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	12/16/2024

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 - Some	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** 50479 Based on staff and resident interview and record review, the facility did not acknowledge nor make a prompt effort to resolve grievances for 5 residents (R) (R3, R4, R6, R7, and R8) of 10 sampled residents. R3 filed a grievance regarding R2 wandering into R3's room unsupervised. The facility did not implement interventions to prevent R2 from wandering into R3's room. R3 indicated R2 continued to wander into R3's room and the grievance was not resolved. R4, R6, R7, and R8 verbally notified staff that R2 repeatedly wandered into their rooms and was not welcome in their rooms. The facility did not document R4, R6, R7, and R8's concerns as grievances and did not implement interventions to prevent R2 from wandering into their rooms. Findings include: The facility's Company Concerns Policy, dated 10/2020, 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 and his/her representative may speak to any member of the facility staff and report the nature of the grievance or submit a written concern form .3. Upon notification of a resident concern, information sufficient to identify the individual registering the concern .will be recorded. 4. The concern officer will route the grievance to the appropriate department head related to the grievance filed, and an investigation of the grievance will be conducted. Based on the nature of the grievance, the concern officer will initiate any additional interventions that are indicated at the time .5. After thorough research has been conducted, the department head and/or concern officer will work in tandem with staff identified as key individuals critical to problem resolution for the specific identified concern. All efforts will be made to effectively and expeditiously resolve the grievance. 6. All concerns receive immediate priority and must be investigated with efforts made towards resolution within seven days. 7. The resident will be provided with a verbal follow-up to their grievance including the following information: a. The name of the department head who conducted the follow-up investigation. b. The steps taken to investigate and resolve the concern. c. The final result of the concern . (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including Non-Alzheimer's dementia with severe behavioral disturbances, anxiety, restlessness, and agitation. R2's Minimum Data Set (MDS) assessment, dated 9/3/24, indicated R2 had severe cognitive impairment. R2's care plan, dated 7/15/24 with a target date of 1/1/25, indicated R2 wandered throughout the halls to look at different things due to a new environment, but did not exit seek. The care plan contained the following interventions: Continue to monitor (R2's) wandering (initiated 7/31/24); Redirect/reorient as needed/appropriate (initiated 7/31/24). R2's plan of care also indicated R2 was and had the potential to be physically and/or verbally aggressive to staff (initiated 8/19/24). On 12/4/24, Surveyor reviewed the facility's October, November, and December 2024 grievance logs. A grievance, dated 10/17/24, indicated R3 stated R2 entered R3's room and rummaged through R3's belongings. No other grievances were documented related to R2 entering residents' rooms. On 12/4/24 at 10:10 AM, Surveyor interviewed R3 who indicated R2 enters R3's room several times per week. R3 stated R2 scares the hell out of me. R3 indicated R3 filed a formal grievance with the facility and stated R2 was not welcome in R3's room. R3 indicated the facility did not follow-up with R3 or resolve R3's grievance. R3 indicated the facility had not done anything to prevent R2 from entering R3's room and R2 continued to enter R3's room. R3 stated R3 calls staff to remove R2 when R2 enters R3's room. On 12/4/24 at 10:25 AM, Surveyor interviewed R4 who indicated R2 often enters R4's room. R4 stated R4 does not feel safe around R2 due to R2's aggressive behavior. R4 described the following incident to the Surveyor: R2 entered R4's room and yelled at R4. R2 was positioned in front of R4's door and blocked R4's exit from the room. R4 felt trapped in the room and felt threatened when R2 aggressively pointed R2's finger at R4 and told R4 to shut up. R4 felt R2 would have swung at R4 if R4 had moved closer to R2. R4 indicated the altercation ended when R2's spouse entered R4's room and removed R2 from the room. R4 reported the incident to several staff and informed staff that R2 was not welcome in R4's room. R4 indicated R2 continued to enter R4's room after the incident. On 12/4/24 at 10:35 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-C who indicated R2 was mobile and independently self-propelled around the facility in a wheelchair. R2 grabbed at other residents and on one occasion bit another resident. CNA-C was directed by management to keep R2 away from other residents. CNA-C indicated R2 wanders into other residents' rooms daily. Staff attempt to redirect R2 out of residents' rooms as quickly as possible. On 12/4/24 at 10:45 AM, Surveyor interviewed R5 who indicated R2 often wanders into residents' rooms without supervision. R5 witnessed R2 hit staff. R5 indicated R2 enters R5's room, yells, and takes small items from R5's room including pencils and magazines. R5 did not report the incidents to staff because R5 thought staff were already aware of R2's behavior. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24 at 11:10 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who worked on R2's unit and was familiar with R2's behavior. LPN-D indicated R2 had severe dementia and behaviors that included wandering, yelling, hitting, scratching, and biting. LPN-D indicated R2 wandered into other residents' rooms at least once per week. LPN-D reported concerns about R2's wandering to Director of Nursing (DON)-B. LPN-D indicated R2's wandering was discussed during daily huddle meetings on multiple occasions. LPN-D indicated R6 complained about R2 entering R6's room and asked that R2 not be allowed in R6's room, however, R2 continues to wander into R6's room. On 12/4/24 at 11:15 AM, Surveyor interviewed R6 who indicated R6 was fearful of R2 and distressed by interactions with R2. R6 stated R2 rummages through R6's personal belongings and makes disparaging remarks to R6. R6 stated R6 made repeated complaints to staff about R2 entering R6's room and told staff on multiple occasions that R2 was not welcome in R6's room. R6 stated R2 continues to enters R6's room. R6 indicated R6 does not feel the facility has taken R6's concerns seriously. R6 stated, (R2) makes me a