Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525488	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook at Black River Falls	1311 Tyler St Black River Falls, WI 54615

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 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. 51804 Based on observation, interview and record review, the facility did not ensure medications were administered in a safe and effective manner for 1 out of 6 residents (R2). RN set down Resident (R) 2's medications on tray table and left the room. There is a Self-Administration Assessment by the facility stating R2 is incapable of self-administering medications. When RN came back to the room resident had to tell her she took medications already when RN attempted to administer. This is evidenced by: The facility policy, titled Self-Administration of Medications dated May 2020, states: Each resident as the right to self-administer medication if he or she can do so. 2. If a resident desire to participate in self-administration, the interdisciplinary team will assess the competence of the resident to participate by completing a Medication Self Administration Assessment UDA. 6. The nurse will obtain a physician's order for each resident self-administering medication. The facility policy, titled Medication Storage dated January 2023, states: It is the policy of this facility to ensure all medications housed on our premised will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure . security. 1. General Guidelines: . C. During a medication pass, medications must be under the direct observation of the person administering medication or locked in the medication storage area/cart. R2 was admitted to the facility 12/11/24 and has diagnoses that include, but not limited to, paranoid schizophrenia; major depressive disorder, single episode; unspecified, anxiety disorder; chronic kidney disease, stage 4 (severe); chronic respiratory failure with hypercapnia, other specified disorders of nose and nasal sinuses. (continued on next page)

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

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Minimum Data Set (MDS) assessment, dated 12/18/24, indicated R2 has a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating R2 was cognitively intact. R2's Self-Administration of Medication Assessment, completed 12/11/24, showed that R2 is capable with assistance to administer her own medication. R2 was scored as not capable opening/closing, accurately telling time to take medication, administering nasal sprays or drops, administering inhalants or inhalers and other areas of the assessment. On 01/22/25 at 10:26 AM, Surveyor observed Director of Nursing (DON) B pass medications to R2. At this time R2 was to receive Deep Sea Nasal Spray (saline) 1 spray each nares (nostril) and ProAir Albuterol Inhaler 2 puffs inhalation orally every 4 hours DON B obtained and took medications to R2 in her room. DON B was called by another staff member. DON B set the nasal spray and inhaler on the tray table in front of R2 and left the room. Surveyor observed R2 administer 4 saline sprays to each nostril and self-administer 2 puffs of her Albuterol. When DON B came back to the room, she picked up the spray and started to take cap off when R2 informed her she already took it. DON B stated oh, well let's get your inhaler. R2 informed DON B she took that also. DON B took both meds back to the medication cart, and came back with a glass of water so R2 could rinse her mouth. On 01/22/25 at 3:03 PM, Surveyor interviewed DON B regarding self-administration of medications. DON B stated self-medication assessments and mini-mental assessments are completed on residents interested in self-administering medications. DON B stated her expectation would be to not leave medication with someone who did not pass self-administration assessment.