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	07/23/2025

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 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. 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 all 46 residents residing in the facility.The facility did not monitor and document food cooling temperatures.Staff did not test the Quaternary sanitizing solution (used to sanitize food preparation surfaces) per manufacturer's instructions. In addition, the facility did not monitor the Quaternary sanitizing solution for proper water temperature and parts per million (PPM). Findings include:Food Cooling:The 2022 Food and Drug Administration (FDA) Food Code documents at 3ˆ501.14 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 2022 FDA Food Code documents at section 3ˆ501.15 Cooling Methods: (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3ˆ501.14 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.During an initial kitchen tour that began at 8:17 AM on 7/21/25, Surveyor observed the following cooked items/leftovers in the reach- in cooler:~ A steam table container labeled Cheesy eggs and ham dated 7/21/25~ A steam table container labeled Puree sausage dated 7/20/25~ A steam table container labeled Puree eggs dated 7/20/25~ A container labeled Oatmeal dated 7/20/25~ A steam table container labeled Burgers/Hot dogs dated 7/19/25Surveyor did not observe a food cooling log for the pre-cooked and cooled foods. On 7/22/25 at 12:10 PM, Surveyor interviewed Dietary Manager (DM)-D who indicated the food cooling log was in a binder. DM-D went to retrieve the documentation and indicated there were no cooling logs for the foods in the reach-in cooler. DM-D indicated the cheesy and pureed eggs were no longer in the cooler and were consumed by residents that morning. DM-D indicated staff should cool foods properly and document per policy and regulation. DM-D also confirmed the foods observed in the cooler were not documented as properly cooled using a food safety cooling method.Quaternary Sanitizer:During an initial kitchen tour that began at 8:17 AM on 7/21/25, Surveyor noted the three-compartment sink contained a sanitizer bucket. Surveyor observed a sanitizer log next to the three-compartment sink and noted the log did not contain documented PPM but contained white or multi-colored Hydrion Quaternary sanitizer strips. Tthe log contained a column for the water temperature but did not contain documentation of water temperatures.Surveyor observed a poster above the three-compartment sink that indicated the following: QUAT Hydrion 65-75 degree water temperature with PPM at 150-400. On 7/22/25 at 12:10 PM, Surveyor interviewed DM-D who indicated the three-compartment sink is used to fill buckets for sanitizing kitchen prep areas. DM-D confirmed staff taped Hydrion Quaternary sanitizer test strips to the log and verified staff do not document PPM of the sanitizing solution. DM-D confirmed the test strips change colors and when adhered to the log no longer display the same color. DM-D confirmed the strips do not accurately record the PPM. DM-D (continued on next page)

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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	also confirmed the log contains a column to document the water temperature of the sanitizing solution and verified staff do not test the water temperature of the sanitizing buckets prior to testing the PPM as required.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and staff and resident interview, the facility did not ensure food was served at a safe and appetizing temperature for 5 residents (R) (R5, R6, R8, R12, and R30) of 16 sampled residents.During interviews on 7/21/25 and 7/22/25, R5, R6, R8, R12 and R30 indicated their food was not appetizing and was served at a temperature they did not prefer. A test tray obtained during meal service on 7/22/25 indicated the food was not served at a palatable temperature.Findings include:1.On 7/21/25, Surveyor reviewed R5's medical record. R5 had diagnoses including chronic deep vein thromboses (DVTs) of bilateral lower extremities, chronic obstructive pulmonary disease (COPD), neuropathy, edema, and anxiety. R5's Minimum Data Set (MDS) assessment, dated 5/29/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 had intact cognition. R5 was R5's own decision maker.On 7/21/2025 at 1:16 PM, Surveyor interviewed R5 who indicated food is delivered cold at every meal. R5 indicated R5 does not ask staff to reheat the food because staff are too busy during meals.On 7/22/25 at 9:26 AM, Surveyor interviewed R5 who indicated breakfast was served cold. R5 indicated R5 did not ask staff to reheat the meal because staff are too busy to reheat food to a temperature that is palatable for R5. 2. On 7/21/25, Surveyor reviewed R6's medical record. R6 had diagnoses including dementia, end stage renal disease (dialysis), COPD, and depression. R6's MDS assessment, dated 6/3/25, had a BIMS score of 10 out of 15 which indicated R6 had moderate cognitive impairment. R6 had an activated decision maker for healthcare decisions.On 7/21/25 at 9:16 AM, Surveyor interviewed R6 who indicated food is delivered cold all the time. R6 also indicated R6 uses butter but the butter does not melt and stays solid. 