nervous wreck. (R2) gives me a headache and stresses me out. I feel scared in my own room because of (R2). On 12/4/24 at 1:10 PM, Surveyor interviewed R7 who resided in the room next to R2. R7 indicated R2 enters R7's room nearly every day. R7 indicated R2 has gone through R7's drawers and personal items and has torn up papers in R7's room. R7 indicated R2 repeatedly yells and cusses at R7 while in R7's room and has called R7 disparaging names such as bitch. R7 indicated approximately a week prior, R2 entered R7's room and kicked R7 in the left shin. R7 reported the incident to Med Tech (MT)-F. R7 indicated R7 informed multiple staff that R2 was not welcome in R7's room. R7 indicated there has been no follow-up to prevent R2 from entering R7's room uninvited. On 12/4/24 at 1:30 PM, Surveyor interviewed Registered Nurse (RN)-E who confirmed R2 wandered into residents' rooms daily. RN-E indicated R2 was impulsive and restless and stated staff should redirect R2 away from residents' rooms. RN-E indicated the facility expects residents to activate their call lights if R2 is in their room. RN-E indicated R2's wandering interventions include giving R2 a baby doll to cuddle or magazines to rip up, however, the interventions are ineffective. RN-E described an incident approximately a week prior when R8 reported R2 was in R8's room. R8 told RN-E that R2 was not welcome in R8's room. RN-E did not document the incident because RN-E did not think it was a formal complaint. RN-E denied RN-E was notified that R2 kicked R7 and that R2 yelled at other residents and called them derogatory names. RN-E indicated any physical or verbal abuse should be reported, documented in progress notes, and investigated. RN-E indicated staff should report all resident complaints made verbally or in writing and all complaints should be investigated. On 12/4/24 at 1:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A was unaware that any resident aside from R3 had complained about R2 entering their room. NHA-A denied NHA-A was notified that R2 was verbally and physically aggressive toward other residents. NHA-A indicated incidents of verbal or physical abuse should be reported and documented. NHA-A indicated R3's grievance was addressed by reminding staff to redirect R2 when R2 wanders into residents' rooms. NHA-A provided staff education on redirecting wandering residents from other residents' rooms on 10/29/24 and 10/30/24. NHA-A confirmed no new interventions were implemented to prevent R2 from entering other residents' rooms after R3's grievance. NHA-A indicated interviews with other residents were not completed in response to R3's grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24 at 2:00 PM, Surveyor interviewed DON-B who indicated DON-B was aware that R2 wandered into residents' rooms and was aware of R3's complaint. DON-B indicated DON-B was not aware that other residents had concerns about R2 wandering into their rooms and was not aware that R2 was verbally and physically aggressive toward other residents. DON-B indicated verbal and physical altercations between residents should be documented and reported by administration. On 12/4/24 at 2:15 PM, Surveyor interviewed MT-F who worked on R2's unit. MT-F indicated R2 wandered into residents' rooms nearly every day and frequently needed redirection. MT-F indicated R2 and R6 sometimes got into verbal arguments in common areas, but R2 was easily redirected. MT-F confirmed R2 frequently entered R7's room and that R7 had complained about R2 being in R7's room. MT-F indicated R7 asked MT-F and other staff to keep R2 out of R7's room. MT-F indicated DON-B was aware of R2's wandering which was discussed in daily huddles. MT-F denied MT-F was informed by R7 that R2 kicked R7. On 12/4/24 at 4:05 PM, Surveyor interviewed R8 who indicated R2 wandered into R8's room on several occasions. R8 asked nursing staff to keep R2 out of R8's room, but did not file a formal grievance. R8 enjoyed doing jigsaw puzzles and stated R2 had entered R8's room in the past and torn up R8's puzzles. R8 indicated R8 barricades R8's door with a bedside table to prevent R2 from entering the room. On 12/4/24 at 4:20 PM, Surveyor interviewed NHA-A who indicated staff were educated in daily huddles to report all resident concerns. NHA-A indicated verbal and written complaints should be documented as grievances. NHA-A indicated NHA-A expects staff to report, document, and address all residents' concerns per the facility's grievance process.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, staff, resident, resident representative interview, and record review, the facility did not ensure the resident environment remained free of abuse for 1 resident (R) (R2) of 10 sampled residents. R9 had a history of sexually inappropriate behavior toward residents and staff. R2 had a history of wandering in and out of residents' rooms unsupervised. On 10/23/24, R10 reported to R2's Guardian (GDN-O) that R9 had groped R2's breast in the dining room. GDN-O reported the allegation to Nursing Home Administrator (NHA)-A. R2 was not assessed for injury and there were no interventions put in place to supervise R9 and R2. The facility's failure to supervise a resident with a history of sexually inappropriate behavior and a vulnerable resident who wandered in the facility unsupervised created a finding of immediate jeopardy that began on 10/23/24. NHA-A was notified of the immediate jeopardy on 12/6/24 at 11:00 AM. The immediate jeopardy was removed on 12/6/24, however, the deficient practice continues at a scope/severity level D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include: The facility's Abuse Prevention Program policy indicates: The purpose of this policy is to assure the facility is doing all that is within its control to prevent occurrences of abuse .This will be done by: .identifying occurrences and patterns of potential mistreatment; immediately protecting residents involved in identified reports of possible abuse .; implementing systems to promptly and aggressively investigate all reports and allegations of abuse .and making the necessary changes to prevent further occurrences .V. Protection of Residents: The facility will take steps to prevent potential abuse while the investigation is underway. VI. Internal Investigation: 1. All incidents will be documented whether or not abuse .was alleged or suspected. 