STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018636	A. BUILDING: _____ B. WING _____	R-C 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW MANOR	920 WEST 5TH STREET NEILLSVILLE, WI 54456

(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 09/11/2024, Surveyors conducted a licensure survey, verification visit, and complaint investigation at Meadow View Manor. Data collected through 09/25/2024. Three of 3 complaints were substantiated . Six deficiencies identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 7	{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 send a written report to the Department within 3 working days after a resident's whereabouts were unknown. Findings include:	N 163		

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

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N 163	Continued From page 1 On 04/22/2024 and 06/27/2024, the department received 3 complaints with concerns about supervision of residents. The provider is licensed to care for 8 residents in the client groups: Emotionally disturbed/Mental Illness, Traumatic Brain Injury, Developmentally Disabled, Physically Disabled, and Correctional Clients On 09/11/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 09/01/2013 and had a guardian. Resident 1 had diagnoses that included autism, deafness-nonspeaking, mental retardation, impulse disorder, moderate intellectual disabilities-developmentally disabled, unspecified lack of expected normal physiological development in childhood-developmental delay, and anxiety disorder. Resident 1's individual service plan (ISP), last dated 01/08/2024, indicated s/he needed 24/7 supervision for wandering/running away behaviors. Resident 1's ISP indicated Resident 1 was independently ambulatory but did need railing support and extra time when going up and down flights of stairs. Surveyor reviewed Resident 1's incident reports. Resident 1's incident reports noted that s/he had elopements on 04/12/2024 and 05/05/2024. On 09/11/2024 at approximately 9:25 AM, Surveyors interviewed Registered Nurse (RN) C. RN C stated s/he reported both incidents to the department. On 09/10/2024 at approximately 4:00 PM, Surveyor reviewed Department records and	N 163		

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N 163	Continued From page 2 found no evidence of self-reports for either incident. On 09/24/2025 at approximately 3:00 PM, Surveyor interviewed RN C. RN C clarified s/he did not report to the department for either incident and would be updating the reporting process for the future. The provider did not ensure a written report was sent to the Department within 3 working days after Resident 1's whereabouts were unknown.	N 163		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify Resident 1's legal representative after Resident 1 eloped from the facility. Findings include: The provider is licensed to care for 8 residents in the client groups emotionally disturbed/mental Illness, traumatic brain injury, developmentally disabled, physically disabled, and correctional	N 169		

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N 169	Continued From page 3	N 169		

clients.

On 04/22/2024 and 06/27/2024, the department received 3 complaints regarding supervision concerns.

On 09/11/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 09/01/2013 and had a guardian. Resident 1 had diagnoses that include autism, deafness-nonspeaking, mental retardation, impulse disorder, moderate intellectual disabilities-developmentally disabled, unspecified lack of expected normal physiological development in childhood-developmental delay, and anxiety disorder.

On 09/11/2024 at approximately 10:47 AM, Surveyor interviewed Registered Nurse (RN) C. RN C provided Surveyors with all incident reports for Resident 1. On 04/08/24, Resident 1 eloped from the building, crashing the facility van across the street. The incident report was dated 04/12/24. On the bottom of the report, it indicated the family and/or guardian were notified on 04/12/24 at 7:00 AM.

On 09/12/2024 at 10:17 AM, Surveyor interviewed Case Manager (CM) F. CM F stated s/he found out about the 04/08/24 elopement when s/he happened to be at the facility visiting another resident on 05/03/24. CM F stated s/he then called Resident 1's guardian to let him/her know. CM F stated his/her phone call to the guardian was the first notification the guardian had received regarding this incident.

On 09/12/2024 at 8:56 AM, Surveyor interviewed Guardian G. Guardian G stated s/he first found out about the 04/08/24 incident when CM F notified him/her via phone.

