

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER Meadowbrook at Oconto Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 100 E Highland Dr Oconto Falls, WI 54154	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342</p> <p>Based on staff interview and record review, the facility did not ensure the provision of a safe environment that was free of accident hazards for 1 resident (R) (R1) of 5 sampled residents.</p> <p>On 5/17/24, R1 reported to staff that R1 fell out of a Hoyer lift when Certified Nursing Assistant (CNA)-C transferred R1 alone. On 5/18/24, R1 went to the hospital and was diagnosed with a left hip fracture. In addition, staff did not adequately assess R1 following R1's reported fall and had increased pain which delayed R1's diagnosis.</p> <p>Findings include:</p> <p>The facility's Change of Condition policy, with a revision date of October 2020, indicates: To ensure prompt notification of the resident, the attending physician, and durable power of attorney/responsible party of changes in the resident's physical, psychosocial and/or mental condition and/or status .Specific information that requires prompt notification includes, but is not limited to: .1. A significant change in the resident's physical/psychosocial/mental condition; m. A need to alter the resident's medical treatment significantly; .3. Nurse will complete assessment and document findings in resident's record including but not limited to vital signs, pain, respiratory status as applicable, cardiac status as applicable, etc. Notification of medical professional and resident representative will be documented in the medical record .</p> <p>The facility's undated Abuse Prevention Program policy indicates: .2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation .4. Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable .</p> <p>On 5/21/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral vascular accident (also known as a stroke) affecting the left non-dominant side. R1's Minimum Data Set (MDS) assessment, dated 2/25/24, stated R1's Brief Interview for Mental Status (BIMS) score was 15 out of 15 which indicated R1 had intact cognition. R1's medical record indicated R1 was responsible for R1's healthcare decisions. R1 was transferred to the hospital on 5/18/24. R1's care plan indicated R1 required the use of a full mechanical lift with the assistance of two staff for all transfers.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing progress note dated 5/18/24, indicated: Between 7:30 AM and 8:00 AM, R1 complained R1's left hip and leg hurt very badly. Writer noted no redness but the area was tender to touch. Writer tried to have R1 straighten R1's legs but R1 started yelling. Writer asked if R1 wanted to go to the emergency room (ER) to be evaluated. R1 stated, Yes. I've been wanting to go. R1 stated R1 was dropped from a Hoyer lift. Writer was confused because there was no documentation of a fall, but R1 was getting Tylenol more often and cold packs. Writer called Director of Nursing (DON)-B and physician. R1 was sent to the ER at 8:12 AM. When the ambulance arrived, Emergency Medical Technicians (EMTs) asked if R1 had any recent falls. Writer stated there were no recent falls documented. A hospital staff called later and asked if R1 was aware of what went on daily. Writer stated R1 knew who writer was that morning, where R1 was, R1's name, the year, and that R1 was in a lot of pain. When the hospital staff asked if R1 was alert and oriented, writer stated yes. The hospital staff stated R1 said R1 was dropped on the floor during a Hoyer lift transfer by a named CNA. Writer called DON-B who stated there was an investigation regarding an episode R1 had with therapy when therapy staff tried to get R1 to stand in a sit-to-stand lift. DON-B indicated R1 let R1's self hang in the lift but was next to R1's bed and didn't end up on the floor. The hospital staff called again and stated R1 had a left hip fracture and was scheduled for surgery the next day. The hospital staff was concerned that R1 kept stating R1 was dropped on the floor during a transfer with a named CNA. Writer told the hospital staff about what DON-B said regarding therapy and the sit-to-stand lift. The hospital staff was convinced differently and stated writer needed to look into it more.