 wakes up late, weighs R17's self, and may forget to communicate R17's weight to staff. LPN-E verified R17's weight is required to determine the dialysis machine settings each night. On 5/8/24 at 2:06 PM, Surveyor interviewed DON-B who verified R17 had missing weights. DON-B stated DON-B will work on improving the dialysis program and obtain clarification on the MD order to use the EDW for daily weights. DON-B indicated DON-B called the dialysis clinic and confirmed there was no documented communication regarding R17's increased weight. The dialysis clinic recommended the facility develop a log to be kept by R17's dialysis machine so R17 can document R17's daily weights.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47248 Based on staff interview and record review, the facility did not ensure a physician order was transcribed for 1 resident (R) (R4) of 5 sampled residents. R4's hospital discharge paperwork, dated 4/4/24, contained an order for emergency administration of diazepam (an anxiolytic and sedative medication) during a seizure lasting longer than three minutes. The order was not transcribed in R4's medical record. Findings include: The facility's Physician Orders policy, with a revision date of March 2020, indicates: Physician orders are obtained to provide clear direction regarding the care of the resident .Orders given by a physician or state permitted health care professional must be accepted by a licensed nurse and documented in the resident's medical record .Transcribing a written/faxed order .Once the order is verified, the receiving licensed nurse documents the word noted next to the written order along with his or her signature with title and date .after noting an order, the receiving licensed nurse enters the order into the electronic medical record and ensures it is active in the electronic administration record . On 5/6/24, Surveyor reviewed R4's medical record. R4 had an activated Power of Attorney for Healthcare (POAHC) and diagnoses including quadriplegia and generalized idiopathic epilepsy and epileptic syndromes. R4's Minimum Data Set (MDS) assessment, dated 4/14/24, indicated R4 had a Brief Interview for Mental Status (BIMS) score of 0 out of 10 which indicated R4 had severe cognitive impairment. R4's medical record indicated R4 had a seizure lasting longer than three minutes on 3/31/24. R4 was sent to the emergency room (ER) and admitted due to an infection. R4's hospital discharge paperwork, dated 4/4/24, contained an order for diazepam 20 mg (milligram) rectal gel suppository to insert rectally as needed for seizures lasting longer than three minutes. The pharmacy delivered the order on 4/4/24 which was signed by nursing staff. The diazepam order was not transcribed in R4's medical record and was not contained on R4's medication administration record (MAR) or treatment administration record (TAR). On 5/6/24 at 1:25 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R4 had an order for diazepam and confirmed the medication was delivered by the pharmacy. When Surveyor asked if the diazepam order was transcribed, DON-B reviewed R4's medical record and confirmed the order was not transcribed in R4's medical record which meant if R4 had a seizure lasting longer than three minutes, the medication would not be administered.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure medication regimens were reviewed monthly and pharmacy recommendations were reviewed and acted upon by a physician for 1 resident (R) (R32) of 5 sampled residents. A monthly medication regimen review (MRR) was not completed for R32 in September 2023, October 2023, November 2023, December 2023, January 2024, and March 2024. In addition, pharmacy recommendations for April 2024 were not acted upon or reviewed by R32's physician. Findings include: From 5/6/24 to 5/8/24, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] with diagnoses including neoplasm of uncertain behavior of brain, moderate persistent asthma with (acute) exacerbation, acute respiratory failure with hypoxia, and acute on chronic diastolic (congestive) heart failure. R32's Minimum Data Set (MDS) assessment, dated 4/7/24, contained a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R32 had intact cognition. R32 had an activated Power of Attorney for Healthcare (POAHC). Surveyor reviewed R32's medications and noted on 4/11/24, R32 was prescribed 100 mg (milligrams) of doxycycline hyclate (an antibiotic) two times daily for three months for