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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 04/24/2024
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 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** 44863 Based on interview and record review. the facility did not ensure residents received treatment and care in accordance with professional standards of practice for 1 of 16 sampled residents (R161). The facility did not follow physician orders for R161, to obtain a follow up oncology appointment after a newly diagnosed condition requiring further evaluation, within 2-4 days after admission. Findings: The facility's admission checklist included, in part . Admitting nurse begin the process, orders, assessment, introduction, progress notes. 2nd nurse continues checking of items on the list. 3rd nurse completes, the checklist then goes to the DON/ADON for final checks and review. All orders need to be 2nd check by a nurse and 2 signatures are needed on each page. To be done within the first 4-8 hours of admission. 1st nurse enters in queue, 2nd nurse verifies. Note appointments, labs, etc. in appropriate place. R161 was admitted to the facility on [DATE]. Diagnoses included lesion noted on the left ninth rib, possible metastatic disease. R161's hospital discharge summary, dated 04/12/24, included the following information: -Page 1/7, Follow-up issues to address: 1. Would need outpatient follow-up with oncology in view of lesion in the ninth left rib. -Page 2/7, CT scan of the chest showed evidence of destructive lesion in the left ninth rib, which could represent a metastatic disease. Patient would need outpatient follow-up with oncology to evaluate this. -Page 3/7, Follow-up care: Physician consult oncology within 2-4 days, let ninth rib lesion, possible metastatic disease, please evaluate. -Page 3/7, Discharge orders: Medical service: oncology and hematology, discharge follow-up, refer to: provider not specified, lesion in left ninth rib, possible metastatic disease. Please evaluate. Please schedule appointment. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Page 4/7, Diagnostic studies: 4. Destructive lesion involving the posterior left ninth rib could reflect metastatic disease. Whole-body bone scan could be further diagnostic value. On 04/19/24, a skilled nursing home visit was completed with R161. The documentation included the following: -Diagnoses included (relative only): Nodule Pulmonary 01/15/18, Lung Interstitial Disease 03/19/19. -Review of systems, He does feel winded with any type of exertion but also has significant generalized weakness. -Assessment & Plan: 1. Lung Interstitial Disease: Previously seen by pulmonology in 2019. He is not currently on any inhaler treatments and is fairly asymptomatic. 12. Pneumonia Community Acquired: Resolved. Will follow up with chest x-ray in one month. -Orders: Collect CBC and Magnesium. On 04/21/24, Surveyor reviewed and noted R161 did not have a care plan related to diagnosis, treatment, or care of left ninth rib lesion. On 04/21/24, Surveyor reviewed and noted R161's physician orders did not include a follow up oncology appointment. On 04/22/24 at 8:40 AM, Surveyor interviewed R161. R161 confirmed knowledge of the oncology referral, and indicated he did not know if this appointment was scheduled. On 04/22/24 at 3:00 PM, Surveyor interviewed Social Services Assistant (SSA) G. SSA G reported she schedules resident appointments. SSA G described the facility process to schedule appointments includes the charge nurse or Director of Nursing (DON) reviewing and confirming appointments to be scheduled, this includes appointments for new admissions. Appointments requiring scheduling are placed in a file at the nurse's station and SSA G collects the file and schedules the appointments. SSA G keeps appointment data on a spreadsheet. SSA G confirmed she did not receive R161's information to schedule a follow-up appointment with oncology. On 04/22/24 at 3:20 PM, Surveyor interviewed Registered Nurse (RN) H. RN H indicated she did not work last week, when R161's appointment would have been scheduled. RN H confirmed SSA G's account of the facility's procedure of scheduling appointments. RN H reviewed R161's hospital discharge orders and confirmed the orders included a follow-up appointment to be scheduled with oncology in 2-4 days. RN H reported she was not sure why R161's appointment was not scheduled. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/24 at 3:50 PM, a progress note was entered in R161's record stating, This writer talked to the resident about the oncology follow up that he came from MMC [Marshfield Medical Center] with. The resident stated that was for Mayo. This writer stated that it was from MMC when he went to the ER the 2nd time. MMC wanted the resident to follow up with oncology but, are unable to make the appointment until the VA does a prior authorization. This writer stated that the resident needed to call the VA to have them to the PA done. Resident stated that he understood but wasn't sure if he wanted it at MMC. This writer stated that we could get a referral at Mayo if he would like that instead of MMC. Resident wanted to know if it could be at Mayo instead. This writer stated yes that this is possible that we would have [doctor] get the referral sent. Resident stated he understood and would wait for Mayo. On 04/23/24 at 9:05 AM, Surveyor interviewed DON B. DON B stated she did not work last week. DON B reported the acting charge nurse is responsible to review orders, including orders for new admissions. DON B stated if a charge nurse is unavailable the DON is responsible to review orders. DON B stated it would be an expectation, per facility protocol, R161's orders would have been reviewed and appointment scheduled per the hospital discharge summary. DON B reported the facility was waiting for R161's insurance provider to complete authorization for the oncology referral. DON B stated, The hospital didn't tell us it went to the [VA]. On 04/23/24, Surveyor reviewed R161's record since admission. Surveyor noted no indication the facility made attempts to schedule R161's appointment prior to 04/22/24. There is no indication the facility had communication with other providers related to R161's referral.

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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** 44863 Based on observation, interview and record review, the facility did not evaluate for hazards or risks related to oscillating percussion vest for a resident with a diagnosis of quadriplegia and assessed as high risk for aspiration. Deficiency identified for 1 of 6 residents (R26) reviewed for accidents. Findings: R26 was admitted to the facility on [DATE]. Diagnoses included quadriplegia, traumatic brain injury, diaphragmatic hernia with obstruction, dysphagia, feeding tube for nutrition, history of aspiration pneumonia, aphasia, contractures of bilateral hands, epilepsy, muscle spasms, and tremors. Minimum data set (MDS) assessment completed on 03/27/24, confirmed staff assessment indicated R26's cognition was severely impaired. R26 is dependent on all staff for activities of daily living (ADLs). R26's physician orders included: Start date, 11/23/2023. Afflo Respiratory Vest, use x 30 minutes twice daily (BID) while sitting up in w/c. Stop tube feeding during session. Check mouth after session and suction as needed (PRN). Check lung sounds after session. R26's care plan included: -Altered respiratory status related to history of aspiration pneumonia, date initiated 04/27/21. -On 04/22/24, Afflo vest, as ordered due to recurrent pneumonitis was added to R26's care plan; Afflo Respiratory Vest, use x 30 minutes BID while sitting up in w/c. Stop tube feeding during session. Check mouth after session and suction prn. Check lung sounds after session. -Communication problem related to aphasia; date initiated 04/27/21. Unable to make needs known, anticipate needs, the resident is able to communicate by nodding/shaking head and yes/no answers, at times. The care plan does not address if R26 is safe to be left alone with the vest in place, or how supervision will be provided during the Afflo vest treatment. R26's recent history: -July 2023, endoscopy (examination of upper digestive tract), confirmed R26's status to be, 'nothing by mouth (NPO), due to high aspiration risk.' -08/15/23, a nursing home visit was completed, and an order recommending chest physiotherapy and equipment for oscillating chest wall vest was obtained. -10/06/23-10/09/23, hospitalization due to sepsis/pneumonia. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/11/23-10/17/23, hospitalization due to hypoxia. -10/19/23-10/30/23, hospitalization due to pneumonia. -10/31/23, order for oscillating chest vest sent to durable medical equipment (DME) supplier. -11/11/23-11/14/23, hospitalization due to pneumonitis. -11/22/23, Communication with Physician/Provider, Situation: Fax sent to [doctor] to update that resident did receive the Afflo Respiratory Vest this AM. Needing orders for the recommended twice daily 30-minute sessions, stop tube feeding during session, sit upright, and check mouth and lung sounds after. Awaiting response. The Afflo vest manufacturer instructions for use, indicated children and disabled persons should not use the Afflo vest without supervision, https://www.rehabmart.com/pdfs/afflovest_percussive_therapy_cystic_fibrosis_vest_user_manual.pdf On 04/21/24 at 9:53 AM, Surveyor attempted to interview R26. Surveyor noted R26 was alone in his room, sitting up in wheelchair, wearing a vest around his chest. R26 