3. On 7/21/25, Surveyor reviewed R8's medical record. R8 had diagnoses including type 2 diabetes mellitus, chronic kidney disease stage 3, anxiety, and depression. R8's MDS assessment, dated 5/5/25, had a BIMS score of 15 out of 15 which indicated R8 had intact cognition. R8 was R8's own decision maker.On 7/21/25 at 11:08 AM, Surveyor interviewed R8 who indicated the food is not really great and stated R8 chooses to eat in R8's room. R8 indicated R8's room trays contain cold and lukewarm food which is not appetizing. R8 indicated even when the food is lukewarm it is not at a good temperature. R8 indicated R8 receives a meal tray timely because R8 is one of the first ones served. R8 indicated despite receiving room trays on time, the food is not served at an appetizing temperature. On 7/21/25 at 12:11 PM, Surveyor observed R8 receive a lunch tray. Surveyor interviewed R8 who indicated the vegetables were cold and the burger was warm. R8 indicated R8 was not going to eat cold vegetables. On 7/22/25 at 7:45 AM, Surveyor interviewed R8 who indicated yesterday's dinner was warm but not hot or appetizing. R8 stated if the meal is not at a desired temperature, R8 does not ask staff to reheat the meal because staff are too busy. R8 stated R8 will just not eat the cold items.4. On 7/21/25 Surveyor reviewed R12's medical record. R12 had diagnoses including type 2 diabetes mellitus, cellulitis, and pressure injury stage 4. R12's MDS assessment, dated 5/16/25, had a BIMS score of 15 out of 15 which indicated R12 had intact cognition. R12 was R12's own decision maker.On 7/21/25, at 11:44 AM, Surveyor interviewed R12 who indicated the food is not always hot and does not taste good at times due to the temperature. 5. On 7/21/25, Surveyor reviewed R30's medical record. R30 had diagnoses including osteomyelitis, dysphagia, post traumatic stress disorder (PTSD), and sprain of ligaments of cervical spine. R30's MDS assessment, dated 6/3/25, had a BIMS score of 14 out of 15 which indicated R30 had intact cognition. R30 was R30's own decision maker.On 7/21/25, at 11:15 AM, Surveyor interviewed R30 who indicated food for all meals arrives cold. R30 confirmed R30 receives meal trays and eats in R30's room.During a continuous observation that began at 10:25 AM on 7/22/25, Surveyor observed lunch service at the kitchen steam table. Surveyor noted the first room tray cart was full and one room tray was on top of the cart. Surveyor continued to observe lunch service and noted room trays for a second meal cart were placed in the cart. Surveyor requested a test tray as the last tray was served. Surveyor noted the tray cart was full and R8's tray was transported on top of the cart. The test tray was placed next (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to R8's tray on top of the cart. The cart left the kitchen to begin delivery to residents at 11:51 AM and Surveyor and Dietary Manager (DM)-D followed the cart to the unit. At 12:03 PM (halfway through the delivery of meal trays), DM-D removed the test tray from the top of the cart and temped the food. Surveyor observed DM-D obtain the following temperatures of food served to residents for lunch:~ The roast beef was 124 degrees Fahrenheit (F); The peas were 127 degrees F; The mashed potatoes were 123 degrees F.DM-D indicated kitchen staff received complaints from residents regarding food temperatures. DM-D indicated the facility has two meal service carts and had a third cart at one time. DM-D did not know if the plate warmer worked correctly or if the warmer was plugged in during meal service.On 7/22/25 at 12:07 PM, DM-D and Surveyor went to the kitchen and noted the plate warmer was not plugged in. When staff plugged in the plate warmer, Surveyor noted the light did not ignite. DM-D indicated the plate warmer was fixed a while ago and might need to be replaced. DM-D indicated the steam table was recently replaced due to resident complaints about cold food and indicated there were recent food temperature concerns from residents.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure 3 residents (R) (R5, R7, and R6) of 16 sampled residents were given the right to participate in care planning.R5 was admitted to the facility in December of 2024. R5's medical record did not contain documentation of any care conferences.R7 was admitted to the facility in August of 2024. R7's medical record did not contain documentation of any care conferences.R6 was admitted to the facility in November of 2024. R6's medical record did not contain documentation of any care conferences.Findings include: The facility's Care Plan Conference policy, revised 2/2021, states the Interdisciplinary Team, in conjunction with the resident and/or the resident representative, will develop the plan of care based on the comprehensive assessment. The care plan conference is held to identify