</p> <p>On 5/21/24 at 9:37 AM, Surveyor interviewed R1 via phone. R1 stated R1 had a shower earlier in the evening on 5/16/24 and at approximately 8:00 PM, CNA-C transferred R1 via Hoyer lift from wheelchair to bed. During the transfer, R1's nightgown caught on something which caused R1 to slip out of the sling onto the floor. R1 stated R1 fell approximately three feet and landed pretty much on my ass. R1 stated another staff was with CNA-C and provided a physical description and the staff's first name. R1 stated R1 did not experience pain at the time of the fall, but experienced pain later that night. R1 stated, I asked to go to the hospital. They said I wasn't hurt. R1 stated R1's pain that night was a level 8 on a scale of 0-10 with 10 being the worst pain. R1 stated on 5/17/24, R1's pain worsened pretty close to a 9 or 10 and on 5/18/24 a different nurse said I should go to the ER. R1 said R1 wanted to go to the ER and stated, I had wanted to go last night.</p> <p>On 5/21/24 at 9:58 AM, Surveyor interviewed CNA-D who indicated R1 should be transferred with a Hoyer lift and two staff. CNA-D indicated R1 wanted to be transferred with a sit-to-stand lift but that wasn't safe.</p> <p>On 5/21/24 at 10:01 AM, Surveyor interviewed CNA-E who indicated R1 should be transferred with a Hoyer lift and two staff. CNA-E stated CNA-E worked 6:00 AM to 2:00 PM on 5/17/24 and used a Hoyer lift to transfer R1. CNA-E stated CNA-E was told in shift report that R1 complained of pain, but R1 did not complain of pain to CNA-E.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/24, Surveyor reviewed R1's May 2024 Medication Administration Record (MAR), Treatment Administration Record (TAR), and administration notes. R1 received scheduled Tylenol 650 mg (milligrams) every morning. R1 also had an order for Tylenol 650 mg every four hours as needed (PRN). R1's MAR indicated R1 received one dose of PRN Tylenol on 5/1/24, 5/2/24, 5/3/24, 5/4/24, 5/6/24, 5/9/24, 5/12/24, 5/13/24, and 5/16/24. R1 received two doses of PRN Tylenol on 5/5/24, 5/7/24, 5/11/24, and 5/14/24. R1 received PRN Tylenol on 5/17/24 at 12:00 AM for a pain level of 4, at 5:00 AM for a pain level of 6, at 11:53 AM for a pain level of 6, and at 11:00 PM for a pain level of 3. Administration notes indicated the dose R1 received at 12:00 AM was for body pain, the dose R1 received at 5:00 AM was for right hip pain, the dose R1 received at 11:53 AM was for resident reports left upper leg pain and requested (Tylenol,) provided, cold pack applied and the dose R1 received at 11:00 PM was for left hip pain.</p> <p>A progress note, dated 5/17/24 at 3:00 AM, indicated: R1 complained of hip pain but was unable to receive PRN Tylenol because R1 received it 3 hours prior. R1 was repositioned and provided with an ice pack per R1's request. After repositioning, R1 stated it feels better. Will continue to monitor.</p> <p>R1's MAR indicated the Tylenol doses were effective. R1's TAR indicated R1 had an order for Biofreeze (a topical medication used to relieve mild to moderate pain) PRN for right shoulder pain. R1 received the medication on 5/17/24 at 5:01 AM. An administration note stated, Put on left hip.</p> <p>On 5/21/24, Surveyor reviewed the facility's investigation which indicated: On 5/17/24, Licensed Practical Nurse (LPN)-F told DON-B that R1 stated R1 fell on the evening of 5/16/24 during a Hoyer lift transfer and the sling broke. DON-B interviewed Physical Therapy Assistant (PTA)-G, CNA-C, and Medication Technician (MT)-H. On 5/18/24, R1 went to the ER for leg pain and was diagnosed with a hip fracture. Surgery was scheduled for 5/19/24. R1 reported to hospital staff that R1 fell from a Hoyer lift on 5/15/24 and staff didn't do anything. R1 did not tell facility staff right away because R1 did not want to get CNA-C in trouble. DON-B updated RDO (Regional Director of Operations). DON-B reported during a therapy session with a sit-to-stand lift on 5/15/24, R1 was lowered to the bed when R1's knees buckled. R1 did not fall and the sling was intact. On 5/20/24, the facility's cameras were reviewed. A camera indicated CNA-C used a sit-to-stand lift to transfer R1 and also used a Hoyer lift to transfer R1 alone on the 5/16/24 PM shift. CNA-C was terminated. CNA-I was interviewed and stated CNA-I used a sit-to-stand lift with CNA-C to transfer R1. Education was provided to CNA-I. On 5/20/24, Regional Director of Sales and Marketing (RDSM)-J completed a hospital visit. R1 reported CNA-C and LPN-K used the Hoyer lift to put R1 into bed after R1's shower. R1 said R1's hip did not hurt at that time.