STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020433	A. BUILDING: _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR AT THE MEADOWS LLC THE	590 W. ROLLING MEADOWS DR FOND DU LAC, WI 54937

(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 10/11/2024, Surveyor conducted a complaint investigation and probationary survey at Manor at the Meadows LLC (The). Three deficiencies were identified. The complaint was substantiated. Census: 12	N 000		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a written report was sent to the Department within 3 working days after 2 of 2 residents whereabouts were unknown when they eloped from the facility. Resident 1 eloped from the facility on 6 occasions. The provider did not report the elopements to the Department.	N 163		

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

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Resident 2 eloped on 1 occasion. The provider did not report the elopement to the Department.

Findings include:

On 07/23/2024, the Department received a complaint alleging concerns with resident elopements.

On 10/11/2024, Surveyor reviewed resident records and identified the following:

Example 1: Resident 1

Resident 1 was admitted to the facility on 07/11/2024 with a diagnosis of Alzheimer's. Resident 1 had an activated healthcare power of attorney. Resident 1's individual service plan (ISP) with an unknown date indicated "Needs Some Supervision" and Wandering section was blank.

Resident 1's incident report dated 10/06/2024 documented:
"Writer was in the medication room and other staff was assisting guest when the front door wander guard alarm went off. Writer and other staff went out the door to see if someone was outside and we saw [Resident 1] walking past the canopy outside; ....[Resident 1] was refusing to come back inside and shoving staff out of [his/her] way while [s/he] walked towards Pioneer Road attempting to cross .....Guest was yelling at both staff the whole time saying we are keeping [him/her] here and [s/he's] leaving."

Resident 1's progress notes documented:
"08/23/2024: [Resident 1] and [Resident 3] were sitting at the tables in the back at 2:10 pm. Staff sat with them for awhile and then came in

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N 163	Continued From page 2	N 163		

because it was shift change. When staff looked out there again at 2:30 pm, staff could not find them. They figured out how to open the gate and were picking weeds in the field next to the fence. Staff had them come in for some ice water.

08/08/2024: Writer got a call from the Meadows staff at 7:10 pm about [Resident 1] sitting on a wooden chair out front of the Meadows. Writer and staff had no idea that [s/he] got out of the community building. Writer walked over to the Meadows and redirected [Resident 1] back to the community building.

08/05/2024: Writer got a call from the Meadows staff around 4:30 pm about [Resident 1] having gotten over to the Meadows. Writer and staff had no idea that [s/he] had gotten out. Writer saw [him/her] go to [his/her] bedroom to go to the bathroom about 10 minutes before the call. [Resident 1] did not go out the front door, so we think [s/he] got out door 6. Although, after staff brought [Resident 1] back, writer checked door and it rung on the phone but not on the call system. Writer never heard or saw door 6 pop up on the phone. Not sure if it malfunctioned or what exactly what happened.

@ 530 AM: Writer was doing 5am checks when writer opened [Resident 1's] door and [s/he] was not in there. Writer looked in other guests' rooms and made sure the other doors were locked. Staff could not find [Resident 1]. Writer went to staff and told [him/her], [s/he] could not find [Resident 1]. Staff went outside to look for [Resident 1], staff opened up door 4 and noticed [Resident 1] walking around outside.

07/30/2024: Writer was getting out of car after lunch and noticed [Resident 1] standing in the

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parking lot. Writer approached [Resident 1] and asked what [s/he] was doing. [Resident 1] said that the people inside said it was okay for [Resident 1] to come out. Writer attempted to redirect [Resident 1] back to the building. [Resident 1] was lightly pushing writer to the street as writer was trying to redirect."

Surveyor reviewed the Department's files for any self-report regarding Resident 1's elopements. No self-reports were submitted.

Example 2: Resident 2

Resident 2 was admitted to the facility on 07/16/2024 with a diagnosis of dementia. Resident 2 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 2's ISP with an unknown date indicated "Supervision: 24-hour supervision. Wandering: Exit seeking mostly through the front entrance doors, staff 1;1 most of the day to prevent exit seeking."