resident needs and establish obtainable goals .The facility must encourage residents and/or their representatives to participate in care planning including their attendance at the care planning conference. The facility must make efforts to schedule care planning meetings at the best time of day for residents and representatives .Document the care planning conference in the progress notes. Be sure to include at least the following information: summary of the meeting; list of attendees; and if the resident and/or their representative do not participate in the meeting, document the reason why 1.On 7/21/25, Surveyor reviewed R5's medical record. R5 was admitted to facility on 12/20/24. R5's medical record did not contain documentation of any care conferences. On 7/21/25 at 9:54 AM, Surveyor interviewed R5 who stated the facility does not communicate with R5 regarding discharge planning or R5's plan of care. R5 stated R5 has not had a care conference since R5 was admitted to the facility. On 7/23/25 at 11:28 AM, Surveyor interviewed Social Services Director (SSD)-M who stated R5 had a care conference upon admission, however, SSD-M was unable to find documentation of any care conferences. SSD-M indicated care conferences should be completed quarterly. 2. On 7/21/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE]. R7's medical record did not contain documentation of any care conferences. On 7/21/25 at 10:13 AM, Surveyor interviewed R7 who stated R7 had not had a care conference since R7 was admitted to the facility. On 7/23/25 at 11:28 AM, Surveyor interviewed SSD-M who stated R7 had a care conference upon admission, however, SSD-M was unable to find documentation of any care conferences. SSD-M indicated care conferences should be completed quarterly. 3. On 7/21/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE]. R6's medical record did not contain documentation of any care conferences. On 7/21/25 at 9:54 AM, Surveyor interviewed R6 who stated the facility does not communicate with R6 or R6’s Power of Attorney (POA). R6 indicated questions are asked about R6's treatment plan and discharge but no answers are received. R6 was not aware of any care conferences for R6. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/25 at 11:31 AM, Surveyor interviewed SSD-M who stated R6 had two care conferences, however, SSD-M was unable to find documentation of any care conferences. SSD-M indicated care conferences should be completed quarterly. On 7/23/25 at 1:17 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated care conferences should be completed on a quarterly basis.

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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** Based on staff and resident interview and record review, the facility did not ensure 1 resident (R) (R28) of 17 sampled residents was offered the opportunity to create or obtain Power of Attorney for Healthcare (POAHC) paperwork.R28 was admitted to the facility on [DATE]. The facility did not obtain R28's POAHC document or offer R28 the chance to fill out a new document prior to 7/21/25. 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 .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 7/21/25, Surveyor reviewed R28's medical record. R28 was admitted to the facility on [DATE]. R28's medical record did not contain POAHC documentation or a POAHC refusal document. On 7/21/25 at 10:15 AM, Surveyor interviewed R28 who stated R28's POAHC document was at home in a safe and R28's family had access to the document.On 7/21/25 at 1:50 PM, Surveyor interviewed Social Services Director (SSD)-M who stated R28 informed SSD-M that a copy of an advanced directive was in R28's safe at home and R28's family had access to the document. Surveyor reviewed a documented conversation with R28's family member that occurred on 5/12/25 and contained a request for a copy of the document. R28's medical record did not contain any further documented attempts to contact the family member to obtain R28's POAHC document. On 7/23/25 at 1:14 PM, Surveyor interviewed Director of Nursing (DON)-B who stated staff are expected to either obtain a copy of a resident's POAHC document or offer to create a new one.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and staff and resident interview, the facility did not provide a safe, clean, comfortable, and home-like environment for 1 resident (R) (R31) of 16 sampled residents.The facility did not ensure food debris, spills, dirt, and used medical supplies were removed from R31's floor or that R31's garbage was emptied in a timely manner. Findings include:On 7/21/25, Surveyor reviewed R31's medical record. R31 had diagnoses including pressure ulcer of sacral region stage 2, paraplegia, infection and inflammatory reaction due to indwelling urethral catheter, and pressure ulcer of right buttock stage 3. R31's Minimum Data Set (MDS) assessment, dated 6/26/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R31 had intact cognition. R31 was R31's own decision maker.On 7/21/25 at 9:15 AM, Surveyor observed R31 in