hidradenitis suppurativa (a condition that causes small, painful lumps to form under the skin). On 4/12/24, the order was changed to 100 mg doxycycline monohydrate two times daily for eighty eight days. A Pharmacy Consultant Report, dated 4/14/24, indicated R32 was prescribed doxycycline and Milk of Magnesia which may impact absorption and effectiveness. The pharmacy recommended the facility obtain an order to administer doxycycline at least two hours before or after Milk of Magnesia with plenty of water. It was also recommended that R32 remain upright for at least 10 minutes after doxycycline administration. On 5/8/24, the facility provided Surveyor an updated Pharmacy Consultation Report from 4/14/24 signed by Director of Nursing (DON)-B on 5/8/24. On the report, DON-B indicated R4 did not use Milk of Magnesia in the last 90 days and it would be discontinued. The report also indicated the additional recommendation would be added to R32's doxycycline order. On 5/8/24 at 1:40 PM, Surveyor interviewed DON-B who confirmed the only documentation for R32's monthly pharmacy MRR was the 4/14/24 recommendation report and a Consultation Report, dated 2/12/24-2/13/24, that listed residents, including R32, who were reviewed with no recommendations for February 2024. DON-B verified R32's 4/14/24 pharmacy recommendations were not acted on until 5/8/24 and did not provide evidence that the recommendations were reviewed by R32's physician.

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Meadowbrook at Appleton	1335 S Oneida St Appleton, WI 54915

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 48794 Based on staff interview and record review, the facility did not ensure the individual designated as the food and nutritional services director met the minimum qualifications for the role. This had the potential to affect 47 of 48 residents residing in the facility. Dietary Manager (DM)-G did not complete an approved dietary manager or food service manager certification course or other related education. Findings include: On 5/6/24 at 8:40 AM, Surveyor interviewed DM-G who stated DM-G was hired as a Dietary Aide 3 years ago and was promoted to Dietary Manager a little over a month ago. DM-G did not indicate DM-G had any prior experience or training. DM-G stated DM-G was working with Nursing Home Administrator (NHA)-A and Regional Dietitian (RD)-P to get certified but was not enrolled and had not started a certification program. DM-G stated RD-P was in the building monthly and was available via email or phone. On 5/6/24 at 3:05 PM, Surveyor interviewed NHA-A who stated NHA-A was aware DM-G was not certified or enrolled in a certified training program. NHA-A stated RD-P and NHA-A have been working to get training set up for DM-G. On 5/7/24 at 1:38 PM, Surveyor conducted a follow-up interview with DM-G who stated DM-G spoke with RD-P and NHA-A and was enrolled in training to be a certified Dietary Manager as of 5/6/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48794 Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect 47 of 48 residents residing in the facility. Staff did not monitor or document food cooling temperatures. The handwashing sink did not reach the required minimum temperature for proper hand hygiene. A can opener was not properly cleaned. Staff left visibly soiled oven mitts on top of condiment containers. Chemicals used for cleaning were stored by food containers and near food preparation areas. On two occasions, three resident room trays were delivered to the floor uncovered and on top of the food cart. Staff did not test or document parts per million (PPM) of the quaternary sanitizing solution per manufacturer's instructions. Seven food items were not dated when opened, not discarded when beyond the use-by/expiration date, and/or not stored appropriately. Findings include: The facility's Storage, Prepare, Distribute and Serve Food policy, dated April 2020, indicates the facility follows the Federal Food and Drug Administration (FDA) Food Code. 1. Cooling Temperatures The FDA Food Code 2022 documents at 3-501.14 Cooling: (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 Celsius (C) (135 Fahrenheit (F)) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. (B) Time/temperature control for safety food shall be cooled within 4 hours to 5 C (41 F) or less. The FDA Food Code 2022 documents at section 3-501.15 Cooling Methods: (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of food being