

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK AT CHETEK		STREET ADDRESS, CITY, STATE, ZIP CODE 708 TANTER ST CHETEK, WI 54728		
(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 03/07/2025, Surveyor completed a licensure survey at Meadowbrook of Chetek. Data was collected through 3/10/2025. Three deficiencies were identified. Census: 8	U 000		
U 171	89.26(4) ANNUAL REVIEW A tenant's capabilities, needs and preferences identified in the comprehensive assessment shall be reviewed at least annually to determine whether there have been changes that would necessitate a change in the service or risk agreement. The review may be initiated by the facility, the county department designated under sub. (3)(c)2., or at the request of or on the behalf of the tenant. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a tenant's capabilities, needs and preferences identified in the comprehensive assessment were reviewed at least annually to determine if there were changes to be made to the service or risk agreement. Findings include: On 03/08/2025, Surveyor reviewed tenant records and identified the following: Tenant 2 was admitted 11/08/2023. Tenant 2's assessment on 11/14/2023 identified that s/he was a fall risk but his/her record did not contain an updated fall risk assessment in 2024.	U 171		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK AT CHETEK		STREET ADDRESS, CITY, STATE, ZIP CODE 708 TANTER ST CHETEK, WI 54728		
(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 171	Continued From page 1 Tenant 3 was admitted 08/26/2016. Tenant 3's record contained a comprehensive assessment in 2023. Tenant 3's medication assessment in 2023 stated that Tenant 3 did not need help with medication administration. Tenant 3 had been getting medication assistance from the facility for the last few years. Tenant 3's record had no evidence of a comprehensive assessment in 2024. The only assessment completed in 2024 was an activities of daily living (ADL) assessment. On 03/07/2025 at approximately 11:18 AM, Surveyor interviewed Tenant 3. Tenant 3 stated s/he received help with medication administration for 1 pill in the morning and 1 pill at night. Tenant 3 stated the provider had been providing him/her with this service for "quite a few years." On 03/07/2025 at approximately 12:25 PM, Surveyor interviewed Caregiver C. Caregiver C stated the provider had been helping administer Resident 3's pain pill for about the last 2-3 years. Caregiver C showed Surveyor where they stored Tenant 3's pain medication in a locked cabinet. On 03/07/2025, Surveyor interviewed Administrator A and Director of Regional Operations B. Administrator A acknowledged that comprehensive assessments need to be completed yearly or upon change in condition. Administrator A also acknowledged that the comprehensive assessment needed to include all required contents.	U 171		
U 188	89.27(4) SERVICE AGREEMENT REVIEW AND UPDATE. The service agreement shall be reviewed when there	U 188		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK AT CHETEK		STREET ADDRESS, CITY, STATE, ZIP CODE 708 TAINTER ST CHETEK, WI 54728		
(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 188	Continued From page 2 is a change in the comprehensive assessment or at the request of the facility or at the request or on behalf of the tenant and shall be updated as mutually agreed to by all parties to the agreement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 tenants had a signed service agreement consistent with the comprehensive assessment. On 03/07/2025 at approximately 12:36 PM, Surveyor reviewed tenant records and identified the following: Tenant 1 was admitted 09/24/2022. Tenant 1 completed a signed service agreement upon admission, but the service agreement was not reviewed or updated annually or upon change in condition with the comprehensive assessment. Tenant 2 was admitted 11/08/2023. Tenant 2 completed a signed service agreement upon admission, but the service agreement was not reviewed or updated annually or upon change in condition with the comprehensive assessment. Tenant 3 was admitted 08/26/2016. Tenant 3 completed a signed service agreement upon admission, but the service agreement was not reviewed or updated annually or upon change in condition with the comprehensive assessment. On 03/10/2025, Surveyor interviewed Administrator A, Director of Regional Operations B and Director of Nursing D. Administrator A acknowledged that a service agreement must be updated annually or upon change in condition. Administrator A stated they are already working	U 188		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK AT CHETEK			STREET ADDRESS, CITY, STATE, ZIP CODE 708 TAINTER ST CHETEK, WI 54728		
(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 188	Continued From page 3 on getting these added to their computer system so things do not get missed moving forward.	U 188			
U 189	89.28(1) Risk Agreement (1) REQUIREMENT As a protection for both the individual tenant and the residential care apartment complex, a residential care apartment complex shall enter into a signed, jointly negotiated risk agreement with each tenant by the date of occupancy. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 tenants (Tenant 1, Tenant 2, and Tenant 3) sampled, had risk agreements identifying conditions that put the tenants at risk of harm or injury. Findings include: Tenant 1 was admitted 09/24/2022. Tenant 1's record contained no evidence of a signed negotiated risk agreement at the date of occupancy. Tenant 2 was admitted 11/08/2023. Tenant 2's record contained no evidence of a signed negotiated risk agreement at the date of occupancy or when s/he was identified as a fall risk. Tenant 3 was admitted 08/26/2016. Tenant 1's record contained no evidence of a signed negotiated risk agreement at the date of occupancy or upon changes in condition to Tenant 3's services.	U 189			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK AT CHETEK			STREET ADDRESS, CITY, STATE, ZIP CODE 708 TANTER ST CHETEK, WI 54728		
(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 189	Continued From page 4 On 03/10/2025, Surveyor interviewed Administrator A, Director of Regional Operations B and Director of Nursing D. Administrator A acknowledged that a risk agreement must be updated annually or upon change in condition. Administrator A stated they were already working on getting these all added to their computer system so things do not get missed moving forward.	U 189			