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N 169	Continued From page 4 On 09/24/2024 at approximately 3:00 PM, Surveyor interviewed Administrator A. Administrator A stated that Resident 1's Managed Care Organization (MCO) informed him/her CM F's visit on 05/03/24 was the first time they were made aware of the incident that occurred on 04/08/24.	N 169		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not notify the Department within 7 days after a change in administrator. Findings include: On 09/10/24, Surveyor reviewed the provider's information with the Department, which indicated Licensee A was the administrator. On 09/11/24 at approximately 10:47 AM, Surveyors interviewed Registered Nurse (RN) C. RN C stated Administrator B was now considered the Administrator. S/he stated Licensee A was currently listed but was only doing the maintenance and accounting for the building. RN C stated s/he did not know how to report the change to the Department. According to the provider's employee roster, Administrator B was hired on 11/09/23. On 09/24/24 at approximately 3:00 PM, Surveyor	N 200		

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N 200	Continued From page 5 interviewed RN C. RN C stated the Department should have received an email with the administrator update and would follow up. On 09/25/24 at approximately 11:20 AM, the department received an initial email from RN C with the administrator update.	N 200		
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 observation, record review and interview, the provider did not review and revise Resident 1's individual service plan (ISP) when Resident 1 had an elopement on 04/12/2024 and 05/05/2024. Findings include: On 09/11/2024 at approximately 9:00 AM, Surveyors observed alarms on all exit doors.	N 389		

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N 389	Continued From page 6 On 09/11/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 09/01/2013 and had a guardian. Resident 1 had diagnoses that included autism, deafness-nonspeaking, mental retardation, impulse disorder, moderate intellectual disabilities-developmentally disabled, unspecified lack of expected normal physiological development in childhood-developmental delay, and anxiety disorder. On 09/11/2024, Surveyor reviewed Resident 1's ISP. The ISP read, in part: Wandering: "Is high risk for wandering and needs 24/7 monitoring from staff. [Resident 1] has a history of wandering inside and outside the facility. [Resident 1] will go outside whenever s/he wants [sic] to prevent him/her from wandering off the property [sic] the backyard is fenced in." Supervision Needs: "Needs 24/7 care ... [s/he] can see the smoke alarms but needs cueing from staff on where to go, and staff needs to be present to monitor elopement when [s/he] is outside. [Resident 1] does not always respond immediately to the emergency lights and does require cues to evacuate the building safely. [S/he] has no danger awareness, and staff assist [him/her] in maintaining [his/her] safety at home and in the community." Resident 1's record included incident reports, which indicated that after the elopement on 04/12/2024, the staffing ratio was increased until a big alarm was placed, and staff were to do 2-hour safety checks. The incident report after the elopement on 05/05/2024 indicated the same interventions were still in place from the	N 389		

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N 389	Continued From page 7 04/12/2024 elopement and facility-wide alarms would be installed on 05/08/2024. On 09/11/2024 at 10:47 AM, Surveyor interviewed Registered Nurse (RN) C. RN C stated they also had staff do 2-hour checks during the day and every 4 hours during the overnight. RN C stated the safety checks were not documented by staff. RN C stated that after the elopement on 04/12/2024, an alarm system was installed on 04/18/2024, but staff could not hear the alarm throughout the whole facility. RN C stated the big alarm was installed on 05/03/2024. RN C stated they also temporarily increased the staff ratio during the busy times in the morning and afternoon until the big alarm was installed. RN C stated they had staff stop getting Resident 1 up earlier in the morning because this was when Resident 1 was eloping, when staff were helping other residents. RN C stated the facility van keys were pulled from the vehicle as well. On 09/24/2024 at approximately 3:00 PM, Surveyor interviewed RN C about updating Resident 1's ISP after his/her elopements. RN C stated that s/he did care plan updates that were located on a separate form, different from the ISP. The care plan update would be signed and acknowledged by staff. RN C stated s/he would go over the care plan update verbally with the guardian and the guardian would not be sent a written copy unless requested. Surveyor requested documentation of the care plan update, with a deadline of 09/25/24 at 4:00 PM. On 09/25/2024, Surveyor reviewed the care plan update sent by RN C. The care plan update, dated 04/08/2024, did not have staff acknowledgement signatures included, and listed the following interventions:	N 389		