2. Any incident or allegation involving abuse .will result in an investigation. Resident Protection Investigation Paths: .If an allegation of physical sexual contact without penetration is involved: Do a full body exam. Check range of motion. Consult with a physician as to the need for further diagnostic examination or X-rays . On 12/4/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including Non-Alzheimer's dementia with severe dementia with behavioral disturbances, anxiety, restlessness, and agitation. R2's Minimum Data Set (MDS) assessment, dated 9/3/24, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R2 had severe cognitive impairment. R2 had a Guardian for healthcare decisions. On 12/4/24, Surveyor reviewed R9's medical record. R9 was readmitted to the facility on [DATE]. R9 had diagnoses including vascular disease, cerebral infarction, and diabetes. R9's MDS assessment, dated 9/21/24, had a BIMS score of 13 out of 15 which indicated R9 was not cognitively impaired. R9 was R9's own decision maker. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/4/24, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including acute kidney failure, depression, and diabetes. R10's MDS assessment, dated 10/19/24, had a BIMS score of 15 out of 15 which indicated R10 was not cognitively impaired. R10 was R10's own decision maker. On 12/4/24 at 10:42 AM, Surveyor interviewed GDN-O who indicated R10 approached GDN-O on 10/23/24 and reported that before GDN-O arrived at the facility, R10 witnessed R9 fondle R2's breast in the dining room. R10 informed GDN-O that Registered Nurse (RN)-G moved R9 away from R2 and out of the dining room. When GDN-O asked RN-G why GDN-O was not notified, GDN-O indicated RN-G thought someone else was going to report it. GDN-O asked NHA-A to see footage from the video camera in the dining room but was denied. GDN-O was still upset two days later, asked NHA-A for more follow-up, and was again denied the ability to view video footage of the incident. GDN-O stated NHA-A indicated there was a split second in the video when R9 reached for R2, but R2 brushed R9's hand away. GDN-O asked to see the video a third time and was denied. GDN-O relayed the observations reported by NHA-A to R10. R10 indicated that was not accurate and told GDN-O that R9 had R9's hand on R2's breast for a while and was rubbing it. GDN-O indicated the facility should have reported the incident to the police. GDN-O indicated GDN-O was not happy with R2's care because R2 was often unsupervised and left to roam at will in the facility. R9's medical record contained the following: ~A progress note, dated 10/23/24 at 5:16 PM by RN-G, indicated R9 reached for another resident and the writer pulled R9 away. No contact was made when writer was present. R9 was escorted from the dining room. ~A progress note, dated 10/24/24 at 10:41 AM, indicated R9 has had increased sexual behaviors toward staff and residents. Staff redirected and educated R9 that sexual thoughts were normal but R9 should respect others' space and bodies. The note was sent by RN-H to Primary Physician (PP)-M and Nurse Practitioner (NP)-N and asked them to advise. ~A note, dated 10/24/24 at 3:07 PM, indicated R9 had daily behaviors and redirection was only partially effective and seemed less effective than previously. The note was entered by RN-H in response to PP-M and NP-N and asked them to advise. ~A note, dated 10/25/24 at 3:34 PM, indicated R9 had a new order for finasteride 5 milligrams (mg) daily prescribed by NP-N. R2's medical record did not contain documentation of the alleged sexual assault in the dining room on 10/23/24 or a skin assessment following the allegation of abuse. R10's medical record did not indicate R10 witnessed or reported a sexual assault in the dining room on 10/23/24. On 12/4/24 at 2:10 PM, Surveyor observed R9 in bed with the door open. R9 was not wearing pants and R9's buttock and groin were visible from the hallway. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/4/24 at 4:24 PM, Surveyor interviewed R10 who recalled the 10/23/24 incident involving R2 and R9 without being prompted. R10 indicated R9 groped R2 on the chest in the cafeteria for approximately one minute. As R10 made R10's way over to stop the incident, a staff quickly and urgently moved R9 away from R2. R10 was unsure if the staff saw what happened between R9 and R2 but thought they did due to the quick separation of the residents. R10 told GDN-O what R10 witnessed when GDN-O arrived to see R2 that day. R10 also reported the incident to NHA-A in a brief conversation. R10 indicated NHA-A seemed unconcerned. R10 was positive there was physical contact and stated the front of R2's shirt was moving when staff moved R9 away from R2. On 12/4/24 at 4:33 PM, Surveyor interviewed R9 who indicated (through head nods, head shakes, word mouthing, and hand gestures) that R9 did not touch anyone's breast. R9 indicated NHA-A talked to R9 about not touching people. When asked if NHA-A talked to R9 because R9 had touched someone, R9 nodded yes. On 12/4/24, Surveyor attempted to interview R2 who was unable to answer questions. On 12/4/24 at 4:42 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-L who worked on 10/23/24 but did not witness the incident between R9 and R2. CNA-L was informed that R9 attempted to touch R2's breast by an unknown staff. CNA-L indicated R9 was often naked in R9's room or naked on the bottom half in bed with the door open. CNA-L indicated R9 was handsy, grabbed staffs' butts, and told people they had nice asses. When asked what interventions were in place for R9's sexual behavior, CNA-L stated staff verbally redirected R9 and documented after the behavior occurred. CNA-L indicated R2 was often in other residents' rooms. CNA-L indicated there was no stopping R2. CNA-L felt there was not enough staff to appropriately supervise R2. On 12/4/24 at 4:54 PM, Surveyor interviewed RN- I who worked on 10/23/24 but was not aware of the incident between R9 and R2. When asked if R9 touched R2's breast, RN-I stated the incident rang a bell but RN-I was unsure if there was a touch or an attempt. RN-I indicated coworkers often talked about R9's sexual behavior and how they had to redirect R9. On 12/4/24 at 5:04 PM, Surveyor interviewed Med Tech (MT)-F who was outside the dining room window and saw R9 approach and reach for R2 on 10/23/24. When MT-F knocked on the window, R9 pulled R9's arm back from R2. MT-F indicated a staff then entered the dining room and pulled R9 away from R2. MT-F did not think anything sexual happened, but was later told (by an unknown staff) that R9 had touched R2. When asked what interventions were in place for R9, MT-F indicated R2 was not allowed in the dining room without staff or R2's spouse to protect R2 from being touched by R9. MT-F stated MT-F could not keep R9 out of the dining room but could try to protect R2. MT-F was unsure if the intervention to separate R9 and R2 was care planned and stated NHA-A and Director