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	02/03/2026

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 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** Based on interview and record review, the facility did not report an incident of potential neglect to the state agency immediately upon learning of an incident wherein resident (R) received the wrong medication which required administration of Narcan and hospitalization, nor did the facility submit the 5-day investigation within 5 days as required. The facility practice had the potential to affect 1 of 8 residents (R1). The facility policy titled Abuse prevention program facility procedures training program and staff materials undated, states under Option 5: Possible Neglect: Means the failure to provide goods or services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress or could be reasonably expected to cause, pain, injury or deathR1 was admitted to the facility on [DATE], with diagnoses that include orthostatic hypotension (condition, which is defined as low blood pressure (hypotension) that occurs upon standing) and neurocognitive disorder with Lewy bodies.R1's admission Minimum Data Set (MDS) dated [DATE] indicates R1 had a Brief Interview of Mental Status (BIMS) of 14 out of 15, indicating R1 is cognitively intact. R1 has an Activated Power of Attorney for Health Care (APOAHC). On 07/04/25, a licensed nurse administered medications to R1 meant for R3. Medications received included an Opioid of Oxycontin ER 20 mg and Amlodipine 5mg (can cause serious side effects of low blood pressure).R1's physician was contacted immediately, and orders were received to administer Narcan and send R1 to emergency department (ED).On 07/04/25, R1 was taken to ED for observation of medication error and was evaluated by physical therapy and was found to be markedly orthostatic (sudden drop in blood pressure) and was administered intravenous (IV) electrolytes and hydration with plan to discharge back to facility.On 07/05/25, R1's hospital records indicate R1's blood pressure was noted to start trending low and decision was made to transfer to another hospital for admission.On 07/06/25, R1 was transferred back to the facility with no further concerns.On 02/03/26 at 12:39 PM, Surveyor interviewed Nursing Home Administrator (NHA) A and Director of Nursing (DON) B regarding if incident of R1 receiving wrong medications was reported to State Survey Agency. Per DON B, who stated it was not reported due to it being the licensed nurse's first medication error, information was relayed to corporate office, and an internal investigation and education was provided. When Surveyor asked if Narcan and hospitalization would qualify for being reported, DON B stated there were no noted signs or symptom effects of receiving wrong medication.

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 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** Based on record review and interviews, the facility failed to conduct a thorough investigation and implement corrective action in a timely manner for 1 of 8 residents (R) R3, resulting in 2 additional significant errors to occur for R1 and R5.R3 was administered incorrect opioid pain medication on 07/02/25.R1 was administered medications for R2, which required receiving Narcan and hospitalization on 07/04/25.R5 was administered medication that was discontinued and wrong dosage form on 07/06/25.The facility's policy, titled Medication Administration last revised on 12/2025, states: Resident medications are administered in an accurate, safe, timely and sanitary manner.Under section labeled Procedure states in part the following: Verify the medication label against the medication sheet for accuracy of drug frequency, duration, strength and route. If the label and medication sheet are different .or any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule.Example 1R3 was admitted to facility on 06/23/25 with diagnoses that include multiple rib fractures.On 06/23/25, R3 was prescribed Oxycodone HCL (an Opioid) 5mg 1 tablet every 6 hours for pain which was discontinued On 06/26/25, R3's order for Oxycodone was discontinued and physician prescribed Hydrocodone 5-325 mg 1 tablet every 6 hours for pain.On 07/02/25, R3 received the wrong opioid medication that was previously discontinued and not removed from circulation.Example 2R1 was admitted to the facility on [DATE], with diagnoses that include orthostatic hypotension (condition is defined as low blood pressure (hypotension) that occurs upon standing) and neurocognitive disorder with Lewy bodies.R1's admission Minimum Data Set (MDS) dated [DATE], indicates R1 had a Brief Interview of Mental Status (BIMS) of 14 out of 15, indicating R1 is cognitively intact. R1 has an Activated Power of Attorney for Health Care (APOAHC). On 07/04/25, a licensed nurse administered medications to R1 meant for R2. Medications received included an opioid of Oxycontin ER 20 mg and Amlodipine 5mg (can cause serious side effects of low blood pressure).R1's physician was contacted immediately, and orders were received to administer Narcan and send R1 to emergency department (ED).On 07/04/25, R1 was taken to ED for observation of medication error and was evaluated by physical therapy and was found to be markedly orthostatic (sudden drop in blood pressure) and was administered IV electrolytes and hydration with plan to discharge back to facility.On 07/05/25, R1's hospital records indicate R1's blood pressure was noted to start trending low and decision was made to transfer to another hospital for admission.Example 3R5 was admitted to facility on 03/21/25, with diagnoses that include chronic obstructive pulmonary disease, chronic pancreatitis and generalized anxiety disorder.On 06/02/25, R5 was placed on hospice care. R5's Significant Change MDS dated [DATE] indicated R5 had a BIMS of 15/15, which indicates intact cognition.On 06/02/25, R5 was prescribed Lorazepam (anti-anxiety) oral concentrate (liquid) 0.25 ml every 4 hours as needed for terminal anxiety.On 06/19/25, R5's Lorazepam medication was discontinued and not removed from circulation. The facility's log for controlled substance initiated on 06/02/25 is labeled with Lorazepam 0.5 mg tablet with documentation indicating that R5 received wrong medication form on 06/04/25, 06/05/25, 06/06/25, 06/09/25 and 06/10/25.On 07/06/25, the facility's log indicated that R5 received wrong medication form and administered after medication was discontinued.On 02/03/26 at 2:26 PM, Surveyor interviewed Director of Nursing (DON) B and Assistant Director of Nursing (ADON) C regarding medication errors. DON B and ADON C were aware of medication errors and conducted education on 07/07/25 to licensed nursing staff on the 5 medication rights as expected.On 02/03/26 at 2:46 PM, Surveyor interviewed DON B who stated the errors should not have occurred and expectation would be to ensure residents are receiving the correct medication and form. DON B further stated that it was a holiday weekend and nurse management were working on the floor and conducting education to all licensed (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff on 07/07/25.On 02/03/26 at 3:30 PM, Surveyor interviewed Nursing Home Administrator (NHA) A, DON B and Director of Clinical Services D regarding significant medication error that occurred on 07/02/25 wherein licensed nurse who made the error was educated on Medication 5 Rights and expectation, but all licensed nurses were not educated prior to their next shift, resulting in 2 significant medication errors to occur (07/04/25 and 07/06/25) before all licensed staff were properly educated.

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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 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 a system was in place to establish disposition of destroying controlled drugs for 2 of 6 residents (R) (R2 and R5) reviewed for medication errors.R2's Lyrica was not destroyed in a timely fashion and by 2 licensed nurses.R5's Lorazepam medication was discontinued and not removed from circulation.The facility policy titled, Destruction of Unused Drugs, revised [DATE], states: All unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations. This includes having a witness to medications being destroyed.Example 1On [DATE] at 1:25 PM, Surveyor reviewed R2's Narcotic sheet that states, .