Resident 2's progress notes documented: "08/19/2024: At approximately 1530, writer noticed [Resident 2] was no longer in the great room. Writer began looking for [Resident 2] in the B wing in other guests' units. At this time; [Resident 2] was brought back to the facility by a taxi driver. Post office [wo/man] is the one who discovered [Resident 2] over by the Radisson, and had the taxi bring [him/her] back over here. The front door alarm did not sound when [Resident 2] walked out; writer is putting motion sensor by front door as a precaution for the time being as it is not used until night."

Surveyor reviewed the Department's files for any self-report regarding Resident 2's elopements. No

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N 163	Continued From page 4 self-reports were submitted. On 10/11/2024 at 1:10 PM, Surveyor interviewed Community Manager B. Community Manager B confirmed Resident 1 and Resident 2 had successful elopements on the above dates and the provider did not self-report. Community Manager B reported s/he did not know about the requirement until recently. Surveyor shared reporting requirements for a CBRF. Cross Reference: N0426 DHS 83.38(1)(b) Supervision N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 163		
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 Individual Service Plans (ISPs) were updated to reflect the needs of	N 389		

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N 389	Continued From page 5 Resident 1. Resident 1's ISP was not updated to reflect new interventions to mitigate his/her elopement and suicidal risks. Findings include: On 10/11/2024, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 07/11/2024 with a diagnosis of Alzheimer's. Resident 1 had an activated healthcare power of attorney. Resident 1's individual service plan (ISP) with an unknown date indicated "Needs Some Supervision" and Wandering/Suicide sections were blank. Resident 1's progress notes documented: "10/07/2024 at 3:15 PM: Late entry: Approximately 10:00 am writer heard front entrance door wander guard alarm sounding. Writer went outside and [Resident 1] was with staff. Staff outside of entrance door sitting on the bench. Writer sat next to [Resident 1] and staff went inside. Writer sat with [Resident 1] for about 20 minutes reassuring and listening to [him/her]. There were times [s/he] did cry and [s/he] stated [s/he] was sad because [s/he] missed [his/her] parents and children. [S/he] hugged me thanked me for sitting with [him/her] and asked who I was. Writer explained and we walked back in to the community holding hands and writer assisted [him/her] to read [his/her] newspaper in front of the TV. Other staff stated to writer that [Resident 1] told [him/her] nobody likes [him/her] and [s/he] wanted to kill [him/herself].	N 389		

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10/06/2024: [Resident 1] was escorted back into [his/her] unit after prior incident; guest stated, "If I cannot see my kids, I will kill myself." Writer will monitor guest more frequently throughout the shift and will let the following shift know.

10/05/2024: Writer observed that [Resident 1] stormed out of door 4 after speaking with other guests, and began looking for an exit by walking around the perimeter of the patio.

09/06/2024: Writer heard door four wander guard alarm go off, so writer approached the patio where writer observed [Resident 1] turning the gate handle and proceeding to attempt to leave the gated area. [Resident 3] was with a guest as well but was not attempting to elope and was standing under patio watching [Resident 1]. Writer was able to redirect guest from the gate and back into community, but guest was agitated as [s/he] stated [s/he] needed to find [his/her] parents ....Gate was not latched from the outer fence and was able to be opened by handle. Writer did latch it and it is not able to be opened now. Writer will inform other staff to monitor [Resident 1] location closely tonight as [s/he] appears to be exit seeking.

09/05/2024: [Resident 1] was walking towards the front door. Writer went to stop [Resident 1] and ask where [s/he] was going. [Resident 1] said, "I'm leaving, no one loves me."

08/29/2024: Writer was in nurse's station charting when [Resident 1] and [Resident 3] walked by heading for the front door. Writer approached [Resident 1] and [Resident 3] and both stated that they were leaving and walking to their cars.

08/25/2024: Writer noticed [Resident 1] did not

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have [his/her] air tag on when [his/her] family came to visit around 1600.