of Nursing (DON)-B gave the directive several times during daily huddles. On 12/4/24 at 5:08 PM, Surveyor interviewed PP-M who was aware R9 had increased sexual behavior toward residents and staff but was not aware of any specific incidents, including the incident on 10/23/24. PP-M indicated Surveyor should speak with NP-N regarding R9's finasteride order. PP-M indicated finasteride was most likely prescribed to decrease R9's sexual behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/4/24 at 5:12 PM, Surveyor interviewed CNA-K who worked on 10/23/24 but was not aware of the incident between R9 and R2 and was not aware of a directive to keep R9 away from R2. CNA-K heard from coworkers that R9 offered them money to touch their breasts. CNA-K stated R2 was often in other residents' rooms and indicated CNA-K could not keep track of R2 if CNA-K was completing cares. CNA-K indicated it was especially difficult after 6:00 PM and R2 was left to roam the halls. CNA-K indicated if R2 was not in the hall, R2 was probably in another resident's room. CNA-K tried to keep R2 in common areas. On 12/4/24 at 5:27 PM, Surveyor interviewed RN-G who stated R9 offered staff money for sexual favors. RN-G indicated R9's behaviors were often verbal, however, R9 reached for body parts and patted people's bottoms. RN-G verified RN-G removed R9 from the dining room on 10/23/24, directed R9 to R9's room, and told R9 that R9 could not touch or approach people without their permission. RN-G did not see any contact between R9 and R2 which was what RN-G documented. When asked why RN-G separated R9 and R2 if nothing occurred, RN-G indicated RN-G did not think R9 and R2 should be in close proximity to each other. When asked what interventions were in place for R9's sexual behavior, RN-G indicated staff verbally redirected R9 and documented R9's behavior. RN-G indicated R9 was prescribed medication to decrease sexual behavior, but the medication was not as effective as they had hoped. RN-G reported the 10/23/24 incident to NHA-A and DON-B after GDN-O confronted RN-G about the incident. GDN-O would not share who reported the allegation of sexual contact to GDN-O. RN-G could not say R10's report of sexual contact between R9 and R2 was false, however, RN-G did not see any sexual contact when RN-G moved R9 away from R2. RN-G entered R9's order for finasteride on 10/25/24 but did not communicate with the physician about R9's increased sexual behavior. After reading the order and notes in R9's medical record, RN-G stated RN-G believed the medication was started because R9 had behavior toward R2. When asked if R9 had touched other residents, RN-G stated, No. Most of the time it is (R2) or staff. RN-G was aware that R9 had offered money to see staffs' breasts and had asked staff to rub R9 sexually. On 12/4/24 at 7:36 PM, Surveyor interviewed RN-H who worked on 10/23/24. RN-H indicated RN-H heard from other staff that R9 made sexual comments and attempted to grab them. RN-H noted an increase in R9's behavior and messaged the physician who prescribed finasteride. RN-H discussed the medication with another nurse because it was not typically prescribed. RN-H was not familiar with R9's care plan but indicated staff used redirection to address behavior after it occurred. RN-H tried to keep an eye on R9 when R9 was in common areas. RN-H indicated R9 wheeled R9's self toward other residents. RN-H moved R9 if R9 got too close to female residents to foreshadow (R9's) intent. When asked if R9 had touched R2 inappropriately, RN-H stated RN-H did not witness the incident on 10/23/24 but it sounded in line with R9's behavior and things discussed. RN-H indicated R2 could not be alone in the dining room as a result of the incident on 10/23/24. When asked if R9 targeted R2, RN-H indicated R9 targeted females in general. RN-H was not aware of any monitoring interventions for R9 and indicated sexual behavior should be addressed on a resident's care plan. On 12/5/24 at 8:53 AM and at 8:59 AM, Surveyor observed R9 self-propel R9's wheelchair in the 100 wing hall, 200 wing hall, and through a common area without supervision. Surveyor observed R2 in the common area at the same time but not near R9. On 12/5/24 at 11:25 AM, Surveyor interviewed CNA-J who worked on 10/23/24 but was not aware of R9's behavior or of a directive to keep R9 and R2 apart. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/5/24 at 12:16 PM, Surveyor interviewed NP-N who indicated staff reported R9's increased sexual behavior toward staff and residents to NP-N. When NP-N asked staff if redirection helped, staff indicated redirection did not work like it used to and indicated R9 had daily behaviors. NP-N prescribed finasteride for R9's sexual behavior, possible prostate issues, and history of urinary retention. NP-N indicated finasteride was the least restrictive medication for R9's behavior. On 12/5/24 at 1:24 PM, Surveyor interviewed DON-B. When asked what interventions were in place for R2 who wandered into other residents' rooms, DON-B indicated staff should redirect R2 with food, drinks, books, a doll, or to lay down and the behavior should be addressed on R2's care plan. DON-B was aware there was a grievance regarding R2's wandering and indicated R2's care plan was not yet updated. DON-B indicated R9 did not have daily sexual behaviors and was unsure why staff indicated that. DON-B confirmed DON-B and NHA-A directed staff to keep R9 and R2 apart following the incident on 10/23/24. DON-B and NHA-A interviewed R9 who told them R9 reached for R2 to stop R2 from ripping pages out of a magazine. DON-B verified R10 stated R9 groped and touched R2's breast. DON-B did not feel there was a reason for R10 to lie. DON-B and NHA spoke with Chief Nurse Officer (CNO)-P and Regional Director of Operations (RDO)-Q and determined the allegation was unsubstantiated. DON-B was unsure if the incident happened or not, but indicated an intervention was added to keep R9 and R2 apart and not allow R2 in the dining room without R2's spouse or staff. DON-B indicated the interventions should be part of R2 and R9's care plans. DON-B indicated R9 was mostly independent and was not monitored for going into other residents' rooms. DON-B indicated R9 and R2 were not on increased supervision. DON-B confirmed R9 was prescribed finasteride for increased sexual behaviors and indicated staff should redirect and document R9's behavior. DON-B reviewed camera footage from the dining room on 10/23/24 and indicated R9 reached toward R2 and R2 moved R9's arm away. DON-B could not definitively tell if R9's hand was or was not touching R2. DON-B indicated there was something in R2's hand but they could not determine