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N 389	Continued From page 8 " "[S/he] had an elopement attempt involving the facility vehicle. " An alarm system will be ordered and installed asap (as soon as possible). " Staff pull all keys from vehicles. " Facility van key will be kept in a locked drawer [sic] the medication cart when not being used. " 2 hour checks during awake hours and 4 hours checks for sleeping hours. " Temporary alarms have been placed throughout the facility until the big alarm is in. " Change to resident assignments. See new assignment lists." The care plan update was not signed by Resident 1's guardian, any members of Resident 1's care team, and had no staff acknowledgment signatures.	N 389		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of	N 397		

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N 397	Continued From page 9	N 397		

elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure at least one qualified resident care staff was on duty and awake if at least one resident in the facility was in need of supervision, intervention, or services on a 24-hour basis to prevent, control, or improve the resident's constant or intermittent mental or physical condition that may occur or may become critical at any time.

Findings include:

On 4/22/2024 and 06/27/2024, the department received 3 complaints regarding supervision concerns.

The provider is licensed to care for 8 residents in the client groups emotionally disturbed/mental Illness, traumatic brain injury, developmentally disabled, physically disabled, and correctional clients.

On 09/11/2024, Surveyor reviewed Resident 1's record. Resident 1's ISP stated s/he was a high risk for wandering and needed 24/7 supervision.

On 09/11/2024, Surveyor reviewed the employee schedule. The schedule indicated day staff worked from 7:30 AM - 6:00 PM and the night staff worked from 6:00 PM -7:30 AM. Caregiver D

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N 397	Continued From page 10 worked 58 hours straight every other weekend. Caregiver E had also worked 58 hours straight on the opposite weekend as well. On 09/11/2024 at 10:47 AM, Surveyor interviewed RN C. RN C stated they also had staff do 2-hour checks during the day and every 4 hours during the overnight. RN C stated the safety checks were not documented by staff. On 9/11/2024 at approximately 11:50 AM, Surveyor interviewed Caregiver D. Caregiver D stated s/he only worked on Wednesdays during the week and s/he worked double shifts on the weekends. On 9/23/2024 at approximately 9:18 AM, Surveyor interviewed Administrator A. Administrator A stated they did have some staff members who worked long weekend shifts. Administrator A stated that staff was required to do 2-hour checks on all residents during the night shift. S/he stated that often staff members would set alarms for every 2 hours but would take naps in-between the 2-hour checks. On 9/24/2024 at approximately 3:00 PM, Surveyor interviewed Registered Nurse (RN) C. RN C stated that staff were semi-awake on overnight shift, where they would sleep for a few hours in between checks and respond to alarms. RN C confirmed that multiple residents needed 24-hour supervision. RN C stated they would switch staffing to 24-hour awake staff. Cross References: N0426 DHS 83.38 (1) (b) Supervision	N 397		

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N 426	Continued From page 11	N 426		
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 record review and interview, the provider did not ensure residents were adequately supervised. Resident 1 eloped twice within a month. Findings include: The provider is licensed to care for 8 residents in the client group emotionally disturbed/mental illness, traumatic brain injury, developmentally disabled, physically disabled, and correctional clients. On 4/22/2024 and 06/27/2024, the department received 3 complaints regarding supervision concerns. On 09/11/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 09/01/2013 and had a guardian. Resident 1 had diagnoses that included autism, deafness-nonspeaking, mental retardation, impulse disorder, moderate intellectual disabilities-developmentally disabled,	N 426		

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unspecified lack of expected normal physiological development in childhood-developmental delay, and anxiety disorder.

On 09/11/2024, Surveyor reviewed Resident 1's ISP. The ISP read, in part:

Wandering: "Is high risk for wandering, and needs 24/7 monitoring from staff. [Resident 1] has a history of wandering inside and outside the facility. [Resident 1] will go outside whenever s/he wants [sic] to prevent him/her from wandering off the property the backyard is fenced in."

Supervision Needs: "Needs 24/7 care ... [S/He] can see the smoke alarms but needs cueing from staff on where to go, and staff needs to be present to monitor elopement when [s/he] is outside. [Resident 1] does not always respond immediately to the emergency lights and does require cues to evacuate the building safely. [S/he] has no danger awareness, and staff assist [him/her] in maintaining [his/her] safety at home and in the community."