bed. R31 expressed concerns with room cleanliness, specifically that the floor is dirty and the garbage is overflowing. R31 also indicated housekeeping was an issue. Surveyor observed clothing, linens, and various items stacked on R31's heating and cooling register. Surveyor noted R31's garbage was almost full and contained used personal protective equipment (PPE) and food. Surveyor also observed dirt, dust, food debris, a cotton swab used to clean wounds, and a lancet top on R31's floor. R31 indicated there is one housekeeper that does a good job but indicated no one had been in to clean R31's room or take out the garbage in a few days. R31 also indicated housekeeping does not clean on a regular basis. R31 stated R31 cannot physically do the tasks and relies on housekeeping to do them. On 7/21/25 at 1:09 PM, Surveyor observed R31 in bed and noted R31's floor was still dirty, the garbage was overflowing, and clothing, linens, and other items were still stacked on R31's heating and cooling register. Surveyor also noted the cotton swab and lancet top were still on the floor. R31 indicated no one cleaned R31's room or removed the garbage. R31 also indicated staff changed R31's socks earlier that morning and threw them on the floor next to the hamper. On 7/22/25 at 7:54 AM, Surveyor noted R31's room was in the same condition as the previous day. Surveyor observed an orange peel, a cotton swab, two lancet tops, dirt, and black debris on the floor and an overflowing garbage can that contained used PPE. R31 indicated no one cleaned R31's room, removed clothing and linens from the heating and cooling register, or took out the garbage. R31 indicated the housekeeper that does a good job would hopefully be in that day and clean R31's room. On 7/22/25 at 1:26 PM, Surveyor noted R31's room was still in the same condition as previously observed at 7:54 AM. Surveyor observed an orange peel, two lancet tops, dirt, and debris on R31's floor and an overflowing garbage can. Surveyor noted the cotton swab that was previously on the floor was in the garbage. R31 indicated R31 asked staff and was told someone would clean R31's room that day. On 7/22/25 at 1:28 PM, Surveyor interviewed Housekeeper (HSK)-F who indicated laundry and housekeeping staff do both jobs. HSK-F indicated one staff who usually works in laundry is on leave and HSK-F and another housekeeping staff were doing all of the housekeeping. HSK-F indicated there are usually two housekeepers per wing but currently there is only one per wing which is not enough. HSK-F indicated Maintenance Director (MD)-E is the laundry and housekeeping supervisor and is responsible for ensuring housekeeping and laundry tasks are completed per residents' requests and preferences. On 7/22/25 at 1:50 PM, Surveyor interviewed MD-E in R31's room. MD-E confirmed R31's floor contained dirt, debris, and black-colored stains and R31's garbage was overflowing. MD-E confirmed there were lancet tops on the floor and stacked laundry and linens on the the heating and cooling register. MD-E indicated resident rooms should be cleaned daily which includes removing the garbage and cleaning the floor. MD-E indicated one staff is on leave and the facility is attempting to hire. MD-E indicated one housekeeper comes in at 11:00 AM and only does floors. MD-E confirmed R31's room was not cleaned on 7/21/25 or 7/22/25.

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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** Based on staff interview and record review, the facility did not develop a comprehensive bowel and bladder care plan for 1 resident (R) (R7) of 16 sampled residents.R7 was admitted to the facility in August of 2024. Documentation indicated R7 was occasionally incontinent of bladder, typically during the night. R7's comprehensive care plan, updated on 5/16/25, did not include problems, goals, or interventions related to incontinence. Findings include: On 7/21/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including schizophrenia, dysphagia (difficulty swallowing), depression, and diabetes. R7's most recent Minimum Data Set (MDS) assessment, dated 5/16/25, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R7 had moderate cognitive impairment. The MDS assessment also indicated R7 was occasionally incontinent of bladder and did not have a toileting program. R7 was R7's own decision maker. On 7/21/25, Surveyor reviewed R7's Certified Nursing Assistant (CNA) charting related to urinary incontinence over the last 30 days and noted R7 was incontinent on 4 out of 73 occurrences, all during the night shift. On 7/21/25 at 1:12 PM, Surveyor interviewed CNA-J who stated R7 was continent at all times and independent with toileting. CNA-J was not aware R7 was occasionally incontinent during the night shift. On 7/21/25 at 1:22 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R7's comprehensive care plan did not include problems, goals, or interventions related to urinary incontinence. DON-B stated toileting/incontinence status should be included in a resident's comprehensive care plan.

