STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013768	A. BUILDING: _____ B. WING _____	R-C 08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS AT SPRINGBROOK(THE)	861 CRITTER CT ONALASKA, WI 54650

(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 07/30/2025, Surveyor conducted a verification visit and two complaint investigations at the Meadows at Springbrook. Data collection continued through 08/04/2025. Two of 2 complaints were substantiated. Two deficiencies were identified. The deficiencies identified in Statement of Deficiency (SOD) M3TF11, dated 05/01/2025, were corrected. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 35	{N 000}		
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	N 389		

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

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N 389	Continued From page 1	N 389		

provider did not ensure Resident 2's individual service plan (ISP) was updated to include his/her needs related to his/her fall risk.

Findings include:

On 06/02/2025, the department received a complaint regarding resident falls.

On 07/30/2025 at approximately 11:45 AM, Surveyor interviewed Administrator A. When asked about resident falls, Administrator A stated Resident 2 slid out of his/her wheelchair. Resident 2 was on hospice and did not require medical intervention but later expressed pain in his/her bottom area. Administrator A stated that any time staff were pushing residents in their wheelchairs, the wheelchair foot pedals should be on. Administrator A stated s/he did not believe Resident 2's foot pedals were on during the fall because Resident 2 had just gotten out of the shower. Administrator A stated the foot pedals should be available at all times and sometimes staff took them off in the bathroom when they pushed residents into the shower. Administrator A stated the use of foot pedals was resident specific. Administrator A stated some residents did not use foot pedals at all. Surveyor requested a copy of Resident 2's fall report and ISP.

Resident 2 was admitted on 08/19/2021 and had an activated power of attorney for healthcare. Resident 2's ISP, dated 07/30/2024, identified Resident 2 as a fall risk. The ISP indicated Resident 2 required an assist of 1 staff with bathing and transfers.

A fall report, with an incident date of 05/16/2025, read, in part, "Staff transferred resident to wheelchair after a shower, [sic] staff [sic] had a

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N 389	Continued From page 2	N 389		

towel under [his/her] feet for support as well as a towel on the handrail. Resident was placed in wheelchair and when staff went to move wheelchair to toilet when [sic] resident slid out of chair due to [his/her] feet dragging on the floor and the towel under the resident slid with [him/her.]"

At approximately 12:30 PM, Surveyor interviewed Administrator A and Director of Nursing (DON) B. DON B stated Resident 2 required staff assistance with transferring into his/her wheelchair and required staff to push him/her in his/her wheelchair. Resident 2 could not independently push him/herself in the wheelchair. When asked how staff were trained on wheelchair protocols, Administrator A stated they would receive training upon hire and when new residents were admitted. Administrator A stated the provider did not have a wheelchair usage policy. When asked why staff may have taken the pedals off, Administrator A stated that sometimes staff could not get a mechanical lift in the shower far enough.

On 08/04/2025, at 11:19 AM, Surveyor emailed Administrator A and requested Resident 2's most recently updated ISP.

At 12:56, Surveyor received an email from Administrator A with Resident 2's current ISP. The ISP included the following:

-Under a section titled, "Bathing," it read, in part, "Spa Tub: Assist 2. Staff to assist resident with spa bath twice a week." The date above the section was 02/06/2024. Under the "Services/Interventions" section of the bathing category, it read, in part, "Transfer: HOYER (mechanical lift). Staff to remind resident it is time

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N 389	Continued From page 3 to transfer. Assure mobility equipment as applicable is nearby before transfer." The date above the section was 06/03/2025. Under a "Falls" section of the ISP, it read, in part, "[Resident 2] has a history of fall [sic] with significant injury. Staff will provide every two hour observation checks and remind [Resident 2] will [sic] wear [his/her] pendant to notify staff in case of a fall. Under a "Mobility" section, it read, in part, "[Resident 2] uses a manual w/c (wheelchair) and needs staff assist to/from meals and activities." The ISP did not include interventions for the use of foot pedals or other positioning devices to promote safe seating and prevent sliding.	N 389		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration 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 staff provided medication administration to meet the needs of Resident 1. Resident 1 was sent to the emergency room (ER) and prescribed Furosemide as needed for leg	N 432		

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swelling after s/he had a sudden onset of weeping edema. Resident 1 did not receive Furosemide after his/her ER visit.

