STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013097	A. BUILDING: _____ B. WING _____	R 03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS OF FALL RIVER (THE)	**101 HOMETOWN AVE FALL RIVER, WI 53932**

(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
{U 000}	INITIAL COMMENTS On 03/30/2026, Surveyor conducted a verification visit at Meadows of Fall River (The), a RCAC in Fall River. One deficiency was identified. This is a repeat deficiency - See Statement of Deficiency (SOD) 78UP11, dated 10/23/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 31	{U 000}		
U 118	89.23(2)(a)2.c SERVICES SUFFICIENT SERVICES. Minimum required services. A residential care apartment complex shall have the capacity to provide all of the following services to all tenants, either directly or under contract: c. Nursing services: health monitoring, medication administration and medication management. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure nursing services, including medication administration and	U 118		

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

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U 118	Continued From page 1	U 118		

medication management, were provided as ordered by the physician for 2 of 3 tenants reviewed.

Tenant 1 did not receive his/her insulin as prescribed.
Tenant 2's blood pressure was not monitored with the administration of his/her furosemide administered daily at 12:00 p.m.

This is a repeat deficiency. See Statement of Deficiency (SOD) 78UP11, dated 10/23/2025.

Findings include:

On 03/30/2026, Surveyor conducted a verification visit and identified the following concerns.

Example 1 - Tenant 1:

Tenant 1 was admitted to the provider's complex on 07/01/2021. Tenant 1's record indicated the provider's staff managed his/her medications, which included management of diabetes. Tenant 1's physician orders included the following:

- Novolog 100 unit/ml (Start Date: 01/18/2026) - Inject daily at mealtimes and at bedtime per sliding scale: 151-200=1 unit, 201-250=2 units, 251-300=4 units, 301-350=5 units, 351-400=5 units. *Inject 7 units in addition to sliding scale at breakfast and lunch.
- Lantus 100 unit/ml (Start Date: 01/18/2026) - Inject 30 unites at bedtime. No insulin if blood sugar (BS) is less than 150.

Tenant 1's medication administration record (MAR), dated 02/20/2026 to 03/30/2026, documented the following occurrences when Tenant 1 did not receive his/her insulin as

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U 118	Continued From page 2 ordered: - 02/20/2026 7:56 p.m. BS=120; Lantus 100 unit/ml 30 units given. *Per order, Lantus should have been held. - 02/25/2026 8:00 p.m. BS=356; 4 units of insulin given *Per order, 5 units of insulin should have been administered. - 02/26/2026 8:14 p.m. BS=280; 2 units of insulin given. *Per order, 3 units of insulin should have been administered. - 02/27/2026 8:01 p.m. BS=225; 1 unit of insulin given. *Per order, 2 units of insulin should have been administered. - 02/28/2026 7:46 p.m. BS 352; 4 units of insulin given. *Per order, 5 units of insulin should have been administered. - 03/01/2026 7:24 p.m. BS 352; 4 units of insulin administered. *Per order, 5 units of insulin should have been administered. - 03/02/2026 7:39 p.m. BS 218; 1 unit of insulin administered. *Per order, 2 units of insulin should have been administered. - 03/10/2026 11:48 a.m. BS 349; 5 units of insulin administered. *Per order, 4 units of insulin should have been administered. - 03/20/2026 7:33 a.m. BS=122; 1 unit of insulin administered. *Per order, 0 units of insulin should have been administered. - 03/21/2026 8:07 p.m. BS=140 Lantus 100 unit/ml 30 units was administered. *Per order, Lantus should have been held.	U 118		

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U 118	Continued From page 3	U 118		

- 03/24/2026 12:03 p.m. BS=240; 0 units of insulin administered.
*Per order, 2 units of insulin should have been administered.
- 03/28/2026 7:26 a.m. BS=117; 1 unit of insulin administered.
*Per order, 0 units of insulin should have been administered.
- 03/28/2026 10:59 a.m. BS=140; 1 unit of insulin administered.
*Per order, 0 units of insulin should have been administered.
- 03/30/2026 7:17 a.m. BS=122; 1 unit of insulin administered.
*Per order, 0 units of insulin should have been administered.

On 03/30/2026 at approximately 11:30 a.m., Surveyor reviewed the above occurrences when Tenant 1 did not receive his/her insulin as prescribed with Administrator A and RN B. RN B confirmed the errors. Upon reviewing the errors, Administrator A, RN B and Surveyor concluded the provider's electronic charting program had the incorrect sliding scale entered prompting some of the errors and additional errors were made from caregivers selecting the incorrect BS range to instruct what amount of insulin to give. Administrator A stated, "We have work to do."

Example 2 - Tenant 2

Tenant 2 was admitted to the provider's complex on 03/24/2025. Tenant 2's record included an order, dated 02/25/2026, to increase furosemide 20 mg - 2 tablets in the morning and 1 tablet at noon; hold if systolic blood pressure less than 95. Tenant 2's Medication Administration Record (MAR), dated 03/01/2026 to 03/30/2026, documented blood pressure readings in the

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U 118	Continued From page 4 morning, but did not document blood pressure readings prior to each of Tenant 2's administration of furosemide at noon. On 03/30/2026 at approximately 11:00 a.m., Surveyor interviewed Nurse B. Surveyor shared concern that Tenant 2's blood pressure was not monitored with his/her noon furosemide administration. Nurse B reviewed Tenant 2's physician orders and confirmed Tenant 2's blood pressure should have been monitored with the noon administration of furosemide. RN B stated Tenant 2 often refused vitals monitoring and reached out to Tenant 2's physician to see if the blood pressure monitoring could be discontinued.	U 118		