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	05/21/2026

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a comprehensive infection prevention and control program was established and maintained. Specifically, the facility failed to ensure staff used Personal Protective Equipment (PPE) for Enhanced Barrier Precautions (EBP), sanitize mechanical lifts between resident use, complete proper hand hygiene, or provide residents with hand-hygiene before meals.-Registered Nurse (RN) C and Licensed Practical Nurse (LPN) D entered R23's room and conducted wound care on R23's open leg wounds without donning PPE prior to and during wound care treatment, having the ability to potentially spread infection to all 75 residents in the facility.-Certified Nursing Assistant (CNA) R and LPN D did not wear PPE while transferring R4 with the Hoyer mechanical lift.-CNA J and CNA G did not clean/sanitize the Hoyer lift after use on R3 who is on enhanced barrier precautions and then used it to transfer R15, having the ability to potentially spread infection to 1 of 1 resident (R15)-RN Q did not sanitize hands after doffing gloves following administration of nasal spray for R72 nor before administering eye drops to R72. This had the ability to potentially affect 1 of 18 residents observed for medication administration.-Facility staff did not offer hand hygiene to 4 of 17 residents present in the dining room for 2 meals. R15, R1, R6, R80 self-propel their wheelchairs to the dining room and feed themselves. Example 1 Facility policy titled Enhanced Barrier Precautions, last revised 5/2026, states, All staff are expected to comply with all designated precautions .an order for enhanced barrier precautions will be obtained for residents with .chronic wounds such as pressure ulcers, indwelling medical devices such as urinary catheters, feeding tubes .PPE for enhanced barrier precautions is only necessary when performing high-contact care activities .high contact care activities include: dressing, bathing, transferring, providing hygiene .device care. R23 was admitted to facility on 04/16/2026 with diagnoses that include malignant neoplasm of tongue, pressure ulcer of sacral region (stage 3), and venous ulcers of lower extremities. On 05/18/2026, Surveyor reviewed R23's current physician orders for wound care: -Initiated 4/23/2026 - Coccyx - Cleanse with normal saline, pat dry, apply SSD 1% cream and plain Calcium Alginate to wound bed, skin prep to peri wound, cover with silicone superabsorbent bordered foam dressing. Daily and as needed (PRN). -Initiated 04/23/2026 Bilateral Heels - Apply skin prep and bordered foam dressings every other day and PRN.-Initiated 05/06/2026 Diabetic Toe Ulcers - Paint with Betadine and leave open to air. Weave lamb's wool in between toes every other day and PRN. for diabetic ulcer (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Initiated 05/14/2026 Right Lower Extremity Venous Ulcers - Cleanse with normal saline, pat dry, apply Dermaphor to dry skin, xeroform to wound beds, cover with ABD pads, wrap with kerlix and secure using Fix Tape. Every other day and PRN for venous ulcers. On 05/19/2026 at 3:00 PM, Surveyor observed no signage outside of R23's room indicating need for EBP precautions. On 05/19/2026 at 3:05 PM, Surveyor observed RN C and LPN D enter R23's room and conduct wound care on R23's open wound without donning PPE prior to and during wound care treatment. On 05/19/2026 at 3:41 PM, Surveyor observed RN C and LPN D step outside R23's room and don PPE after discussing length of stay for R23 being over 30 days and before continuation of wound care. On 05/19/2026 at 4:08 PM, Surveyor interviewed RN C regarding no EBP signage outside R23's door and no observation of PPE worn prior to doing leg wounds, exiting room after discussion of R23 being admitted over 30 days and don PPE prior to completing wound care on G-tube dressing and coccyx wound. RN C stated just realizing when we were in room doing wound care R23 was here more than 30 days so now wounds are chronic and should be placed on EBP. Surveyor asked if all residents are placed on EBP only after 30 days, and RN C wasn't sure and will need to check. On 05/21/26 at 11:10 AM, Surveyor interviewed Director of Nursing (DON) B regarding observation of no PPE and signage for R23 and asked about the 30-day chronic wound process. DON B was unable to provide evidence or explanation of no signage or donning PPE prior to wound care for R23. Example 2 R4 was admitted to the facility on [DATE] with diagnoses that include intraspinal abscess and granuloma, pressure ulcer of left buttock stage 4, paraplegic and colostomy (bag attached surgically to outside of body to collect feces). On 05/19/2026 at 11:28 AM, Surveyor observed signage outside R4's room indicating EBP to be used during all high contact episodes with R4. On 05/19/2026 at 12:30 PM, Surveyor observed CNA R and LPN D perform a Hoyer lift transfer on R4. CNA R and LPN D did not don PPE upon entering R4's room or during Hoyer lift transfer of R4. Surveyor observed CNA R and LPN D experience high level physical contact with R4 while placing Hoyer sling under R4 when in bed, and during proper positioning of R4 into wheelchair. Example 3 On 05/19/26 at 7:26 AM, Surveyor observed Certified Nursing Assistant (CNA) J and CNA G use the Hoyer lift to transfer R3 from R3's wheelchair to a recliner. R3 is on Enhanced Barrier Precautions (EBP) in relation to a Foley catheter. CNA J then removed the lift to a small room off the dining room for charging. CNA J plugged in the Hoyer lift and did not clean/sanitize it. On 05/19/26 at 7:39 AM, Surveyor observed CNA H and CNA G take the same Hoyer lift that had not been cleaned into R15's room and use it to get R15 out of bed and into R15's wheelchair. On 05/19/26 at 8:27 AM, Surveyor interviewed CNA G about mechanical lift cleaning. CNA G stated that the lifts should be cleaned after every resident to prevent the spreading of germs. CNA G stated each lift has a container of sanitizing wipes in a bag that hangs on the lift. CNA G reported the nursing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	staff receive education in relation to this and nursing managers perform audits to make sure it is being done. Example 4 The facility policy titled, Hand Hygiene, states, . Hand hygiene is always the final step after removing and disposing of personal protective equipment (PPE). R72 was admitted on [DATE] with diagnoses of glaucoma, congestion, nasal crusting, and rhinorrhea. On 05/19/2026 at 7:34 AM, Surveyor observed Registered Nurse (RN) Q sanitize hands, don gloves and administer saline nasal 3% to R72. RN Q doffed gloves and reapplied clean gloves without sanitizing hands, then administered Dorzolamide-Timolol 2-0.5% eye drops to both eyes. RN Q doffed gloves again and applied new gloves without sanitizing hands and at 7:33 AM, RN Q administered Ipratropium Bromide Nasal solution 0.03% to R72. On 05/19/2026 at 10:33 AM, Surveyor interviewed Director of Nursing (DON) B and asked what they expect staff to complete following doffing gloves. DON B stated it is expected staff sanitize their hands every time they doff gloves, before, between, and after each medication administration. Example 5 On 05/18/26 at 12:10 PM, Surveyor observed no hand hygiene offered to residents prior to lunch. R15, R1, R6, and R80 self-propelled their wheelchairs to the dining room and feed themselves. 