was not able to move his arms or hands but was able to nod his head up and down when asked questions. On 04/22/24 at 7:28 AM, Surveyor observed R26 alone in his room, sitting up in wheelchair, wearing Afflo chest vest. On 04/22/24 at 7:57 AM, Surveyor interviewed Certified Nursing Assistant (CNA) I. CNA I reported R26 wears the chest vest to help with congestion. CNA I reported licensed nursing staff is responsible to apply and remove the chest vest. On 04/22/24 at 8:14 AM, Surveyor observed CNA K and Licensed Practical Nurse (LPN) J remove R26's chest vest. LPN J exited R26's room. CNA K provided R26 with oral care. CNA K used several toothettes to remove mucous from R26's mouth, as R26 had a large amount of mucous in his in his oral cavity. CNA K stated, We will have to the nurse come in and check on you [R26]. Surveyor did not observe nursing staff check R26's lung sounds, per physician's orders. R26 is unable to use a call light to ask for assistance, should R26 have increased secretions following the Afflo Vest treatment. On 04/22/24 at 8:49 AM, Surveyor interviewed LPN J. LPN J stated the chest vest helps R26 as he is a high aspiration risk. LPN J reported R26 has had the chest vest for, a long time, because of hospitalization s from aspiration pneumonia. It is put on for 30 minutes and is automatic. LPN J confirmed licensed nursing staff are responsible to apply and remove the vest. Surveyor asked LPN J how staff ensure R26 is safe to wear the vest unsupervised, and LPN J responded, That is a good question. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/24 at 12:04 PM, Surveyor interviewed LPN C. Surveyor asked LPN C if R26 requires suctioning after Afflo chest vest sessions, LPN C stated, Sometimes he does, it depends on the day. We use a toothette to clean his mouth. We have not had to suction him in a while. LPN C reported R26 is not able to use his call light due to his physical diagnoses, and is not able to call for assistance, so staff anticipate his needs. Surveyor asked LPN C if R26 was safe to wear chest vest unsupervised, LPN C stated, We usually have him by the nurse's station or we leave his door open so we can observe him from the hall. On 04/22/24 at 1:13 PM, Surveyor interviewed Director of Nursing (DON) B. DON B provided Surveyor with R26's respiratory care plan. R26's care plan included Afflo chest vest twice daily. Surveyor asked DON B if this was included in R26's care plan prior to 04/22/24, and DON B stated, It was not in there, I am not going to lie. DON B reported R26 has had the chest vest for a few months due to his aspiration risk. DON B confirmed she would expect licensed nursing staff to complete respiratory assessment after chest vest sessions, as this is ordered and in R26's treatment administration record. Surveyor asked DON B if an assessment had been completed to ensure R26 was safe to wear the chest vest unsupervised and to determine what supervision is needed while the vest is being used. DON B stated she was not sure and would look for this. On 04/23/24 at 11:51 AM, Surveyor interviewed DON B. DON B stated DON B spoke with corporate staff about R26's chest vest. It was reported to DON B an assessment to determine if R26 was safe to wear the chest vest unsupervised was not needed as staff assess him after every session. DON B questioned if the facility needed an assessment to determine safety.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46694 Based on observations, record review and interview, the facility did not ensure that residents who are medicated by enteral means received the appropriate treatment to prevent complications during medication administration through a Gastric tube (G-tube). This was observed with 1 of 1 resident (R38) observed for medication administration through a G-tube. R38 received medication without ensuring the G-tube was appropriately placed prior to medication administration. Findings include: The American Association of Critical Care Nurses, April 2016, Initial and Ongoing Verification of Feeding Tube Placement in Adults advises, .Checking Tube Location at Regular Intervals After Feedings Are Started, Unfortunately, feeding tubes can become dislocated during use. For this reason, it is necessary to monitor tube location at regular intervals while the tube is being used for feedings or medication administration. Observing for change in external tube length .Reviewing routine chest and abdominal radiography reports . Observing for changes in volume of feeding tube aspirates .Testing pH and observing the appearance of feeding tube aspirate if feedings have been off for at least 1 hour . Facility policy titled, Enteral Feeding and Medication Administration revised March 2020, states in part: .3. Check for proper tube placement prior to each feeding/medication administration (or every 4 hours for critically ill residents) by aspirating gastric contents or by auscultation while injecting 10ml of air into tube . R38 was admitted on [DATE] with diagnoses of epilepsy, cerebral palsy, and functional intestinal disorder. Doctor order for valproic acid 250 milligrams (mg)/5 milliliters (ml), give 10 ml's via G-tube five times a day related to epilepsy. On 04/24/24 at 10:05 AM, Surveyor observed medication pass with Licensed Practical Nurse (LPN) C. LPN C poured 10 ml's of valproic acid into a medication cup at the medication cart. LPN C put on Personal Protective Equipment (PPE) before entering R38's room. LPN C went to R38's bedside and placed the feeding pump on hold. LPN C gathered supplies, placed a paper towel on the bedside table and put the supplies on the paper towel. LPN C clamped the G-tube on the patient side of the connection, disconnected the feeding tube and put on the pump. LPN C removed gloves, performed proper hand hygiene and put new gloves on. LPN C wiped a stethoscope with alcohol wipe and stated, I'm going to listen for proper placement. I'm going to inject a little air in there. Using a 60 ml syringe R38 injected 10 ml's of air into the G-tube while listening with the stethoscope just below the G-tube insertion site, and replied, I heard it. LPN C then performed proper medication administration with the remaining observation. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 10:12 AM, Surveyor asked LPN C, Injecting the G-tube with air, is that typically how you check for placement of the tube? LPN C replied, Yep. On 04/24/24 at 10:31 AM, Surveyor interviewed Director of Nursing (DON) B regarding observations made during medication pass via the G-tube. Surveyor asked DON B, When checking placement of G-tube would you expect the nurse to inject air while listening for noise? DON B replied, Yes, that is actually in our policy to inject air. Surveyor informed DON B that this process was no longer the standard of practice. DON B replied, I will inform my nursing staff right away and we will revise our policy today.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47807 Based on observation, interview and record review, the facility did not ensure proper hand hygiene with food handling in accordance with professional standards for food service safety. Dietary staff did not use hand hygiene after touching dirty surfaces and continued to serve food; also hair nets were not used in areas that require hair nets. This has the potential to affect one resident who would receive the coffee, and 4 plates prepared in an unsanitary manner. Findings include: The facility policy, entitled Personal Cleanliness and Hygienic Practices, dated February 2020, States in part, 4. All dietary staff, including the Dietary Manager, and any person entering the kitchen, must wear an approved hair restraint to keep hair and particles in the hair from falling into the food. Hair restraints must entirely cover all hair . 6. Single-use gloves shall be worn as necessary to prevent bare hand contact with ready-to-eat food and shall be changed when they become soiled. Hands must be washed before putting on gloves and after removing gloves. On 04/21/24 at 9:28 AM, Surveyor performed an initial walkthrough of the kitchen. During the walkthrough Surveyor observed a sign on the door where Certified Nursing Assistants (CNA)s entered the kitchen reading, Hairnets required past this point. After a few minutes, CNA L entered the kitchen through the doors where the sign was located. Surveyor asked CNA L why they were not wearing a hair net at this time. CNA L indicated CNA L was just grabbing coffee. The coffee machine was located close to the door and near the cooking and plating areas of the kitchen. CNA L's uncovered hair could easily fall into the coffee cup. On 04/22/24 at 11:53 AM, Surveyor observed the point of service plating before lunch was served. During the observation, Surveyor observed Dietary Cook (DC) N using gloves to place a piece of bread onto a resident's plate. During the observation, Surveyor observed DC N touching their glasses resting on their face, and directly after touching their glasses, touched pieces of bread and placed them on two plates without changing gloves and did not use hand hygiene. DC N also needed to cook an alternative food item for a resident and was touching the stove controls. Directly after touching store controls, DC N touched pieces of bread and placed them on two plates to be served for lunch, without changing gloves and using hand hygiene. On 04/22/24 at 12:10 PM, Surveyor interviewed DC N and asked if they typically used gloves when serving bread. DC N said they did when they were not serving multiple items. Surveyor asked about touching of the glasses and stove controls. DC N said they could see how touching those items could be concerning. On 04/22/24 at 1:22 PM, Surveyor interviewed Dietary Manager (DM) M regarding the concerns observed. DM M said they would expect anyone entering the kitchen to wear a hair net; this has been a problem in the past and they will correct it. Surveyor asked about the use of gloves when plating resident food. DM M said they would expect staff to use tongs or change gloves and wash hands if unclean items are touched during the serving process.