| 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 _____ | C 12/12/2024 |

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

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| N 000 | Initial Comments<br><br>On 12/10/2024, Surveyor completed a compliant investigation at Meadow View Manor. Data collected through 12/12/2024.<br><br>The complaint was substantiated.<br><br>One deficiency identified.<br><br>Census: 6 | N 000 | | |
| N 355 | 83.32(3)(k) Rights of Residents: Self-determination<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview,+ the provider did not ensure Resident 1's right to make decisions related to daily routines and other aspects of life which enhance the resident self-reliance and support the resident's autonomy and decision-making.<br><br>Resident 1's television (TV) remote was removed from his/her room, not allowing him/her to watch TV.<br><br>Findings include:<br><br>On 10/15/2024, the Department received a complaint that expressed concerns resident rights were being violated. | N 355 | | |

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

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| N 355 | Continued From page 1<br><br>The provider is licensed to care for 8 residents in the client groups emotionally disturbed/mental illness, physically disabled, correctional clients, developmentally disabled, and traumatic brain injury.<br><br>On 12/10/2024 at approximately 9:45 AM, Surveyor reviewed Resident 1's record. Resident 1's diagnoses included: anxiety, major depressive disorder, microcephaly, and mild cognitive impairment. Resident 1 had a guardian. Resident 1's individual service plan (ISP) contained a handwritten note under the mental health/behavioral section, dated 9/30, that stated, "At times will refuse cares or getting out of bed. Staf [sic] should reaproch [sic] with different alternating staff. If [Resident 1] still refuses and [s/he] is incontenent [sic] staff can change in bed [sic] if refused 2 meals staff can call gardian [sic]."<br><br>On 12/10/2024 at approximately 10:00 AM, Surveyor requested misconduct reports for the last 4 months from Administrator A. Surveyor reviewed a paper that was titled "Record of Verbal Disciplinary Action." The verbal warning was for Caregiver B and dated 09/30/2024, for an incident that happened on 09/29/2024. Under the type of problem or violation the form read, "unplugged resident TV so they would allow staff to complete cares since resident was laying [sic] in incontinence all day refusing cares." The report also noted that the guardian and case manager were updated about the situation.<br><br>On 12/10/2024 at approximately 11:15 AM, Surveyor interviewed Caregiver B about the incident that occurred on 09/29/2024. Caregiver B stated s/he was working the day shift on the date | N 355 | | |

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| N 355 | Continued From page 2 | N 355 | | |

of the incident and that s/he unplugged Resident 1's TV but left the remotes in the room. Caregiver B stated that s/he told Caregiver C, who came in for his/her shift at 6:00 PM, what s/he had done. Caregiver C stated that s/he never told Caregiver C not to plug the TV back in.

On 12/10/2024 at approximately 11:40 AM, Surveyor interviewed Resident 1. Resident 1 stated that s/he got along well with Caregiver B but did get upset with him/her once. Resident 1 reported that one day when s/he would not get up, Caregiver B unplugged the TV and took his/her remotes.

On 12/11/2024 at approximately 8:54 AM, Surveyor interviewed Guardian D. Guardian D stated s/he was notified on 09/30/2024, that Resident 1's remote was taken and his/her TV was unplugged for the whole weekend. Guardian D stated that s/he was told this happened because Resident 1 refused to get out of bed or eat. Guardian D stated that with Resident 1's diagnoses sometimes "you have to make [him/her] want to do things, punishing them doesn't work". Guardian D also stated, "They are humans" and believes this was a dignity issue.

On 12/11/2024 at approximately 10:28 AM, Surveyor interviewed Caregiver C. Caregiver C stated that when s/he came on shift, s/he tried to get Resident 1 up. Resident 1 told Caregiver C s/he was not getting up. Caregiver C noted that Resident 1's light was still on in his/her room, so s/he shut it off. Caregiver C stated that Caregiver B then told him/her that s/he was leaving the light on until Resident 1 got up. Caregiver C also reported that Caregiver B told him/her that s/he took Resident 1's remotes away. Caregiver C stated that s/he saw Caregiver B with the remotes

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walking towards the back of the facility. Caregiver B reported that when Caregiver C came back, the remotes were gone, and when Caregiver C asked him/her where the remotes were, Caregiver C said, I am not telling you. Caregiver C reported that s/he wrote a statement about this situation.

On 12/11/2024 at approximately 4:13 PM, Surveyor received Caregiver C's statement regarding the situation on 09/29/2024, from Administrator A. The statement from Caregiver C read, "On 09/29/24 I came in at 6pm (shift change) [sic] [Caregiver B] was telling me [Caregiver C] that [Resident 1] refused to get out of bed for cares, meals, and activities all day so [s/he] took away [his/her] remotes to [his/her] tv for the night, [sic] came back in the morning at 7:30am to give them back."

On 12/12/2024 at approximately 9:44 AM, Surveyor interviewed Administrator A. Administrator A stated s/he was aware of the situation that occurred on 09/29/2024 and had told Caregiver B it was okay to take Resident 1's remotes away/unplug the TV. Administrator A said s/he was trying to find the balance between safety of the resident and resident rights. Administrator A stated that s/he acknowledged this was a resident rights violation. Administrator A stated that it was unclear whether the remotes were taken or if the TV was just unplugged but acknowledged that both would be a violation of resident rights. Administrator A stated that s/he did contact the ombudsman regarding the issue after it happened and they informed him/her that it was in fact a violation of resident rights. Administrator A reported that the ombudsmen told him/her to always air on the side of resident rights in the future if s/he was ever questioning a situation when an issue like this arises.

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| N 355 | Continued From page 4<br><br>The provider did not ensure Resident 1 had the ability to watch TV in his/her whenever s/he wanted. | N 355 | | |