[R2] is to be given Pregabalin (Lyrica) 50 mg capsule by mouth two times a day ordered on [DATE]. Surveyor observed R2's narcotic sheet to have a crossed of X over top the whole sheet with Destroyed RN on [DATE] with one signature at the bottom.On [DATE] at 3:44 PM, Surveyor interviewed DON B about destruction of the Pregabalin (Lyrica) 50 mg capsule by mouth two times a day ordered on [DATE] but was not given to R2. Surveyor asked DON B the time frame on how quickly narcotics or controlled substances should be destructed and the process for destruction. DON B reported to Surveyor that all controlled substances should be discarded right away once it is known that residents will not be using the controlled substance or by provider's orders to discontinue. DON B reported that R2's order for the Pregabalin (Lyrica) 50 mg capsule by mouth two times a day ordered on [DATE] was discontinued and changed to Pregabalin (Lyrica) 75 mg capsule by mouth two times a day and should have been destroyed right away and was not. DON B reported there should have been 2 licensed staff destroying the controlled substance, but DON B only sees that one licensed nurse destroyed R2's Pregabalin (Lyrica).Example 2On [DATE], R5 was prescribed Lorazepam (anti-anxiety) oral concentrate (liquid) 0.25 ml every 4 hours as needed for terminal anxiety.The facility's log for controlled substance initiated on [DATE] is labeled with Lorazepam 0.5 mg tablet with documentation indicating that R5 received medication after being discontinued on [DATE]. On [DATE] at 2:26 PM, Surveyor interviewed Director of Nursing (DON) B and Assistant Director of Nursing (ADON) C regarding medication errors. DON B and ADON C indicated they were aware of medication errors and conducted education on [DATE] to licensed nursing staff on the 5 medication rights as expected and destruction of medications.On [DATE] at 2:29 PM, Surveyor observed Registered Nurse (RN) E at the medication cart. Surveyor asked RN E to explain process for controlled substance destruction. RN E reported that RN E destroys controlled substance with the drug buster located in the medication storage room and that RN E always has two nurses signing off and verifying the destruction correctly.

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that a system is in place to ensure that residents are free of any significant medication error for 6 of 9 residents (R) (R1, R3, R5, R7, R8, and R9) reviewed for medication errors.R1 is cited at a scope and severity level of G (actual harm that is not immediate jeopardy/isolated). R1 was administered R2's medications, which required R1 to receive Narcan and hospitalization. R3 was administered incorrect pain medication.R5 was administered medication that was discontinued and wrong dosage form.Pharmacy found that R7 had the wrong dose in the medical record for R7's Tacrolimus.R8 received a different resident's 40 mg tab of Atorvastatin. R9 received another resident's medications consisting of gabapentin, clonidine, and Vitamin D.This is evidenced by:The facility's policy, titled Medication Administration last revised on 12/2025, states: Resident medications are administered in an accurate, safe, timely and sanitary manner.Under section labeled Procedure states in part the following: Verify the medication label against the medication sheet for accuracy of drug frequency, duration, strength and route. If the label and medication sheet are different .or any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. Never administer medications from an unmarked container.Example 1R1 was admitted to the facility on [DATE] with diagnoses that include orthostatic hypotension (condition is defined as low blood pressure (hypotension) that occurs upon standing) and neurocognitive disorder with Lewy bodies.R1's admission Minimum Data Set (MDS) dated [DATE] indicates R1 had a Brief Interview of Mental Status (BIMS) of 14 out of 15, indicating R1 is cognitively intact. R1 has an Activated Power of Attorney for Health Care (APOAHC). On 07/04/25, per facility investigation report, Registered Nurse (RN) F placed med cart between rooms of R1 and R2 and was setting up medications meant for R2. RN F heard a scream down hallway and left medication cart to see what was happening. RN F returned to the cart when R1 asked RN F some questions, and RN F handed R1 medications that were meant for R2. Medications of R2 that R1 received included an Opioid of Oxycontin ER 20 mg and Amlodipine 5mg (can cause serious side effects of low blood pressure).R1's physician was contacted immediately, and orders were received to administer Narcan and send R1 to emergency department (ED).On 07/04/25, R1 was sent to ED for evaluation of medication error and was originally found to be stable and plan was to return back to facility. On 07/05/25, R1's hospital records indicate R1 was being evaluated by therapy department and was found to be markedly orthostatic (sudden drop in blood pressure). Blood pressure was documented to drop 75/34 after standing and when placed back into bed noted to improve to 131/61. The decision was made to transfer R1 to another hospital for