what. DON-B and NHA-A interviewed staff and did education during a huddle regarding reporting signs of abuse. DON-B was not aware that GDN-O was not notified and confirmed GDN-O should have been notified. When asked why R9 was determined to be credible but R10 was not, DON-B did not answer. On 12/5/24 at 2:19 PM, Surveyor interviewed NHA-A who indicated R9 was inappropriate with staff, however, NHA-A was not aware that R9 was inappropriate with residents. NHA-A was unsure why notes to R9's physician indicated R9 had increased sexual behavior toward staff and residents. NHA-A indicated R9 was alert and redirectable. When asked why NHA-A directed staff to keep R9 and R2 apart, NHA-A stated there was an incident when R9 reached over R2 and R2 swatted R9's arm away. NHA-A stated there was no harm and R2 was not hurt. NHA-A indicated GDN-O did not want R9 by R2, so NHA-A and DON-B instructed staff to keep R9 and R2 apart. When asked why R10's allegation of abuse and GDN-O's concerns were disregarded, NHA-A indicated there was no intent from R9. NHA-A confirmed residents' concerns should be reported and investigated. When Surveyor indicated a concern regarding R2 entering others' rooms was reported in October 2024, NHA-A stated R2 was redirected when R2 entered others' rooms. NHA-A verified the behavior should be on R2's care plan. NHA-A agreed staff needed to supervise R2 for R2's safety and the safety of others. NHA-A indicated NHA-A viewed camera footage from the 10/23/24 incident and didn't see abuse. When Surveyor stated DON-B indicated the video was unclear, NHA-A indicated R2 quickly put R2's hand up to push R9 away and it did not appear abuse occurred. NHA-A indicated other residents were not interviewed following the incident. When asked why GDN-O was not allowed to see the video from 10/23/24, NHA-A indicated NHA-A had to check with corporate and did not hear back. (continued on next page)

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	12/16/2024

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/5/24 at 3:16 PM, Surveyor interviewed NHA-A and DON-B who indicated the facility no longer had the video from the incident on 10/23/24. On 12/5/24 at 3:51 PM, Surveyor completed a follow-up interview with MT-F. When asked if R9 had touched anyone, MT-F stated no, but R9 was a pervy guy with staff and MT-F did not trust R9 not to do anything to R2 which was why MT-F knocked on the window when R9 reached toward R2. MT-F indicated R9 was like a predator going for the weakest person. On 12/5/24, Surveyor reviewed the facility's soft file regarding the incident. A typed, unsigned, and undated document provided by NHA-A indicated NHA-A was notified of the incident by DON-B via phone on 10/23/24 at 6:30 PM. On 10/24/24, GDN-O arrived at the facility at 8:00 AM and asked NHA-A to investigate the incident. An investigation had not been started before GDN-O's request. Camera footage from the dining room indicated R2 was brought to the dining room at 4:45 PM. R9 entered the dining room at 4:50 PM and sat by R2. At 4:52 PM, R9 reached over and R2 brushed R9 away. NHA-A documented the incident was one to two seconds and it did not appear that R9 groped R2. At 4:55 PM, staff moved R9 away from R2. NHA-A notified GDN-O that there was no abuse. The file included an undated, handwritten note from RN-G stating RN-G saw R9 approach R2 and reach for R2. RN-G entered the dining room and removed R9. RN-G informed R9 that R9 could not touch residents and asked R9 to go to R9's room. A handwritten note from MT-F, dated 10/23/24, indicated MT-F knocked on the window when MT-F saw R9 wheel to R2's table and called the charge nurse who removed R9 immediately. MT-F stated R9 did not touch R2. A handwritten note from RN-I, dated 10/23/24, stated RN-I saw R9 wheel R9's chair close to R2. RN-I yelled at R9 to stop as R9 moved closer to R2. R9 stopped reaching for R2 and RN-I intervened before R9 touched R2. RN-I moved R2 to the other side of the room and away from R9. (Note: Surveyor contacted RN-I to clarify disputing statements provided by RN-I. RN-I stated the incident RN-I referred to in the handwritten statement occurred in the common room by the television and was not the incident that occurred between R9 and R2 in the dining room on 10/23/24.) On 12/6/24 at approximately 8:00 AM, Surveyor interviewed NHA-A who indicated NHA-A began interviewing other residents (primarily female residents) about abuse that morning (12/6/24) to ensure their safety. On 12/6/24, NHA-A presented Surveyor with an unsigned typed note from RN-H, dated 12/5/24, that indicated RN-H mistakenly wrote resident on RN-H's progress note to PP-M and NP-N on 10/24/24 that indicated R9 had increased sexual behavior toward staff and other residents. The typed note indicated RN-H did not know if R9 had sexual behavior toward other residents. On 12/5/24, Surveyor reviewed R9's plan of care which indicated R9 had the potential to be physically and verbally inappropriate due to poor impulse control (initiated 10/29/24). The following interventions were noted: Redirect R9 to spend private time in R9's room should R9 choose to gratify R9's self (dated 10/29/24); Attempt non-pharmacological approaches including redirection, explain what is not acceptable, and encourage R9 to sit at a men's table (dated 12/5/24). Target behaviors (revised 12/5/24) included: talking sexual, asking to see a woman's breast, touching in inappropriate areas, offering items or money for sexual favors. R9's plan of care did not contain any interventions to monitor R9 around other residents or keep R9 separated from R2. (continued on next page)

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 12/16/2024
