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	0017916	A. BUILDING: _____ B. WING _____	R-C 07/11/2023

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APPLE CREEK PLACE I	5102 N CHERRYVALE AVENUE APPLETON, WI 54913

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{N 000}	Initial Comments On 06/27/2023, with additional information gathered through 07/11/2023, Surveyors conducted 10 complaint investigations, a self-report review, and a verification visit at Apple Creek Place I. Nine complaints were substantiated. One complaint was unsubstantiated. Fourteen of 18 deficiencies were corrected. Thirteen deficiencies were identified. Four of 13 deficiencies were repeat violations, see Statements of Deficiency (SOD) DGJM11 (dated 02/11/2021) and SOD 0NAU11 (dated 11/02/2023). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 15	{N 000}		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department within 3 working days after law enforcement personnel were called to the facility as a result of an incident that jeopardized the	N 164		

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

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health, safety, or welfare of the residents or employees.

Findings include:

The provider is licensed to serve up to 22 residents with diagnoses of developmentally disabled, physically disabled, advanced age, terminally ill and irreversible dementia/Alzheimer's.

On 02/24/2023, 03/28/2023, 04/10/2023, and 06/13/2023, the department received complaint information that alleged residents were involved with law enforcement personnel responding to the CBRF.

On 06/27/2023, Surveyor reviewed a facility progress note dated 03/28/2023 where Resident 2 had not received his/her Tylenol. Resident 2 then contacted law enforcement who arrived at the facility.

On 06/27/2023, Surveyor reviewed an incident report dated 06/04/2023 which involved Resident 2 and Caregiver D. The incident report identified Resident 2 caused a disturbance to other residents and had a verbal disagreement with Caregiver D at approximately 9:30 PM. Law enforcement was called to facility to assist.

On 06/27/2023, Surveyor reviewed a facility progress note dated 06/10/2023 where Resident 2 alleged assault against a caregiver. Law enforcement responded to the facility.

On 06/27/2023 at approximately 1:15 PM, Surveyors interviewed Resident 2 who shared s/he had frequent contact with law enforcement. S/he reported s/he would call law enforcement if

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N 164	Continued From page 2 s/he felt threatened, and they would respond. Resident 2 indicated the facility staff have also called law enforcement to the facility on numerous occasions. On 07/10/2023 at approximately 2:00 PM, Surveyor interviewed Director A who verified law enforcement had been at the facility on numerous occasions and no reports were submitted to the department for those events.	N 164		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not notify the department within 7 days after there was a change in administrator. Findings include: On 06/27/2023 at approximately 9:30 AM, Surveyors interviewed Community Director A and Corporate Administrator B. Surveyors asked when Community Director A took over because s/he was not listed on the facility facesheet and the department did not have any records of a change. Community Director A stated that s/he had taken over sometime in March of 2023 and wasn't sure if the previous director had sent in the information. Corporate Administrator B stated that s/he was unsure if there was notification either and that they would check with the corporate office. On 06/27/2023 at approximately 2:30 PM,	N 200		

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N 200	Continued From page 3 Surveyors requested to have information sent via email. Surveyors never received documentation of an administrator change as of 07/10/2023.	N 200		
N 383	83.35(1)(c) Listed areas for assessments. Assessment. Areas of assessment. The assessment, at a minimum, shall include all of the following areas applicable to the resident: 1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health, including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including, choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known. 10. Social participation, including interpersonal relationships, communication skills, leisure time activities, family and community contacts and vocational needs.	N 383		

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N 383	Continued From page 4	N 383		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not complete an assessment for Resident 1's ability to control and self-administer his/her own medications.

Findings include:

On 02/03/2023 and 04/10/2023, the department received complaint information that alleged residents were not receiving their medications as ordered.

On 06/27/2023, Surveyors requested to review Resident 1's Medication Administration Record for March 2023. Resident 1's March 2023 MAR stated his/her Acetaminophen was self-administered for his/her morning dose at 8:00 AM and 12:00 PM. These were the only medications that were indicated that Resident 1 was supposed to self-administer. Resident 1's March 2023 MAR stated Resident 1 was to take two 500 MG tablets by mouth four times daily for pain at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM.

On 06/27/2023 and on 07/10/2023, Surveyors requested Resident 1's physician orders for his/her Acetaminophen and the facility's assessment for Resident 1 to self-administer. As of 07/10/2023, Surveyor did not receive Resident 1's Acetaminophen orders.