admission due to no current hospital beds being available. R1 required intravenous (IV) electrolytes and hydration with plan to discharge back to facility.On 07/06/25, R1 was transferred back to facility with no further concerns.Example 2R3 was admitted to facility on 06/23/25 with a diagnosis of multiple rib fractures.On 06/23/25, R3 was prescribed Oxycodone HCL (an Opioid) 5mg 1 tablet every 6 hours for pain, which was discontinued On 06/26/25, R3's order for Oxycodone was discontinued and physician prescribed Hydrocodone 5-325 mg 1 tablet every 6 hours for pain.On 07/02/25, R3 received the wrong opioid medication that was previously discontinued and not removed from circulation.Example 3R5 was admitted to facility on 03/21/25 with diagnoses that include chronic obstructive pulmonary disease, chronic pancreatitis, and generalized anxiety disorder.On 06/02/25, R5 was placed on hospice care.On 06/02/25, R5 was prescribed Lorazepam (anti-anxiety) oral concentrate (liquid) 0.25 ml every 4 hours as needed for terminal anxiety but was dispensed/administered in pill form.On 06/19/25, R5's Lorazepam medication was discontinued and not removed from circulation which resulted in R5 receiving a dose on 07/06/25.The facility's log for (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	controlled substance initiated on 06/02/25 is labeled with Lorazepam 0.5 mg tablet with documentation indicating that R5 received wrong form of medication on 06/04/25, 06/05/25, 06/06/25, 06/09/25 and 06/10/25.On 07/06/25, the facility's log indicated that R5 received wrong form of medication and was administered after medication was discontinued.Example 4Surveyor reviewed facility's medication errors from July 2025-present and found three medication errors as stated, .-On 11/26/25 upon pharmacy review of [R7's] medications, pharmacy found that [R7] had the wrong dose in the medical record for [R7's] Tacrolimus. It was transcribed as Tacrolimus 5mg give 2 tablets twice a day. [R7's] original physician order was Tacrolimus 0.5 mg give two tablets twice a day. Immediate action: Order was immediately taken out of medical record but [R7] received the wrong dose in the morning time medication administration. Call was placed to the transplant center, update to RN, update the MD, [R7] updated, monitored for overdose, and DON notified as well.-On 12/15/25 Nurse accidentally gave [R8] a different resident's 40 mg tab of atorvastatin. Immediate action: Provider was called, DON notified, [R8] was monitored for muscle aches or pain. Monitoring in place for 3 days every shift. Medication Administration competency was completed for the nurse who gave wrong medication to [R8].-On 01/22/26 Both residents in room have the same initials. Medication cups were set on each of the residents' bedside tables for them to take. [R9] took medications right away without looking at the cup while the other resident looked at her cup realizing that the medications in the cup were not hers. Nurse had administered the other residents' medications of gabapentin, clonidine, and vitamin D. Provider notified, DON notified, 15-minute checks on affected resident until further orders from Provider.On 02/03/26 at 2:26 PM, Surveyor interviewed Director of Nursing (DON) B and Assistant Director of Nursing (ADON) C regarding medication errors. DON B and ADON C were aware of medication errors and conducted education on 07/07/25 to licensed nursing staff on the 5 medication rights as expected.On 02/03/26 at 2:46 PM, Surveyor interviewed DON B who stated the errors should not have occurred and expectation would be to ensure residents are receiving the correct medication and form. On 02/03/26 at 3:30 PM, Surveyor interviewed Nursing Home Administrator (NHA) A, DON B and Director of Clinical Services D regarding significant medication error that occurred on 07/02/25 wherein licensed nurse who made the error, was educated on Medication 5 Rights and expectation, but all licensed nurses were not educated prior to their next shift, resulting in 2 significant medication errors to occur (07/04/25 and 07/06/25) before all licensed staff were properly educated. NHA A further indicated that a Performance Improvement Project was initiated on 07/07/25 and facility conducted 3 weeks of medication audits that concluded on 07/22/25 and was reviewed monthly with Quality Assurance Process Improvement process until determined facility was in compliance and stated the project was closed out on 11/25/25 with no further medication errors identified.