17 total residents were present. On 05/19/2026 at 8:13 AM, Surveyor observed no hand hygiene offered to residents prior to serving breakfast. R15, R1, R6, and R80 self-propelled their wheelchairs to the dining room and feed themselves. 17 total residents were present.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure each resident is free from unnecessary drugs as evidenced by facility not providing adeuate drug monitoring for 5 of 5 residents (R) (R2, R5, R9, R11 and R45) reviewed for unnecessary medication reviews.R2 received Hydroxyzine HCl 25 mg by mouth one time a day related to anxiety disorder, unspecified. Physician orders stated for facility to document number of times the resident [R2] exhibits the following behaviors, Nervousness, Restlessness, sweating, increased heart rate, difficulty sleeping or trouble concentrating.)R2 received Trazodone HCL 50mg one time a day for insomnia. Physician orders stated for facility to document number of times the resident exhibits the following behaviors: crying, tearfulness, social isolation, changes in appetite, mood swing, or difficulty sleepingR2's Treatment Administration Record (TAR) only showed documentation using a checkmark that a behavior occurred and not the number of episodes for each behavior.R5's received Risperidone Oral Tablet 1 mg by mouth three times a day for depression, Buspirone HCl Oral Tablet 10 MG 10 mg by mouth three times a day related to anxiety disorder, Trazodone HCl 100 mg by mouth one time a day for insomnia, Duloxetine HCl (aka Cymbalta) Give 2 capsule by mouth one time a day related to major depressive disorder, recurrent. Physician orders stated for facility to document number of times the resident exhibits the following behaviors: crying, tearfulness, social isolation, changes in appetite, mood swing, or difficulty sleeping.3 times a day.R5's TAR only showed documentation using a checkmark that a behavior occurred and not the number of episodes for each behavior.R9 received Bupropion HCl 300 mg. Give 1 tablet by mouth one time a day related to major depressive disorder, Sertraline HCl 100 mg. Give 1 tablet by mouth one time a day related to major depressive disorder. Take with 50mg to equal 150mg, Sertraline HCl Oral Tablet 50 mg. Give 50 mg by mouth one time a day related to major depressive disorder. Take with 100mg to equal 150mg, Trazodone HCl 100 mg. Give 1 tablet by mouth one time a day for insomnia Physician orders stated for facility to document number of times the resident exhibits the following behaviors: crying, tearfulness, social isolation, changes in appetite, mood swing, or difficulty sleeping.R9's TAR only showed documentation using a checkmark that a behavior occurred and not the number of episodes for each behavior.R45 received Buspirone HCl. Give 1 tablet by mouth three times a day related to generalized anxiety disorder.R45's care plan states: Resident is prescribed a medication for anxiety. Document number of times the resident exhibits the following behaviors: Nervousness, restlessness, sweating, increased heart rate, difficulty sleeping, or trouble concentrating.R45's TAR only showed documentation using a checkmark that a behavior occurred and not the number of episodes for each behavior.R11 received Seroquel Oral Tablet 50 mg. Give 1 tablet by mouth one time a day related to bipolar disorder, R11's orders stated: Antipsychotic - Resident [R11] is prescribed a medication for anxiety/bipolar disorder. Document number of times the resident exhibits the following behaviors: Delerium, paranoia, hallucinations, mood swings, or agitation.R11's TAR only showed documentation using a checkmark that a behavior occurred and not the number of episodes for each behavior. The facility policy titled, Psychotropic Management, revised December 2025, states: The facility will use psychotropic medication therapy only when clinically indicated to enhance the quality of life, while maximizing functional potential and well-being of the resident.Under section titled Practice Guidelines (5), states: The licensed nurse will institute the appropriate behavior monitoring from associated with the medication category. -a. Identity and document objective and quantifiable specific behaviors. -b. Document the number of episodes of behaviors.-c. Document interventions and outcomes.Example 1R2 was admitted to the facility on [DATE] with diagnoses including insomnia and anxiety disorder.R2's care plan initiated 07/02/25: Mood Problem related to (r/t) anxiety indicates Targeted Behavior of anxiousness, verbal/anger outbursts and isolation/withdrawn. Monitor/record/report to MD as needed (prn) acute episode feelings or sadness; (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skillsR2's psychotropic physician orders state:-On 04/22/2026, Hydroxyzine HCl 25 mg by mouth one time a day related to anxiety disorder, unspecified.-On 11/23/2025, Document number of times the resident exhibits the following behaviors, Nervousness, Restlessness, sweating, increased heart rate, difficulty sleeping or trouble concentrating.) -On 04/22/2026, Trazodone HCL 50mg one time a day for insomnia.-On 11/23/2025, Document number of times the resident exhibits the following behaviors: crying, tearfulness, social isolation, changes in appetite, mood swing, or difficulty sleepingOn 05/20/26 at 9:48 AM, Surveyor reviewed R2's Treatment Administration Record (TAR) for number of behavior episodes. R2's TAR showed documentation of using a checkmark instead of the number of episodes.Example 2R5 was admitted to the facility on [DATE] with diagnoses including Post-Traumatic Stress Disorder (PTSD), major depressive disorder recurrent, obsessive-compulsive disorder, and history of suicide.R5's care plan initiated 11/03/23:- The resident uses antipsychotic medication (Risperidone) r/t major depression with history of suicidal ideation.