STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525449	A. Building B. Wing	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook at Oconto Falls	100 E Highland Dr Oconto Falls, WI 54154

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff and resident interview and record review, the facility did not thoroughly investigate and resolve grievances for 2 residents (R) (R4 and R5) of 7 sampled residents. R4 and R5 expressed concerns to staff that R3 frequently called out. Grievance forms were not completed and the grievances were not thoroughly investigated or resolved. Findings include: The facility's Company Concerns Policy, with a revision date of October 2020, indicates: Concerns may be filed orally or in writing and may be anonymous if so desired. 1. At the time a concern is noted (either verbal or written), the resident or his/her representative may speak to any staff member and report the nature of the grievance or submit a written concern form. 2. The staff member will, at the time of the concern, attempt to resolve the issue or direct the resident/representative to the appropriate department head or staff member for further action and/or notify the Concern Officer. 3. Upon notification of a resident concern, information sufficient to identify the individual registering the concern, the name of the resident (if not the individual submitting the information), date of receipt, nature of the concern, and location of the resident will be recorded. On 10/14/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including hemiplegia following cerebral infarction (stroke) affecting left non-dominant side, aphasia following cerebral infarction, dysphasia following cerebral infarction, and anxiety. R3's Minimum Data Set (MDS) assessment, dated 9/28/24, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R3 had severely impaired cognition. R3 had a guardian. A progress note, dated 10/2/24 at 5:00 AM, indicated R3 called out but was unable to verbalize what R3 needed. Music and low lights were ineffective. As needed (PRN) lorazepam was administered at 12:20 AM but was no longer effective. Staff were unable to redirect R3 at that time and would assist R3 into R3's chair for a change in environment. A progress note, dated 10/3/24 at 1:19 PM, indicated R3 was seen by an Medical Doctor (MD) who gave orders to hold lorazepam, start tramadol 50 milligrams (mg) twice daily (BID) for 7 days, and provide follow-up on R3's symptoms. The note indicated staff would attempt to treat R3's pain to see if it helped with calling out. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, date 10/7/24 at 8:15 AM, indicated R3 yelled out and had anxiety that morning. An Registered Nurse (RN) reported no change with the addition of tramadol. R3 was on scheduled Tylenol and duloxetine 60 mg for pain/anxiety as well. Scheduled and PRN lorazepam was added again. Staff were asked to update the MD on R3's behaviors in one week. A progress note, dated 10/10/24 at 10:33 PM, indicated R3 was agitated and appeared to have visual hallucinations during the shift, including yelling, crying, and pointing/hitting at the wall and ceiling. PRN Ativan was administered but was ineffective. The MD was updated. On 10/14/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including spinal stenosis and chronic obstructive pulmonary disease (COPD). R5's MDS assessment, dated 7/22/24, had a BIMS score of 15 out of 15 which indicated R5 had intact cognition. On 10/14/24 at 10:24 AM, Surveyor interviewed R5 who resided in the room next to R3. R5 indicated R5 spoke to multiple staff about R3's calling out behavior. R5 indicated R5 spoke to someone last week and was told the facility was trying different things with R3, but some of the things they were trying would take time. R5 indicated R5 was not sleeping well and did not want to get run down and sick. R5 indicated the facility had not offered anything to R5 except to shut R5's door which R5 did not not want to do because R5 was claustrophobic. R5 indicated R5 felt bad for R3 because nothing seemed to help R3. On 10/14/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes. R4's MDS assessment, dated 9/23/24, had a BIMS score of 15 out of 15 which indicated R4 had intact cognition. On 10/14/24 at 10:46 AM, Surveyor interviewed R4 who indicated R4 spoke to multiple staff about R3 frequently calling out and felt nothing had been done since it kept occurring. R4 indicated staff spoke with R4 on 10/11/24 but indicated they could not share anything for privacy reasons. R4 indicated R4 could keep R4's door closed which helped; however, sometimes R3 called out for hours and R4 felt R4 was snapping at others more. On 10/14/24 at 11:15 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-C) who indicated R4 and R5 expressed concerns to CNA-C regarding R3's frequent calling out. CNA-C indicated CNA-C tried to empathize with R4 and R5 but didn't share much due to privacy. CNA-C indicated staff try different things with R3, but sometimes nothing helps. CNA-C indicated CNA-C reported R4 and R5's concerns to a nurse; however, CNA-C had not spoken with the Director of Nursing (DON). On 10/14/24 at 12:08 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated R4 and R5 expressed concerns to LPN-D about R3's frequent calling out. LPN-D indicated LPN-D knew Social Worker (SW)-E was updated. On 10/14/24, Surveyor requested the facility's grievance file. Surveyor noted there were no grievances for R4 or R5 on a grievance list that was provided. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/25 at 1:45 PM, Surveyor interviewed SW-E who was aware of R4's concerns. SW-E indicated SW-E contacted the Ombudsman last week for guidance on residents' rights and dignity. SW-E said another staff spoke to R5 last week and indicated it was more of a concern that R3 wasn't being assisted than that R5 was bothered by R3 calling out. SW-E indicated SW-E was the individual who filled out grievance forms; however, SW-E did not fill out grievance forms for R4 and R5. SW-E indicated the Ombudsman shared information that SW-E provided to R5. On 10/14/24 at 3:00 PM, SW-E provided Surveyor with the information the Ombudsman provided via email on 10/9/24. When SW-E provided the information to Surveyor, SW-E indicated SW-E had filled out a grievance form.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff and resident interview and record review, the facility did not ensure care plans were updated for 4 residents (R) (R3, R4, R5, and R2) of 7 sampled residents. R3's care plan was not updated to indicate R3 frequently called out and did not include interventions to offer R3 when R3 called out. R4's care plan was not updated with interventions to offer R4 when R4 expressed concern about another resident frequently calling out. R5's care plan was not updated with interventions to offer R5 when R5 expressed concern about another resident frequently calling out. R2's care plan was not updated to indicate R2 no longer required 1:1 supervision. Findings include: The facility's Comprehensive Care Plan policy, with a revision date of February 2021, indicates: .5. The care plan is reviewed on an ongoing basis and revised as indicated by the resident's needs, wishes, or a change in condition. At a minimum, the care plan is updated with each comprehensive and quarterly assessment in accordance with Resident Assessment Instrument (RAI) requirements. 1. On 10/14/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including hemiplegia following cerebral infarction affecting left non-dominant side, aphasia following cerebral infarction, dysphasia following cerebral infarction, and anxiety. R3's Minimum Data Set (MDS) assessment, dated 9/28/24, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R3 had severely impaired cognition. R3 had a guardian. R3's medical record contained the following progress notes: A progress note, dated 8/20/24 at 1:36 PM, indicated R3 took as needed (PRN) lorazepam almost daily and sometimes twice daily due to calling out and restlessness. An Interdisciplinary Team (IDT) progress note, dated 8/28/24 at 11:16 AM, indicated R3 called out to get staffs' attention. PRN medication was administered when R3 was anxious. A progress note, dated 8/29/24 at 3:50 PM, indicated R3's guardian was notified that the Medical Doctor (MD) recommended to schedule R3's lorazepam. R3's guardian agreed to have R3's lorazepam scheduled once or twice daily and agreed to increase the frequency to every 8 hours if appropriate. R3's guardian was also notified that R3 called out overnight and indicated R3 was in pain. R3's guardian indicated R3 took gabapentin at bedtime prior to R3's admission to the facility. R3's guardian agreed to restart the medication if indicated. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note, dated 10/2/24 at 5:00 AM, indicated R3 called out and was not able to verbalize what R3 needed. Music and low lights were ineffective. PRN lorazepam was administered at 12:20 AM and was no longer effective. Staff were unable to redirect R3 at that time and would assist R3 into R3's chair for a change in environment. A progress note, dated 10/3/24 at 1:19 PM, indicated R3 was seen by an MD who gave orders to hold lorazepam, start tramadol 50 mg (milligrams) twice daily for 7 days, and follow-up on R3's symptoms. The noted indicated staff would attempt to treat R3's pain to see if it helped with calling out. A progress note, dated 10/7/24 at 8:15 AM, indicated R3 yelled out and had anxiety that morning. A Registered Nurse (RN) reported no change with the addition of tramadol. R3 was on scheduled Tylenol and duloxetine 60 mg for pain/anxiety as well. The note indicated scheduled and PRN lorazepam would be added again and staff should update the MD on R3's behavior in 1 week. A progress note, dated 10/10/24 at 10:33 PM, indicated R3 appeared to be having visual hallucinations and was agitated, yelling, crying, and pointing at/hitting the wall and ceiling. PRN Ativan was ineffective. The MD was notified. On 10/14/24 at 11:15 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-C who worked regularly with R3. CNA-C indicated R3's vocalizations occurred daily and it was difficult to figure out what was going on with R3. CNA-C indicated R3 had medication to help with pain and anxiety and had a TV and radio which sometimes calmed R3. CNA-C indicated staff try to get R3 in R3's chair or bring R3 to the lobby or nurses' station. CNA-C indicated other residents (mostly R4 and R5) expressed concerns to CNA-C that R3 called out. CNA-C indicated CNA-C tries to empathize with residents who express concerns though CNA-C can't share much due to privacy. CNA-C indicated CNA-C worked at the facility for a month but hadn't spoken to the Director of Nursing (DON) about the concerns. CNA-C indicated R3 had been calling out since CNA-C started at the facility. On 10/14/24 at 12:08 