STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525672	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook at Chetek	725 Knapp St Chetek, WI 54728

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on staff interview and record review, the facility did not ensure 1 resident (R), R1, of 3 sampled residents reviewed for conveyance of resident funds, had funds returned to the Power of Attorney (POA), family, or estate within 30 days of resident death. The facility did not refund R1's trust funds to POA within 30 days of death. Findings include: The facility policy entitled, Resident Trust Accounts, dated ,d+[DATE], states in part: .#7. Upon the death of a resident with a personal fund deposited with the facility, the facility will convey promptly the residents' funds and final accounting of those funds, to the individual administering the residents estate . On [DATE] at 8:40 a.m., Surveyor toured facility. After tour was completed, a sample of residents was chosen from a list of discharged /expired residents during time frame of [DATE] to [DATE]. This list included R1. Surveyor reviewed R1's record. R1 was admitted to the facility on [DATE]. Resident expired [DATE]. Surveyor reviewed R1's account history. R1's trust account activity indicates a positive balance of $180.11. The log activity does not document any conveyance of funds to the Power of Attorney (POA). On [DATE] at 12:38 PM, Surveyor interviewed R1's Family Member (FM) C and asked if R1's trust account has been closed out and remaining balance refunded to FM C after R1's death. FM C indicated the facility refuses to pay it to FM C stating that FM C still owes a balance of $5,000 dollars. On [DATE] at 1:25 p.m., Surveyor interviewed Nursing Home Administrator (NHA) A who indicated that NHA A would need to review R1's trust account as a remaining balance does not sound right. On [DATE] at 1:37 p.m., Surveyor interviewed Accounts Receivable Specialist D and asked why R1's funds had not been conveyed within 30 days after R1's death back on [DATE]. Accounts Receivable Specialist D stated, There must be a mistake as all trust accounts are conveyed within 30 days of discharge or death. Accounts Receivable Specialist D indicated that R1's trust account balance would be sent right away to FM C.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on interview and record review, the facility did not immediately report to the physician on call post falls for 2 of 3 residents (R) reviewed for falls (R1 and R2). Findings include: The facility policy titled, Change in Condition Policy, dated 08/2024, states in part: .-#1: The physician and durable power of attorney/ responsible party will be notified when there has been a change that is sudden in onset, a change that is a marked difference in usual signs/symptoms and/or the signs/symptoms are unrelieved by measures already prescribed. -#2: a. significant change g. change in level of consciousness j. A discovery of injuries if an unknown source . Example 1 R1 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, cerebral infarction, hemiplegia and hemiparesis affecting left non-dominant side, frontal lobe and executive function deficit following cerebral infarction, and muscle weakness. R1's minimum data set (MDS) assessment, completed on 08/27/24, confirmed R1 scored 5 out of 15 during a brief interview for mental status (BIMS), indicating severely impaired cognition. R1 was at risk for falls. R1 requires supervision and set-up assistance with eating, sit to stand. R1 requires partial to moderate assistance with transferring, and dressing lower body, and putting on/taking off footwear. R1 requires substantial maximal assistance from staff for personal hygiene, showering/bathing, and toileting. Surveyor reviewed R1's progress notes which stated in part, .-On 09/09/24 [R1] was found on the floor lying next to bed tangled up in bedding, examined on floor for injuries and none noted at this time. CNA and nurse assisted [R1] to stand and sit on the side of bed. Range of motion done on all extremities and no injury noted and [R1] showed no pain . Surveyor found no documentation that the provider was notified of R1's fall on 09/09/24. Surveyor reviewed investigation report dated 09/13/24 which stated in part, .It has been determined that the Registered Nurse (RN) on 09/09/24 did not inform physician, [Director of Nursing (DON) B], [Nursing Home Administrator (NHA) A], [Family Member (FM) C], or Hospice nurse that R1 fell on ,d+[DATE]. RN was disciplined for not following policy . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2 R2 was admitted to the facility on [DATE], with diagnoses including unspecified dementia with severe agitation, dysphagia, unsteadiness on feet, repeated falls, and osteoarthritis. R2's minimum data set (MDS) assessment, completed on 10/03/24, confirmed R2 requires total assistance on staff for sit to stand, transferring, dressing lower body, putting on/taking off footwear, personal hygiene, showering/bathing, and toileting. R2 was at risk for falls. Surveyor reviewed R2's progress notes which stated in part, .On 10/09/24 [R2] had an unwitnessed fall. -On 10/24/24 [R2] slid out of wheelchair unto ground after [R2's] middle finger caught in the wheel of the wheelchair . Surveyor found no documentation that the provider was notified of R2's fall on 10/09/24. Surveyor found no documentation that the provider was notified of R2's fall on 10/24/24. On 10/29/24 at 11:42 AM, Surveyor observed R2 sitting in wheelchair in common lounge area on hall 100. Surveyor observed R2 to have severe multi-colored bruising on R2's right side of face. R2 had a bump noted on R2's forehead. On 10/29/24 at 1:50 PM, Surveyor interviewed DON B and asked if physician was notified when R1 fell on [DATE]. DON B indicated that the nurse on duty did not call physician to inform physician of R1's fall. DON B indicated that on 09/10/24 when hospice nurse arrived to facility, R1 was found to have a bruise on R1's hip and was not moving R1's leg. DON B indicated that at that time physician, FM C, and hospice were told R1 fell the previous day on 09/09/24. DON B indicated that DON B opened an investigation and reprimanded the nurse on duty on 09/09/24. Surveyor asked DON B if staff notified physician when R2 fell on [DATE] and 10/24/24 as Surveyor could not find any documentation stating that physician was notified. DON B indicated that staff did not notify physician after R2's two falls. DON B indicated that DON B didn't even know R2 fell until DON B arrived at work one day and observed R2's face with bruises all over the right side. Surveyor asked DON B if R2 had hit her head and face when R2 fell on [DATE]. DON B indicated that R2 must have by the looks of R2's face. Surveyor asked DON B what the physician ordered for R2 once physician knew R2 fell and had facial injuries. DON B indicated that DON B really doesn't know as nothing is documented in the electronic health record.

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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 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** 48793 Based on observations, interviews and record reviews, the facility did not provide care and treatment by professional standards of practice to maintain a resident's highest practicable level of physical well-being for 2 of 3 residents (R) reviewed. (R1 and R2) R1 and R2 did not receive accurate assessments and treatment following falls. Findings include: The facility policy titled, Fall Management, dated 07/2020, states in part: .#1. When a fall occurs, the resident is assessed for injury by the nurse. -#2. The nurse will enter the event information into risk console, complete an incident report, complete the SBAR communication form and progress note, add the fall even to the 24 hour report, and initiate the interdisciplinary post fall review. -#3. The nurse communicates the fall to the attending physician and the residents representative. -In the event a resident has a fall and it has been determined they hit their head, or it cannot be determined if they hit their head (unwitnessed), the nurse initiates the following actions: All items listed under fall event above are completed, and neurological checks are completed an documented per instructions . R1 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, cerebral infarction, hemiplegia, and hemiparesis affecting left non-dominant side, frontal lobe and executive function deficit following cerebral infarction, and muscle weakness. R1's minimum data set (MDS) assessment, completed on 08/27/24, confirmed R1 scored 5 out of 15 during a brief interview for mental status (BIMS), indicating severely impaired cognition. R1 was at risk for falls. R1 requires supervision and set-up assistance with eating, sit to stand. R1 requires partial to moderate assistance with transferring, and dressing lower body, and putting on/taking off footwear. R1 requires substantial maximal assistance from staff for personal hygiene, showering/bathing, and toileting. Surveyor reviewed R1's progress notes which stated in part, .-On 09/09/24 [R1] was found on the floor lying next to bed tangled up in bedding, examined on floor for injuries and none noted at this time. CNA and nurse assisted [R1] to stand and sit on the side of bed. Range of motion done on all extremities and no injury noted and [R1] showed no pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 09/10/24, [R1] seen today at the request of the hospice Certified Nurse Assistant (CNA) stating that [R1] had had a decline in status. [R1] is seen and upon arrival charge nurse stated that [R1] had fallen on 09/09/24. This was not reported to hospice services and to the family. [R1] is found to have a bruise on her right hip approximately 5 inches in circumference, [R1] was noted to have mottling to [R1's] waist. [R1] was able to make known that [R1] had back pain and [R1] was grabbing at her right thigh. [R1] has facial grimacing. Family was called and informed of [R1's] fall on 09/09/24, physician notified of fall on 09/09/24 and morphine concentrate was ordered