STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010211	A. BUILDING: _____ B. WING _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW	601 HAGEN AVE NEW RICHMOND, WI 54017

(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
M 000	INITIAL COMMENTS On 05/15/2024, Surveyor conducted a complaint investigation and abbreviated licensure survey at Meadow View. The complaint was substantiated. Two violations were identified. Census: 4	M 000		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident prescription medications remained in their original containers as received from the pharmacy. Medications were prepared ahead of administration and stored in cups. On 03/12/2024, Resident 1 ingested medications from one of these cups that had been prepared for another resident. Findings include:	M 458		

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

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M 458	Continued From page 1 On 03/15/2024, the Department received a complaint about the provider's medication system. On 05/15/2024 at 7:50 AM, Surveyor entered the facility and observed a small cup on the counter with Resident 2's name on it. At 8:09 AM, Surveyor observed Caregiver A pull a small clear cup with Resident 4's name on it from the medication cabinet. The cup contained various medications. Caregiver A handed the cup of medication to Resident 4. At 8:12 AM, Surveyor observed Caregiver A remove another cup from the medication cabinet and hand it to Resident 1. This cup also contained various medications. At 8:13 AM, Surveyor interviewed Caregiver A. Caregiver A stated s/he prepped medications ahead of time and kept the cups with medications in them in the locked cabinet until residents were ready to take their medications. At approximately 8:20 AM, Surveyor interviewed Program Manager (PM) B. PM B informed Surveyor of an incident on 03/12/2024 where Resident 1 accidentally took Resident 2's medications. PM B stated Resident 1 went to the office for his/her evening medications, saw a cup with medications in it, and took them when Caregiver C was not looking. Surveyor reviewed the incident report, which read, "While staff was punching out [Resident 1's] meds [s/he] came into the office to get them. When staff turned to put the bubble packs back into [his/her] med (medication) drawer [Resident 1] picked up a different resident's meds [sic] cup and took them thinking they were [his/hers]." The report indicated Resident 1 ingested the following medications not prescribed to Resident 1 on	M 458		

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M 458	Continued From page 2 03/12/2024 at 8:37 PM: - Carbamazepine 100 mg - Carbamazepine 400 mg - Lorazepam 1 mg - Melatonin 3 mg - Oxybutynin 5 mg - Phenytoin 100 mg - Risperidone 0.5 mg - Risperidone 1 mg	M 458		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain a medication administration record (MAR) for 2 of 4 residents (Resident 3 and Resident 4) that included the time of administration. Findings include: The provider is licensed to care for 4 residents in the client groups developmentally disabled, emotionally disturbed/mental illness, and traumatic brain injury.	M 466		

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M 466	Continued From page 3 On 05/15/2024, Surveyor observed Caregiver A administer Resident 4's medication as 8:09 AM and Resident 3's medication at 8:12 AM. Caregiver A left the facility at 8:30 AM. Surveyor did not observe Caregiver A document either administration. Surveyor reviewed Resident 4's and Resident 3's MAR in the provider's electronic charting system. Caregiver A documented both residents' medications were administered at 7:01 AM.	M 466		