NAME OF PROVIDER OR SUPPLIER: Meadowbrook at Oconto Falls		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 E Highland Dr, Oconto Falls, WI 54154	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/5/24, Surveyor reviewed R9's task documentation which indicated staff should document sexual behaviors each shift. Despite the fact that Surveyor interviewed multiple staff who indicated R9 had repeated and/or daily sexual behaviors, NP-N was notified of R9's increased behaviors, and finasteride was prescribed to help with sexual behavior, only one instance of sexual behavior was documented in October 2024 (not on 10/23/24). There were two entries of sexual behavior in November 2024 and no entries for December as of 12/5/24. On 12/5/24, Surveyor reviewed R2's plan of care which indicated R2 wandered the halls (initiated 7/31/24). Interventions included to monitor and redirect R2 as appropriate. A focus added to R2's plan of care (dated 8/19/24) indicated R2 was aggressive to others. An intervention (dated 12/4/24) indicated to attempt non-pharmacological approaches. A revision (dated 12/4/24) indicated staff should offer alternatives to occupy R2 if R2 wandered into residents' rooms. (Note: R2's plan of care did not indicate R2 wandered into other residents' rooms prior to 12/4/24.) Interventions (dated 12/4/24) indicated to get permission before touching, note changes in behavior, and notify the physician. The failure to supervise a resident with a history of inappropriate sexual behavior following an allegation of abuse involving a resident who wandered unsupervised in the facility created a reasonable likelihood for serious harm for R2 and other residents and led to a finding of immediate jeopardy. The facility removed the jeopardy on 12/6/24 when it completed the following: 1. Initiated one-to-one supervision for R9 who will be at least arms-length from and not seated near female residents. 2. Updated R9's behavior care plan and implemented interventions in accordance with R9's behavior patterns. 3. Consulted with R9's providers for suggestions and interventions. 4. Educated staff on abuse, behavior documentation, and updated care plan interventions.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on staff, resident, and resident representative interview and record review, the facility did not report an allegation of abuse to the State Agency (SA) for 1 resident (R) (R2) of 10 sampled residents. R10 and R2's Guardian (GDN-O) reported an allegation of sexual abuse that occurred on 10/23/24. The facility did not report the allegation to the SA. Findings include: The facility's Abuse Prevention Program policy indicates: .IV. Internal Reporting Requirements and Identification of Allegations .Any allegation of abuse or any incident that results in serious bodily injury will be reported to the required regulatory agencies immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours .VII. External Reporting: .When an allegation of abuse .has been made, the Administrator, or designee, shall complete and submit a Division of Quality Assurance (DQA) form F-62617 notifying DQA that an occurrence of potential abuse .has been reported to the Administrator and is being investigated. This report shall be made immediately. The term immediately as it is used in this policy in relation to reporting abuse .shall be defined as following management of the immediate risk to the resident or residents, including the administration of necessary medical attention, and establishing the safety of the resident or residents involved or not later than two hours after forming the suspicion, if the events that caused the suspicion result in serious bodily injury, or not later than 24 hours, if the events that cause the suspicion do not result in serious bodily injury. On 12/4/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including Non-Alzheimer's dementia with severe behavioral disturbances, anxiety, restlessness, and agitation. R2's most recent Minimum Data Set (MDS) assessment, dated 9/3/24, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R2 had severe cognitive impairment. R2 had a Guardian who was R2's decision maker. On 12/4/24, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and readmitted on [DATE]. R9 had diagnoses including heart disease, cerebral infarction, and diabetes. R9's most recent MDS assessment, dated 9/21/24, had a BIMS score of 13 out of 15 which indicated R9 was not cognitively impaired. R9 was R9's own decision maker. On 12/4/24, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including acute kidney failure, depression, and diabetes. R10's most recent MDS assessment, dated 10/19/24, had a BIMS score of 15 out of 15 which indicated R10 was not cognitively impaired. R10 was R10's own decision maker. On 12/4/24 at 10:42 AM, Surveyor interviewed GDN-O who indicated R9 had groped R2's breast on 10/23/24. GDN-O felt a proper investigation was not completed and the police were not notified. GDN-O indicated R10 witnessed the incident, however, GDN-O was not allowed to view video of the incident. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 4:24 PM, Surveyor interviewed R10 who recalled the incident on 10/23/24 between R2 and R9. R10 indicated R10 saw R9 grope R2 on the chest for approximately one minute in the cafeteria. R10 indicated R10 was on R10's way to stop the incident when a staff urgently and quickly moved R9 away from R2. R10 was unsure if the staff saw what happened between R9 and R2, but thought the staff did due to the quick removal. R10 told GDN-O what R10 witnessed when GDN-O arrived to see R2 later that day. R10 confirmed R10 briefly spoke to Nursing Home Administrator (NHA)-A about the incident and reported that R9 groped R2's chest. R10 indicated NHA-A seemed unconcerned with the information R10 shared about R9's behavior. R10 stated R10 was positive there was physical contact and indicated the front of R2's shirt was moving when staff moved R9 away from R2. On 12/5/24 at 1:24 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated the incident on 10/23/24 was not reported to the SA because DON-B, NHA-A, Chief Nursing Officer (CNO)-P, and Regional Director of Operations (RDO)-Q determined there was no need to report the incident because there was no intent from R9. On 12/5/24 at 2:19 PM, Surveyor interviewed NHA-A who indicated NHA-A did not submit a report to the SA after participating in a phone conversation with DON-B, CNO-P, and RDO-Q where it was determined that the incident was not reportable because there was no intent.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on staff, resident, resident representative interview and record review, the facility did not report an allegation of sexual abuse to the State Agency (SA) for 1 resident (R) (R2) of 10 sampled residents. R10 and R2's Guardian (GDN-O) reported an allegation of sexual abuse that occurred on 10/23/24. The facility did not thoroughly investigate the allegation of abuse. Findings include: The facility's Abuse Prevention Program policy indicates: .VI. Internal Investigation: 1. All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment, or misappropriation of resident property occurred, was alleged, or suspected. 