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 48793 Based on observations, interviews, and record reviews, the facility did not provide anticoagulation therapy for 2 of 3 residents (R) (R1 and R8) reviewed. -Facility failed to verify and transcribe new physician orders with increased Warfarin dose which resulted in R1 not receiving the correct Warfarin dose. This resulted in R1 being sent to the Emergency Department (ED) needing an intravenous (IV) drip of heparin for adequate warfarin anticoagulation, and lovenox bridging until the international normalized ratio (INR) was back in therapeutic range. This example is cited at actual harm. -Facility failed to verify and transcribe R8's new physician orders with increased Warfarin dose changes. Findings include: The facility policy titled Anticoagulant Therapy, revised May 2020, states: .Effectively monitor residents receiving anticoagulant therapy and reduce the risk of bleeding by maintaining therapeutic blood levels in accordance with physician orders. #3. Confirm with the physician the desired INR and/or PT testing schedule and therapeutic range at the time of the anticoagulant therapy order. #4. Initiate and order anticoagulant therapy labs per physician's order. #6. Upon receipt of lab results, review INR and/or PT lab results for abnormal values. #8. Report lab results and current medication order to physician. #9. Throughout anticoagulant therapy monitor the resident for signs and symptoms of bleeding. #11. Document lab results, current dosage, and physician orders on the anticoagulant therapy flow sheet. Documentation: #1. Physician order #2. Nurses' notes. #3. Anticoagulant therapy flow sheet #4. Medication administration record. #5. Resident Care plan. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	#6. Key documentation elements: c. Pertinent lab results . On 01/22/25, Surveyor reviewed R1's medical record. R1 was admitted to facility on 09/27/24 with diagnoses including in part: Heart failure unspecified, presence of prosthetic heart valve, long term current use of anticoagulants, history of transient ischemic attacks (TIA) and cerebral infarction without residual effects, weakness, hyperlipidemia, chronic kidney disease, and bradycardia. R1's Minimum Data Set (MDS) assessment, dated 10/03/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R1 had intact cognition. MDS section GG for functional ability indicated R1 had impairment to one side upper extremity: impairment to both lower extremities. R1 needed setup for eating, setup for oral hygiene, partial/moderate assistance for dressing, partial/moderate assistance for rolling, sitting to lying, toilet transfer, and sit to stand. Surveyor reviewed R1's care plan initiated on 09/03/24. Surveyor did not find an anticoagulant care plan in place. Surveyor reviewed R1's physician orders, which stated in part: -On 10/01/24 Warfarin Sodium 2mg tablet, give 1 tablet by mouth one time a day related to presence of prosthetic heart valve. -On 10/29/24 draw INR. Surveyor reviewed clinic lab result, dated 10/29/24, which indicated R1's INR result 1.3; goal is 2.0-3.0; Order to increase warfarin dosing to 4mg Tuesdays (starting today) and 2mg all other days; recheck INR in 2 weeks. Surveyor observed that the new order for R1 with warfarin increase to 4mg was not transcribed into physician orders or the Medication Administration Record (MAR). Surveyor reviewed R1's October 2024 MAR which stated in part: -On 10/29/24, 10/30/24, 10/31/24, 11/01/24, and 11/02/24, R1's medication order of Warfarin 2mg give 1 tablet by mouth one time a day was blank and not signed out on R1's MAR. Surveyor did not find that R1's Warfarin medication was given on 10/29/24, 10/30/24, 10/31/24, 11/01/24, or 11/02/24. Surveyor reviewed R1's Treatment Administration Record (TAR) and did not find that anticoagulant therapy was being monitored for side effects of bleeding or adverse reactions to medication administration of anticoagulants. Surveyor reviewed progress notes which stated in part: On 11/03/24 at 7:59 PM, Writer noticed R1 did not have warfarin on MAR. Order stated he was to have INR on 10/29/24. Writer than found INR results and new orders under the document tab. MD on call notified of the doses of warfarin missed. MD gave new warfarin orders, recheck INR on 11/05/24. DON notified. R1 updated. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-On 11/05/24 at 12:37 PM, nursing progress note states R1 was at lunch and nurse noted R1 couldn't open left eye, was asked to smile and R1 couldn't, and R1 was not able to squeeze nurse's hands tightly. Facility called an ambulance and R1 sent to ED for evaluation. -On 11/05/24 at 9:48 PM, writer called rural hospital for an update on resident. ER staff stated resident was being transferred to higher level of care hospital with diagnosis of TIA. -On 11/05/24 at 10:13 p.m., R1 was admitted to the hospital. CT showed Carotid Terminus Aneurism (a bulge or dilation in the wall of the internal carotid artery at its termination point) and high-grade stenosis of distal right M1 (a narrowing of the right side of the brain's main blood vessel near its furthest point of origin, potentially impacting blood flow to the brain tissue supplied by that artery). CT showed no acute intracranial findings but chronic infarcts of both cerebellar hemispheres and right occipital lobe noted. R1 required IV administration of heparin 50 units/ml in 1/2 normal saline (NS) continuous because of the mechanical valve without adequate warfarin anticoagulation, and lovenox bridging of 0.8 ml under the skin every 12 hours until the international normalized ratio (INR) was back in therapeutic range. Following discharge on 11/08/24 at 9:42 a.m., R1's orders included: follow-up with neurology, schedule consult to neurosurgery for right carotid aneurysm and distal M1 stenosis, lovenox injections until INR is therapeutic, Warfarin dose on discharge-4mg Tuesday and 2 mg all other days, recheck INR on 11/11/24, repeat echocardiogram in 1 month and primary care provider (PCP) follow-up. R1's speech was mildly slurred upon admission and at discharge. Hospital documentation stated speech is mildly slurred but could be R1's baseline, no obvious aphasia noted, and patient moves all four extremities. -On 11/08/24 at 3:32 PM, R1's admission orders included: Lovenox twice a day, Warfarin 2mg a day except for 4 mg on Tuesdays. Lab is to draw INR on 11/11/24. Surveyor requested facility's investigation of R1's missed anticoagulation therapy medication on 10/29/24, 10/30/24, 10/31/24, 11/01/24, and 11/02/24, which stated in part: . In conclusion a medication error occurred, resident missed doses of Warfarin on 10/29/24, 10/30/24, 10/31/24, 11/01/24, and 11/02/24. [LPN D] failed to process new warfarin orders on 10/29/24 when received from Clinic. [LPN D] noted on 11/03/24 that she had made the error. MD updated with new orders obtained. [R1] assessed for adverse effects of missed doses on 11/03/24 with no findings . On 01/22/25 at 1:06 PM, Surveyor interviewed Director of Nursing (DON) B and asked DON B to explain the event on 11/05/24 that happened to R1 when Warfarin medication was not given on 10/29/24, 10/30/24, 10/31/24, 11/01/24, and 11/02/24. DON B indicated that Licensed Practical Nurse (LPN) D had missed the new order for Warfarin dose change on 10/29/24 and did not transcribe the order in the computer before leaving evening shift. DON B indicated that R1 did not receive 5 doses of Warfarin. DON B indicated that R1 had to be transferred out to emergency room (ER) on 11/05/24. Surveyor asked DON B what DON B's expectation of timeframe is when nurses process INR results and any new physician orders related to Warfarin dose changes. DON B indicated that nurses are to process the INR results and physician orders right away on their shift. DON B indicated that DON B's expectation is that two nurses are always reviewing the INR results and processing new physician orders pertaining to Warfarin. DON B indicated the second nurse has to sign off in the Warfarin binder. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 01/23/24 at 9:32 AM, Surveyor interviewed Nurse Practitioner (NP) H and asked if NP H has knowledge of R1 missing Warfarin doses on 10/29/24, 10/30/24, 10/31/24, 11/01/24, and 11/02/24. NP H indicated NP H was not aware when the missed doses were happening, but facility made NP H aware on 11/03/24. NP H said that missing Warfarin doses was not ok and could have contributed to R1's TIAs. R1 has a mechanical valve in place and needed to be anticoagulated appropriately. Example 2 On 01/22/25, Surveyor reviewed R8's medical record. R8 was admitted to facility on 05/26/2021 with diagnoses including in part: Chronic atrial fibrillation, type 2 diabetes mellitus, and atherosclerotic heart disease. Surveyor reviewed R8's physician orders, which stated in part: -On 01/21/25 Check INR one time. -Warfarin Sodium oral tablet 6mg, Give 6mg by mouth one time a day every Monday, Tuesday, Wednesday, Friday, Saturday, and Sunday with end date 01/21/24. Surveyor reviewed R8's January MAR which stated in part: .Warfarin Sodium give 6mg by mouth one time a day every Monday, Tuesday, Wednesday, Friday, Saturday, and Sunday. End date 01/21/24. Surveyor did not find any additional Warfarin orders on R8's MAR. On 01/22/24 at 12:15 PM, Surveyor observed Anticoagulant Binder at the nurses' station. Surveyor