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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** Based on observation, staff interview, and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 1 resident (R) (R25) of 4 sampled residents.R25 fell on 5/2/25. An intervention was added to R25's care plan to ensure R25's bed was in the lowest position. The intervention was not consistently followed. Findings include:The facility's Fall Management Policy, revised October 2024, indicates: .9. The Interdisciplinary Team designee will discuss recommended significant changes to the care plan to minimize repeat falls with the resident and/or resident's representative. The care plan will be reviewed and/or revised as indicated .Kardexes (abbreviated care plans used by nursing staff) are updated as appropriate .On 7/21/25, Surveyor reviewed R25's medical record. R25 was admitted to the facility on [DATE] and had diagnoses including sequalae following cerebrovascular disease, dysphagia, hemiplegia, and hemiparesis. R25's Minimum Data Set (MDS) assessment, dated 5/15/25, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R25 had severe cognitive impairment. R25 had an activated Power of Attorney for Healthcare (POAHC).A facility investigation indicated staff discovered R25 on the floor between R25's bed and window on 5/2/25 at 4:00 PM. R25 had a laceration on the top of the head and could not recall what R25 was attempting to do. The investigation indicated the fall occurred because R25 was exhibiting terminal restlessness. An intervention was added to have R25's bed in the lowest position. A care plan, initiated on 5/2/25, contained an intervention to ensure R25's bed was in the lowest position.On 7/22/25 at 7:44 AM, Surveyor observed R25 in bed and noted R25's bed was in the highest position.On 7/22/25 at 7:53 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-H who indicated R25 was not a fall risk and independently held the bed remote and adjusted the height of the bed. After reviewing R25's care plan, LPN-H verified R25's bed should be in the lowest position. LPN-H adjusted the height of R31's bed and removed the handheld control from R25. On 7/22/25 at 1:26 PM, Surveyor interviewed Director of Nursing (DON)-B who verified staff should follow a resident's care plan. On 7/22/25 at 2:23 PM, Surveyor observed R25 in bed and noted R25's bed was in a medium height position. On 7/22/25 at 2:23 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-I who verified R25's bed was not in the lowest position but should be. CNA-I then lowered R25's bed.

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	07/23/2025

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not provide the appropriate care and services for 2 residents (R) (R31 and R25) of 3 sampled residents with an indwelling catheter.R31 recently recovered from a urinary tract infection (UTI). On 7/21/25, R31's uncovered catheter bag was observed on the floor.R25 had a history of UTIs. On 7/22/25, R25's catheter bag was observed on the floor.Findings include: The facility's Catheter Care Policy, revised July 2025, indicates: …9. Ensure drainage bag is located below the level of the bladder to discourage backflow of urine . The Centers for Disease Control and Prevention (CDC) Guideline For Prevention of Catheter-Associated Urinary Tract Infection 2009 https://www.cdc.gov/infection-control/hcp/cauti/index.html, indicates: .III. Proper Techniques for Urinary Catheter Maintenance .B. Maintain unobstructed urine flow .2. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor . 1. On 7/21/25, Surveyor reviewed R31's medical record. R31 had diagnoses including pressure ulcer of sacral region stage 2, paraplegia, infection and inflammatory reaction due to indwelling urethral catheter, neurogenic bladder, and pressure ulcer of right buttock stage 4. R31’s Minimum Data Set (MDS) assessment, dated 6/26/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R31 had intact cognition. R31 was R31's own decision maker. R31’s medical record indicated R31 was transferred to the emergency room (ER) on 6/22/25 due to cognitive change, weakness, and cloudy urine and diagnosed with a UTI. R31 received intravenous (IV) antibiotics in the ER, was prescribed oral antibiotics, and returned to the facility. On 7/21/25 at 9:15 AM, Surveyor observed R31 in bed and noted R31’s uncovered catheter bag was hung from the side of the bed and in contact with the floor. R31 indicated R31 recently had a UTI, was upset the catheter bag was on the floor, and stated, “That bag should not be on the floor like that.” R31 indicated the catheter bag is usually placed in a blue (dignity) bag. R31 indicated the dignity bag and keeping the catheter bag off the floor help with infection prevention. R31 indicated R31’s floor had not been cleaned in a few days and was dirty. On 7/21/25 at 9:22 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-G in R31's room. CNA-G indicated R31's catheter bag should not be on the floor. Surveyor observed CNA-G rehang the bag on the side of the bed and ensure it was off the floor. CNA-G did not place the bag inside a dignity bag. On 7/23/25 at 8:08 AM, Surveyor observed R31 in bed with the door open and noted R31’s catheter bag was hung facing the open door and hallway and was not in a dignity bag. On 7/23/25 at 9:13 AM, Surveyor observed R31 in bed with the door open and noted R31’s catheter bag was hung facing the door and hallway was not in a dignity bag. R31 indicated R31 was upset that the bag was hung on the side of the bed that faced the door and hallway and indicated R31 did not like bag hung on that side. R31 also indicated the catheter bag should be covered with a dignity bag. R31 indicated R31 would ask staff to move the bag and cover it with a dignity bag. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/25 at 9:24 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated residents with catheters should have a dignity bag and stated R31 had a dignity bag if R31 left the room. DON-B acknowledged a dignity bag should be used if a resident’s catheter bag is visible from the hallway and verified catheter bags should be hung below the bladder and should not be on the floor for infection prevention purposes. 2. On 7/21/25, Surveyor reviewed R25's medical record. R25 was admitted to the facility on [DATE] and had diagnoses including sequalae following cerebrovascular disease, UTI, dysphagia, hemiplegia, and hemiparesis. R25's MDS assessment, dated 5/15/25, had a BIMS score of 0 out of 15 which indicated R25 had severe cognitive impairment. R25 had an activated Power of Attorney for Healthcare (POAHC). On 7/22/25 at 10:51 AM, Surveyor observed R25 and noted R25's catheter bag was hung from the side of R25's bed. R25's bed was in the lowest position and the catheter bag was on the floor. On 7/22/25 at 10:52 AM, Surveyor interviewed CNA-I who verified R25's catheter bag was on the floor. CNA-I indicated when CNA-I put R25's bed in the lowest position, CNA-I did not notice that R25's catheter bag was on the floor. CNA-I verified catheter bags should not be on the floor. On 7/22/25 at 1:24 PM, Surveyor interviewed DON-B who stated staff should adjust catheter bags so they do not touch the floor.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure 2 residents (R) (R35 and R4) of 2 sampled residents who were fed via enteral feeding (a way of sending nutrition right to the stomach or small intestine via tube) received care and services to avoid complications.On 7/21/25, Registered Nurse (RN)-C did not check for placement or residual prior to administering medication and enteral feeding to R35 .On 7/21/25 Licensed Practical Nurse (LPN)-H did not check placement or residual prior to administering medication to R4. Findings include: The facility's Enteral Feeding and Medication Administration Policy, dated March 2020, indicates: .Registered Nurse (RN)/Licensed Practical Nurse (LPN) will administer nutrition and medication through nasogastric, gastrostomy, or jejunostomy tube upon order of physician to provide nutrition and hydration for residents with compromised nutritional status or inability to consume oral intake .3. Check for proper placement prior to each feeding/medication administration (or every 4 hours for critically ill residents) by aspirating gastric contents or by auscultation while injecting 10 milliliter (ml) of air into tube. Notify physician if it appears tube has been displaced. 1. On 7/21/25, Surveyor reviewed R35's medical record. R35 was admitted to facility on 5/24/23 and had diagnoses including Parkinsonism, cerebral infarction, systemic inflammatory response, muscle wasting, atrophy, and neurocognitive disorder. R35's Minimum Data Set (MDS) assessment, dated 3/28/25, indicated R35 was dependent on staff for transfers, hygiene, dressing, feeding, and bathing. R35's tube feeding care plan, dated 8/30/23, contained an intervention to check for tube placement and gastric contents/residual volume per facility protocol and orders. On 7/21/25 at 11:54 AM, Surveyor observed RN-C administer an acidophilus capsule and Jevity 1.5 calorie 240 ml via percutaneous endoscopic gastrostomy (PEG) tube for R35. RN-C sanitized hands, donned a gown and gloves, opened R35's PEG tube port, and flushed the tube with 60 ml of water. RN-C then administered acidophilus with 30 ml water and flushed the tube with 60 ml of water. RN-C then administered 240 ml of Jevity 1.5 calorie and flushed with 60 ml of water. On 7/21/25 at 11:58 AM, Surveyor interviewed RN-C who indicated R35 did not have orders to check placement or residual. RN-C indicated RN-C often checks placement and residual if a resident is new and in rehab, however, R35 has had a PEG tube for a long time. On 7/23/25 at 11:32 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated it is a standard of practice to check placement and nurses should check for placement when administering medication or feeding via PEG tube. DON-B indicated one of the nurses approached DON-B yesterday and indicated they did not check placement when administering a medication via PEG tube. DON-B indicated DON-B educated all nurses on the facility's policy and put orders in the Medication Administration Record (MAR) for all residents with PEG tubes. 