2. Any incident or allegation involving abuse .will result in an investigation .If an allegation of physical sexual contact without penetration is involved: Do a full body exam. Check range of motion. Consult with a physician as to the need for further diagnostic examination or X-rays . The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) as required in Section 300.695 in the following situations: Intentional sexual touching or fondling or sexual exploitation (i.e., use of an individual for another person's sexual gratification, arousal, advantage, or profit); or for sexual abuse of a resident by a staff member, another resident, or visitor. On 12/4/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including Non-Alzheimer's dementia with severe behavioral disturbances, anxiety, restlessness, and agitation. R2's most recent Minimum Data Set (MDS) assessment, dated 9/3/24, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R2 had severe cognitive impairment. R2 had a Guardian who was R2's decision maker. On 12/4/24, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and readmitted on [DATE]. R9 had diagnoses including vascular disease, cerebral infarction, and diabetes. R9's most recent MDS assessment, dated 9/21/24, had a BIMS score of 13 out of 15 which indicated R9 was not cognitively impaired. R9 was R9's own decision maker. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 10:42 AM, Surveyor interviewed GDN-O who indicated R9 fondled R2's breast in the dining room on 10/23/24. GDN-O indicated R10 approached GDN-O on 10/23/24 and stated before GDN-O arrived at the facility that day, R10 witnessed R9 fondle R2's breast. R10 also indicated a staff (Registered Nurse (RN)-G) moved R9 away from R2 and out of the dining room. GDN-O asked RN-G why GDN-O was not informed of the incident. GDN-O indicated RN-G thought someone else notified GDN-O. GDN-O asked Nursing Home Administrator (NHA)-A if GDN-O could view footage from the video camera in the dining room but was denied. GDN-O indicated GDN-O was still upset two days later and asked NHA-A for more follow-up. GDN-O again asked NHA-A to see the video of the incident but was denied. GDN-O said NHA-A indicated there was a split second in the video where R9 reached for R2, but R2 brushed R9's hand away. GDN-O asked to see the video a third time but was denied. GDN-O relayed NHA-A's video observation to R10 who indicated NHA-A's observation was not accurate. R10 told GDN-O that R9 rubbed and touched R2's breast for a while. GDN-O indicated the facility should have reported the incident to the police but did not. GDN-O further indicated GDN-O was not happy with R2's care. GDN-O indicated R2 was often in other residents' rooms, was not supervised by staff, and was left to roam at R2's will. On 12/4/24 at 4:24 PM, Surveyor interviewed R10 who recalled the incident on 10/23/24 between R9 and R2. R10 stated R10 saw R9 grope R2 on the chest for approximately one minute in the cafeteria. R10 was making R10's way over to stop the incident when a staff quickly and urgently moved R9 away from R2. R10 was unsure if the staff saw what was happening between R9 and R2, but felt the staff did due to the quick removal. R10 told GDN-O what R10 witnessed on 10/23/24 when GDN-O arrived to see R2 later that day. R10 confirmed R10 spoke briefly to NHA-A and reported that R9 groped R2's chest. R10 indicated NHA-A seemed unconcerned with what R10 shared about R9's behavior. R10 stated R10 was positive there was physical contact and that the front of R2's shirt was moving when staff moved R9 away from R2. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24, Surveyor reviewed a soft file of the incident. A typed, undated, unsigned document provided by NHA-A indicated NHA-A was notified of the incident by Director of Nursing (DON)-B via phone on 10/23/24 at 6:30 PM. On 10/24/24, GDN-O came to the facility at 8:00 AM and asked NHA-A to investigate the incident. Per NHA-A's notes, an investigation had not been started prior to GDN-O's request. NHA-A's notes stated NHA-A and DON-B reviewed video footage of the incident that indicated R2 was brought to dining room on 10/23/24 at 4:45 PM. R9 entered the dining room at 4:50 PM and sat by R2. At 4:52 PM, R9 reached over to R2 and R2 brushed R9 away. NHA-A documented the incident was 1-2 seconds and indicated it did not appear that R9 groped R2. At 4:55 PM, staff moved R9 away from R2. NHA's notes indicated NHA-A notified GDN-O that the incident did not involve abuse. The soft file indicated GDN-O was fine with the determination and did not want to report it. The soft file also included a handwritten, undated note signed by RN-G that stated RN-G saw R9 approach and reach for R2. RN-G entered the dining room, removed R9, informed R9 that R9 could not touch residents, and asked R9 to go to R9's room. A handwritten note signed by Medication Technician (MT)-F, dated 10/23/24, indicated MT-F knocked on the dining room window when MT-F saw R9 wheel to R2's table. MT-F called the charge nurse who came immediately and removed R9. MT-F stated R9 did not touch R2. A third handwritten document signed by RN-I, dated 10/23/24, indicated RN-I saw R9 wheel R9's wheelchair close to R2 and immediately told R9 to stop. RN-I indicated R9 stopped reaching for R2 and RN-I intervened before R9 touched R2. RN-I moved R2 to the other side of the room and away from R9. Surveyor contacted RN-I after the survey to clarify disputing statements provided by RN-I during the investigation. RN-I stated the incident referred to in RN-I's statement in the soft file happened in the common room by the television and was not the same incident that happened between R9 and R2 in the dining room on 10/23/24. Surveyor noted the soft file did not contain resident interviews to ensure residents felt safe and were free from abuse at the time of the incident. Surveyor noted resident interviews were not completed until 12/6/24. Surveyor also noted R10's interview with NHA-A was not well documented and indicated R10 was uncertain of what R10 saw despite the fact that R10's interview with Surveyor on 12/4/24 was consistent with what R10 reported to GDN-O on 10/23/24. In addition, there were discrepancies in the statements from RN-I, RN-G, and MT-F. RN-G and MT-F's statements were related to the incident on 10/23/24, however, RN-I's statement described a separate incident. In addition, DON-B and NHA-A's statements differed on what could be clearly viewed on video of the incident. DON-B indicated DON-B could not see if R9 had touched R2 and could not see if R2 had something in R2's hand. In addition, staff did not complete a skin assessment for R2 following the incident. On 12/5/24 at 1:24 PM, Surveyor interviewed DON-B who indicated if a resident has a concern, the concern should be reported and thoroughly investigated. On 12/5/24 at 2:19 PM, Surveyor interviewed NHA-A who indicated if a resident has a concern, the concern should be reported and investigated. When asked about the investigation for the incident on 10/23/24, NHA-A indicated the facility could have done a better job with obtaining resident statements.

