STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525605	A. BUILDING _____ B. WING _____	**09/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEADOW VIEW HEALTH SERVICES	**3613 S 13TH ST SHEBOYGAN, WI 53081**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** Based on staff interview, family interview, and record review, the facility did not ensure services to prevent decreased mobility were provided for 1 Resident (R) (R3) of 4 sampled residents. Staff did not ambulate (walk) R3 twice a day in the hallway per mobility care plan for 26 of 30 days reviewed; R3 fell four times between 6/28/2020 and 8/26/2020. Findings include: On 9/8/2020, Surveyor reviewed R3's medical record which documented R3 fell four times in the previous four months. Falls occurred on 6/28/2020, 7/8/2020, 7/31/2020, and 8/26/2020. R3's care plan documented a care plan was initiated on 8/22/2019 related to limited mobility. The only intervention listed was a nursing restorative walking program which stated one staff should assist R3 to walk with a wheeled walker twice per day in the hallway. Thirty days of R3's walk in corridor task documentation was reviewed and documented R3 was walked twice a day on 8/11/2020, 8/13/2020, 8/22/2020, and 8/25/2020 (13.33% of days this intervention was implemented for the reviewed period of time/missed 86.66%). Surveyor noted R3 was never documented as refusing ambulation. On 9/9/2020 at 9:14 AM, Surveyor interviewed R3's activated Power of Attorney (POA)-D via telephone as part of a complaint investigation alleging staffing issues in the facility. Surveyor asked if any of R3's needs or care plan were not being fulfilled. POA-D responded that R3 needed to be walked down the hall and taken outdoors on nice days. POA-D explained keeping in touch with R3 through window visits and telephone calls. POA-D indicated that from conversations with R3, POA-D believed ambulation was not occurring as care planned. On 9/9/2020 at 12:55 PM, Surveyor interviewed Assistant Director of Nursing (via telephone) who confirmed working as Interim Director of Nursing (IDON)-C during the time of survey. IDON-C verified R3's restorative walking program should be documented under the walk in corridor task. IDON-C expressed an expectation that staff perform R3's mobility care plan restorative walking intervention as written which would be practiced as R3 being assisted to ambulate once on AM shift and once on PM shift. IDON-C expected staff to document a reason in R3's record if unable to complete the intervention. On 9/9/2020 at 8:42 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-G regarding ambulation programs. CNA-G indicated ambulation programs can be difficult to implement depending on how many staff are in building during a given shift. On 9/9/2020 at 11:23 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E regarding ambulation programs via telephone. LPN-E verified being a full-time staff person at the facility who is typically assigned the wing R3 resides on. LPN-E verified R3's ambulation intervention was not consistently implemented. LPN-E indicated that consistent caregiver (staff familiar with and frequently assigned to a specific area) CNAs usually would report to the nurse if ambulation didn't happen so a nurse or other staff person could help address meeting the need. Surveyor summarized R3's hallway ambulation documentation to LPN-E. LPN-E expressed surprise that R3 was only ambulated twice a day for four of the previous thirty days and indicated CNAs were not reporting missing ambulation that frequently. On 9/9/2020 at 10:56 AM, Surveyor interviewed LPN-F via telephone regarding ambulation programs. LPN-F indicated LPN-F would assist R3 with ambulation if LPN-F saw R3 walking independently. LPN-F verified ambulation programs sometimes were missed.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.