- The resident uses anti-anxiety medications (Buspar) r/t anxiety disorder. - The resident uses antidepressant medication Cymbalta for major depressive disorder and Trazodone for insomnia.-The resident has depression and anxiety r/t comorbidities and PTSD. Monitor/document/report every shift any s/sx of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxiety or health-related complaints, tearfulness.-R5's psychotropic physician orders state:-On 4/18/2025 Risperidone Oral Tablet 1 mg by mouth three times a day for depression-7/12/2024 Buspirone HCl Oral Tablet 10 MG 10 mg by mouth three times a day related to anxiety disorder.-On 12/31/2025 Trazodone HCl 100 mg by mouth one time a day for Insomnia please cut in half before giving.-On 10/13/2023 Duloxetine HCl (aka Cymbalta) Give 2 capsule by mouth one time a day related to major depressive disorder, recurrent.-On 11/22/2025 Document number of times the resident exhibits the following behaviors: crying, tearfulness, social isolation, changes in appetite, mood swing, or difficulty sleeping.3 times a day.On 05/20/26 at 9:48 AM, Surveyor reviewed R52's Treatment Administration Record (TAR) for documentation of the number of targeted behavior episodes. The TAR documented a checkmark instead of the number of episodes.Example 3R9 was admitted to facility on 06/19/2024 with diagnoses including major depressive disorder and anxiety disorder.R9's care plan includes:-Initiated 06/28/24 the resident uses antidepressant medications .Sertraline related to depression. Resident is taking Trazodone for insomnia. Monitor/document/report every shift any s/sx of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxiety or health-related complaints, tearfulness.-Initiated 08/01/25: The resident has a mood problem r/t anxiety disorder and major depressive disorder. Monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skillsR9's physician orders state:-On 06/17/2025 Bupropion HCl 300 mg. Give 1 tablet by mouth one time a day related to major depressive disorder.-On 02/20/2025 Sertraline HCl 100 mg. Give 1 tablet by mouth one time a day related to major depressive disorder. Take with 50mg to equal 150mg.-On 12/20/2025 Sertraline HCl Oral Tablet 50 mg. Give 50 mg by mouth one time a day related to major depressive disorder. Take with 100mg to equal 150mg.-On 11/22/2025: Resident is prescribed a medication for depression. Document number of times the resident exhibits the following behaviors: crying, tearfulness, social isolation, changes in appetite, mood swing, or difficulty sleeping.-On 05/14/2026 Trazodone HCl 100 mg. Give 1 tablet by mouth one time a day for insomniaOn 05/20/26 at 9:48 AM, Surveyor reviewed R9's Treatment Administration Record (TAR) that was ordered of documenting the number of targeted behaviors. The TAR was documented using a checkmark instead of the number of episodes.Example 4R45 was admitted to the facility on [DATE] with diagnoses including anxiety disorder.R45's care plan initiated 2/06/2026 states resident uses (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anti-anxiety medications related to anxiety disorder. Monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetiteR45's physician orders state:-On 05/14/2026, Buspirone HCl. Give 1 tablet by mouth three times a day related to generalized anxiety disorder.-On 05/20/2026, R45's care plan states: Resident is prescribed a medication for anxiety. Document number of times the resident exhibits the following behaviors: Nervousness, restlessness, sweating, increased heart rate, difficulty sleeping, or trouble concentrating.On 05/20/2026 at 9:48 AM, Surveyor reviewed R45's Treatment Administration Record (TAR) for documentation of the number of targeted behavior episodes. The TAR documented a checkmark instead of the number of episodesExample 5R11 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder.-R11's care plan initiated 12/18/2025, states resident uses an antipsychotic medication (Seroquel) r/t bipolar disorder with intervention Monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/eating habits; change in sleep patterns; diminished ability to concentrate; change inpsychomotor skills.R11's physician orders state:-On 12/18/25: Seroquel Oral Tablet 50 mg. Give 1 tablet by mouth one time a day related to bipolar disorder.-On 12/19/2025: Antipsychotic - Resident is prescribed a medication for anxiety/bipolar disorder. Document number of times the resident exhibits the following behaviors: Delerium, paranoia, hallucinations, mood swings, or agitation.On 05/20/2026 at 9:48 AM, Surveyor reviewed R45's Treatment Administration Record (TAR) for documentation of targeted behavior episodes. The TAR documented a checkmark instead of the number of episodesOn 05/20/2026 at 10:56 AM, Surveyor interviewed Certified Nursing Assistant (CNA) O regarding documentation expectation of behaviors of residents. CNA O stated all residents have same behavior task with a selection of behaviors they complete during the shift. On 05/21.26 at 11:10 AM, Surveyor interviewed DON B regarding targeted behavior orders recorded on the TAR record showing checkmarks instead of the number of episodes. DON B stated, I don't know what happened there.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that 1 resident (R) of 18 residents reviewed for residents' rights can exercise their rights without interference, coercion, discrimination, or reprisal from the facility in a sample of 18 residents (R10). The facility did not allow R10 an advanced diet unless R10 ate meals in a common dining area instead of in R10's room per R10's preference resulting in R10 refusing puree consistency meals, which in turn contributed to weight loss. The facility did not provide R10 and R10's family education on risks and benefits of R10 consuming regular texture meals brought in by R10's family which could result in R10 suffering physical harm due to R10 having dysphagia (difficulty swallowing).Findings include: Facility policy, last revised 2/2026, states, Facility staff will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes the maintenance or enhancement.R10 was admitted to the facility on [DATE] and has diagnoses including cerebral infarction (stroke of the brain), dysphagia (difficulty swallowing) and aphasia (difficulty speaking).R10 has a brief interview for mental status score (BIMS) of 9/15, which means moderate cognitive impairment. R10 makes own healthcare decisions. On 05/19/2026 at 6:59 AM, record review on R10 indicated the following: R10 had a significant weight loss of 10.05% since admission on [DATE]. On 04/20/2026, registered dietician (RD) S documented a mini nutrition score of 6.0, which means malnourished. RD S' notes state, Resident is able to get out of bed/chair but does not go out.resident has moderate decrease in food intake. On 04/29/26, nursing documentation stated, Fax sent regarding resident refusing tube feedings. On 04/30/2026, provider aware of weight loss, refusal of tube feedings, and decreased meal intake. On 05/11/2026, resident care conference note states, .