cooled: (1) Placing the food in shallow pans; (2) Separating the food into smaller or thinner portions; (3) Using rapid cooling equipment; (4) Stirring the food in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/6/24 at 12:45 PM, Surveyor interviewed Dietary Aide (DA)-S who stated leftover food is placed in the refrigerator. DA-S was unsure how leftover food is cooled. On 5/7/24 at 1:38 PM, Surveyor interviewed Dietary Manager (DM)-G who stated staff place leftover food in smaller containers on the counter and put the containers in the cooler when the contents reach the appropriate temperature. DM-G confirmed the facility does not have a process to monitor cooling. 2. Handwashing Sink The FDA Food Code 2022 documents at section 5-202.12 Handwashing Sink, Installation (A): A handwashing sink shall be equipped to provide water at a temperature of at least 29.4 degrees C (85 degrees F) through a mixing valve or combination faucet. On 5/6/24 at 8:40 AM, Surveyor entered the kitchen for an initial tour. Upon entering the kitchen, Surveyor used the handwashing sink and noted the water was cool/room temperature after 20 seconds. On 5/6/24 at 11:33 AM, Surveyor again used the handwashing sink for 20 seconds and noted the water did not rise above room temperature. A sign posted near the sink indicated the water should reach at least 100 degrees for appropriate hand hygiene. On 5/7/24 at 1:38 PM, Surveyor interviewed DM-G who checked the water temperature in the handwashing sink. A thermometer indicated a temperature of 77 degrees after the hot water ran for 25 seconds. DM-G agreed the water temperature did not reach the recommended temperature. 3. Can Opener The FDA Food Code 2022 documents at 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. During an initial tour of the kitchen on 5/6/24 at 8:40 AM, Surveyor observed a can opener that contained dried debris and food residue on the blade. On 5/7/24 at 1:38 PM, Surveyor interviewed DM-G who indicated the can opener was wiped down and cleaned monthly by staff. DM-G verified the blade of the can opener contained debris and acknowledged it could contribute to cross contamination. 4. Soiled Oven Mitts The FDA Food Code documents at 4-803.11 Storage of Soiled Linens: Soiled linens shall be kept in clean, nonabsorbent receptacles or clean, washable laundry bags and stored and transported to prevent contamination of food, clean equipment, clean utensils, and single-service and single-use articles. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the initial kitchen tour and follow up visits to the kitchen on 5/6/24 and 5/7/24, Surveyor observed two oven mitts on top of condiment containers next to the ovens. The mitts were discolored and stained and contained what appeared to be food debris. Surveyor observed DA-S and DM-G use the mitts on several occasions to touch surfaces, including oven doors, pots, and pans, and then place the mitts on top of the condiment containers. On 5/7/24 at 1:38 PM, Surveyor interviewed DM-G who removed the oven mitts and acknowledged placing soiled oven mitts on top of food containers could lead to cross contamination. 5. Chemical Storage The facility's Chemical Use and Storage policy, dated April 2020, indicates consideration is given to the proper handling and storage of chemicals to minimize the risk of food contamination and injury .Chemicals are stored in a dry area away from food storage and preparation areas, food contact surfaces, and other chemicals that react with them. During an initial kitchen tour on 5/6/24 at 8:40 AM, Surveyor observed several cleaning chemicals and wire brushes stored on the bottom shelf of a rolling cart next to the ovens. The shelf contained wire cleaning brushes with dirt-like debris and products including a stainless steel cleaner, ZymeWorx (a bienzymatic floor cleaner), CitraWorx (an all-purpose cleaner), bleach, and [NAME] Gone (an adhesive remover). On 5/7/24 at 1:38 PM, Surveyor interviewed DM-G who showed Surveyor the chemical storage and cleaning supply closet. DM-G stated chemicals are usually stored in the closet, but more frequently used chemicals are kept on the cart for ease of use. DM-G acknowledged chemicals should be stored in the cleaning closet for safety. 