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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. Based on interview, observation and record review, the facility did not ensure that a system was in place to ensure residents receive medications that are properly labeled and administered accordingly for 2 of 8 residents (R5, R6) reviewed for medication errors. R5 was administered medication that was discontinued and incorrect dosage form. R6 was administered medication without proper labeling.The facility's policy, titled Medication Administration last revised on 12/2025, states: Resident medications are administered in an accurate, safe, timely and sanitary manner.Under section labeled Procedure states in part the following: If the label and medication sheet are different .or any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. Never administer medications from an unmarked container.Example 1R5 was admitted to facility on 03/21/25 with diagnoses that include chronic obstructive pulmonary disease, chronic pancreatitis and generalized anxiety disorder.On 06/02/25, R5 was placed on hospice care. On 06/02/25, R5 was prescribed Lorazepam (anti-anxiety) oral concentrate (liquid) 0.25 ml every 4 hours as needed for terminal anxiety but was dispensed/administered in pill form.On 06/19/25, R5's Lorazepam medication was discontinued and not removed from circulation and received a dose on 07/06/25.The facility's log for controlled substance initiated on 06/02/25 is labeled with Lorazepam 0.5 mg tablet with documentation indicating that R5 received wrong medication form on 06/04/25, 06/05/25, 06/06/25, 06/09/25, 06/10/25 and a dose without physician order on 07/06/25.Example 2On 02/03/26 at 2:29 PM, Surveyor observed Registered Nurse (RN) E at the medication cart. Surveyor asked RN E to explain process for narcotic administration. RN E reported that RN E checks physician order against the medication bottle or container before administering medications. RN E showed Surveyor the narcotic box on medication cart. Surveyor observed a morphine bottle with no label of a resident identifier or what the correct dose was to be given to whoever the morphine bottle belonged to. Surveyor observed a handwritten #36 on the unlabeled bottle in permanent marker. Surveyor asked RN E if RN E knew whose morphine concentration was in the bottle that had #36 written on the bottle. RN E started searching through narcotic books and found that the bottle belonged to R6. RN E confirmed that R6's morphine oral concentration bottle was not labeled correctly with R6's identifying information such as name, date of birth , when pharmacy dispersed medication to meet residents' rights for proper medication administration. RN E viewed R6's narcotic sheet and stated, This morphine has been administrated 13 times and is not properly labeled. RN E reported to Surveyor that RN E didn't even know R6's name was not on the bottle as it should be. Surveyor asked RN E about medication destruction. RN reported always have two nurses signing off and verifying destruction.On 02/03/26 at 2:26 PM, Surveyor interviewed Director of Nursing (DON) B and Assistant Director of Nursing (ADON) C regarding medication errors of R5 and R6. DON B and ADON C were aware of medication errors and conducted education on 07/07/25 to licensed nursing staff on the 5 medication rights as expected.On 02/03/26 at 2:46 PM, Surveyor interviewed Director of Nursing (DON) B and asked DON B's expectation for liquid narcotics, such as morphine, being labeled and properly identifiable for whose medication the liquid bottle of morphine should be in medication cart. DON B reported that all liquid medications, especially liquid morphine, should be labeled correctly with correct resident identifier, date of birth , pharmacy date dispersed and a date when liquid morphine was opened so staff know when it expires. DON B's expectation is that whoever stocked R6's liquid morphine that the label should have been placed on it before administering. DON B reported that if a staff member observes no label on the liquid morphine, the nurse is not supposed to administer the medication but contact DON (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B and destruct the morphine accordingly with two nurses as verification and reorder a new bottle of liquid morphine from pharmacy for correct administration. DON B further stated the errors should not have occurred and expectation would be to ensure residents are receiving the correct medication and form.