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated R3 yelled quite a bit. When asked what staff do to assist R3, LPN-D indicated staff offer a change of position, get R3 up in R3's chair, and have R3 sit out front or in the lobby. LPN-D indicated R3's doctor and family worked on medication changes and had tried scheduled and PRN Ativan which didn't usually help. LPN-D indicated R3 was on a one week tramadol trial which didn't help either. LPN-D indicated R3 had a TV and radio which sometimes helped as did having someone in R3's room. LPN-D indicated two residents (R4 and R5) expressed concerns about R3 calling out. On 10/14/24, Surveyor reviewed R3's care plan and noted calling out was not listed as a target behavior. Surveyor also noted the interventions staff were using were not on R3's care plan. 2. On 10/14/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including spinal stenosis and chronic obstructive pulmonary disease (COPD). R5's MDS assessment, dated 7/22/24, had a BIMS score of 15 out of 15 which indicated R5 had intact cognition. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/14/24 at 10:24 AM, Surveyor interviewed R5 who indicated R5 was good but tired. When Surveyor asked why R5 was tired, R5 asked if Surveyor heard the yeliing and indicated the yelling was constant. During the interview, Surveyor heard R3 (in the adjacent room) call out frequently. Surveyor noted R3's door was closed and R5's door was open. R5 indicated R5 was tired and did not want to get run down and get sick from not sleeping. R5 indicated R5 talked to multiple staff who said the facility was trying different things but nothing was helping. R5 indicated staff try to keep R3's door closed, but R5 can still hear R3. R5 indicated R5 did not want to close R5's door due to claustrophobia. R5 indicated staff hadn't offered R5 any alternatives like a sound machine. Surveyor reviewed R5's care plan which did not contain interventions to assist R5 when R5 expressed concerns about R3 calling out. On 10/14/24 at 1:45 PM, Surveyor interviewed Social Worker (SW)-E who indicated staff spoke to R5 last week. SW-E indicated R5 didn't indicate R3 calling out bothered R5, but indicated R5 was concerned that R3 was in distress. SW-E indicated R5 did not like R5's room door closed because R5 was claustrophobic. Surveyor noted the preference was not on R5's care plan. SW-E acknowledged care plan interventions for those who reside near R3 and expressed concerns are important as well. 3. On 10/14/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes. R4's MDS assessment, dated 9/23/24, had a BIMS score of 15 out of 15 which indicated R4 had intact cognition. On 10/14/24 at 10:46 AM, Surveyor interviewed R4 who indicated R4 was bothered by R3 frequently calling out. R4 indicated R4 could leave R4's room when R4 wanted and close R4's door which helped. R4 indicated R4 felt more short tempered due to R3 calling out. R4 indicated R4 talked to multiple staff but nothing was done. Surveyor reviewed R4's care plan which did not contain interventions to assist R4 when R4 expressed concerns about R3 calling out. On 10/14/24 at 1:45 PM, Surveyor interviewed SW-E who acknowledged R4 did not have care plan interventions to assist R4 when R3 called out. SW-E indicated SW-E spoke to R4 last week, contacted the Ombudsman, and provided R4 with information on residents' rights. SW-E acknowledged care plan interventions for residents who expressed concerns about R3 calling out were important until the facility could work with R3's physician and guardian to find a strategy that worked for R3. On 10/14/24 at 2:08 PM, Surveyor interviewed DON-B who confirmed R3's care plan was not updated to indicate R3 called out and did not contain interventions for staff to use when R3 called out repetitively. DON-B also acknowledged the importance of care plan interventions to assist R4 and R5 when they expressed concerns about R3 calling out. 49563 4. On 10/14/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including right-sided subdural hematoma, chronic seizure disorder, altered mental status, left clavicle fracture, and left 3-7 rib fractures. R2's MDS assessment, dated 7/17/24, had a BIMS score of 4 out of 15 which indicated R2 had severe cognitive impairment. R2 had an activated Power of Attorney for Healthcare (POAHC). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed a care plan (initiated on 7/15/24) that indicated R2 was at risk for falls and was on 1:1 supervision. A care plan (initiated on 7/16/24) indicated R2 had limited physical mobility and neurological deficits and was on 15-minute checks. On 7/24/24, R2 was involved in an altercation with R1 which caused harm to R1. Because R2's care plan was not updated appropriately, it caused confusion at the time of the incident regarding the supervision level that was required for R2. On 10/14/24 at 12:05 PM, Surveyor interviewed Registered Nurse (RN)-F who did not recall if R2 was on 1:1 supervision or 15-minute checks at the time of the altercation. RN-F indicated 1:1 supervision was provided at times when R2 was rambunctious. On 10/14/24 at 12:25 PM, Surveyor interviewed CNA-G who was unsure if R2 was on 15-minute checks or 1:1 supervision. CNA-G indicated 15-minute checks were documented on a clipboard by nurses and CNAs. On 10/14/24 at 2:38 PM, Surveyor interviewed DON-B who verified staff should update a resident's care plan when there is a change in the resident's plan of care.