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	10/22/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility policy review, record review, and interview, the facility failed to provide the necessary care to ensure residents' activities of daily living (ADLs) needs were met, which affected 1 (Resident #2) of 3 residents reviewed for ADLs. Specifically, the facility did not transfer Resident #2 out of bed for several hours due to the slings for the mechanical lift used to transfer the resident being unavailable.Findings included:A facility policy titled, Lift and Transfer Policy, revised 10/2020, indicated, All resident care will be provided in a safe, appropriate, and timely manner in accordance with the resident's care plan.An admission Record indicated the facility admitted Resident #2 on 11/15/2023. According to the admission Record, the resident had a medical history that included diagnoses of dementia, chronic pain, anemia, and abnormalities of gait and mobility.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/24/2025, indicated Resident #2 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #2 was dependent on staff for transfers. The MDS indicated Resident #2 did not refuse care during the assessment period.Resident #2's Care Plan Report, included a focus area initiated 11/20/2023, that indicated the resident had limited physical mobility related to dementia and weakness. Interventions indicated that the resident required assistance from two staff for transfers (initiated 11/18/2024) and indicated that staff were to use a full body lift to transfer the resident (revised 02/01/2025).During an interview on 10/22/2025 at 12:51 PM, Resident #2's Responsible Party (RP), RP C, stated that they arrived at the facility to visit the resident at around 2:00 PM on 08/17/2025. RP C stated staff had told them that Resident #2 had been in bed for about an hour before they (RP C) arrived. The RP stated staff came in at around 5:00 PM and told them that the slings for mechanical lifts were still being washed, so they could not get Resident #2 out of bed. The RP stated that they did not think Resident #2 should stay in bed from 1:00 PM until the following day. RP C stated that staff did not get Resident #2 out of bed for the remainder of that evening and stated that they (RP C) left the facility at 7:00 PM that evening.During an interview on 10/22/2025 at 12:16 PM, Certified Nurse Aide (CNA) A stated she had gotten Resident #2 out of bed on the morning of 08/17/2025 and put the resident back in bed at around 1:00 PM. CNA A stated Resident #2's sling had been soiled, so staff put it in the wash. CNA A stated Resident #2's RP asked about getting the resident back up after lunch, and she told the RP that the slings were all being washed, so they could not get the resident up. CNA A stated she did not get Resident #2 up the remainder of her shift and had given report to the incoming CNA that Resident #2 wanted to get up, but the slings were still drying.During an interview on 10/22/2025 at 2:18 PM, CNA B stated that they did not get Resident #2 out of bed on the evening of 08/17/2025 because there were no clean slings available for the lift. During an interview on 10/22/2025 at 11:14 AM, the Director of Nursing (DON) stated she expected residents who were dependent on staff for transfers to be out of bed just like everyone else. The DON stated that the facility received a complaint from Resident #2's RP that there was an incident on 08/17/2025 in which staff had left Resident #2 in bed despite wanting to get up. The DON stated staff told Resident #2 that the slings for the lift were all being washed, so they could not get the resident out of bed. The DON stated that all the slings should not have been washed at the same time.During an interview on 10/22/2025 at 2:03 PM, the Administrator (ADM) stated she expected staff to assist residents out of bed when they requested and per their care plan. The ADM stated she expected staff to get residents up and out of bed for meals, activities, and as desired.