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 _____	C 08/28/2023

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 From 08/28/2023 to 09/01/2023, Surveyor conducted a complaint investigation and standard survey at Meadows of Fall River, a RCAC in Fall River. Two deficiencies were identified. The complaint was substantiated. Census: 36	U 000		
U 127	89.23(3)(f) SERVICES SERVICE QUALITY. Meals and snacks served to tenants shall be prepared, stored and served in a safe and sanitary manner. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure meals and snacks were served in a safe and sanitary manner. Food was observed in the dining room that was expired and/or not stored properly. Findings include: On 08/28/2023 at approximately 10:00 a.m., Surveyor observed condiments on dining room tables, with no tenants present eating. Surveyor observed the following condiments on the tables, warm to touch: - A bottle of Everything Aioli with a best buy date of 05/01/2021 and instructions to refrigerate upon opening.	U 127		

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

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U 127	Continued From page 1 - A bottle of Yellow Mustard with instructions to store in a cool, dry place. - A jar of All American Jam with instructions to refrigerate after opening. - A bottle of Vidalia Onion Mustard, dated 10/2020, with instructions to refrigerate after opening. - A bottle of Strawberry Fruit Spread with instructions to refrigerate after opening. - A bottle of Grape Fruit Spread with instructions to refrigerate after opening. - A jar of salsa with instructions to refrigerate promptly after opening. On 08/28/2023 at approximately 10:30 a.m., Surveyor interviewed Dietary B. Surveyor asked Dietary B if the condiments observed were placed on tables prior to meals or always left on the tables. Dietary B stated the condiments are left on the tables all the time.	U 127		
U 238	89.29(3)(c)1.a. ADMISSION & RETENTION OF TENANTS (3) TERMINATION OF CONTRACT. (c) Procedures for termination. 1.a. Except as provided under subd. 2., a residential care apartment complex shall provide 30 days advance notice of termination to the tenant and the tenant's designated representative, if any. If there is no designated representative, the facility shall notify the county department of social or human services under s. 46.21, 46.22 or 46.23, Stats.	U 238		

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U 238	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a 30-day advance notice of termination was provided to Tenant 1's designated representative. Findings include: On 08/28/2023 at approximately 9:00 a.m., Surveyor conducted a complaint investigation alleging the provider's complex denied a tenant's return to the facility when his/her needs had not changed. On 08/28/2023 at approximately 11:00 a.m., Surveyor reviewed Tenant 1's record. Tenant 1 was admitted to the provider's complex on 01/06/2020 with diagnoses including repeated falls. Tenant 1 had an activated Health Care Power of Attorney. Tenant 1's most recent assessment was dated 02/27/2023. Tenant 1's most recent service agreement/care plan was dated 03/13/2023, which documented that Tenant 1 required assistance of 1 for mobility, total assistance for transfers, and had behaviors including picking/scratching at skin, striking out, yelling and using foul language. Tenant 1 had a risk agreement related to falls. Tenant 1's progress notes, dated 07/01/2023 to 08/11/2023, documented s/he required assistance of 2 for transfers and/or cares on 07/02/2023, 07/05/2023, 07/22/2023 and 08/05/2023. The progress notes documented a sit to stand lift was used with Tenant 1 on 08/07/2023, but the recommendation was made on 08/08/2023 to use assistance of 2 for transfers. Incident reports documented Tenant 1 had a fall on 08/11/2023 at 11:42 a.m. and 08/11/2023 at 3:25 p.m. while transferring to the toilet. Tenant 1 was sent to the	U 238		

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U 238	Continued From page 3	U 238		

emergency room following both falls. As of 08/28/2023, Tenant 1 was not residing at the facility.

On 08/28/2023 at approximately 12:00 p.m., Surveyor interviewed Administrator A. Administrator A stated Tenant 1 was sent to the emergency room (ER) following both falls on 08/11/2023. Administrator A stated Tenant 1 was returned to the provider's complex following the 1st ER visit, but that the provider denied Tenant 1's return to the complex following the 2nd fall because the complex was no longer able to meet Tenant 1's needs. Administrator A clarified that the complex was unable to meet Tenant 1's needs because s/he was requiring 2-3 staff for transfers and had some behavioral concerns. Surveyor shared observation that Tenant 1 had intermittently required assistance of 2 since 07/02/2023 and exhibited behaviors, such as calling out and striking out. Surveyor asked Administrator A if s/he had completed a new assessment based on Tenant 1's change in condition or issued a 30-day notice. Administrator A replied, "No. I have the 30-day discharge notice typed up but hadn't issued it. We were going to explore hospice and I had talked with the [managed care organization]." Administrator A did not comment as to why the provider did not reassess Tenant 1's needs.

On 08/28/2023 at approximately 1:00 p.m., Surveyor reviewed concern with Administrator A and Nurse C that Tenant 1 was denied return to the provider's complex following a hospitalization, yet his/her needs had not changed from prior to his/her hospitalization. Administrator A voiced frustration with Surveyor's concern and repeated that s/he had the 30-day discharge notice typed up but had not issued the notice.

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U 238	Continued From page 4 On 08/28/2023 at approximately 3:30 p.m., Surveyor interviewed Social Worker D, who worked at the local hospital. Social Worker D stated following Tenant 1's first ER visit on 08/11/2023, the provider was upset with the hospital for sending Tenant 1 back to the provider's complex and stated they would send Tenant 1 right back to the hospital. Social Worker D stated following the 2nd ER visit, the provider then refused to accept Tenant 1 back to the facility. On 09/01/2023 at approximately 8:00 a.m., Surveyor reviewed hospital records. A note, dated 08/11/2023, stated "[Family] notes current complaints are the same as [Tenant 1's] chronic complaints." A note dated, 08/14/2023, stated "Spoke with [Care Manager] through [MCO]. [S/he] informed me that [the provider] didn't even tell them [Tenant 1] was having any issues there until 08/10, so that they had not been working with [the provider] for weeks to find new placement as was sated by the facility staff. [MCO] also submitted a facility concern to the appropriate parties because it appears that [the provider] decided they did not want [Tenant 1] as a resident to [him/her] anymore and discharged to the hospital although we had told them earlier in the day Friday that [Tenant 1] was medically cleared and at [his/her] previous baseline so this was an inappropriate request from them. Previous documentation in [primary care physician] note from 08/09 states that [Tenant 1] was at risk of losing [his/her] placement due to [his/her] outbursts and being uncooperative with staff. The staff here have had no concerns with behaviors or appropriateness from pt. Prior notes state that outbursts are reportedly related to uncontrolled pain ...".	U 238		

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U 238	Continued From page 5 Tenant 1 was sent to the emergency room on 08/11/2023 and was medically ready to return to the provider's complex; however, the provider denied Tenant 1's return. The provider stated they could no longer meet Tenant 1's needs; however the complex had not completed an assessment indicating there was a change in Tenant 1's condition from the time Tenant 1 was sent to the ER to the time Tenant 1 was ready to discharge from the hospital and the complex had not issued a 30-day notice.	U 238		