[RD S] asked if the resident can be graduated to a different diet. ST stated that resident should be going to the dining room.ST stated that due to safety, resident would need to eat in the cafeteria so that staff can monitor.resident then can eat small, chopped textures and hot have to eat the pureed. Resident didn't like that idea, but family encouraged. Review of certified nursing assistant (CNA) task charting indicated R10 refused meals 51 times in a 30 day look back period. R10 ate less than 50% of meals 17 times. Between 05/18/2026 at 9:59 AM and 05/20/2026 at 1:56 PM, R10 was observed in bed with pureed meals on bedside table untouched. On 05/19/2026 at 7:11 AM, Surveyor asked registered nurse (RN) Q what R10's eating pattern was. RN Q stated R10 often declines tube feedings and meals. RN Q stated R10 can eat. However, Speech Therapist (ST) P encouraged R10 go out to the main dining room to be supervised and then they will advance R10's diet to minced, but for now R10 must be pureed if R10 chooses to stay in room to eat.On 05/19/2026 at 8:47 AM, Surveyor asked R10 the reason for not eating pureed breakfast meal. R10 stated, I don't like the food, look at that. I cannot eat that. It looks terrible. R10 stated she asked for 2 slices of toast with jelly, but it was not provided. R10 showed Surveyor dietary request form on meal tray, and it indicated toast was requested by R10. There was no toast on R10's meal tray. On 05/20/2026 at 11:57 AM, during interview with CNA O about R10's meal preferences, CNA O stated R10 did not like pureed food. CNA O stated R10's family brings in regular food for her such as hamburgers and donuts and R10 eats them. CNA O denied witnessing R10 choking while eating regular foods. On 05/20/2026 at 7:36 AM, Surveyor interviewed ST P about R10's refusal to eat pureed foods. ST P stated a speech therapy evaluation found R10 pockets food on the left side of mouth and R10 does not know it is there. ST P confirmed R10 does not like pureed diet and is able to have advanced diet, but R10 needs supervision during meals because of risk of choking. ST P stated, We don't have the staff to sit in the room with her. ST P acknowledged R10 has the right to eat meals in her room and the facility should have someone there to assist R10. ST P stated, We should be coming up with something so she can eat in her room and have a different diet. ST P denied being aware of R10's family bringing regular food for R10 to eat. ST (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P stated staff did not make her aware and both R10 and family need to be educated on how to do a finger sweep of pocketed foods in R10's cheek, as well as risks of R10's choking hazard. ST P stated no education was done for R10 and family of risks/benefits of R10 not complying with pureed diet. ST P confirmed no risk/benefit consent was obtained by R10 when choosing to eat regular texture foods in room and/or without staff supervision.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not develop and implement a comprehensive person-centered care plan for each resident, including services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 18 residents (R) reviewed for care planning (R15).-R15 has an open surgical wound with a wound vac present, and a laceration to 5th left toe with no care plan related to Enhanced Barrier Precautions (EBP).Findings include:On 05/19/26 at 1:30 PM, Surveyor reviewed R15's medical record. R15 was readmitted to the facility on [DATE] after a surgical procedure to the left hip/thigh. R15 has an open wound with a wound vac in place to the left thigh, and a laceration to the left 5th toe which would warrant the use of enhanced barrier precautions (EBP).On 05/19/26 at 1:35 PM, Surveyor reviewed R15's care plan and noted no implementation of an EBP care plan to prevent infection.On 05/20/26 at 1:04 PM, Surveyor interviewed Infection Preventionist (IP) L about EBP. IP L stated that IP L is the main person that places the signage and Personal Protective Equipment (PPE) bins out when indicated. IP L stated IP L and Director of Nursing (DON) B usually discuss who requires EBP. IP L stated things such as wounds, catheters, feeding tubes, history of MDROs and Nephrostomies would warrant EBP. IP L stated that they get their information from the county health department and that the health department gives them guidelines and websites to look at. Sometimes they go by the CDC guidelines. IP L stated staff is educated on precautions at monthly meetings, at orientation, and there is a packet available at the nurse's station. When asked if a resident with a laceration that needed treatment, and a surgical wound with a wound vac, would require EBP, IP L stated, That's a tricky one. And when asked specifically about R15, IP L stated they should have put R15 on EBP and that it was missed. IP L acknowledged this information should be placed in the care plan.On 05/20/26 at 1:13 PM, Surveyor interviewed DON B about EBP. DON B stated the Interdisciplinary Team (IDT) team discusses daily at morning meeting who should be on precautions and as referrals come in they discuss it ahead of time. DON B stated IP L places the signage and PPE bins, but the floor nurses can after hours. When asked what kind of things might warrant use of EBP, DON B stated catheters, peg tubes, wounds, chronic/open wounds. When asked about R15 with a surgical wound and wound vac, and a laceration requiring treatment, DON B stated, We were just all talking about this, and indicated that yes, R15 should be on EBP. On 05/21/26 at 8:38 AM, Surveyor interviewed Licensed Practical Nurse (LPN) F. LPN F stated R15's wound vac is to be removed on 05/25/26 and that a new order will begin for gauze and paper tape to the surgical site. LPN F stated that if LPN F were the one to remove the wound vac, LPN F would use standard precautions, EBP, and would wear a gown and gloves for sure.

