Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017668	A. BUILDING: _____ B. WING _____	C 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA MEADOWS	1480 N 7TH ST MANITOWOC, WI 54220

(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 04/23/2026, Surveyor conducted a complaint investigation at Magnolia Meadows in Manitowoc. One (1) of 1 complaint was substantiated. As a result of the survey, 1 deficiency will be issued. Census: 21	N 000		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the ISP (Individual Service Plan) for 1 of 1 (Resident 1) resident reviewed was reviewed and revised when there was a change in the resident's needs, abilities or physical or mental condition. Resident 1 arranged for his/her own transportation to go to a grocery store	N 389		

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

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N 389	Continued From page 1	N 389		

approximately an hour away. When Resident 1 returned to the facility, Guardian B requested additional interventions regarding supervision and transportation. Resident 1's ISP was not revised to include interventions to prevent an incident like this from happening again.

Findings Include:

On 03/26/2026, the department received a complaint regarding resident supervision.

On 04/23/2026, Surveyor conducted an onsite visit. A sample of residents was selected including the resident record of Resident 1.

Resident 1 was admitted to the facility on 11/19/2025 with diagnoses to include frontal lobe and executive function deficit following other cerebrovascular disease, other forms of scoliosis and low back pain. Resident 1 has a court appointed guardian. Resident 1's ISP with a printed date of 04/23/2026 indicated Resident 1 is independent with ambulation, transfers, toileting and shopping tasks. Resident 1 is not a wandering risk. The ISP also states Resident 1 "has frontal lobe dementia, and this can cause [him/her] to do things that [s/he] thinks is right when they are not."

A pre-admission assessment dated 11/04/2025 stated, "alert & oriented x2," can be "anxious or argumentative at times," "smokes - decided to hitch hike to gas station and then to a friends house," "wants to be in the community," "just wants to go home. wants to drive," and "needs supervision while outside when smoking."

On 04/23/2026 at 9:15 AM, Surveyor interviewed Assistant Executive Director A. Assistant

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N 389	Continued From page 2 Executive Director A stated Resident 1 called a transportation company and set up a ride to the grocery store in Plymouth. Assistant Executive Director A stated s/he was coming in the door and saw Resident 1 getting into the transport van. Assistant Executive Director A thought it was odd because s/he didn't think Resident 1 had an appointment. Assistant Executive Director A asked Executive Director if s/he had made a transportation van request for Resident 1 and Executive Director stated no. Assistant Executive Director A stated s/he then proceeded to call Resident 1's guardian to find out if s/he made an appointment. Guardian B stated s/he did not arrange transportation so then Guardian B called transportation company to find out what was going on. Assistant Executive Director A stated Resident 1 was brought back to the facility by the transportation company with no injury. Assistant Executive Director A mentioned that Resident 1 had an incident at his/her previous assisted living facility where s/he was found hitch hiking on a major highway. Assistant Executive Director A stated shortly after that incident, Resident 1 moved to the current facility. This was the first incident at this facility and there have been no further attempts. Assistant Executive Director A stated they have talked with Resident 1 and s/he knows what s/he did was dangerous. Assistant Executive Director A also indicated they have talked with the transportation company and Resident 1 is not allowed to make van appointments by self any longer; it must be done by facility staff. Assistant Executive Director A stated they have been trying to have a care plan meeting with Guardian B but have not been able to coordinate schedules. Assistant Executive Director A stated that Resident 1 is not allowed to go out by self anymore and needs supervision while in the community.	N 389		

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N 389	Continued From page 3 On 04/23/2026 at 10:00 AM, Surveyor interviewed Resident 1. Resident 1 stated s/he was from the Plymouth area and "had a chance to get back there." Resident 1 elaborated that s/he called a transport company and a van picked him/her up at the facility and brought him/her to a grocery store in Plymouth. Resident 1 stated s/he bought items and then the van took him/her back to the facility. Resident 1 stated s/he has no mental deficits and just wants to get out of the facility and can leave on his/her own in the community. On 04/23/2026 at 10:30 AM, Surveyor interviewed Guardian B. Guardian B verified s/he is the court appointed guardian for Resident 1. Guardian B stated prior to moving to current assisted living facility, Resident 1 resided at another assisted living facility. Guardian B stated at the previous facility, Resident 1 had left the facility and was found hitch hiking on a major highway. At that time, it was decided to move Resident 1 to his/her current facility. Guardian B stated s/he received a call from Assistant Executive Director A asking Guardian B if s/he made a transportation appointment for Resident 1. Guardian B stated s/he did not and that is when Assistant Executive Director A informed Guardian B that Resident 1 got in a van and was not at the facility. Guardian B stated s/he then called transportation company and they called the van driver, however, the van driver had said s/he had just dropped Resident 1 off at the grocery store. Guardian B then called police, who also received a call from the grocery store. The police were unable to do anything, however, the transportation company drove back and were able to get Resident 1 back into the van and take Resident 1 back to the facility. Guardian B stated	N 389		

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N 389	Continued From page 4 s/he didn't have any parameters for leaving the facility or phone use at the time of the incident for Resident 1, however, stated the facility was aware of the previous incident at the prior facility so assumed they would have been watching Resident 1 more closely. Guardian B stated s/he has spoken to the transport company and they will no longer be accepting van reservations from Resident 1. Guardian B stated the facility wanted to have a care conference the day the incident happened, however, Guardian B was unavailable. A conference was supposed to happen today but they had to cancel and reschedule for tomorrow, but Guardian B has not heard back to confirm. On 04/23/2026 at approximately 1:00 PM, Surveyor interviewed Executive Director C. Executive Director C verified the ISP was not updated to include current interventions related to supervision, phone use and transportation. Executive Director C stated they have been trying to have a meeting with Guardian B but have been unsuccessful in those attempts. Executive Director C stated they will reach out again to Guardian B and the managed care organization and the ombudsman to facilitate a care plan meeting so discuss interventions and ISP.	N 389		