STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017941	A. BUILDING: _____ B. WING _____	C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK SENIOR LIVING AT BLACK R	109 N 14TH ST BLACK RIVER FALLS, WI 54615

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 07/23/2025, Surveyor conducted a complaint investigation at Meadowbrook Senior Living at Black River Falls. Data collection continued through 07/28/2025. The complaint was substantiated. Six deficiencies were identified. Two of the 6 were repeat deficiencies. See Statement of Deficiency (SOD) PBMY11, dated 11/10/2023, SOD XP5111, dated 01/29/2024 and SOD XP5112, dated 08/14/2024. Census: 14	N 000		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not notify the department within 7 days after there was a change in the administrator. Findings include: On 07/23/2025 at approximately 11:40 AM, Surveyor entered the facility and asked to speak to the designated administrator for the facility. Administrator A introduced him/herself and stated s/he was in charge of the facility. On 07/24/2025, at 8:13 AM, Surveyor emailed Administrator A and asked when s/he assumed administrator duties.	N 200		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 200	Continued From page 1 At approximately 8:15 AM, Surveyor reviewed the facility's electronic file for any correspondences related to the administrator change. No communication had been received regarding the change from Previous Administrator (PA) G to Administrator A. At 9:35 AM, Surveyor received an email from Administrator A that read, in part, "My official start date with the facility was 3/17/2025." At 4:02 PM, Surveyor emailed Administrator A and asked if the department was notified of the administrator change. On 07/28/2025 at 9:35 AM, Surveyor received an email from Administrator A that read, "No, it does not appear after speaking with my boss that the notification was done in relation to the Assisted Living."	N 200		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on record review and interview, the	N 409		

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N 409	Continued From page 2	N 409		

provider did not ensure the facility maintained a proof-of-use record for Resident 4's hydrocodone that was audited, signed, and dated daily by the administrator or designee.

Findings include:

On 06/02/2025, the department received a complaint regarding resident medications.

On 07/23/2025 at approximately 11:45 AM, Surveyor interviewed Administrator A. When asked if the provider had any recent issues with medication management, Administrator A stated they did have recent concerns. Administrator A stated there were various issues with medications, which led to the termination of Wellness Director (WD) D. Administrator A stated the provider identified there was a lack of audits completed by WD D. Administrator A stated they were working diligently to correct the issues.

At approximately 1:50 PM, Surveyor interviewed Administrator A regarding WD D's termination. Administrator A stated the provider conducted an investigation and identified narcotic counts were not getting done. Administrator A stated a medication had gone missing but it was later found, and it was not identified as misappropriation. It was during the investigation, the provider noticed WD D was not doing routine audits, and the narcotic log was not signed appropriately. Administrator A stated that due to the severity of the concerns, it was decided to sever employment with WD D. Surveyor requested WD D's termination letter and internal investigation documentation.

At approximately 2:00 PM, Surveyor reviewed the following documentation related to WD D's

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termination:

-A document, dated 05/23/2025, identifying Resident 4 as the resident involved and WD D as the witness. The person conducting the interview was Administrator A. Under the "Statement," section of the document, it read, in part, "I came in last night to review the narc (narcotic) logs due to an error being brought to my attention by [Caregiver E] and [Caregiver F] to say that a pill was missing. [Caregiver E] and [Caregiver F] completed the narc count and stated there was one pill missing from [Resident 4's] Vicodin. [Caregiver F] had pre-popped out the medication and taped it back in on 5/18 as [s/he] did not give the pill before the resident left for the hospital ...1. Medication count was reviewed at CBRF (Community Based Residential Facility) meeting on 5/22 in which it was noted that the narc count has been off at times. Did you complete a narc audit at that time? No, I did not. 2. Were you aware of errors in the narc count and the narc log not being signed out appropriately? Yes. 3. Do you have any documentation of audits completed at any time? No, not that I know of."

