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 _____	**08/05/2020**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review the facility did not ensure physician notification of a change for one resident (R) (R5) of six sampled residents. R5 refused medications, removed oxygen and had some confusion. Findings include: On [DATE], Surveyor conducted a record review. R5 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R5's most recent Minimum Data Set (MDS) assessment indicated that R5 required up to extensive assistance from staff for transferring and toileting. R5 expired at the facility on [DATE]. R5's progress note dated [DATE] at 9:18 AM indicated, Resident refused all AM medications. Resident keeps taking off 02 stating he does not want it on. 02 @ 93% A late progress note created on [DATE] for [DATE] at 1:20 PM, stated,Went into residents room, resident was naked from waist down, writer asked resident why he was naked. Resident stated that he was in a nudest colony and was hot, that he was just trying to cool off. Resident refused to eat breakfast. Resident daughter called, writer talked with her and stated that resident was more confused. Resident daughter stated that she wanted to ger her as a POA she also stated that she tried to do it in the hospital but the hospital told her that they could not do that. The residents daughter asked if we could get the ball rolling on that. Writer went and asked the social worker about getting that started. Surveyor interviewed Licensed Practical Nurse (LPN)-C on [DATE] at 1:50 PM. LPN-C was on the AM shift of duty on [DATE] and R5 was on LPN-C's assigned wing. LPN-C indicated getting report at the start of the AM shift and then interacting with R5 in R5's room prior to beginning medication administration. LPN-C reported R5 was alert and said hello, and indicated he did not need anything. LPN-C reported that R5 refused all AM medications. LPN-C reported that at some point between 1:00 PM and 1:30 PM, a certified nursing assistant (CNA) came out of R5's room and told LPN-C that R5 didn't have his oxygen on. R5 told LPN-C he did not want the oxygen on and to leave him alone. LPN-C reported that after leaving R5's room going to the nurse's station and being handed the telephone by another staff person. LPN-C indicated R5's daughter was on the telephone. R5's daughter indicated to LPN-C not being able to contact R5 via the phone in R5's room. LPN-C reported telling R5's daughter to call R5's room again and that LPN-C would have a staff member go to R5's room and hand R5 the phone. LPN-C reported telling R5's daughter to talk to R5 and encourage R5 to not refuse medications or remove the oxygen. LPN-C reported sending a CNA to R5's room and that CNA reported back that R5's phone did ring and CNA handed the phone to R5 and left R5's room. Surveyor asked LPN-C if R5's doctor was updated regarding R5's confusion and refusal of medications and removal of oxygen. LPN-C stated, I'm pretty sure I did but I can't remember. I don't know if I faxed or talked with the doctor. LPN-C reported R5 had, maybe a little confusion, but pretty normal for him. LPN-C indicated R5 was on the 24-hour report board for monitoring as a new admission. LPN-C reported R5 did not require increased oxygen, but did keep removing the oxygen during the shift. R5 did not have increased oxygen needs on [DATE] per LPN-C. Facility policy titled, Change of Condition of the Resident, with a revision date of [DATE], stated, Change of condition refers to a deviation from the patient/resident's baseline in physical, cognitive, behavioral or functional domains. This change can be negative or positive. The change of condition may be short lived or extend for a period of time and presents as a shift from the norm for that specific patient/resident. The policy procedure directs staff to notify the attending practitioner of the resident's condition, when changes are noted. Clinical Follow Up notes in R5's medical record, from date of admission to date of expiration, indicated R5's decisions were consistent and reasonable, that R5 was alert and oriented, able to make needs known, pleasant and cooperative, withdrawn/quiet, anxious, expresses according to situation, and was without behaviors and wearing oxygen continuously. R5's medical record notes did not include documentation that resident refused medications, removed oxygen, or displayed confusion during R5's stay at facility with the exception of [DATE]. R5's medical record had no documentation that a provider was updated on [DATE] regarding R5's confusion, refusal of medications and removal of oxygen. Documentation in R5's medical record did not indicate R5 was confused, refused medications or removed his oxygen prior to [DATE].

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