</p> <p>An interview with PTA-G, dated 5/17/24, indicated: CNA-C asked PTA-G if PTA-G would help CNA-C transfer R1 with a sit-to-stand lift. PTA-G told CNA-C therapy staff worked on a sit-to-stand transfer with R1 the previous day and R1 had to 'let go' and was hanging with R1's entire weight in the lift and had to be set down. CNA-C stated CNA-C would use a Hoyer lift.</p> <p>An interview with CNA-C, dated 5/17/24, indicated: CNA-C asked PTA-G to help CNA-C transfer R1 with a sit-to-stand lift because staff had been transferring R1 that way. PTA-G said R1 didn't do well with a sit-to-stand lift and told CNA-C to use a Hoyer lift. CNA-C stated CNA-C used a Hoyer lift from then on and never used a Hoyer lift alone with R1.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/24 at 11:42 AM, Surveyor interviewed DON-B who stated sometime between lunch and 2:00 PM on 5/17/24, LPN-F told DON-B that R1 stated R1 fell out of a lift. DON-B started interviews and notified Nursing Home Administrator (NHA)-A. DON-B was unsure if R1 was interviewed on 5/17/24.</p> <p>On 5/21/24 at 12:02 PM, Surveyor interviewed R1 via phone again. When asked how R1 got off the floor following the fall on 5/16/24, R1 stated, (CNA-C) helped pick me up. (CNA-C) got behind me. (CNA-C) did it by (CNA-C's) self. When asked if there was another staff in the room, R1 gave a physical description and first name of a nurse. R1 stated the nurse watched CNA-C pick R1 up off the floor without a lift.</p> <p>R1's medical record indicated on 5/16/24 at 7:57 PM, staff weighed R1 via Hoyer lift scale. R1's weight was 302 pounds.</p> <p>On 5/21/24 at 12:42 PM, Surveyor interviewed CNA-L via phone. CNA-L stated CNA-L worked the PM shift on 5/16/24 but did not transfer R1. CNA-L stated CNA-M had the name R1 gave Surveyor (as being the second staff in the room when CNA-C picked R1 off the floor. When Surveyor provided CNA-L with the physical description given by R1, CNA-L stated LPN-K fit the description and went by a nickname that was the same first name as CNA-M.</p> <p>On 5/21/24, Surveyor reviewed the facility's staffing schedule for 5/16/24 which indicated neither CNA-M or LPN-K worked the PM shift on 5/16/24.</p> <p>On 5/21/24 at 1:17 PM, Surveyor interviewed PTA-G who stated therapy staff worked with R1 for leg and upper arm strength to allow R1 to be transferred via sit-to-stand lift because R1 did not like the Hoyer lift. PTA-G stated therapy staff were allowed to use the sit-to-stand lift during R1's therapy sessions, but nursing staff were directed to use a Hoyer lift. PTA-G stated R1 showed improvement with strength and tolerance prior to the evening of 5/16/24. When asked if R1 was lowered to the bed during a therapy session on 5/15/24, PTA-G stated therapy staff worked with R1 in the therapy room, not R1's room. PTA-G stated on 5/16/24, a CNA asked if PTA-G would help with a sit-to-stand transfer to get R1 into a shower chair. PTA-G said no. PTA-G stated, I came into work the next day to work with (R1). (R1) told me (R1) had a fall from the Hoyer lift. I followed up with (Director of Rehab (DOR)-N). (DOR-N) looked in (R1's) nursing notes and didn't see anything. I documented in my notes as potential fall. PTA-G stated on 5/17/24, PTA-G only did stretching with R1 because R1 was in a lot of pain and had poor initiation of trunk flexion which was a change from earlier in the week. PTA-G stated R1 wanted to try standing in the sit-to-stand lift on 5/17/24 but couldn't do it as (R1) was very limited with pain. PTA-G stated R1 never had a care plan intervention for use of a sit-to-stand lift and stated staff should have always used a Hoyer lift to transfer R1.</p> <p>R1's PT Daily Treatment Notes indicated the following:</p> <p>~ 5/15/24: R1 performed pre-standing activity of trunk flexion with minimal assistance provided .R1 completed 10 repetitions to prep for transfers and is able to lift lower extremities onto and off the sit-to-stand platform .R1 is able to maintain standing position for an increased time of 1:30 minutes, then 1:40 minutes. R1 exhibited improved knee extension with standing and has an improved posture in the highest position. R1 has a 'hanging' posture toward the end of duration and will further benefit from standing balance training .