-A disciplinary action report, dated 05/27/2025. The report read, in part, "[WD D] was placed on suspension pending investigation on 5/23/25. During this investigation, it was determined that [WD D] did not routinely audit and supervise staff medication administration, particularly in regard to narcotic medication count and administration. [WD D] had identified this concern in standard practice March 2025, which audits and education to staff were to be completed. [WD D] did not complete audits or education, which resulted in further medication count discrepancies with the potential for harm to facility residents ...A staff member informed [WD D] of a potential miscount

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N 409	Continued From page 4 in the narcotic log on 5/21/25. [WD D] stated during the interview that [s/he] does not recall this, and was likely distracted by completing a different task ...[WD D] had then begun to rewrite all narcotic administration logs for the residents in the facility. This can be seen as falsification of medical documentation ...During the investigation, several staff member [sic] noted that they had reported errors in the narcotic count to [WD D] on multiple occasions with no action taken." Under a "Disciplinary action being taken," section, it indicated [WD D] was terminated. Cross Reference N0410 DHS 83.37(1)(k) Medication Error or Adverse Reaction Cross Reference N0415 DHS 83.37(2)(d) Documentation of Medication Administration	N 409		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by:	N 410		

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N 410	Continued From page 5 Based on record review and interview, the provider did not notify Resident 5's prescribing practitioner, nurse, or pharmacist when s/he did not receive his/her prescribed medication for 2 or more consecutive days. Findings include: The provider is licensed to serve up to 32 residents in the following client groups: advanced aged and irreversible dementia/Alzheimer's disease. On 06/02/2025, the department received a complaint regarding resident medications. On 07/23/2025 at approximately 11:45 AM, Surveyor interviewed Administrator A. When asked if the provider had any recent issues with medication management, Administrator A stated the provider identified there was a lack of communication with residents' providers regarding medication issues. Administrator A stated those issues contributed to the termination of Wellness Director (WD) D. At approximately 2:30 PM, Surveyor reviewed Resident 5's record. Resident 5 was admitted on 08/10/2023 and had multiple diagnoses, including secondary hypertension, essential (primary) hypertension, chronic obstructive pulmonary disease, obstructive sleep apnea, and peripheral vascular disease. Resident 5 had a guardian. Resident 5's Individual Service Plan (ISP), revised on 09/24/2024, stated, in part, "MEDICATION - medications are dispensed by staff and make sure [s/he] takes them."	N 410		

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N 410	Continued From page 6 Resident 5's May 2025 MAR included the following: Amlodipine Besylate Tablet 10 MG. Give 1 tablet by mouth one time a day for high bp (blood pressure) -05/01/2025 through 05/04/2025, there was a "7" entered on the corresponding date. On the chart code, it read, "7 = Sleeping." -05/05/2025 was blank. -05/06/2025 indicated a 7. Aspirin EC Low Strength Oral Tablet Delayed Release 81 MG. Give 1 Tablet by mouth one time a day for bloot [sic] clot prevention. -05/01/2025 through 05/04/2025 there was a "7" entered on the corresponding date. On the chart code, it read, "7 = Sleeping." -05/05/2025 was blank. -05/06/2025 indicated a 7. Triamterene HCTZ Oral Tablet 37.5-25 MG. Give .5 tablet by mouth one time a day related to secondary hypertension. -05/01/2025 through 05/04/2025, there was a "7" entered on the corresponding date. On the chart code, it read, "7 = Sleeping." -05/05/2025 was blank. -05/06/2025 indicated a 7. Breo Ellipta Inhalation Aerosol Powder. 1 puff inhale orally 2 times a day related to other asthma. -05/01/2025 through 05/04/2025, there was a "7" entered on the corresponding date for the morning dose. On the chart code, it read, "7 = Sleeping." -05/05/2025 was blank on the morning dose. -05/06/2025 indicated a 7 on the morning dose.	N 410		

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N 410	Continued From page 7 At approximately 2:15 PM, Surveyor interviewed Administrator A. When asked about the number of medications marked with a 7, Administrator A stated Resident 5 would not have received his/her medications at those times. When asked if Resident 5's provider was made aware Resident 5 did not receive his/her scheduled medications on those days, Administrator A stated s/he did not know. When asked how any communication would have been documented, Administrator A stated it may be in the progress notes or in fax history. Surveyor requested Resident 5's progress notes and any faxes sent to Resident 5's prescribing physician from May 2025 - current. At approximately 2:30 PM, Surveyor reviewed Resident 5's progress notes. Surveyor did not obtain any faxes for review. There was no indication Resident 5's medical provider was informed that Resident 5 had not taken his/her medications for more than two consecutive days. Cross Reference N0409 DHS 83.37(1)(j) Proof-Of-Use Record Cross Reference N0415 DHS 83.37(2)(d) Documentation of Medication Administration	N 410		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the	N 415		

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resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that at the time of medication administration, the person administering the medication, documented in the resident record the name, dosage, date and time of medication taken, and initialed the medication administration record (MAR).