opened the book to find R8's communication sheet in the binder not fully completed. Surveyor observed communication sheet to be missing two nurse signatures for validation of processing new physician orders on 1/05/24, 11/26/24, 12/24/24, and 01/21/25. Surveyor reviewed Warfarin communication sheet which stated in part: .On 01/21/25, Hold coumadin today 01/21/25 and then continue 4mg every Thursday and 6mg every other day. Next INR draw is 02/04/25 . On 01/22/25 at 12:20 PM, Surveyor observed only one nurse signature that verified new physician orders of Warfarin. Surveyor reviewed MAR and physician orders and found no documentation of the new orders from the Warfarin communication sheet from the day before. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 01/22/25 at 12:41 PM, Surveyor interviewed DON B and asked what DON B's process is for receiving, verifying, and transcribing new Warfarin orders and lab INR results. DON B indicated that when INR results come in from the lab, two nurses verify lab results, notify appropriate provider, and receive new physician orders. One nurse is to write this down on the Warfarin communication sheet and transcribe in the Electronic Health Record (EHR), then the second nurse verifies the accuracy and signs the Warfarin communication sheet. Surveyor asked DON B if there have been two nurses reviewing Warfarin dose changes and INR results for R8 as the Warfarin communication binder shows that there have not been two nurses signing off on INR results or physician orders on the anticoagulant flow sheet located in binder at nurses' station since November 5, 2024. DON B indicated that two nurses are supposed to be, but DON B can see this is not being done appropriately. Surveyor indicated to DON B that Surveyor did not find the new Warfarin orders in the MAR for R8 in R8's EHR. Surveyor also noted that Surveyor could not find the new Warfarin order in the physician orders in the EHR that is due this evening 01/22/25 with the Warfarin dose change. DON B indicated the new Warfarin order is not transcribed in R8's EHR. DON B indicated that DON B would have gotten to the order later today after auditing the Warfarin communication binder. Surveyor asked DON B when does DON B audit the Warfarin communication binder. DON B indicated that DON B reviews it daily Monday through Friday. Surveyor asked why DON B has not caught that R8's Warfarin communication sheet in the binder does not have two nurses' signatures verifying the accuracy of the medication changes since November 5, 2024. DON B indicated that DON B did not realize there have not been two nurses verifying and that DON B will need to audit that better going forward.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51804 Based on observation, interview and record review, the facility did not ensure medications were stored securely and in accordance with currently accepted professional practice. The medication cart was left unlocked in 1 out of 2 medication carts. This is evidenced by: The facility policy, titled Medication Storage dated January 2023, states: It is the policy of this facility to ensure all medications housed on our premised will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure . security. 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, . On 01/22/25 at 10:03 AM, Surveyor observed an unattended medication cart unlocked outside R5's room on 300 hall. On 01/22/25 at 10:06 AM, Surveyor observed 5 different staff members walk by the unlocked, unattended medication cart. On 01/22/25 at 10:10 AM, Surveyor observed Licensed Practical Nurse (LPN) C walk out of R5's room and grab the unlocked medication cart and walk down the hallway. On 01/22/25 at 10:12 AM, Surveyor interviewed LPN C and asked what LPN C's normal process is when leaving the medication cart unattended outside a resident's room. LPN C indicated that the medication cart is usually locked when it is unattended. LPN C indicated that LPN did not lock the medication cart before entering R5's room and shutting the door. On 01/22/24 at 3:00 PM, Surveyor interviewed Director of Nursing (DON) B and asked expectation for medication carts unattended and unlocked. DON B indicated that DON B's expectation is that all medication carts are not to be left unattended and unlocked for any reason. DON B indicated that LPN C should have locked the medication cart before going into R5's room and shutting the door.