Findings include:

On 06/02/2025, the department received a complaint regarding medication administration.

On 07/30/2025, at approximately 12:30 PM, Surveyor reviewed Resident 1's record.

Resident 1 was admitted on 08/22/2022 and had an activated power attorney for healthcare. Staff progress notes included the following:

05/14/2025 at 1:49 PM: "Differences - Other: At breakfast time, Resident was complaining about pain in [his/her] legs. When staff was trying to get Resident to the breakfast table, Resident showed staff [his/her] right calf. Resident has multiple red spots that look like blisters from [his/her] leg weeping. Resident's legs and feet are extremely swollen ..."
05/14/2025 at 3:04 PM: "Aide staff notify RN (Registered Nurse) of sudden onset of edema and vomiting this morning ...4+ weeping edema to ble [sic] ...Tri-state contacted and resident is taken to Gundersen Emplify by Tri-State."
05/15/2025: No notes regarding edema. Resident 1 did report pain.
05/16/2025 at 3:39 PM: "Resident received new orders for furosemide 40mg - give 1 tablet by mouth daily as needed for visible water retention; give as needed for lower leg swelling ..."
05/17/2025: No notes regarding edema. Resident 1 did report pain.
05/18/2025-05/20/2025: No progress notes charted.
05/21/2025 at 12:55 PM: "Resident was seen by

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N 432	Continued From page 5 [Medical Provider] at the VA clinic in La Crosse for a follow-up after [his/her] ED (emergency department) visit. New orders for Furosemide 20mg by mouth twice daily for leg swelling. Compression for lower legs have been ordered..." Resident 1's May 2025 Medication Administration Record (MAR) included the following: -Furosemide Tab 40 MG. Give 1 tablet by mouth once daily as needed for lower leg swelling/visible water retention. Adverse effects included: gout, diabetes mellitus, tetany, anorexia, increased thirst, restlessness, xerostomia, abnormal glucose tolerance test, acute generalized exanthematous pustulosis. Effective date: 05/14/2025. End date: 05/21/2025. On 05/14/2025, the MAR was marked with a digital "X." Between 05/15/2025 and 05/21/2025, all the spaces were blank. It did not appear Resident 1 was given Furosemide. At approximately 12:45 PM, Surveyor interviewed Director of Nursing (DON) B. When asked about Resident 1's ER visit, DON B stated that when staff reported the sudden onset of edema, s/he decided Resident 1 should be sent to the ER. DON B stated Resident 1 came back from the ER with Furosemide. When asked about why the spaces were blank on the MAR, DON B stated s/he remembered seeing the medication had not been used, and it was his/her understanding it was not given. DON B stated sometimes staff did not administer PRN (as needed) medications and they did not have evaluation skills. DON B stated s/he was concerned Resident 1 did not get the Furosemide following the ER visit. DON B stated that when Resident 1 was seen for his/her ER follow up, his/her provider was upset. DON B stated they needed a better system, and s/he asked to have the medication scheduled. DON B	N 432		

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N 432	Continued From page 6 stated staff did not always see PRN orders unless they pop into the PRN list. At approximately 1:45 PM, Surveyor interviewed Caregiver C. When asked about Resident 1, Caregiver C was able to recall the ER visit that resulted in a Furosemide order. Caregiver C stated Resident 1's legs really ballooned up and s/he called DON B to check it out. Caregiver C stated Resident 1 was prescribed Furosemide and they had issues with that. Caregiver C stated it was put in as a PRN order and a lot of the staff did not know about the order. Caregiver C stated it was miscommunication with the provider. Caregiver C stated that if something was added as a PRN, staff did not always notice. Caregiver C stated new scheduled medications would activate a pop-up notification on their electronic medication system. Caregiver C stated PRN medications did not activate a pop-up notification. Caregiver C stated they got a call from Resident 1's medical provider that asked if Resident 1 had received the Furosemide. Caregiver C stated, "at the time, [s/he] did not."	N 432		