This is a repeat deficiency. See Statement of Deficiency (SOD) XP5111, dated 01/29/2024.

Findings include:

The provider is licensed to serve up to 32 residents in the following client groups: advanced aged and irreversible dementia/Alzheimer's disease.

On 06/02/2025, the department received a complaint regarding resident medications.

On 07/23/2025, at approximately 11:45 AM, Surveyor interviewed Administrator A. When asked if the provider had any recent issues with medication management, Administrator A stated the provider identified there was a lack of medication audits completed by Wellness Director (WD) D. Administrator A stated they were working diligently to correct the issues.

At approximately 2:00 PM, Surveyor reviewed documentation related to an internal investigation and termination of WD D. A disciplinary action

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N 415	Continued From page 9 report for WD D, dated 05/27/20254, read, in part, "Failure to meet expectations of job description, outlined duties, and leadership role in a manner that has the potential to jeopardize the health, safety, and well-being of facility residents, as well as the direction and leadership of the staff ...CBRF (Community Based Residential Facility) Wellness Director Position Snapshot includes the following daily duties that were not met: Verify completion of RA (Resident Assistant) assignments/tasks, Med (Medication) pass, MAR/TAR (Task Administration Record) review/audits." The investigation documentation included MARs for 8 different residents. There were digital initials on most medications, indicating they were signed as administered. There were 19 areas on the MARs that included handwritten initials. There were 6 blank spaces on the MARs which were assigned to medications. When asked about the handwritten initials, Administrator A stated WD D had instructed staff to backdate the blank areas of the MARs. Administrator A stated WD D did not audit the medications to confirm if they were or were not administered to the residents. When asked about the blank spaces on the MARs, Administrator A stated it was unknown if the residents received those medications. Cross Reference N0409 DHS 83.37(1)(j) Proof-Of-Use Record Cross Reference N0410 DHS 83.37(1)(k) Medication Error or Adverse Reaction	N 415		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free	N 489		

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from odors.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure all rooms were clean and free from odors. There was a strong smell of urine in the south hallway of the facility.

This is a repeat deficiency. See Statement of Deficiency (SOD) PBMY11, dated 11/10/2023, SOD XP5111, dated 01/29/2024, and SOD XP5112, dated 08/14/2024.

Findings include:

On 07/23/2025 at approximately 12:05 PM, Surveyor toured the facility. There was a strong smell of urine in the south facing hallway. The smell seemed to be more pungent outside of Resident 1's room. The smell was noticeable and penetrated the air past several resident rooms located around the identified room.

At approximately 12:15 PM, Surveyor interviewed Resident 2 in his/her room, which was in the south facing hallway. Resident 2 stated s/he noticed the "wet urine" smell often and believed it was because resident incontinence products accumulated in the rooms.

At approximately 1:25 PM, Surveyor observed Caregiver C mopping the floor in the south facing hallway. When asked about housekeeping duties, Caregiver C stated the provider did not have a housekeeper and cleaning tasks were shared among caregivers. Caregiver C stated 3 rooms were cleaned each shift. When asked about the remaining rooms, s/he stated it changed depending on the day and resident needs.

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N 489	Continued From page 11 At approximately 2:45 PM, Surveyor interviewed Administrator A. Surveyor shared concerns related to the odors and housekeeping tasks. Administrator A stated s/he noticed the urine smell at times but did not think it was present all the time.	N 489		
N 516	83.46(4)(e) Electrical outlets. Outlets. Electrical outlets shall be located to limit the use of extension cords. Extension cords shall not be used in lieu of permanent wiring. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure extension cords were not used in place of permanent wiring. Findings include: On 07/23/2025, Surveyor observed an extension cord used in lieu of permanent wiring in the following location: - In a shared bathroom identified as "Shower 3." There was an orange extension cord resting on a sharps container that was stretched up into the ceiling behind multiple ceiling panels. The one end was hanging near a scale on the floor. The other end was plugged into a wall outlet approximately 12 inches from the bathroom sink. At approximately 1:15 PM, Surveyor asked Administrator A about the cord. Administrator A stated it did appear to be an extension cord, and it should not be there. Administrator A found Maintenance Person (MP) B and asked him/her to remove it. MP B stated the cord was placed	N 516		

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N 516	Continued From page 12 there before s/he assumed the maintenance role. MP B stated s/he believed it was placed there to power the floor scale.	N 516		