6. Uncovered Transported Food The facility's Storage, Prepare, Distribute and Serve Food policy, dated April 2020, indicates it is the policy of the facility that all food/beverages must be covered when leaving the kitchen. On 5/6/24 at 11:33 AM, Surveyor observed room tray service and noted three trays on top of a room tray cart contained bowls of watermelon and strawberries that left the kitchen uncovered and were transported to residents' rooms. On 5/7/24 at 11:08 AM, Surveyor observed room tray service and noted two trays on top of a room tray cart had plates of cake that left the kitchen uncovered and were transported to residents' rooms. On 5/7/24 at 1:38 PM, Surveyor interviewed DM-G who acknowledged food items should be covered when they leave the kitchen. 7. Quaternary Sanitizing Solution (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	TMA Quaternary Sanitizer directions for use indicate: Allow sanitized surfaces to adequately drain and air dry before contact with food, so that little or no residue remains. Do not rinse. For articles too large for immersing, apply a solution of 1-2.67 ounces per 4 gallons of water (150-400 ppm active) to sanitize hard, non-porous food contact surfaces with a brush, cloth, mop, sponge, auto scrubber, mechanical spray device, hand pump, coarse pump or trigger spray device. For spray applications, spray 6-8 inches from the surface . Surfaces must remain wet for at least 5 minutes. Allow sanitized surfaces to adequately drain and then air dry before contact with food, so that little or no residue remains. Do not rinse. Prepare a fresh solution daily or when visibly dirty. For mechanical application, used solution must not be reused for sanitizing applications but may be used for other purposes such as cleaning. During an initial kitchen tour on 5/6/24 at 8:40 AM, Surveyor interviewed DM-G who stated the facility does not have a process to ensure proper chemical sanitization is monitored for the 3-compartment sink and the sanitizing buckets. DM-G stated the facility does not use test strips to test ppm of the sanitizing solution. On 5/6/24 at 12:25 PM, Surveyor observed DA-T fill a sanitizing bucket. DA-T did not test the ppm of the sanitizing solution. Surveyor interviewed DA-T who stated DA-T did not receive education or training on chemical sanitization. DA-T stated DA-T fills sanitizing buckets with chemicals and water in a ratio that DA-T feels is appropriate. 8. Food Labeling/Storage The FDA Food Code 2022 documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: (A) Except when packaging food using a reduced oxygen packaging method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, ready-to-eat, time/temperature control for food safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as day 1. The FDA Food Code 2022 documents at 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition (A): A food specified in 3-501.17 (A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17 (A), except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17 (A). During an initial kitchen tour on 5/6/24 at 8:40 AM, Surveyor and DM-G observed the following: -Three unlabeled, undated bulk packages of Cheerios -Banana cake dated 5/2/24 with a discard date of 5/5/24 -An open gallon of milk with an expiration date of 4/29/24. -An open and undated Thick n' Easy Apple Juice with label instructions to discard within 10 days of opening. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An open Thick n' Easy thickened lemon water, dated 3/28/24, with label instructions to discard within 10 days of opening. -An open Thick n' Easy Apple Juice, dated 3/15/24, with label instructions to discard within 10 days of opening. -Lemon juice on a shelf above the stove, dated 5/4 (and observed again on 5/7) with label instructions to refrigerate after opening. DM-G immediately discarded the items.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50467 Based on observation, staff interview, and record review, the facility did not ensure 2 residents (R) (R15 and R4) of 2 residents were provided services to help prevent the transmission of infection. R15 had an order for droplet precautions pending further testing related to respiratory concerns. On 5/8/24, Surveyor observed Certified Nursing Assistant (CNA)-I assist R15's roommate (R4) with a room tray. CNA-I did not wear personal protective equipment (PPE) in the room. During an observation of wound care on 5/8/24, Registered Nurse (RN)-H reached beneath RN-H's gown to obtain a flashlight and scissors from RN-H's pocket. Without disinfecting the scissors, RN-H used the scissors to cut a dressing used to pack R4's wound. Findings include: The Centers for Disease