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 12/16/2024
NAME OF PROVIDER OR SUPPLIER Meadowbrook at Oconto Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** 50479 Based on observation, staff and resident interview, and record review, the facility did not ensure appropriate supervision was in place for 1 resident (R) (R2) of 3 residents who wandered and was physically and verbally aggressive. R2 wandered throughout the facility and was physically and verbally aggressive. The facility did not appropriately supervise R2 to protect R2 and other residents. In addition, the facility did not revise R2's plan of care to include behavioral and monitoring interventions. Findings include: The facility's Dementia Care policy, dated March 2020, indicates: Residents with dementia-related diagnoses will have individualized care plans developed by the Interdisciplinary Team which provide person-centered care that is supportive, promotes comfort, recognizes individual needs/preferences, and includes past life experiences and preferences when possible .The facility's behavior committee will monitor residents for new and worsening behaviors and will implement individualized care approaches to address behavioral issues. The behavior committee will monitor for unnecessary medication use and implement non-pharmacological interventions unless clinically contraindicated . On 12/4/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including Non-Alzheimer's dementia with severe behavioral disturbances, anxiety, restlessness, and agitation. R2's Minimum Data Set (MDS) assessment, dated 9/3/24, indicated R2 had severe cognitive impairment. R2's plan of care, initiated 7/31/24, indicated R2 wandered through the halls to look at different things due to a new environment but did not exit seek. The care plan contained a goal that R2 would not leave the facility unattended (initiated 7/31/24). Interventions, dated 7/31/24, instructed staff to monitor R2's wandering and redirect/reorient as needed/appropriate. R2's plan of care, initiated 8/19/24, indicated R2 was and had the potential to be physically and verbally aggressive to staff and contained a goal that R2 would not harm R2's self or others. Interventions, dated 8/19/24, instructed staff to administer medications as ordered and assess behaviors every shift. R2's plan of care, initiated 7/31/24, indicated R2 yelled, hit, pushed, grabbed, and pinched staff during toileting and activities of daily living (ADLS) and contained a goal (dated 8/26/24) that R2 would not harm R2's self or others. An intervention, dated 10/14/24, indicated R2 would not sit within arms reach of another resident when in the dining room for meals and activities. On 12/4/24, Surveyor reviewed R2's Medication Administration Record (MAR) which contained the following orders and administration information: (continued on next page)

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 12/16/2024
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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ Lorazepam oral tablet 0.5 milligrams (mg) every eight hours as needed for anxiety, agitation, and restlessness. R2 received seven doses of lorazepam in September 2024, eleven doses in October 2024, and fifteen doses in November 2024. ~ Quetiapine fumarate oral table 25 mg by mouth once daily. R2 received quetiapine fumarate daily as ordered in September, October, and November 2024. ~ Rivastigmine transdermal patch 4.6 mg/24 hours to be applied daily for dementia with behavioral disturbances. R2 received rivastigmine daily as ordered in September, October, and November 2024. No medication dose adjustments were made in September, October, or November 2024 for the above medications. On 12/4/24, Surveyor reviewed R2's Treatment Administration Record (TAR) which indicated the following: ~ R2 had increased anxiety, tearfulness, crying, and behaviors on sixteen days in September 2024 and fourteen days in October 2024. R2's medical record did not indicate R2's physician was notified of the frequency and severity of R2's dementia/behavior, the increased doses of lorazepam that R2 received, or that R2's medication regimen was not effectively managing R2's behaviors. In addition, R2's care plan was not updated to address R2's dementia/behavior in September 2024 despite the frequency of R2's behavior. On 12/4/24 at 10:20 AM, Surveyor interviewed R1 who indicated R2 bit R1's finger when R1 was seated near R2 in the dining room. R1 indicated that the bite did not break the skin but was painful. On 12/4/24 at 10:35 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-C who indicated R2 was mobile and self-propelled R2's wheelchair around the facility. R2 frequently yelled out unintelligibly, hit, scratched, and cussed at staff during cares. CNA-C indicated R2 grabbed at other residents and bit another resident (R1). CNA-C indicated CNA-C was directed by management to keep R2 away from other residents for their protection. CNA-C indicated R2 wanders into residents' rooms daily and staff attempt to redirect R2 as quickly as possible. CNA-C indicated staff give R2 a baby doll and wheel R2 to a quiet area when R2's behavior escalates. CNA-C indicated the interventions are sometimes ineffective. On 12/4/24 at 10:45 AM, Surveyor interviewed R5 who indicated R2 often wanders into residents' rooms without supervision. R5 indicated R2 entered R5's room on multiple occasions and yelled or took small items including pencils and magazines. R5 witnessed R2 hit staff. On 12/4/24 at 11:10 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated LPN-D worked on R2's unit and was familiar with R2's behavior. LPN-D indicated R2 had severe dementia and exhibited wandering, yelling, hitting, scratching, and biting behavior. LPN-D indicated R2's behaviors were usually directed at staff, however, R2 had bitten R1. LPN-D indicated R2 wandered into residents' rooms at least once per week. LPN-D reported concerns about R2's wandering to Director of Nursing (DON)-B. (continued on next page)

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	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook at Oconto Falls	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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 1:30 PM, Surveyor interviewed Registered Nurse (RN)-E who indicated R2 was impulsive and continually restless. RN-E confirmed R2 wandered into residents' rooms daily. RN-E indicated R2's dementia/behavior interventions including giving R2 a baby doll to cuddle, redirecting R2 away from other residents, and giving R2 magazines to rip up. RN-E indicated interventions to curb R2's wandering had been ineffective. On 12/4/24 at 1:40 PM, Surveyor observed R2 seated in a central area near other residents. Staff were nearby, but did not have R2 within their line of sight. On 12/4/24 at 1:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed no interventions were implemented to prevent R2 from wandering into other residents' rooms. On 12/4/24 at 2:15 PM, Surveyor interviewed Med Tech (MT)-F who worked on R2's unit and indicated R2 wandered into residents' rooms nearly daily and needed frequent redirection. MT-F indicated R2 and R6 sometimes got into verbal arguments in common areas, but R2 was easily redirected. On 12/5/24 at 1:45 PM, Surveyor interviewed DON-B who indicated approaches to address R2's behavior included directing R2 to a common area, offering R2 food, drink, or books, assisting R2 to lay down in R2's room, and redirecting R2 when R2 wandered. DON-B confirmed the interventions should be documented in R2's plan of care.