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Meadowbrook at Chetek	725 Knapp St Chetek, WI 54728

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure the comprehensive care plan was reviewed and revised for one resident (R) of 18 residents reviewed for care plan timing and revisions in a sample of 18 residents (R10). R10's comprehensive care plan did not:- Include interventions for R10's refusal to wear dentures and how that affects R10's nutritional status which could contribute to R10's weight loss.- Include interventions for R10 refusing to eat meals and alternative meal options provided to R10 which could contribute to R10's weight loss. - Include interventions for R10 refusing tube feedings which could be contributing to R10's weight loss.Findings include: Facility policy titled Comprehensive Care Plan, last revised 01/2026, states, The care plan is reviewed on an ongoing basis and revised as indicated by the resident's needs, wishes, or a change in condition.R10 was admitted to the facility on [DATE] and has diagnoses including cerebral infarction (stroke of the brain), dysphagia (difficulty swallowing) and aphasia (difficulty speaking).R10 has a Brief Interview for Mental Status score (BIMS) of 9/15, which means moderate cognitive impairment. R10 makes own healthcare decisions. On 04/16/2026, R10 has physician orders for tube feedings to be given via a gastric tube 2 times a day. Between 05/18/2026 at 10:09 AM and 05/21/2026 at 9:33 AM, Surveyor made several observations of R10 not wearing dentures during or in between meals. Surveyor observed R10 in bed during all meals, at times with untouched pureed meal. An emesis bag was in place next to R10. On 05/18/2026 at 10:09 AM, Surveyor interviewed R10 on how the scheduled tube feedings were being tolerated. R10 stated tube feedings made her nauseous, therefore R10 often refused them. On 05/18/2026 at 1:28 PM, Surveyor interviewed R10 on status of dentures. R10 stated dentures do not have enamel on them anymore due to tube feedings eroding them. R10 informed Surveyor the dentures are in bedside stand. R10 stated she did not like eating a pureed diet. R10 stated R10 did not want to get out of bed to go to dining room to eat. On 05/19/2026 at 7:11 AM, Surveyor interviewed Registered Nurse (RN) Q on status of R10's tube feedings. RN Q stated R10 often declines tube feedings as they make R10 feel nauseous. Surveyor asked what interventions are in place to alleviate R10's nausea and promote compliance with tube feedings, and RN Q stated R10 receives scheduled Ondansetron (antinausea medication) prior to all meals/feedings. RN Q stated the only other intervention in place for promoting oral intake is R10 should go to the main dining area to receive an advanced diet and have close supervision during meals. On 05/20/2026 at 7:36 AM, Surveyor interviewed certified nursing assistant (CNA) O on the status of R10 not wearing dentures. CNA O stated R10 only wears dentures when family is present for the grandchildren. On 05/20/2026 at 8:08 AM, Surveyor asked CNA O about R10 refusing to eat meals. CNA O stated R10 does not like pureed diet and will refuse to eat it. R10's record review indicated R10 had experienced a 10.05% weight loss since admission on [DATE]. On 05/11/2026, a care conference was held with R10 and R10's family addressing concerns surrounding R10's refusal to eat meals in dining room in order to have an advanced diet and promote food intake. R10's record review showed documentation by Registered Dietician (RD) S in which R10 refused most meals and tube feedings. RD S stated R10's weight loss is due to poor intake and tube feeding refusal.resident does not enjoy pureed diet. A mini nutrition assessment done by RD S on 04/20/2026 indicated R10 had moderate decrease in food intake and did not go out of room to eat. R10's comprehensive care plan did not have interventions and/or alternative approaches in place for R10's refusal to wear dentures, eat pureed meals, go to dining room for meals, or tolerate scheduled tube feedings. CNA care plan did address R10 having dentures, but no indication R10 refused to wear them. CNA care plan did not address R10's refusal to eat meals at times. On 05/20/2026 at 9:33 AM, Surveyor interviewed director of nursing (DON) B what staff expectations were for reviewing and revising resident care plans. DON B stated all nurses can revise care plans. DON B stated staff inform nurses of any changes in residents cares/needs and (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes should be made immediately with new interventions in place. An interdisciplinary team (IDT) meets weekly and assesses residents' needs and makes changes according to their plan of care. DON B confirmed there were no interventions in place on R10's comprehensive care plan addressing R10's refusal to wear dentures, eat in dining room, eat pureed meals, and remain compliant with scheduled tube feedings. ^

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record reviews, the facility did not ensure services provided met professional standards for 2 of 4 residents (R) reviewed for medication pass. (R72 and R10).- Registered Nurse (RN) Q did not cue or assist R72 to blow nose prior to administration of nasal inhalant medication.- Licensed Practical Nurse (LPN) M did not properly check for gastrostomy tube placement prior to administering medications to R10. Example 1 Cleveland Clinic article dated February 18, 2026, under the heading, How To Correctly Use Nasal Spray, indicates, . Shake the nasal spray well. Wash your hands. Scrub your hands thoroughly with soap and water. Before applying, gently blow your nose. This will empty your nasal passages and clear the way for the medicine. R72 was admitted on [DATE] with diagnoses of congestion, nasal crusting, and rhinorrhea. On 05/19/2026 at 7:34 AM, Surveyor observed Registered Nurse (RN) Q administer saline nasal 3% to R72. RN Q did not ask R72 to blow nose prior to administration. At 7:33 AM, Surveyor observed RN Q administer Ipratropium Bromide Nasal solution 0.03% to R72. Again, RN Q did not ask R72 to clear nasal passage prior to administering the nasal spray. On 05/19/2026 at 10:33 AM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectation is for staff to cue or assist residents prior to administering nasal sprays. DON B said staff should ask residents to blow nose prior to administering nasal sprays. Example 2 Facility policy titled Verifying Placement of Feeding Tube, last revised 12/2025, states, Verifying tube placement: for gastrostomy tubes, check that the enteral retention device is properly approximated to the abdominal wall by.taking note of the marking on the tube.check and record length of the tube prior to feeding. R10 was admitted to the facility on [DATE] and has diagnoses inclduing cerebral infarction (stroke of the brain), dysphagia (difficulty swallowing) and aphasia (difficulty speaking). R10 has physician orders for Jevity tube feedings to be administered via a gastric tube twice daily. R10 has physician orders for Fluticasone Propionate Nasal Suspension: 2 sprays in both nostrils one time a day On 05/19/2026 at 7:13 AM, Surveyor observed licensed practical nurse (LPN) M prep for administration of R10's medications via a gastric (PEG) tube placed in R10's abdomen. Surveyor observed LPN M unclamp R10's PEG tube, inject approximately 30cc of air using a piston tip syringe, and auscultate using a stethoscope over R10's epigastrium for air bubbling. LPN M did not check measurement of PEG placement at insertion site, or aspirate for gastric contents prior to administering R10's medications via the PEG tube. On 05/19/2026 at 7:20 AM, Surveyor observed LPN M administer 2 sprays of Fluticasone nasal suspension in each of R10's nostrils. LPN M did not have R10 blow nose prior to administration of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fluticasone nasal sprays. On 05/21/2026 at 9:33 AM, Surveyor interviewed director of nursing (DON) B about what the expectations were for staff when determining proper PEG tube placement prior to administering medications. DON B stated the practice changed a few years ago to check measurement of PEG tube at insertion site and if needed, aspirating gastric contents. DON B stated nurses should not be using auscultation for gastric air bubbling as only means for checking PEG tube placement.

