

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 07/07/2026
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 resident (R) (R1) of 3 sampled residents with a non-pressure wound received treatment as ordered. R1 was admitted to the facility on [DATE] with a surgical wound on the lower spine. R1 did not have a treatment order for the wound until 5/22/26. R1's dressing was not changed while they resided at the facility. Findings include: The facility's Skin Management policy, revised July 2026, indicates: Residents receive care to aid in the prevention or worsening of wound and/or pressure ulcers. Individuals at risk for skin compromise are identified, assessed, and provided treatment to promote healing, prevent infections, and prevent new ulcers from developing. Ongoing monitoring and evaluation are provided for optimal resident outcomes. Residents admitted with skin impairments will have: a physician's order for treatment. The facility's Physician Orders policy, revised January 2026, indicates: Purpose: To ensure physician orders are implemented timely and accurately. Physician orders are obtained to provide clear direction regarding the care of the resident. R1 was admitted to the facility on [DATE] with a diagnosis of L4-L5 transforaminal lumbar interbody fusion with post operation infection methicillin-sensitive Staphylococcus aureus (MSSA) and a surgical wound. R1 was admitted to the facility for wound care and intravenous antibiotic therapy. R1 discharged from the facility on 5/22/26. A hospital discharge record, dated 5/19/26, indicated a wound vac could not be continued at the skilled nursing facility so the discharge plan included frequent dressing changes. (R1's medical record did not contain a wound dressing order upon admission on [DATE].) A wound dressing order (dated 5/22/26) indicated the following: ~ Wound type: post-surgical. Wound location: lower spine. Cover staples with oil emulsion followed by silicone foam border, change every shift and as needed. Every day three times daily. On 7/7/26 at 2:23 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-C who stated they did not complete a dressing change for R1 and was not aware that R1 had a wound dressing. On 7/7/26 at 2:28 PM, Surveyor interviewed interim Director of Nursing (DON)-B who stated the facility's wound physician completed rounds on 5/21/26 and a new dressing change order was entered into R1's medical record on 5/22/26. DON-B verified R1 did not have a dressing change order at the time of admission and nursing staff did not obtain an order. DON-B verified R1's wound dressing was not changed at the facility prior to their discharge on [DATE].		

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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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure effective pain management was provided for 1 resident (R) (R1) of 6 sampled residents. R1 was not provided effective pain management from 5/19/26 through 5/22/26. Findings include: The facility's Pain Management policy, dated July 2026, indicates: The facility will evaluate and identify residents experiencing pain; evaluate their existing pain and the cause(s); determine the type and severity of the pain; and develop a care plan for pain management .3. The Pain Evaluation will be completed in the following circumstances: Resident reports inadequate pain control .4. Following the evaluation, the nurse will notify the physician/licensed practitioner of the findings and document .and implement new orders, if received .12. The licensed nurse, when administering as needed (PRN) pain medication will record the drug administration and the following on the Medication Administration Record (MAR): Pain level using a 0-10 numerical rating scale .as appropriate .Follow-up observations post-intervention to determine the effectiveness of PRN pain interventions. If the resident is asleep or resting, document as an observation in a progress note. R1 was admitted to the facility on [DATE] and had diagnoses including infection of deep incisional surgical site, unspecified abdominal pain, varicose veins of bilateral lower extremities with pain, unspecified chest pain, nerve root and plexus disorder, and intervertebral disc degeneration of lumbar region. An admission Minimum Data Set (MDS) assessment, dated 5/22/26, stated R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R1 had intact cognition. The assessment also indicated R1 was at risk for pain and received scheduled pain medication. A care plan, dated 5/19/26, indicated R1 had pain and the potential for pain due to recent back surgery. The care plan contained interventions to notify the physician if interventions are unsuccessful or if current complaint is a significant change from R1's experience of pain (dated 5/19/26). A hospital Discharge summary, dated [DATE], indicated R1 had a postoperative lumbar wound infection at L4-L5 and chronic midline low back pain. R1 returned to the hospital on 5/22/26. On 7/7/26 at 11:53 AM, Surveyor interviewed R1's Significant Other ((SO)-F) who stated the facility did not administer pain medication as needed to alleviate R1's pain, specifically at night. SO-F stated R1 asked for pain medication one evening and did not receive it for 2 hours. The concern was reported to staff. SO-F stated R1 often cried and complained of pain when they arrived at facility or when they talked with R1 via phone. SO-F stated they discharged R1 from the facility on 5/22/26 and brought R1 to the hospital to be admitted for pain management. R1's physician orders included the following medications for pain:~ Oxycodone-acetaminophen (an opioid medication) 10-325 milligrams (mg) 1 tablet every 4 hours as needed (PRN) for pain (started 5/19/26)~ Tizanidine (a muscle relaxant) 4 mg every 6 hours PRN (started 5/19/26)~ Lyrica (a neuropathic pain agent) 150 mg three times daily for intervertebral disc degeneration, lumbar region without mention of lumbar back pain or lower extremity pain (started 5/19/26)~ Acetaminophen (Tylenol) 650 mg every 8 hours PRN for pain (started 5/19/26)~ Diclofenac sodium external gel 1% (a nonsteroidal anti-inflammatory medication) apply to affected area topically every 6 hours PRN for pain (started 5/19/26)~ Fentanyl transdermal patch (an opioid medication) 72 hour 25 microgram/hour (mcg/hr) apply 25 mcg transdermally every 72 hours related to nerve root and plexus disorder (started 5/20/26) ~ Lidoderm patch 5% (a local anesthetic) apply to affected area topically every 24 hours PRN for pain~ Pain evaluation every shift for pain management (started 5/19/26) R1's MAR indicated oxycodone-acetaminophen was administered on the following dates:~ On 5/19/26 at 9:20 PM for pain at a level 8/10 (with 10 being the worst pain) - a follow-up pain level of 8/10 was documented on (continued on next page)		