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>~ 5/16/24: R1 is able to complete with minimal assistance and exhibits improved forward reaching needed for improved standing posture and prepping for sit-to-stand transfers .R1 performed surface-to-surface transition with use of sit-to-stand .R1 completed 3 static standing trials with R1's longest standing time being 1:30 minutes.</p> <p>~ 5/17/24: R1 seen this morning and stated my legs and back are in a lot of pain due to potential fall with staff. Writer applied passive range of motion (PROM) to bilateral lower extremities in motions of hip flexion and knee flexion/extension. R1 is limited in range of motion (ROM) due to pain and discomfort with passive movement .R1 has increased difficulty with forward reaching. R1 would like to attempt standing with sit-to-stand lift, but is notable hanging prior to initiation of standing and is lowered for safety. Recommended continued use of Hoyer lift due to weakness, poor postural correction, and pain.</p> <p>On 5/21/24 at 2:02 PM, Surveyor interviewed LPN-K who verified LPN-K's nickname was the same name R1 gave Surveyor (as being the second staff in the room when CNA-C picked R1 off the floor). LPN-K verified LPN-K did not work on 5/16/24. LPN-K indicated LPN-K assisted CNA-C with transferring R1 from wheelchair to shower chair via sit-to-stand lift the week prior to 5/16/24. LPN-K indicated the sit-to-stand lift was used because of limited space in the shower area. LPN-K stated R1 stood up pretty good during the transfer. When asked if R1's care plan stated R1 should be transferred with a Hoyer lift, LPN-K stated, Yea. It was a big mistake. LPN-K stated LPN-K did not assist CNA-C with any transfers for R1 from wheelchair to bed in the past couple weeks. When asked if LPN-K saw CNA-C or any staff pick R1 up off the floor without the use of a mechanical lift, LPN-K stated, No, I can't imagine (how it could happen that way due to R1's weight).</p> <p>On 5/21/24 at 2:32 PM, Surveyor interviewed DON-B. When asked what LPN-F reported to DON-B on 5/17/24, DON-B stated, That (R1) reported there was an issue with the lift and (R1) fell with a staff member. DON-B stated R1 initially said the fall occurred on 5/16/24, but hospital notes indicated R1 told hospital staff that R1 fell multiple different times. After LPN-F informed DON-B of the fall, DON-B stated DON-B immediately interviewed staff who worked on 5/16/24 who told DON-B that no fall occurred. DON-B verified R1 wasn't interviewed until 5/20/24. DON-B verified DON-B did not interview R1 on 5/17/24 or ask who was present when R1 allegedly fell from the lift. When asked if LPN-F asked R1 who was present during the transfer, DON-B stated, I do not know. When asked if an assessment should be completed if a resident alleges a fall occurred, DON-B indicated a full pain assessment and a change of condition assessment should be completed. DON-B verified staff did not complete a body check for injuries. DON-B verified DON-B was not aware of a specifically named staff member involved in the alleged fall until DON-B reviewed R1's hospital records on 5/20/24.</p> <p>On 5/21/24 at 2:56 PM, Surveyor interviewed LPN-O who verified LPN-O worked the PM shift on 5/16/24 and assisted CNA-C with transferring R1 from wheelchair to bed via Hoyer lift. LPN-O indicated the transfer went well and R1 had no complaints at the time. LPN-O indicated R1 did not fall out of the lift and R1's nightgown did not get caught during the transfer. When asked if LPN-O saw any staff try to pick R1 off floor without the use of a lift, LPN-O stated, Oh no, (R1)'s too big for anyone to do that. (R1)'s paralyzed on one side.</p> <p>On 5/21/24, Surveyor reviewed additional investigation documents which indicated staff reviewed the facility's camera on 5/21/24 at 9:25 AM and noted on 5/16/24 at 7:21 PM, CNA-C pushed a sit-to-stand lift to the shower room. R1 was in a wheelchair in the hallway. CNA-C put a sling on R1 while R1 was in the wheelchair and was noted to use the sit-to stand lift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/24 at 4:10 PM, Surveyor interviewed NHA-A and DON-B who indicated the resident in the video was R1 and stated the camera angle showed the hall in front of the shower room but did not show the shower room itself. NHA-A and DON-B were unsure if another staff member assisted CNA-C with the transfer because the video showed another staff member pass in the hallway; however, NHA-A and DON-B stated they believed CNA-C completed the sit-to-stand transfer alone.