as needed for pain . -On 09/11/24 IDT reviewed [R1's] fall and discussion of a fall mat will be put into place as a new intervention on care plan . Surveyor found no other documentation of assessment such as vitals, neuros, or head to toe assessment post fall for R1. On 10/29/24 at 12:38 PM, Surveyor interviewed R1's Family Member (FM) C and asked FM C to explain the events that led FM C to discover R1's fall. FM C indicated that FM C arrived on 09/10/24 in the afternoon and found R1 to not be communicating as clearly as R1 normally communicates. FM C indicated that hospice nurse was at the facility at that point and FM C was told by the hospice nurse that R1 had suffered a fall on 09/09/24 and that R1 may possibly have a fractured femur. On 10/29/24 at 1:50 PM, Surveyor interviewed Director of Nursing (DON) B and asked DON B if nurse did a thorough assessment head to toe on R1 as Surveyor could not find an assessment post fall for R1. DON B indicated that nurse did not assess R1 thoroughly. Surveyor asked DON B what does a thorough assessment entail. DON B indicated that DON B would expect neuros, heart, lungs, extremities, and full set of vitals. Example 2 R2 was admitted to the facility on [DATE], with diagnoses including unspecified dementia with severe agitation, dysphagia, unsteadiness on feet, repeated falls, and osteoarthritis. R2's minimum data set (MDS) assessment, completed on 10/03/24, confirmed R2 requires total assistance on staff for sit to stand, transferring, dressing lower body, putting on/taking off footwear, personal hygiene, showering/bathing, and toileting. R2 was at risk for falls. Surveyor reviewed R2's progress notes which stated in part, .-On 10/09/24 [R2] had an unwitnessed fall. -On 10/24/24 [R2] slid out of wheelchair unto ground after [R2's] middle finger caught in the wheel of the wheelchair . Surveyor found no other documentation of assessment such as vitals, neuros, or head to toe assessment post fall for R2. On 10/29/24 at 11:42 AM, Surveyor observed R2 sitting in wheelchair in common lounge area on hall 100. Surveyor observed R2 to have severe multi-colored bruising on R2's right side of face. R2 had a bump noted on R2's forehead. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 1:50 PM, Surveyor interviewed DON B and asked if assessments were done when R2 fell on [DATE] and 10/24/24. DON B indicated that DON B didn't even know R2 fell until DON B arrived at work one day and observed R2's face with bruises all over the right side. Surveyor asked DON B if R2 had hit her head and face when R2 fell on [DATE]. DON B indicated that R2 must have by the looks of R2's face presently. Surveyor asked DON B if the nurse on duty when R2 fell on [DATE] and 10/24/24 completed a complete head to toe assessment. DON B indicated that assessments are not in the electronic health record. DON B assumes the assessment did not get completed for R2. DON B indicated that for R2's situation, DON B would have expected neuros for sure since R2 has so much facial trauma which is indicative of R2 falling on face.

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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** 48793 Based on interview and record review, the facility did not ensure new care planned fall interventions were put into place post falls to prevent further incidents from occurring for 3 of 3 residents (R) R1, R2, and R3 reviewed for falls. R1 was at risk for falls and had a fall on 09/09/24. Facility did not implement new interventions post fall. R2 was at risk for falls, and had two falls, one on 10/09/24 and one on 10/24/24. Facility did not implement new interventions post fall. R3 was at risk for falls and had a fall on 10/21/24. Facility did not implement new interventions post fall. Findings include: Example 1 R1 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, cerebral infarction, hemiplegia and hemiparesis affecting left non-dominant side, frontal lobe and executive function deficit following cerebral infarction, and muscle weakness. R1's minimum data set (MDS) assessment, completed on 08/27/24, confirmed R1 scored 5 out of 15 during a brief interview for mental status (BIMS), indicating severely impaired cognition. R1 was at risk for falls. R1 requires supervision and set-up assistance with eating, sit to stand. R1 requires partial to moderate assistance with transferring, and dressing lower body, and putting on/taking off footwear. R1 requires substantial maximal assistance from staff for personal hygiene, showering/bathing, and toileting. R1's care plan was initiated on 04/22/24, and included the following interventions: FALL care plan: Anticipate the needs of the residents' needs initiated on 04/16/24. Be sure the resident's call light is in reach and encourage the resident to use it for assistance as needed initiated on 04/16/24. Educate the residents/family/caregivers about safety reminders and what to do if a fall occurs as needed initiated on 04/16/24. Ensure that the resident is wearing appropriate footwear when ambulating/transferring as needed initiated on 04/16/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident is wearing appropriate footwear when ambulating/transferring as needed initiated on 04/16/24. Follow the facility fall protocol initiated on 04/22/24. Non-skid sock and/or shoes initiated on 04/22/24. Surveyor reviewed R1's progress notes which stated in part, .