On 07/10/2023 at approximately 2:00 PM, Director A stated they did not have an order for Resident 1 to self-administer his/her own Acetaminophen and they needed to contact the physician to get an order for Resident 1 to self-administer his/her Acetaminophen. Surveyor asked Director A if Resident 1 had an

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N 383	Continued From page 5 assessment completed to ensure Resident 1 was able to safely self-administer his/her medications. Director A stated there was not an assessment completed.	N 383		
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 provider did not ensure Resident 2's individual service plan (ISP) was updated with changes in his/her needs, abilities or physical condition. The provider did not ensure Resident 2's ISP was reviewed with him/ her with changes. This is a repeat violation, see Statement of Deficiency DGJM11, dated 02/11/2021. Findings include: On 02/19/2023 and 03/27/2023, the department received complaint information that alleged	N 389		

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resident needs were not being met.

On 07/07/2023, Surveyor reviewed Resident 2's ISP and noted s/he was re-admitted to the facility on 01/11/2023 (original admission date unknown by provider) with medical diagnoses of paresthesia, hyperglycemia, obesity, osteoarthritis, bipolar mood disorder, chronic pain, and fibromyalgia. Resident 2 was his/her own decision maker and able to make his/her needs known.

On 06/27/2023, Surveyor noted Resident 2's ISP stated:
"Is able to make self understood."
"Independent with personal hygiene with/without use of assistive devices. Resident may need help at times."
"Needs minimal physical assistance (i.e. tying shoes, obtaining clothes from closet, putting on coat) [Resident 2] takes initiative and responsibility for dressing and undressing self without assistance. At times does need assistance."
"Ability to ambulate safely with/without device(s) vulnerability interventions are: [Resident 2] will use four wheeled walker while in community."

On 06/27/2023, Surveyor noted Resident 2's ISP was updated on 01/18/2023. Surveyor noted LPN C's signature was listed on 01/18/2023 with a handwritten notation of Resident 2's name and a note stating Resident 2 refused to sign.

On 06/27/2023 at approximately 1:15 PM, Surveyors observed Resident 2 sitting slumped in a manual wheelchair in his/her room. Surveyors interviewed Resident 2 who stated s/he had troubles lifting his/her arms up very far. Resident 2 reported needing assistance with bathing for

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safety purposes and some dressing because of this. Surveyors observed Resident 2 demonstrate limited range of motion with lifting his/her arms. S/he shared s/he had troubles reaching the paper towels in his/her room. Resident 2 stated s/he had limited mobility and used his/her wheelchair to get around. Resident 2 shared it had "been a while since [his/her] last care plan review." Resident 2 stated s/he had no idea what his/her care plan said and had never received a copy of it. Surveyor inquired whether Resident 2 reviewed a care plan in January 2023 or March 2023, Resident 2 stated no.

On 06/27/2023 at approximately 1:45 PM, LPN C stated Resident 2 utilized a wheelchair for all mobility. LPN C indicated Resident 2 was incontinent, so bed sheets needed to be stripped weekly, but s/he guessed Resident 2's were pulled more than weekly because of incontinence. S/he stated Resident 2 was a 1-staff assist and staff knew and should be assisting him/her with dressing, especially his/her bottom half. LPN C stated s/he updated all care plans in March, including Resident 2's.

On 07/11/2023 at approximately 2:00 PM, Surveyors interviewed Director A who acknowledged Resident 2's current ISP was not updated to reflect changes in Resident 2's mobility, dressing needs, range of motion, and incontinence/cleaning needs. Director A shared LPN C had been completing reviews and was unsure when Resident 2's last review was.