</p> <p>On 5/22/24 at 9:14 AM, Surveyor interviewed CNA-C via phone. CNA-C indicated on 5/16/24, R1 wanted CNA-C to use a sit-to-stand lift for the shower transfer. When CNA-C asked PTA-G to assist, PTA-G said, Absolutely not. CNA-C stated CNA-C gave R1 a shower on the evening of 5/16/24 with the help of CNA-P and a Hoyer lift was used for the shower transfer. CNA-C stated CNA-C and CNA-P used a Hoyer lift to transfer R1 from wheelchair to bed. CNA-C and CNA-P undressed R1, changed the lift pad, transferred R1 from bed to wheelchair, and covered R1 for privacy. CNA-C stated R1 was transported to the shower area via wheelchair because R1 was too heavy to push down the hall in the shower chair. CNA-C stated the shower room was too small for transfers so R1 was taken to the tub room where CNA-C and CNA-P transferred R1 via Hoyer lift from wheelchair to shower chair. CNA-C stated CNA-C was aware of the above-mentioned video. When asked to explain the video, CNA-C stated, I don't explain that. That did not happen. CNA-C stated CNA-C did not pick R1 up off the floor after a fall without the use of a mechanical lift and did not recall a time when R1's nightgown got caught during a lift transfer. CNA-C stated staff did not show the video to CNA-C.</p> <p>On 5/22/24 at 1:16 PM, Surveyor interviewed CNA-P via phone. CNA-P verified CNA-P worked the PM shift on 5/16/24. When asked if CNA-P assisted CNA-C with transferring R1 during the shift, CNA-P stated, I did not. CNA-P verified CNA-P did not assist CNA-C with R1's shower transfer or transfer to bed on 5/16/24. When asked if CNA-P ever saw R1 transferred with a sit-to-stand lift, CNA-P stated, I have never transferred (R1) in a sit-to-stand. I just started working PMs recently. Mostly work night shift and we never get (R1) out of bed at night.</p> <p>On 5/22/24, Surveyor reviewed hospital documentation for R1 which indicated the following:</p> <p>~ A note by a hospital Registered Nurse (RN) on 5/18/24 at 9:08 AM indicated: R1 came via EMS with complaints of left hip pain that started on Wednesday (5/15/24). R1 stated R1 was dropped from the Hoyer lift onto the ground on (5/15/24) by CNA-C. R1 stated R1's left leg hurt on palpation. R1 has left-sided deficits from a stroke in 2024. R1 is alert and oriented to person, place, time, and situation.</p> <p>~ A note by an ER physician on 5/18/24 at 9:16 AM indicated: R1 stated approximately two days ago, R1 was dropped out of a Hoyer lift, fell approximately two feet, and landed on R1's bottom. R1 complained of left hip pain.</p> <p>~ A note by a hospital admission Nurse Practitioner (NP) on 5/18/24 at 12:22 PM indicated: R1 stated the reason R1 came to the ER was for persistent left hip pain. R1 stated on Wednesday (5/15/24), R1 was being transferred via Hoyer lift and slipped out of the lift onto R1's left side. R1 stated neither R1 or the CNA reported the fall at the time and R1 did not want the CNA to get in trouble. By Thursday (5/16/24) morning, R1 had increased pain and was only given ice and Tylenol. Today the pain increased to the point that R1 could not tolerate it and R1 came to the ER for evaluation.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>38793</p> <p>Based on staff interview and record review, the facility did not ensure a Registered Nurse (RN) was on duty at least 8 consecutive hours per day 7 days per week. This practice had the potential to affect all 51 residents residing in the facility.</p> <p>The facility did not have an RN on duty from 5/17/24 at 6:05 PM until 5/19/24 at 12:00 PM.</p> <p>Findings include:</p> <p>On 5/21/24, Surveyor reviewed the facility's assessment, revised 5/14/24, that indicated the facility will have an RN on duty at least 8 consecutive hours per day 7 days per week.</p> <p>On 5/21/24, Surveyor reviewed the facility's waivers. The facility did not have a waiver related to staffing or having an RN on duty.</p> <p>On 5/21/24, Surveyor reviewed the facility's schedules and time sheets from 5/17/24 through 5/20/24. Surveyor noted an RN was on duty until 6:05 PM on 5/17/24, but another RN did not punch in until 6:00 PM on 5/20/24.</p> <p>On 5/21/24 at 9:40 AM, Surveyor interviewed Director of Nursing (DON)-B regarding staffing for the weekend of 5/17/24 through 5/19/24. DON-B verified the RN who was scheduled that weekend did not come in. DON-B verified an RN punched out of the facility on 5/17/24 at 6:05 PM. DON-B stated DON-B came in on 5/19/24 at approximately 12:00 PM and worked until 8:00 PM but did not punch in and out on the time clock.</p>