Control and Prevention (CDC) guideline for PPE indicate: PPE, e.g., gloves, gowns, face masks, respirators, goggles and face shields, can be effective barriers to transmission of infections . The CDC guidelines at https://www.cdc.gov/infectioncontrol/guidelines indicate: Maintain separation between clean and soiled equipment to prevent cross contamination. Remove PPE before entering any non-clinical areas including restrooms, breakrooms, and administrative areas. PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted during patient care. The facility's Dressing Changes policy, with a revision date of March 2020, indicates: To prevent wound contamination and promote healing . 1. On 5/8/24, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] with a primary diagnosis of progressive neurological conditions. R15's Quarterly Minimum Data Set (MDS) assessment, dated 3/2/24, indicated R15 was rarely/never understood. R15 had a legal guardian. R15 had orders, dated 5/7/24, for isolation/droplet precautions, a chest X-ray, a viral panel if negative COVID-19 rapid test, and vital signs every shift for 3 days. On 5/8/24 at 8:15 AM, Surveyor observed CNA-I in R15 and R4's room. CNA-I sat between R15 and R4 and assisted R4 with breakfast. Surveyor observed an isolation cart outside the door and a droplet precautions sign that was not there on 5/7/24. From the doorway, Surveyor asked which resident was on precautions. CNA-I stated, No one. When Surveyor asked if PPE was required due to the PPE cart and sign outside the door, CNA-I replied, I am new, not sure. On 5/8/24 at 8:19 AM, Surveyor asked staff in the hallway about the PPE cart and droplet precautions sign outside R15 and R4's door. A CNA stated they learned in shift report that R15 was on isolation because R15 was tested for respiratory concerns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 at 8:44 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-J regarding R15's precautions. LPN-J stated R4 was on precautions for chronic wounds, but R15 was not on precautions. LPN-J confirmed R15 was tested for respiratory concerns which included a viral respiratory panel and a chest X-ray and stated R15 had a negative rapid COVID-19 swab. When Surveyor asked about the policy for suspected respiratory concerns, LPN-J stated, You should wear mask and gloves and can gown as well. When Surveyor asked specifically about droplet precautions, LPN-J confirmed a gown, mask, and gloves should be worn when entering R15's room. On 5/8/24 at 8:50 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated R4 was on enhanced barrier precautions (EBP) related to R4's wound and stated R15 had a feeding tube. When Surveyor asked DON-B about the PPE cart and droplet precautions sign outside R15 and R4's room, DON-B indicated R15 was not coughing so there was no need for droplet precautions. On 5/8/24 at 10:08 AM, Surveyor interviewed DON-B regarding R15's physician-ordered droplet precautions as of 5/7/24 to which DON-B stated, Not aware of that. 2. From 5/7/24 to 5/8/24, Surveyor reviewed R4's medical record. R4 was readmitted to the facility on [DATE] following a hospitalization . R4 had diagnoses including pressure ulcer of sacral region stage 4, quadriplegia unspecified, unspecified severe protein-calorie malnutrition, and osteomyelitis (bone infection) unspecified sites. R4's Quarterly Minimum Data Set (MDS) assessment, dated 4/14/24, stated R4's Brief Interview for Mental Status (BIMS) assessment indicated R4 was rarely/never understood. R4 had a legal guardian. On 5/8/24 11:13 AM, Surveyor observed RN-H complete wound care for R4 with CNA-K's assistance. During the observation, Surveyor observed RN-H reach beneath RN-H's gown twice to retrieve a flashlight and scissors from RN-H's pocket. Surveyor noted RN-H did not disinfect the scissors prior to cutting a Hydrofera dressing that was placed inside R4's wound. After wound care was completed, CNA-K removed PPE except for CNA-K's face mask which CNA-K wore down the hallway and into another resident's room. RN-H removed PPE except RN-H's face mask on the far side of R4's room and walked across and out of the room. RN-H did not remove RN-H's face mask and replace it with a clean mask. On 5/8/24 at 11:30 AM Surveyor interviewed RN-H who indicated RN-H disinfected the scissors prior to placing them in RN-H's pocket. When Surveyor indicated the scissors were in contact with RN-H's pocket and should be disinfected prior to use, RN-H indicated RN-H could not find R4's scissors in the treatment bag during wound care which is why RN-H used RN-H's personal scissors.