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46694 Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment. Staff did not perform proper hand hygiene during medication administration with Resident (R) 32 and the facility removed droplet precautions on R10 before the required isolation period was complete. This has the potential to affect 2 of 9 residents (R32, R10) observed for medication administration and contact precautions. Staff did not perform proper hand hygiene during medication administration with R32. Facility removed droplet precautions on R10 before the required isolation period was complete. Findings: The facility's policy titled, Hand Hygiene revised September 2022 states in part: .Using Alcohol-Based Hand Gel 1. If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations: .b. Before preparing or handling medications; .f. After providing direct resident care; R32 was admitted on [DATE] with a Brief Interview of Mental Status (BIMS) of 05 which indicates a severe cognitive impact. On 04/22/24 at 7:36 AM, Surveyor observed medication administration with Registered Nurse (RN) D. RN D finished medications with a previous resident and came to the medication cart. Surveyor observed RN D remove medications for R32 and take them to R32. RN D entered R32's room without performing hand hygiene. R32 administered the medications to R32 and returned to the medication cart. R32 did not perform hand hygiene when leaving R32's room. RN D then went to check a blood sugar on a different resident. RN D then performed proper hand hygiene, put on single use gloves and performed this task properly. On 04/23/24 at 1:49 PM, Surveyor informed Director of Nursing (DON) B of the observations that were made of RN D during medication pass. Surveyor asked DON B, What is the expectation regarding hand hygiene and passing medications? DON B replied, The nurse should perform hand hygiene in between residents. 47807 Example 2 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility removed precautions for Resident (R) 10 before their ten days of isolation were completed. Findings include: The facility Policy titled, Coronavirus (Covid -19) Prevention and Response, dated November 2022, states in part, 22. Managing a resident who has been treated for SARS-CoV - 2 infection . b. Utilize Symptom-based strategy for discontinuing transmission based precautions . i. Symptom Based Strategy . 1. Residents with mild to moderate illness who are not moderately to severely immunocompromised: a) At least 10 days have passed since symptoms first appeared and b) At least 24 hours have passed since last fever without the use of fever-reducing medication c) Symptoms (e.g., cough, shortness of breath) have improved R10 was admitted to the facility on [DATE]. R10 tested positive for Covid-19 with onset on 04/11/24 which would be considered day zero of isolation. R10 was placed on droplet precautions immediately after positive test results on 4/11/24. On 04/21/24 at 10:35 AM, Surveyor was able to talk to R10 from the doorway. The door was open, and Surveyor noted that R10 was on contact precautions at the time. R10 sat in a recliner near the door and was able to ambulate on their own to meals and to activities. Surveyor was told by the nearby staff that R10 had just gotten off droplet precautions and their isolation period had ended. Surveyor did not observe R10 leaving their room. On 04/21/24 at 12:07 AM, Surveyor observed that R10 was having their transmission-based precautions level changed from contact precautions to droplet precautions. Surveyor then asked the Director of Nursing (DON) B and Nursing Home Administrator (NHA) A why the sudden change. DON B and NHA A explained that R10 was supposed to still be on droplet precautions, but staff stopped the droplet precautions one day too early. On 04/23/24 at 12:47 PM, Surveyor interviewed Assistant Director of Nursing (ADON) O, who was the Infection Preventionist regarding droplet precautions being removed a day early. ADON O said they were taken off early because staff miscounted the days. Staff did not count the first day of isolation as day zero, they counted it as day one. As a result, droplet precautions were removed a day early. ADON O would expect that anyone positive for COVID would stay on precautions for the full isolation period.