2. On 7/21/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including dysphagia with cerebral vascular accident, obesity, and type 2 diabetes. R4's MDS assessment, dated 6/2/25, had a BIMS score of 15 out of 15 which indicated R4 had intact cognition. The MDS assessment also indicated R4 received enteral feeding via gastronomy tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, dated 5/9/25, indicated R4 required tube feeding post stroke related to tracheostomy, dysphagia, and swallowing issues. The care plan contained interventions to check for tube placement and gastric contents/residual volume per facility protocol. On 7/21/25 at 11:21 AM, Surveyor observed LPN-H administer R4 medication via gastrostomy tube. LPN-H washed hands, applied a gown and gloves, and crushed R4’s medication. LPN-H then added 90 cubic centimeters (ccs) of water and aspirated the medication into a syringe. LPN-H opened R4’s G-tube and administered the medications. Surveyor noted LPN-H did not check placement of the tube prior to administering the medication. Surveyor verified with LPN-H that tube placement should have checked prior to administering medication and that R4's MAR contained an order to check tube placement.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure effective pain management was provided for 1 resident (R) (R5) of 2 sampled residents.R5 had an order for a Fentanyl patch for pain to be changed every three days. During observations on 7/21/25 and 7/22/25, R5's Fentanyl patch was dated 7/17/25. R5 stated R5 felt achy and had difficulty sleeping. Findings include:The facility's Pain Management policy, revised 10/2024, states the facility will develop and implement a care plan for pain management. The goal of the pain management system is to effectively and consistently identify and treat pain .Staff should be proactive to address the resident's pain to aid in achieving relief. Evaluation of pain, implementation of interventions, and communicating with the care team regarding pain management strategies are important components of a successful pain management system .Nursing staff are to administer pain medications as ordered and observe for effectiveness. From 7/21/25 to 7/23/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including chronic deep vein thromboses (DVTs) (blood clots) of both legs, neuropathy, depression, anxiety, and chronic pain. R5's most recent Minimum Data Set (MDS) assessment, dated 5/29/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 had intact cognition. The MDS assessment also indicated R5 experienced pain almost constantly which frequently interfered with day-to-day activities and therapies. R5's comprehensive care plan, revised 5/29/25, indicated R5 experienced chronic pain related to bilateral DVTs of the lower extremities. The care plan contained interventions for repositioning, distraction, heat, and pain medications. On 7/21/25 at 1:24 PM, Surveyor interviewed R5 regarding pain management. R5 indicated R5 had a Fentanyl patch that was changed every three days. Surveyor noted the patch was dated 7/17/25. Per R5's physician order, the patch should have been changed on 7/20/25. R5 stated R5's pain was currently an 8 out of 10 and mostly in R5's legs due to the blood clots. On 7/22/25 at 7:59 AM, Surveyor observed R5's Fentanyl patch and noted it was still dated 7/17/25. R5 stated R5 had a tough time sleeping last night and was achy. R5 stated staff did not offer non-pharmacological interventions for pain but doubted they would be effective. R5's most recent comprehensive pain assessment, dated 7/10/25, stated R5 experienced pain almost constantly which affected R5's sleep and activities. On 7/22/25 at 8:51 AM, Surveyor entered R5's room with Director of Nursing (DON)-B who verified R5's Fentanyl patch was dated 7/17/25. DON-B verified R5's patch should have been changed on 7/20/25 but indicated the facility did not re-order the Fentanyl patch prior to using the last one on 7/17/25. On 7/22/25, Surveyor reviewed R5's Medication Administration Record (MAR) for 7/13/25 through 7/22/25 and noted R5's pain was typically between 5 and 7 out of 10. R5 took as needed (PRN) oxycodone every 6 hours during that time period. On 7/22/25, Surveyor reviewed a fax sent to R5's physician on 7/21/25 requesting a refill for R5's Fentanyl patch. On 7/23/25 at 8:01 AM, Surveyor noted R5's Fentanyl patch was dated 7/22/25. R5 indicated R5 felt much better and rated R5's pain at a 5 out of 10. On 7/23/25, Surveyor reviewed R5's MAR which indicated R5's Fentanyl patch was applied on 7/22/25 at 5:02 PM and R5's pain was rated at a 5 out of 10.

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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** Based on observation, staff interview, and record review, the facility did not ensure transmission-based precautions (TBP) were implemented for 1 resident (R) (R52) of 2 residents with a diagnosis of a transmittable infection.R52 had diagnoses of sepsis and pneumonia and was placed on droplet precautions. Staff did not don the appropriate personal protective equipment (PPE) when entering R52's room on 7/21/25 and 7/22/25. Findings include:The facility's Isolation Precautions policy, revised 3/2020, indicates: To establish transmission-based precautions for residents who are suspected or confirmed to have communicable diseases/infections that can be transmitted to others. Transmission- based precautions will be used when transmission cannot be reasonably prevented by standard precautions alone .Droplet precautions .prior to entering the isolation room, the following steps are required: Perform hand-hygiene and apply gloves and mask prior to entering the room, while providing direct resident care, remove gloves and wash hands after coming in contact with infectious material. Remove gloves and perform hand hygiene before leaving the room.On 7/21/25, Surveyor reviewed R52's medical record. R52 was admitted to the facility on [DATE] and had diagnoses including sepsis, pneumonia, and urinary tract infection (UTI) all due to E-coli, stage 1 pressure injury, chronic obstructive pulmonary disease (COPD), and paranoid schizophrenia. R52's admission Minimum Data Set (MDS) assessment, dated 7/16/25, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R52 had moderately impaired cognition. R52 had an activated decision maker for healthcare decisions. A care plan, dated 7/16/25, indicated R52 had pneumonia and contained the following interventions: Educate R52/family on precaution policies; Follow the facility's policy for implementation of any precautions related to active infection; Staff to follow standard precautions and transmission precautions when appropriate. On 7/21/25 at 9:15 AM, Surveyor observed R52 in R52's room and noted the door contained a sign that indicated R52 was on droplet precautions. Surveyor also observed a PPE cart outside R52's room. On 7/21/25 at 9:18 AM, Surveyor observed Certified Nursing Assistant (CNA)-G enter R52's room with an oxygen tank and close R52's door. CNA-G did not don PPE prior to entering the room. Surveyor also observed CNA-G in R52's room without a mask when CNA-G opened the door. Surveyor interviewed CNA-G who indicated unless CNA-G was doing cares, CNA-G did not need to wear a mask or PPE. CNA-G indicated CNA-G entered R52's room to give R52 oxygen and was not required to wear PPE because CNA-G was not in contact with bodily fluids. On 7/21/25 at 9:28 AM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R52 was on droplet precautions and antibiotics for a UTI, pneumonia, and sepsis. DON-B indicated R52 would be removed from droplet precautions when R52's antibiotics were completed. On 7/22/25 at 7:42 AM, Surveyor observed housekeeping staff change R52's bed linens without wearing gloves or a mask. R52 was in the room at the time. On 7/23/25 at 9:24 AM, Surveyor interviewed DON-B who confirmed staff who enter R52's room should adhere to the facility's policy and procedure for TBP and verified staff should wear a mask when entering the room of a resident on droplet precautions. DON-B verified Surveyor's observations of staff in R52's room without proper PPE was not in accordance with the facility's policy and procedure.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure they completed regular pest control which affected 1 resident (R) (R30) of 17 sampled residents.R30 indicated there were fruit flies in R30's room and R30 had a bug bite on the right hand. The facility did not ensure they completed regular pest control.Findings include:On 7/21/25, Surveyor reviewed R30's medical record. R30 was admitted to the facility on [DATE] and had diagnoses including deep vein thrombosis/pulmonary embolism secondary to factor V Leiden mutation on Xarelto, chronic diastolic congestive heart failure, chronic obstructive pulmonary disease (COPD), and morbid obesity. R30's Minimum Data Set (MDS) assessment, dated 6/9/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R30 had intact cognition. A progress note, dated 7/21/25 at 9:24 AM, indicated the writer updated the Nurse Practitioner (NP) that R30 had a new bug bite on the right hand and had a previous bug bite that became infected. The area was slightly swollen, red, and itchy. The NP ordered hydrocortisone cream 1% three times daily (TID) as needed (PRN).On 7/22/25 at 11:15 AM, Surveyor interviewed R30 who indicated R30 did not get up much. R30 showed Surveyor R30's right hand and indicated R30 had a bug bite. R30 stated something bit R30 and it hurt so bad that R30 woke up and the bite swelled up right away. R30 indicated staff put cream on the bite and it looked better. R30 indicated R30 had been in the hospital due to a right hand infection and did not want to get another infection. R30 indicated the previous infection resulted from R30 wrapping a hospital band around R30's thumb. R30 thought a spider bit R30's hand. Surveyor checked R30's room for spiders and noted several fruit flies in the room. R30 indicated fruit flies are everywhere in the building. On 7/22/25 at 12:25 PM, Surveyor interviewed Maintenance Director (MD)-E who indicated the facility has routine pest care mostly for rodents and outside things. When Surveyor requested to see 6 months of pest control documentation, MD-E indicated MD-E does not keep records of when Company (CP)-K comes to the facility but thought CP-K had been there in May. MD-E indicated CP-K comes monthly to check traps, but MD-E did not have documentation. MD-E indicated CP-K changed hands multiple times and sometimes states they do not have an account for the facility. MD-E provided Surveyor with CP-K's number and indicated the facility had discussed using a different pest control companyOn 7/22/25 at 12:32, Surveyor contacted CP-K and spoke to Customer Service Agent (CSA)-L who indicated CP-K was last at the facility on 2/28/25. CSA-L indicated the facility contacted CP-K on 2/24/25 and CP-K provided services on 2/28/25. CSA-L indicated there was no active service for the facility and no one from CP-K checked traps or sprayed monthly.On 7/22/25 at 2:51 PM, Nursing Home Administrator (NHA)-A provided Surveyor with an invoice that indicated CP-K was last at the facility in February of 2025. NHA-A indicated CP-K told the facility there was an outstanding invoice so CP-K would not come to the facility to provide pest control. NHA-A confirmed the facility does not have a current contract for pest control and has not had pest control since February.