Surveyor reviewed Resident 1's behavior charting from April 2024 - May 2024, which indicated Resident 1 had approximately 17 "escaping outside" attempts.

Resident 1's record included the following incident reports which read, in part:

- 04/12/2024 at 6:45 AM: "[Resident 1] left the facility and got into the facility van that was in the parking lot. [Resident 1] drove the van across the front lawn about 50 feet when s/he [sic] crossed the road and hit a road sign." Under the section immediate correction or steps taken to prevent future incidents, the report read, "Increased

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staffing ratio until big alarm can be place. [sic] Staff to do safety checks every 2 hours."

-5/5/2024 at 10:45 AM: "[Caregiver D] was cleaning [Resident 1's] room and found a construction sign ... callen [sic] Neillsville Police Department to return sign. There was road construction ongoing [sic] and the signs were accessible from the property yard." Under the section immediate correction or steps taken to prevent future incidents, the report read, "Same interventions that have been in place. Facility wide alarms will be fully installed by 05/08/24."
On 9/11/2024 at approximately 9:25 AM, Surveyors interviewed Registered Nurse (RN) C. RN C stated Resident 1 had a history of sporadic elopements. RN C stated that for the elopement regarding the construction cone, they were unsure how Resident 1 got the sign, how long s/he had it, or if s/he left the yard.

On 09/11/2024 at approximately 11:30 AM, Surveyors interviewed Administrator A. Administrator A stated s/he arrived the morning of the incident at 7:20 AM. When s/he arrived, the van was parked in the neighbor's lawn and police were present on scene. Administrator A stated RN E, from the adult family home (AFH) next door, was across the street speaking with the police and Resident 1. RN E returned Resident 1 to the provider. Administrator A reported that Caregiver E, who was currently on shift, was helping another resident at the time of the incident.

On 09/16/2024 at approximately 4:00 PM, Surveyor reviewed the police report dated 04/08/2024, from the Neillsville Police Department, regarding the van incident that occurred. It read, in part:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018636	A. BUILDING: _____ B. WING _____	R-C 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW MANOR	920 WEST 5TH STREET NEILLSVILLE, WI 54456

(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 14 "I arrived on scene and observed a vehicle parked ... The door was locked, and the driver wouldn't roll down the window... it did not appear that [s/he] was injured ... Then, I shut off the vehicle and asked the driver if [s/he] was okay ... [Caregiver E], came running from across the street ... [Caregiver E] explained the driver is [Resident 1], a tenant at this assisted living ... [Caregiver E] said [s/he] saw the vehicle driving all over their property, then it crossed the road, hit a street sign, and drove through the property ...I met with [Administrator A] ... I asked [Administrator A] if [s/he] knows how this incident happened. [Administrator A] said [s/he] wasn't at work yet when this happened, however, [s/he] explained the minivan's key is supposed to be in a drawer and the van's doors never lock. [Administrator A] said it's their policy to keep the vehicle keys inside ...When I was looking for the vehicle insurance, I saw another key for the vehicle by the center console in addition to the key in the ignition. [Administrator A] said one of the employee's [sic] was helping another resident when the door alarms went off, indicating someone was going outside. [Administrator A] said residents aren't allowed outside [sic] that's why they have alarms." On 9/23/2024 at approximately 9:18 AM, Surveyor interviewed Administrator A. Administrator A confirmed that Resident 1 did need 24/7 supervision. Administrator A stated that all residents in the home needed 24/7 supervision. On 9/24/2024 at approximately 3:00 PM, Surveyor interviewed RN C. RN C stated that Resident 1 had motion sensor alarms on his/her bedroom door and alarms on all exit doors. RN C stated they plan to move to fully awake staff on	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018636	A. BUILDING: _____ B. WING _____	R-C 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW MANOR	920 WEST 5TH STREET NEILLSVILLE, WI 54456

(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 15 overnights in the future. The provider did not ensure residents were adequately supervised, when Resident 1 eloped on 04/08/2024, crashing the facility van across the street, and when a construction cone was discovered in Resident 1's room on 05/05/2024, without indication of how it got there. Cross References: N0397 DHS 83.36 (1)(b) Qualified Staff In Charge, On Duty And Awake	N 426		