08/15/2024: Writer went to give [Resident 1] HS medications. [Resident 1] refused. Writer waited a couple of minutes and attempted again. [Resident 1] held the cup of medications, and water in the other hand. Writer stated that [Resident 1] needed to take them. [Resident 1] refused to writer back the medications and entered 104 and shoved writer out of the doorway. Writer stated that [Resident 1] had [his/her] own unit [s/he] could be in. [Resident 1] shoved writer again out of the way and started walking. Writer followed [Resident 1] and asked if writer could have the meds back. [Resident 1] threw them on the couch in the great room and went outside ....[Resident 1] came back into the community and [Resident 1] stated, 'There are people trying to k**l me.'

08/13/2024: Writer noticed [Resident 1] and [Resident 3] trying to pull off [Resident 3's] wander guard. [Resident 1] said [s/he] can take [his/hers] off and [s/he] knew how to take [Resident 3's] off. Writer said not that has to stay on. [Resident 3] said, 'Well it's not that pretty to look at.' Writer redirected them to a different subject.

08/02/2024: [Resident 1's] [sister/brother] stated to writer that [Resident 1] was trying to exit the building when they were visiting and was wondering why the alarm didn't go off when [s/he] was opening the front entrance door. Writer easily redirected by [sister/brother], but [sister/brother] concerned that [s/he] should have something on [him/her]."

A review of Resident 1's progress notes showed

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the provider was using an air tag, wander guard, and frequent checks as interventions for elopement risk. These interventions were not identified on his/her ISP. Further review of progress notes indicated Resident 1 had 6 successful elopements on 10/06/2024, 08/23/2024, 08/08/2024, 08/05/2024 (2x), and 07/30/2024.

The ISP was not updated to include new interventions for staff to use in managing Resident 1's elopement and suicidal risk.

On 10/11/2024 at 9:45 AM, Surveyor interviewed Caregiver C. Caregiver C identified Resident 1 as a high elopement risk and incidents have continued. Caregiver C stated Resident 1 wore a wander guard bracelet, but it was hard for staff to hear if they were providing cares in a resident's room.

On 10/11/2024 at 1:10 PM, Surveyor interviewed Community Manager B regarding the above concerns. Community Manager B confirmed Resident 1 was an elopement risk and used interventions such as an air tag (provided by family) and wander guard. Surveyor asked why Resident 1's ISP did not identify him/her as an elopement risk. Community Manager B stated s/he was behind in updating ISP's and acknowledged Resident 1's ISP should have reflected elopement and suicide risk. Community Manager B reported s/he will work on updating ISPs so caregivers can easily identify how to care for residents.

Cross Reference:
N0163 DHS 83.12(4)(a) Reporting When Resident's Whereabouts Unknown
N0426 DHS 83.38(1)(b) Supervision

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N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not provide supervision adequate to meet the needs 2 of 2 residents reviewed. Resident 1's record identified him/her as a significant elopement risk. Resident 1 had 6 elopement incidents without staff knowledge. On 08/19/2024, Resident 2 left the facility unsupervised and without staff knowledge. At time of incident, Resident 2's record identified him/her as a significant elopement risk and s/he was wearing a wander guard bracelet. Resident 1 had walked across the street to a nearby hotel, which is near a heavily traveled road. Findings include: The facility is licensed to serve up to 44 residents from client groups to include irreversible dementia/Alzheimer's, advanced age, traumatic brain injury, and physically disabled.	N 426		