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Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the facility did not have documentation that R1's provider was updated on their continued complaints of pain. DON-B did not confirm if R1's provider should have been updated, but stated nurses should monitor a resident's pain and update the provider if pain is not effectively managed.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure they accurately acquired and administered medication for 1 resident (R) (R1) of 4 residents in a total sample of 6 residents. R1 was admitted to the facility with orders for Rexulti (an antipsychotic medication), Vyvanse (a central nervous system stimulant), Lyrica (used to treat nerve pain), fentanyl (an opioid medication) and biotin (a vitamin B supplement). The facility did not ensure the medications were acquired or administered as ordered. Findings include: The facility's Medication Administration policy, dated December 2025, indicates: Resident medications are administered in an accurate, safe, timely, and sanitary manner. Medications are administered in accordance with written orders of the attending physician. Verify the medication label against the medication sheet for accuracy of drug, frequency, duration, strength, and route. R1 was admitted to the facility on [DATE] and had diagnoses including infection of deep incisional surgical site, nerve root and plexus disorder, depression, attention-deficit hyperactivity disorder (ADHD) inattentive type, and intervertebral disc degeneration of lumbar region. An admission Minimum Data Set (MDS) assessment, dated 5/22/26, indicated R1 received antidepressant medication, was at risk for pain, and received scheduled pain medication. The assessment did not indicate R1 received antipsychotic medication. A care plan, dated 5/19/26, indicated R1 was prescribed antidepressant, antipsychotic, and pain medication and had the potential for pain. A hospital Discharge summary, dated [DATE], indicated R1 had a postoperative lumbar wound infection at L4-L5 as well as chronic midline low back pain and a history of binge eating disorder. R1 discharged from the facility back to the hospital on 5/22/26. On 7/7/26 at 11:53 AM, Surveyor interviewed R1's Significant Other ((SO)-F) who stated when R1 arrived at the facility on 5/19/26, the facility did not have R1's medications. SO-F stated the nurse told them they had to order the medications from the pharmacy which was located in another city and said some of the medications required a doctor's order which they did not have. SO-F stated all of the orders should have come from the hospital. SO-F stated R1 often cried and complained of pain when SO-F arrived at the facility or talked with R1 via phone. SO-F stated they discharged R1 from the facility on 5/22/26 and brought them to the hospital to be admitted for pain management. A hospital Discharge summary, dated [DATE], included the following orders: ~ Rexulti 2 milligrams (mg) daily for depression (last administered 5/19/26 at 9:03 AM). ~ Vyvanse 40 mg every morning for eating disorder with an associated diagnosis of ADHD (last administered 5/19/26 at 8:52 AM). ~ Lyrica 150 mg three times daily for L4-L5 disc bulge and compression of the spinal nerve root (last administered 5/19/26 at 8:53 AM). ~ Fentanyl 25 micrograms/hour (mcg/hr) 1 patch every third day (72 hours) for surgical site infection, chronic midline low back pain, unspecified sciatica, L4-L5 disc bulge (last administered 5/19/26 at 2:38 AM). ~ Biotin 10000 mcg daily as supplement (no hospital administration record noted). R1's Medication Administration Record (MAR) indicated from 5/19/26 through 5/22/26, orders for Rexulti, Vyvanse, Lyrica, and biotin were signed out as unavailable for administration. On 7/7/26 at 12:29 PM, Surveyor interviewed Registered Nurse (RN)-D who worked with R1 on their day of admission. RN-D stated some of R1's medications had not arrived and the facility did not have them in contingency. RN-D also stated some of the medications required a written prescription from the physician which did not arrive from the hospital and had to be requested. RN-D could not verify which medications were not available but stated one may have been Lyrica. R1's MAR contained an order for a fentanyl patch (dated 5/20/26) that was administered on 5/20/26 at 7:39 AM by Licensed Practical Nurse (LPN)-E. The patch was administered 29 hours after (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the previous patch was administered in the hospital and 43 hours before the next patch administration. On 7/7/26 at 1:07 PM, Surveyor interviewed LPN-E who did not recall if they had administered pain medication or a fentanyl patch for R1. LPN-E acknowledged R1's MAR indicated they administered the patch. LPN-E stated they would follow the physician's order for administration. On 7/7/26 at 3:13 PM, Surveyor interviewed interim Director of Nursing (DON)-B who was not the DON when R1 resided in the facility. DON-B stated nurses should administer medications as ordered by the physician. DON-B stated if a medication is unavailable or if the facility is unable to obtain a medication, the physician should be notified. DON-B verified the physician was not updated when R1's medications were not available.		