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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** Based on interview and record review, the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice for 3 of 18 residents (R) (R9, R10, and R15) reviewed for following physician orders. -Facility failed to notify physician on four occasions when R9's fluid restrictions exceeded 2500 cc in 24 hours as per physician ordered parameters. -Facility failed to provide thorough speech therapy services for R10 which contributed to R10's weight loss as R10 did not wear dentures. -R15's hospital discharge orders were omitted when readmitted , following surgical procedure on R15's left thigh requiring a wound vac. Example 1 R9 was admitted to facility on 06/19/2024 with diagnosis of Cor pulmonale, chronic respiratory failure, and chronic kidney disease. R9's care plan initiated on 06/28/2024, states: The resident is on diuretic therapy r/t diuretic use. Administer diuretic medications as ordered by physician. R9's physician orders dated 06/20/2024 state: 2500 milliliters (ML)/day fluid restriction. Add up total of previous day and enter here. Update MD if exceeds fluid restriction. On 05/20/2026 at 10:07 AM, Surveyor reviewed R9's fluid intake record and noted the following dates above physician parameters of 2500 ml and without notification to physician:-04/01/2026 consumed 2700 ml-04/10/2026 consumed 3140 ml-04/12/2026 consumed 2800 ml-04/26/2026 consumed 2600 ml On 05/20/2026 at 2:24 PM, Surveyor interviewed Registered Nurse (RN) Q regarding facility expectation of updating physician when orders state to notify MD when a resident is out of parameters of an order such as intake fluid amounts. RN Q normally will fax the provider or if the resident is symptomatic, the facility will call the 24-hour switchboard. On 05/20/2026 at 3:26 PM, Surveyor interviewed Director of Nursing (DON) B regarding documentation to support R9's provider was notified of fluid intake of more than 2500 ml in 24 hours. DON B stated was unable to find supporting documentation that provider was notified and the expectation would be nursing would follow physician orders. Example 2 Facility policy titled Specialized Rehabilitation Services, last revised 12/2022, states, Facility shall provide services.to assist [residents] attain, maintain or restore their highest practicable level of physical, mental and psychosocial well-being. R10 was admitted to the facility on [DATE] and has diagnosis that include cerebral infarction (stroke of the brain), dysphagia (difficulty swallowing) and aphasia (difficulty speaking). R10 has a brief interview for mental status score (BIMS) of 9/15, which means moderate cognitive impairment. R10 makes own healthcare decisions. Between 05/18/2026 at 9:59 AM and 05/20/2026 at 1:56 PM, R10 was observed in bed with pureed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meals on bedside table untouched. R10 did not have dentures in place. On 05/18/2026 at 1:28 PM, Surveyor interviewed R10 on status of dentures. R10 stated dentures do not have enamel on them anymore due to R10's tube feedings eroding them. R10 informed Surveyor the dentures are located in R10's bedside stand. R10 denied facility helping with adjusting dentures or any therapy with use of dentures in place. On 05/19/2026 at 1:00 PM, record review indicates R10 stayed at a rehabilitation facility from 03/25/2026 to 4/16/2026, following a cerebral infarction. R10's discharge Summary from the rehabilitation facility, dated 04/15/2026, includes a speech therapy assessment, education and discharge recommendations. The rehabilitation facility's speech therapy assessment included trials with dentures in place and pureed textured solids. The rehabilitation facility recommended speech therapy services to continue at long term care facility to address speech and swallowing deficits and safe swallowing strategies. R10 has physician orders, dated 04/16/2026, for speech therapy evaluation and treatment. On 05/19/2026 at 1:30 PM, record review of speech language and pathology evaluation and plan of treatment done on 04/17/2026 and 05/08/2026 by speech therapists (ST) P, did not reference use of dentures for R10 during or following evaluations. On 05/19/2026 at 1:30 PM, record review of speech therapy encounters for R10, dated 04/27/2026, 04/28/2026 and 04/30/2026 by ST P, did not reference use of dentures during therapy sessions. On 05/20/2026 at 7:36 AM, Surveyor interviewed ST P on the plan for treatment for R10's speech and swallowing deficits. ST P stated R10 has issues with pocketing food in left cheek and continues to have speech therapy sessions. ST P confirmed all speech therapy sessions for R10 were done without the use of R10's dentures. ST P stated facility did not pursue use of dentures for R10 during meals and other times as recommended by the rehabilitation facility because R10 did not have dentures while at facility. ST P confirmed no further follow up was done by ST to locate dentures. Surveyor informed ST P that R10 stated dentures were in bedside stand, and CNA care plan indicated R10 had upper and lower dentures. Surveyor then observed ST P locate R10's dentures in R10's bedside stand. ST P stated was not aware R10 had dentures available. ST P confirmed the rehabilitation facility's speech assessment of R10 with use of dentures and R10 should continue speech therapy sessions at facility trying to eat with dentures. ST P was aware R10 refused pureed diets, chose to eat in room, and had a weight loss of 10% since R10's admission on [DATE]. ST P confirmed speech therapy sessions with use of dentures may assist in R10's compliance with therapeutic diets and/or lessen chances of continued weight loss. Example 3 Findings include: Facility policy titled, Physician Orders, last revised January 2026, includes a purpose of: To ensure Physician orders are implemented timely and accurately and a procedure that includes: The licensed nurse receiving the order and the second licensed nurse verifying the order must ensure it is complete and that it includes.other information as may be necessary to carry out the order accurately and completely. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/19/26 at 6:45 AM, Surveyor reviewed R15's medical record. R15 was readmitted to the facility on [DATE] after surgical procedure. On 05/19/26 at 7:00 AM, Surveyor reviewed the hospital discharge summary from 05/12/26 which indicated R15 had a laceration to the 5th toe on the left foot with a treatment to be completed by nursing. The summary also indicated R15 was to have a follow up appointment with podiatry in relation to fractures of the 4th and 5th left toes. Upcoming appointments on the After Visit Summary (AVS), dated 05/12/26, only listed scheduled appointments for radiology and orthopedic surgery related to the left thigh fracture/fixation. On 05/19/26 at 7:10 AM, Surveyor reviewed R15's orders and care plan and noted no treatment orders for or care plan related to the left foot laceration. On 05/19/26 at 7:37 AM, Surveyor reviewed R15's admission skin assessment, dated 05/12/26, and weekly skin assessment dated [DATE] and noted both indicated no skin impairments to the left foot. On05/19/26 at 7:48 AM, Surveyor reviewed provider notes from 05/15/26 which did not mention the left foot laceration. On 05/20/26 at 8:57 AM, Surveyor interviewed Certified Nursing Assistant (CNA) G about R15's left foot. When asked if R15 had any kind of wound or bandage on the left foot, CNA G stated, I'm not sure. R15 had a sock on. On 05/20/26 at 9:00 AM, Surveyor interviewed Licensed Practical Nurse (LPN) E about R15's left foot and admission orders. LPN E stated LPN E was not sure about a treatment or wound to R15's left foot but knows there is a treatment to the left leg. LPN E told Surveyor LPN E would have to look into it. LPN E stated that admission orders are put in by the house supervisor. On 05/20/26 at 11:33 AM, Surveyor observed R15's left foot. Surveyor was unable to get a close enough look to see the laceration area clearly but did observe a very darkened area to the inner aspect of the 5th left toe. There was no treatment/bandage in place. Bruising was present on the top of the left foot just off the 4th and 5th toes. On 05/20/26 at 12:00 PM, Surveyor reviewed R15's therapy notes which indicated R15 has plateaued, cannot tolerate toe-touch weight bearing, and therapy services would be coming to an end on 06/02/26. On 05/20/26 at 1:13 PM, Surveyor interviewed Director of Nursing (DON) B about admission orders and R15. DON B indicated admission orders are entered by the charge nurse on duty or the floor nurse if after hours or charge nurse is unable. DON B stated the orders are obtained from the hospital AVS and usually the hospital will fax the summary prior to admission. DON B stated that if the discharge summary or an updated AVS indicated a discrepancy or new orders, they will clarify and update. DON B stated the social workers make follow-up appointments. DON B was made aware that R15 had orders for treatment to the left foot as well as a recommendation for follow up appointment with podiatry and neither had been addressed. DON B acknowledged the treatment orders had been omitted and the appointment had not been scheduled.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents received proper treatment and care to maintain mobility and good foot health for 1 of 3 residents (R) reviewed for foot care (R15).-R15's physician discharge orders from hospital were omitted for treatment to the left foot/toes and a follow-up appointment with podiatry was not made for R15. Findings include:Facility policy titled, Physician Orders, last revised January 2026, includes .Physician orders are obtained to provide clear direction regarding the care of the resident .to ensure physician orders are implemented timely and accurately. On 05/19/26 at 6:45 AM, Surveyor reviewed R15's medical record. R15 was readmitted to the facility on [DATE] after surgical procedure on left thigh requiring a wound vac.On 05/19/26 at 7:00 AM, Surveyor reviewed the hospital discharge summary from 05/12/26, which indicated R15 had a laceration to the 5th toe on the left foot with a treatment to be completed by nursing. The summary also indicated R15 was to have a follow up appointment with podiatry in relation to fractures of the 4th and 5th left toes. Upcoming appointments on the After Visit Summary (AVS), dated 05/12/26, only listed scheduled appointments for radiology and orthopedic surgery related to the left thigh fracture/fixation.R15's orders and care plan noted no treatment orders or care plan related to the left foot laceration. On 05/20/26 at 8:57 AM, Surveyor interviewed Certified Nursing Assistant (CNA) G about R15's left foot. When asked if R15 had any kind of wound or bandage on the left foot, CNA G stated, I'm not sure. R15 had a sock on.On 05/20/26 at 9:00 AM, Surveyor interviewed Licensed Practical Nurse (LPN) E about R15's left foot and admission orders. LPN E stated LPN E was not sure about a treatment or wound to R15's left foot but knows there is a treatment to the left leg. LPN E told Surveyor LPN E would have to look into it. LPN E stated admission orders are put in by the house supervisor.On 05/20/26 at 11:33 AM, Surveyor observed R15's left foot. Surveyor observed a darkened area to the inner aspect of the 5th left toe. There was no treatment/bandage in place. Bruising was present 4th and 5th toes of the left foot.On 05/20/26 at 1:13 PM, Surveyor interviewed Director of Nursing (DON) B about admission orders and R15. DON B indicated admission orders are entered by the charge nurse on duty or the floor nurse if after hours or if charge nurse is unable. DON B stated the orders are obtained from the hospital AVS and usually the hospital will fax the summary prior to admission. DON B stated if the discharge summary or an updated AVS indicated a discrepancy or new orders, they will clarify and update. DON B stated the social workers make follow-up appointments. DON B was made aware R15 had orders for treatment to the left foot and a recommendation for a follow up appointment with podiatry and neither had been addressed. DON B acknowledged the treatment orders had been omitted and the appointment had not been scheduled. On 05/21/26 at 9:30 AM, Surveyor interviewed Nursing Home Administrator (NHA) A in relation to policy/procedure for podiatry. NHA A stated the facility does not have one due to no direct facility podiatry services.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents with an indwelling catheter receive the appropriate care and services to prevent urinary tract infections to the extent possible for 3 of 7 residents reviewed for indwelling catheters (R1, R6, R80).-R1 was observed with R1's catheter drainage bag in the wheelchair seat beside R1.-R6 was observed with R6's catheter drainage bag in the wheelchair seat beside R6 with staff present and no intervention.