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N 426	Continued From page 10 On 07/23/2024, the Department received a complaint alleging concerns with resident elopements. On 10/11/2024, Surveyor reviewed resident records and identified the following: Example 1: Resident 1 Resident 1 was admitted to the facility on 07/11/2024 with a diagnosis of Alzheimer's. Resident 1 had an activated healthcare power of attorney. Resident 1's individual service plan (ISP) with an unknown date indicated "Needs Some Supervision" and Wandering section was blank. Review of progress notes showed the provider was using an air tag, wander guard, and frequent checks as elopement interventions. Resident 1's incident report dated 10/06/2024 documented: "Writer was in the medication room and other staff was assisting guest when the front door wander guard alarm went off. Writer and other staff went out the door to see if someone was outside and we saw [Resident 1] walking past the canopy outside; ....[Resident 1] was refusing to come back inside and shoving staff out of [his/her] way while [s/he] walked towards Pioneer Road attempting to cross .....Guest was yelling at both staff the whole time saying we are keeping [him/her] here and [s/he's] leaving." Resident 1's progress notes documented: "08/23/2024: [Resident 1] and [Resident 3] were sitting at the tables in the back at 2:10 PM. Staff sat with them for awhile and then came in because it was shift change. When staff looked	N 426		

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out there again at 2:30 PM, staff could not find them. They figured out how to open the gate and were picking weeds in the field next to the fence. Staff had them come in for some ice water.

08/08/2024: Writer got a call from the Meadows staff at 7:10 PM about [Resident 1] sitting on a wooden chair out front of "The Meadows." Writer and staff had no idea that [s/he] got out of the community building. Writer walked over to the Meadows and redirected [Resident 1] back to the community building.

08/05/2024: Writer got a call from the Meadows staff around 4:30 PM about [Resident 1] having gotten over to the Meadows. Writer and staff had no idea that [s/he] had gotten out. Writer saw [him/her] go to [his/her] bedroom to go to the bathroom about 10 minutes before the call. [Resident 1] did not go out the front door, so we think [s/he] got out Door 6. Although, after staff brought [Resident 1] back, writer checked door and it rung on the phone but not on the call system. Writer never heard or saw door 6 pop up on the phone. Not sure if it malfunctioned or what exactly what happened.

@ 530 AM: Writer was doing 5 am checks when writer open [Resident 1's] door and [s/he] was not in there. Writer looked in other guests room and made sure the other doors were locked. Staff could not find [Resident 1]. Writer went to staff and told [him/her], [s/he] could not find [Resident 1]. Staff went outside to look for [Resident 1], staff opened up door 4 and noticed [Resident 1] walking around outside.

07/30/2024: Writer was getting out of car after lunch and noticed [Resident 1] standing in the parking lot. Writer approached [Resident 1] and

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asked what [s/he] was doing. [Resident 1] said that the people inside said it was okay for [Resident 1] to come out. Writer attempted to redirect [Resident 1] back to the building. [Resident 1] was lightly pushing writer to the street as writer was trying to redirect."

On 10/11/2024 at 9:45 AM, Surveyor interviewed Caregiver C. Caregiver C identified Resident 1 as a high elopement risk and incidents have continued. Caregiver C stated Resident 1 wore a wander guard bracelet, but it was hard for staff to hear if they were providing cares in a resident's room.

Example 2: Resident 2

Resident 2 was admitted to the facility on 07/16/2024 with a diagnosis of dementia. Resident 2 discharged on 08/20/2024. Resident 2 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 2's ISP with an unknown date indicated "Supervision: 24-hour supervision. Wandering: Exit seeking mostly through the front entrance doors, staff 1:1 most of the day to prevent exit seeking."

Resident 2's hospital records dated 03/29/2024 documented:
"Living environment-[s/he] lives at home with [his/her] [husband/wife]. Caregiver-[his/her] [husband/wife] is [his/her] primary caregiver and legal guardian; there is a caregiver in the home when [his/her] [husband/wife] is at work. Recent Hospitalizations/Emergency Visits: Since the last office visit (07/14/2023), [s/he] was hospitalized in Wisconsin for behavioral disturbance and was discharged to the Liberty House. Following elopement at the Liberty House,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020433	A. BUILDING: _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR AT THE MEADOWS LLC THE	590 W. ROLLING MEADOWS DR FOND DU LAC, WI 54937