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 49563 Based on staff interview and record review, the facility did not ensure a staff person designated as the Infection Preventionist (IP) completed specialized training in infection prevention and control. This practice had the potential to affect all 48 residents residing in the facility. Director of Nursing (DON)-B was the facility's designated IP. DON-B did not complete specialized training for infection prevention and control. Findings include: On 5/7/24 at 1:20 PM, Surveyor interviewed DON-B who was the facility's designated IP. When Surveyor asked if DON-B completed specialized infection prevention and control training as required by the Centers for Medicare & Medicaid Services (CMS), DON-B stated DON-B completed the Centers for Disease Control and Prevention (CDC) training modules but did not pass the certification test and could not retake the test until 2025. DON-B stated the facility hired an Assistant Director of Nursing (ADON) who would eventually become the IP, however, the ADON had not started the position yet. On 5/13/24 at 1:28 PM, Regional Consultant (RC)-M provided an email from DON-B, dated 5/13/24 at 1:15 PM, that indicated DON-B completed the CDC training modules and received a certificate for each module after completion but did not pass the final exam. DON-B stated DON-B did not realize there was a timeframe (30 days) to complete a second attempt and missed the deadline. DON-B stated DON-B was informed DON-B could not attempt to take the final test again until 2025.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on staff interview and record review, the facility did not ensure influenza B and pneumococcal vaccinations were reviewed, offered, and administered for 3 residents (R) (R8, R2, and R4) of 5 sampled residents. The facility did not review R8's vaccination history or offer R8 the PCV20 (Prevnar 20(R)) and influenza B vaccines. The facility did not review R2's vaccination history or offer R2 the Prevnar 20(R) and influenza B vaccines. The facility did not review R4's vaccination history or offer R4 the Prevnar 20(R) vaccine. Findings include: Abbreviations (www.cdc.gov): PCV13: 13-valent pneumococcal conjugate vaccine (Prevnar13(R)) PCV20: 20-valent pneumococcal conjugate vaccine (Prevnar 20(R)) PPSV23: 23-valent pneumococcal polysaccharide vaccine (Pneumovax23(R)) The most recent Centers for Disease Control and Prevention (CDC) recommendations for pneumococcal vaccinations indicate: For adults [AGE] years or older who have only received PPSV23, the CDC recommends: Give 1 dose of PCV15 or PCV20. The PCV20 dose should be administered at least 1 year after the most recent PPSV23 vaccination. Regardless of if PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For those who have received PCV13 and 1 dose of PPSV23, the CDC recommends you give 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine. For adults [AGE] years or older who have received PCV13, give 1 dose of PCV20 or PPSV23 at least 1 year after PCV13. Regardless of vaccine used, their vaccines are then complete. The facility's Pneumococcal Vaccine policy, dated September 2022, indicates: .1. All residents of our facility should receive the pneumococcal vaccine if they are [AGE] years of age or older; or younger than [AGE] years with underlying conditions that are associated with increased susceptibility to infection or increased risk for serious disease and its complications .3. Residents, staff, and volunteers may refuse vaccination. Vaccination refusal and reasons why (e.g., allergic, contraindicated, did not want vaccine, etc.) should be documented by the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525264	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook at Appleton	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)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Seasonal Influenza Vaccine policy, dated September of 2022, indicates: The CDC guidelines and recommendations are followed for the prevention and control of seasonal influenza. Influenza is a vaccine-preventable disease and high-risk target groups for vaccination include residents of nursing facilities . as well as those persons who can transmit influenza to those at high risk .2. Influenza vaccines shall be offered to all residents of the facility unless medically contraindicated. 