-R80 was observed with R80's catheter drainage bag and privacy bag wrapped around front wheelchair wheel for 24 minutes without intervention by 4 staff, who were present.Findings include:Facility policy titled, Catheter Care, last revised July 2025, includes.It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.Ensure drainage bag is located below the level of the bladder to discourage backflow of urine.Example 1R1 was admitted to the facility on [DATE]. R1 has a Foley catheter in relation to benign prostatic hyperplasia (BPH), obstructive and reflux uropathy, and chronic kidney disease.R1's care plan which includes a focus of the resident has a catheter related to BPH with obstructive uropathy, and interventions including position catheter bag and tubing below the level of the bladder at all times.On 05/19/26 at 7:49 AM, Surveyor observed R1 transfer from a stationary chair to R1's wheelchair. Certified Nursing Assistant (CNA) J assisted. R1's catheter bag was located in the seat of the wheelchair next to R1 on the right side. Surveyor observed CNA J clip the bag to the sheet in the wheelchair and push the catheter bag back a little before walking away. The catheter bag was not covered and was hanging out of the opening of the wheelchair arm rest and rubbing up against the right wheel. Surveyor was unable to interview R1 due to R1's inability to answer questions. Example 2R6 was admitted to the facility on [DATE]. R6 has a suprapubic urinary catheter related to history of urinary tract infections, calculus of kidney, chronic kidney disease, hydronephrosis, neurogenic bladder, and history of sepsis.On 05/19/26 at 3:10 PM, Surveyor reviewed R6's care plan which includes a focus of resident has a suprapubic catheter.with interventions including position catheter bag and tubing below the level of the bladder at all times.On 05/18/26 at 10:21 AM, Surveyor observed R6 with R6's suprapubic catheter bag sitting in the seat of the wheelchair next to R6 on the left side while in the dining room. CNA H was present in the room and spoke with R6. Surveyor observed CNA H did not acknowledge the location of the catheter bag and left the room.On 05/18/26 at 10:31 AM, Surveyor observed CNA H assisting another resident in the dining room. R6 was sitting to the left of CNA H with the catheter bag still sitting in the wheelchair seat. No intervention by CNA H.Surveyor was unable to interview R6 related to R6's inability to answer questions. Surveyor was unable to interview CNA H.Example 3R80 was admitted to the facility on [DATE]. R80 has a Foley catheter related to BPH and obstructive and reflux uropathy.R80's care plan includes a focus of the resident has a catheter relation to BPH with obstructive uropathy with interventions including position catheter bag and tubing below the level of the bladder at all times.On 05/18/26 at 10:07 AM, Surveyor observed R80 with R80's Foley catheter drainage bag and cover bag entangled in the left front wheel of R80's wheelchair. On 05/18/26 at 10:08 AM, Surveyor observed Activity Aide (AA) K, CNA T, CNA H, and Licensed Practical Nurse (LPN) E, all passing by the R80 with no intervention. On 05/20/26 at 1:13 PM, Surveyor interviewed Director of Nursing (DON) B about catheter tubing and drainage bag placement. DON B stated the drainage bags for catheters should be placed below the bladder, so the urine flows down. DON B stated the expectation would be if a nursing staff member noticed one in the wrong location, they should move it to an appropriate location. DON B was made aware of Surveyor's observations of catheter drainage bags in wheelchair seats and DON B agreed this was not standard of practice.On 05/21/26 at 8:38 AM, Surveyor interviewed CNA G and asked where urinary drainage bags should be (continued on next page)

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	05/21/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed. CNA G stated urinary drainage bags should be hung under the wheelchair in a bag or on the frame of the bed when the resident is in bed. CNA G stated that if CNA G saw a drainage bag in the seat of a wheelchair, CNA G would ask the resident if it was ok to move it to an appropriate place. CNA G stated if CNA G noticed one tangled in the wheel, CNA G would move them to a more private area and fix it.

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	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice for 1 of 2 residents (R) reviewed for nephrostomies (R6).-R6's nephrostomy tubes were placed up and over the back of the wheelchair and placed in a pouch above the kidneys.Findings include:Facility policy titled, Nephrostomy and Cystostomy Tube Care and Maintenance, last revised May 2026 includes.Residents with nephrostomy or cystostomy tubes will receive care consistent with professional standards of practice.Keep the drainage bag below the level of the kidneys at all times.On 05/18/26 at 10:21 AM, Surveyor observed R6's nephrostomy tubes placed up and over the back of the wheelchair and placed in a pouch on the back of the chair above kidney level.On 05/19/26 at 3:05 PM, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE]. R6 has bilateral nephrostomy tubes related to history of urinary tract infections, calculus of kidney, chronic kidney disease, hydronephrosis, neurogenic bladder, and history of sepsis.On 05/19/26 at 3:10 PM, Surveyor reviewed R6's care plan which includes a focus of resident has bilateral nephrostomy tubes, with interventions including position catheter bag and tubing below the level of the bladder at all times.On 05/20/26 at 1:13 PM, Surveyor interviewed Director of Nursing (DON) B about nephrostomy tubing and drainage bag placement. DON B stated the drainage bags for nephrostomies should be placed below the kidneys, so the urine flows down. DON B stated the expectation would be if a nursing staff member noticed one in the wrong location, they should move it to an appropriate location. When asked if it is appropriate for nephrostomy tubes to run up and over the back of a wheelchair and into a pouch on the back of the wheelchair, DON B stated no, because it wouldn't drain correctly. DON made aware of Surveyor's observations of the nephrostomy tubes of one resident up and over the back of the wheelchair with the bag tucked in the pouch behind the wheelchair above kidney level, and DON B agreed this was not standard of practice.On 05/21/26 at 8:38 AM, Surveyor interviewed Certified Nursing Assistant (CNA) G about nephrostomy tubing and drainage bags. CNA G reported that nephrostomy tubing should be beside the resident and it would not be appropriate to hang them over the wheelchair back.