-On 09/09/24 [R1] was found on the floor laying next to bed tangled up in bedding, examined on floor for injuries and none noted at this time. CNA and nurse assisted [R1] to stand and sit on the side of bed. Range of motion done on all extremities and no injury noted and [R1] showed no pain. -On 09/11/24 IDT reviewed [R1's] fall and discussion of a fall mat will be put into place as a new intervention on care plan . Surveyor reviewed the falls care plan and noted the intervention of a fall mat on 9/11/24 was not added. No other interventions were revised or updated after R1's fall on 09/09/24. Example 2 R2 was admitted to the facility on [DATE], with diagnoses including unspecified dementia with severe agitation, dysphagia, unsteadiness on feet, repeated falls, and osteoarthritis. R2's minimum data set (MDS) assessment, completed on 10/03/24, confirmed R2 requires total assistance on staff for sit to stand, transferring, dressing lower body, putting on/taking off footwear, personal hygiene, showering/bathing, and toileting. R2 was at risk for falls. R2's care plan was initiated on 04/22/24, and included the following interventions: FALL care plan: -Be sure the resident's call light is in reach and encourage the resident to use it for assistance as needed initiated on 04/19/16, revised on 05/27/21. -Educate the residents/family/caregivers about safety reminders and what to do if a fall occurs as needed initiated on 04/19/16, revised on 05/27/21. -Ensure that the resident is wearing appropriate footwear when ambulating/transferring as needed initiated on 04/19/16, revised on 05/27/21. -Chair alarm tabs in wheelchair/recliner initiated on 10/26/21. -Leave the bathroom light on during the night so resident is not trying to get to the bathroom in the dark initiated on 12/26/17, revised on 05/27/21. -Low bed initiated on 06/16/16. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Non-skid sock and/or shoes initiated on 04/19/16, revised on 05/27/21. -Grippy strips to floor by bed initiated on 09/05/19. -Toilet in 8pm nightly initiated on 04/23/22. -Toilet at 10pm if R2 is awake initiated on 09/12/24. -Encourage bed or recliner by 9 pm initiated on 09/09/24. Surveyor reviewed R2's progress notes which stated in part, .-On 10/09/24 [R2] had an unwitnessed fall. -On 10/24/24 [R2] slid out of wheelchair unto ground after [R2's] middle finger caught in the wheel of the wheelchair . Surveyor reviewed R2's fall care plan and noted no interventions put into place after R2 fell on [DATE] and 10/24/24. Example 3 R3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of fracture of unspecified neck of the left femur, type 2 diabetes mellitus, history of falling, left bundle branch block, and supraventricular tachycardia with a prosthetic heart valve. R3's minimum data set (MDS) assessment, completed on 09/13/24, confirmed R3 scored 14 out of 15 during a brief interview for mental status (BIMS), indicating intact cognition. R3 independent for sit to stand, transferring, dressing lower body, putting on/taking off footwear, personal hygiene, and toileting. R3 was at risk for falls. R3's fall care plan was initiated on 07/10/18, and included the following interventions: FALL care plan: .-Ensure the resident is wearing appropriate footwear when ambulating/transferring as needed revised on 06/02/21. -Reacher to pick up things off of floor. Therapy will work with R3 regarding task revised on 03/01/21. -Keep walker within reach of resident revised on 03/14/22 . Surveyor reviewed R3's progress notes which stated in part, .-On 10/21/24 [R3] had an unwitnessed fall when ambulating from bathroom to bedside table . Surveyor noted no interventions were put into place on R3's care plan after R3 fell on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 1:50 PM, Surveyor interviewed Director of Nursing (DON) B and asked if R1 had any new interventions implemented after R1 suffered a fall on 09/09/24. DON B indicated that no interventions were put into place until 09/11/24, two days later. Surveyor asked DON B if R2 had any new interventions implemented after R2 suffered two falls on 10/09/24 and 10/24/24. DON B indicated that no interventions were put into place after R2's falls on 10/09/24 and 10/24/24. Surveyor asked DON B if R3 had any new interventions implemented after R3 suffered a fall on 10/21/24. DON B indicated that no interventions were put into place after R3's fall on 10/21/24. Surveyor asked DON B why there were no interventions. DON B indicated that sometimes staff miss implementing a new intervention. DON B indicated that DON B will be doing a training soon with staff to help staff understand importance of care plan interventions post fall to prevent future falls.