3. The current CDC Influenza Vaccine Information Statement will be provided to the resident and/or legal representative to educate on the benefits and risks of receiving the influenza B vaccine. 1. R8 was admitted to the facility on [DATE]. R8 received a PPSV23 vaccine on 7/14/10. R8's medical record did not indicate R8 was offered or administered the PCV20 or influenza B vaccines. 2. R2 was admitted to the facility on [DATE]. R2 received a PPSV23 vaccine on 10/20/14 and refused a vaccine on 10/29/22. R2's medical record did not indicate R2 was offered or administered the PCV20 or influenza B vaccines. 3. R4 was admitted to the facility on [DATE]. R4 received a PPSV23 vaccine on 10/8/07 and a PCV13 vaccine on 11/25/15. R4's medical record did not indicate R4 was offered or administered the PCV20 vaccine. On 5/7/24 at 1:45 PM, Director of Nursing (DON)-B indicated the facility was not up to date with influenza B and pneumococcal vaccinations. DON-B indicated the facility was implementing their policies and will review vaccines annually. On 5/8/24 at 8:10 AM, Regional Consultant (RC)-M provided vaccination documents and indicated that facility did not have the required documents for R8, R2, and R4. RC-M stated the facility started a Process Improvement Plan (PIP) for resident vaccines and provided a copy to Surveyor which indicated: Opportunity for improvement you have identified: resident vaccines not up to date, missing consents/declinations/education for past vaccines, resident vaccine binder missing .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on staff interview and record review, the facility did not ensure medical records contained documentation related to COVID-19 immunization for 3 residents (R) (R19, R2, and R7) of 5 sampled residents. In addition, the facility did not implement a COVID-19 immunization program for staff. R19, R2, and R7's medical records did not include documentation that indicated the facility offered or administered COVID-19 immunizations. The facility did not have proof of a COVID-19 immunization program for staff. Findings include: The facility's COVID-19 Vaccination policy, effective January 2024, indicates: It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine .COVID-19 vaccinations will be offered to residents when supplies are available, as per Centers for Disease Control and Prevention (CDC) and/or Food and Drug Administration (FDA) guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine .15. The facility will educate and offer the COVID-19 vaccine to residents, resident representatives, and staff and maintain documentation of such. 16. The facility will maintain documentation related to staff COVID-19 vaccination and include at a minimum: a. Education to the staff regarding the risks, benefits, and potential side effects of the COVID-19 vaccine; b. The offering of the COVID-19 vaccine or information on obtaining the COVID-19 vaccine; c. The COVID-19 vaccination status of staff and related information as indicated by the NHSN (National Healthcare Safety Network.) . 1. R19 was admitted to the facility on [DATE]. R19's medical record did not indicate R19 was offered, declined, or administered a COVID-19 vaccine. 2. R2 was admitted to the facility on [DATE]. R2's medical record did not indicate R2 was offered, declined, or administered a COVID-19 vaccine. 3. R7 was admitted to the facility on [DATE]. R7's medical record did not indicate R7 was offered, declined, or administered a COVID-19 vaccine. On 5/7/24 at 8:36 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who indicated the facility did not provide staff information on COVID-19 or offered COVID-19 immunizations for staff. On 5/7/24 at 1:45 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated COVID-19 vaccine training for staff and residents was not in place yet. DON-B indicated the facility's policies will be reviewed annually moving forward. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 at 8:10 AM, Regional Consultant (RC)-M provided Surveyor with vaccination documents that indicated the facility did not have the required documents for R19, R2, and R7. RC-M indicated the facility started a Process Improvement Plan (PIP) for resident vaccines and provided Surveyor a copy which indicated: Opportunity for improvement you have identified: resident vaccines not up to date, missing consents/declinations/education for past vaccines, resident vaccine binder missing .