

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525672	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Meadowbrook at Chetek		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a safe discharge for 1 of 3 residents (R1) reviewed of a sample of 4 residents. R1 was not allowed to return to the facility after R1 left the building and did not return prior to 11:59 PM. R1 was located by facility staff the next day and given paperwork for discharge against medical advice. R1 was discharged without a safe discharge plan, without R1's belongings or medications. This is evidenced by: Facility policy titled, Administrative Transfer/Discharge Notice, with a revised date of 12/2025, states: Purpose: It is the policy of the facility to provide each operating facility with a process for resident discharges that are initiated by the facility. Of note: policy does not include guidelines of a resident not returning by 11:59 PM being discharged AMA (against medical advice). R1 was admitted to the facility on [DATE] with multiple sclerosis, paraplegia, supra-pubic catheter, and mild cognitive impairment. R1 was discharged from facility on 07/03/26. R1's most recent significant change Minimum Data Set (MDS) assessment, dated 06/10/26, noted a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 has intact cognition. R1 uses a motorized wheelchair and/or scooter and mechanical lift. R1 has impaired range of motion on both sides of lower extremities. R1 requires dependent assist with toileting hygiene, lower body dressing, putting on/off footwear, sitting to lying, lying to sitting, sitting to standing, chair/bed transfers and toilet transfers. R1's medications include an anticoagulant, diuretic, and opioid. R1's care plan, dated 10/01/24, with a target date of 12/09/26, states: [R1] needs assistance with ADLs (activities of daily living). Interventions include assist of 2 with EZ stand for toileting and transfers. R1's care plan, dated 10/01/24, with a target date of 12/09/26, states: [R1] would like to remain long term at facility with [R1's] discharge goal to remain long term. On 07/15/26 at 3:31 PM, Surveyor interviewed Director of Nursing (DON) B and Nursing Home Administrator (NHA) A regarding the facility's policy on residents leaving the facility. DON B stated that residents are asked to let staff know and sign-out in the log when leaving. Surveyor asked DON B if anyone monitors this log. DON B stated no. Surveyor asked DON B if residents must be back inside the facility at a specific time. DON B said yes, by 11:59 PM, unless they have a provider order for a longer leave. Otherwise, they are considered to have discharged themselves AMA. Surveyor asked DON B how this is explained to residents. DON B stated verbally on admission. Surveyor asked DON B if there was a written policy regarding this. DON B stated no. Surveyor reviewed R1's medical record: On 07/02/26 at 7:30 PM, R1 left the facility on motorized wheelchair. Registered Nurse (RN) C observed R1 leaving and reminded R1 to return to the facility by midnight. R1 was documented stating, have my butt back in the building by midnight. Surveyor reviewed facility's sign-in/sign-out log located in the front entryway and noted R1 had not signed in or out of the facility on 07/02/26. -On 07/16/26 at 8:05 AM, Surveyor interviewed RN C (Registered Nurse) regarding incident. Surveyor asked RN C what that meant for R1 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 525672	Facility ID: 525672 If continuation sheet Page 1 of 3

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be back by midnight. RN C stated R1 frequently left the facility and staff reminded R1 that they needed to back inside the facility by midnight or they would no longer be a resident. Surveyor asked RN C how residents are made aware of this policy. RN C stated they are informed during admission. Surveyor asked RN C if there was anything documented that R1 was made aware of this policy. RN C stated no. Surveyor asked RN C if R1 had ever been out of the facility after midnight prior to this incident. RN C stated no. Surveyor asked RN C if she attempted to call R1. RN C stated yes, more than once, but R1's number was not in service because she kept getting an error message. Progress notes dated 07/03/26 at 12:09 AM, state RN C documented R1 had not returned to the facility. Staff searched inside/outside facility but were unable to locate R1. DON and NHA were notified. At approximately 2:30 AM, RN D, who was reporting to work, observed R1 outside of a local gas station reclined in their motorized wheelchair. RN D asked R1 if they were ok and why they were out of the facility so late. R1 replied she was a night owl and R1 had to watch over their spouse. RN D left R1 at gas station and went to facility to start their work shift RN D notified the on-duty nurse of R1's whereabouts. On 07/16/26 at 7:29 AM, Surveyor interviewed RN D