(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 426	Continued From page 13 [s/he] returned home with additional caregivers coming to the home." Resident 2's progress notes documented: "08/19/2024: At approximately 1530, writer noticed [Resident 2] was no longer in the great room. Writer began looking for [Resident 2] in the B wing in other guest's units. At this time; [Resident 2] was brought back to the facility by a taxi driver. Post office man is the one who discovered [Resident 2] over by the Radisson, and had the taxi bring [him/her] back over here. The front door alarm did not sound when [Resident 2] walked out; writer is putting motion sensor by front door as a pre-caution for the time being as it is not used until night." Surveyor note: The Radisson Hotel and Conference Center parking lot is approximately .2 miles from the entrance of the facility and is located at the intersection of W Rolling Meadows Dr and S Military Road, which were heavily traveled roads with a speed limit of 35 MPH. S Military Road is a dived 4 lane highway that leads to the on/off ramps of Interstate 41. According to the Wisconsin Department of Transportation, the average daily traffic count at that location was last known to be 10,200 vehicles/day. Source: https://wisdot.maps.arcgis.com/apps/webappviewer/index.html?id=2e12a4f051de4ea9bc865ec6393731f8, retrieval date 10/21/2024. On 10/11/2024 at 9:50 AM, Surveyor interviewed Community Manager B. Community Manager B stated the provider was issued their license on 07/01/2024 and the building is not a secure unit. Community Manager B reported the building's side door alarms go to the caregiver's phone they carry during shift and the front/back doors will	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020433	A. BUILDING: _____ B. WING _____	C 10/11/2024

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MANOR AT THE MEADOWS LLC THE	590 W. ROLLING MEADOWS DR FOND DU LAC, WI 54937

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N 426	Continued From page 14	N 426		

alarm if a wander guard gets too close. Community Manager B reported Resident 1 and Resident 2 were elopement risks with successful elopements outside of the facility. Community Manager B reported Resident 1 was on a home visit, but s/he had interventions in place. Community Manager B stated Resident 2 was at the facility for over a month before discharging to a more secured setting. Community Manager B reported Resident 2 used a wander guard bracelet and had to be in line of sight supervision when out of his/her bedroom.

On 10/11/2024 at 10:55 AM, Surveyor interviewed Caregiver D. Caregiver D reported Resident 2 was a high elopement risk and staff had to keep him/her in line of sight supervision when Resident 2 was out of his/her bedroom. Caregiver D reported Resident 2 wore a wander guard bracelet and tried to climb the fence in the back patio area. Caregiver D reported Resident 2 eloped on 08/19/2024 while s/he was working. Caregiver D reported the alarm system did not go off and Resident 2 was found by the postman across the street at the Raddison Hotel.

On 10/11/2024 at 11:25 AM, Surveyor interviewed Community Manager B about Resident 2's elopement on 08/19/2024. Community Manager B confirmed Resident 2 eloped across the street to the Raddison Hotel and was returned by taxi, after the postman alerted the driver s/he might be a resident at the provider. Community Manager B reported the front door alarm did not go off, so the provider switched out Resident 2's wander guard bracelet and had no issue since. Community Manager B demonstrated how the wander guard system worked. The alarm signal was not very loud. Surveyor asked if the front/back door wander guard system was loud

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N 426	Continued From page 15 enough for staff to hear if they were in a residents room providing cares. Community Manager B stated s/he was not sure. On 10/11/2024 at 2:08 PM, Surveyor interviewed Administrator A and Community Manager B regarding the above concerns. Surveyor expressed concern whether the provider's alarm system was loud enough for staff to hear and intermittent incidents of the system not working. Administrator A stated the provider was working with their alarm company to find a solution for the front door. Surveyor noted Resident 1's record indicated s/he cut of his/her wander guard with scissors. Community Manager B confirmed Resident 1 had cut off his/her wander guard and was given a replacement. Community Manager B reported scissors were removed from all resident areas. Cross Reference: N0163 DHS 83.12(4)(a) Reporting When Resident's Whereabouts Unknown N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 426		