regarding the incident. Surveyor asked RN D what the facility policy is for residents not returning to the facility by 11:59 PM. RN D stated that if a resident expects to be gone longer, then they should call the facility and let them know. Surveyor asked if this would still be grounds to be discharged AMA. RN D stated no that it can be adjusted if the facility is updated. Surveyor asked RN D if she had ever informed R1 of the policy to be back at facility by 11:59 PM or R1 would be discharged AMA. RN D stated no, not personally. Surveyor asked RN D if all residents are informed of this policy. RN D stated yes that they are all told this. Surveyor asked RN D if this is documented. RN D stated no. Surveyor asked RN D if there is a written policy stating this. RN D stated no. Surveyor asked RN D how she became aware of this policy. RN D stated she was not sure but as far as she was aware it had always been the policy. Progress notes dated 07/03/26 state at approximately 7:30 AM, DON B and Social Worker (SW) E found R1 at the dam in the park. DON B and SW E asked R1 if they were ok. R1 stated they did not know; they fell asleep cause they were busy watching their spouse all night. SW E explained to R1 that by not returning to the facility by 11:59 PM, R1 had discharged themselves from the facility AMA. R1 stated they thought that meant they had to just come back to the facility a couple minutes here and there. SW E stated no, the rule was to be in the facility at 11:59 PM. R1 stated they didn't know that. SW E provided R1 the AMA form noting that R1 left the facility AMA discontinuing all prescribed medical treatment and chose not to come back to the facility. R1 was noted to refuse to sign the form at 8:11 AM. SW E asked R1 their plans. R1 stated not knowing. SW E informed R1 that Adult Protective Services may be able to help and that R1 could also go the ED (emergency department) if there should be any medical emergencies. R1 was not given her medications and belongings at this time. SW E told R1 that they could pick them up at any time. Of note, facility staff left R1 in a park without medications, shelter, their belongings and did not provide a safe discharge plan for R1. On 07/16/26 at 8:28 AM, Surveyor interviewed DON B regarding this incident. Surveyor asked DON B if she asked R1 why they hadn't called the facility to inform them that R1 would not be back by 11:59 PM. DON B stated R1 said they were busy keeping an eye on their spouse and didn't know they fell asleep. Surveyor asked DON B if R1 knew not being back in the facility by 11:59 PM meant they would be discharging themselves AMA. DON B stated yes this was repeated to R1 numerous times. Surveyor asked DON B if there was documentation of this. DON B stated no. Surveyor reviewed R1's EMS (Emergency Medical Services) report: On 07/03/26 at 1:56 PM, EMS received a page to assist R1 in the local park. R1's spouse had called 911 stating R1 had been evicted from the facility, R1's motorized wheelchair battery was dead, and she had blood in her urine. EMS took R1 to the local (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital for assessment. Surveyor reviewed R1's hospital records: On 07/03/26, R1 was admitted to the hospital with principal diagnosis of multiple sclerosis. R1 discharged AMA on 07/05/26. On 07/15/26 at 3:35 PM, Surveyor interviewed DON B and NHA A regarding discharge process. Surveyor asked if the facility's policy of residents not returning before 11:59 PM is in written form. Both DON B and NHA A stated no. NHA A stated after this incident, it will be changed. Surveyor asked how they knew R1 understood this policy. DON B stated that many staff had told R1 about this policy. Surveyor asked DON B if there was any documentation about this. DON B stated no. On 07/16/26 at 9:07 AM, Surveyor interviewed SW E regarding incident. Surveyor asked SW E if she was aware of R1 wanting to discharge from the facility or if discharging to the park was a safe discharge plan. SW E stated no because R1 needed help transferring into wheelchair and had no other home to go to. Surveyor asked SW E what R1 stated when she was given the AMA form and she was being discharged. SW E stated that initially, R1 said OK and then she said she didn't understand. R1 had stated that she thought being back by 11:59 PM meant popping in and out of the facility at some point. SW E corrected R1 that being back at 11:59 PM meant they had to be inside the facility at 11:59 PM. SW E stated that R1 then stated not knowing this. Surveyor asked SW E if it would be good practice to have this in writing to avoid this kind of confusion. SW E stated yes. R1 has MS, paraplegia, a suprapubic catheter and is dependent on staff for all areas of ADLs. Facility staff did not provide R1 with a safe discharge plan. Facility staff discharged R1 AMA without shelter, medications and R1's belongings. R1 was discharged AMA to a park.		