Cross Reference:
Y3244 Ch 50.09(1)(l) Care

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N 399	Continued From page 8	N 399		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain a current written schedule for staffing the CBRF. The schedules did not include each employee's full name, job assignment, and time worked. The schedules included staff assigned to different CBRFs, but didn't identify which CBRF the staff were assigned to on a given day. Findings include: On 06/27/2023, Surveyor reviewed a sample of provider's schedules with dates between February 2023-present (June 2023). Surveyor noted multiple calendars of the same month with one calendar for every shift (3 shifts). Surveyor noted employee first names and/or employee first names and the first letter of their last names. Surveyor noted 2-6 staff listed on any given day. On 07/07/2023 at approximately 9:30 AM, Surveyor interviewed Director A who stated all 3 CBRF employees were listed on the calendars. Surveyor inquired how it was known what building they were working in and what the staff member's job title was on any given day as they were not identified. Director A stated s/he was unsure as s/he had just taken over the scheduling. On 07/10/2023 at approximately 2:00 PM,	N 399		

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N 399	Continued From page 9 Surveyor interviewed Director A who verified the schedule had not been maintained with employees' full names, job assignments, time worked, and what building they were working in.	N 399		
{N 409}	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure schedule II drugs were audited, signed out, and dated for proof-of-use on a daily basis. This is a repeat deficiency, see Statement of Deficiency 0NAU11, dated 11/01/2022. Findings include: On 06/27/2023, Surveyors conducted a verification visit. On 06/27/2023, Surveyors reviewed the provider's proof-of-use record for May 2023. Surveyor noted the administrator or designee did not audit, sign, and date the proof-of-use record on 05/01/2023, 05/02/2023, 05/05/2023, 05/07/2023, and 05/18/2023.	{N 409}		

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{N 409}	Continued From page 10 On 06/30/2023, Surveyor reviewed provider's Medication policy dated 11/01/2022, "POLICY: Staff at Cornerstone Management Services who administer Schedule II controlled substances must participate in recording Schedule II medications in the bound narcotic log book." Surveyor reviewed provider's Controlled Substance policy with revision date 04/17/2023, "Staff will maintain and document on an individual proof-of-use record each dose of a controlled substance ordered for and administered to a resident. The form will contain the following information: a. Name of medication. b. Dose. c. Resident name. d. Physician name. e. Signature for every dose administered. f. Balance of medication after each dose administered. 1. The Administrator or designee will audit the controlled substances count with another staff person at every change of shift, no less than once daily." On 07/10/2023 at approximately 2:00 PM, Surveyor interviewed Director A and Corporate Administrator B who verified schedule II drugs were not always audited daily.	{N 409}		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name,	N 415		

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dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure documentation of administration of medication was completed for Resident 1 and Resident 2 in their medication administration records (MAR).

Findings include:

On 02/03/2023 and 04/10/2023, the department received complaint information that alleged residents did not receive their medications as prescribed.

On 06/27/2023, Surveyors reviewed Resident 1's March and April 2023 MAR.
Resident 1's MAR had a total of 254 blank entries for administering his/her medications.

Surveyor noted Resident 1 was prescribed the following medications:
-Acetaminophen 500MG Caplet: Take 2 tablets by mouth four times daily for pain at 8:00 AM, 12:00 PM, 4:00 PM, 8:00 PM
Amlodpine 10MG Tab: Take on tablet by mouth once daily at bedtime for high blood pressure at 8:00 AM
Aspirin 81MG EC Tab: Take 1 tablet by mouth once daily for supplement at 8:00 AM
Clotrimazole 1% Cream: Apply 1 application to

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the skin twice daily at 8:00 AM
Colesevelam 625MG Tab: Take 1 tablet by mouth twice daily for Hyperlipidemia at 11:00 AM, 4:00 PM
Gabapentin 100MG Cap: Take 1 capsule by mouth twice daily for Fibromyalgia at 8:00 AM
Glucos/Chond 500/400 MG Cap: Take 1 capsule by mouth once daily for supplement at 8:00 AM
Hydralazine 10 MG Tab: Take 1 tablet by mouth three times daily for high blood pressure at 8:00 AM, 2:00 PM and 8:00 PM
Losartan 50MG Tab: Take 1 tablet by mouth twice daily for Hypertension at 8:00 AM and 8:00 PM
Magnesium Oxide 500MG Tab: Take 1 tablet by mouth once daily for supplement at 8:00 AM
Meloxicam 15MG Tab: Take 1 tablet by mouth once daily for migranes at 8:00 AM
Metformin ER 500MG Tab: Take 2 tablets by mouth twice daily with meals at 8:00 AM and 4:00 PM
Metoprolol Tart 100MG Tab: Take 1 tablet by mouth twice daily for hypertension at 8:00 AM and 8:00 PM
Multivitamin Tab: Take 1 tablet by mouth once daily for supplement at 8:00 AM
Triamcinolone 0.1% Cream: Apply topically to affected area twice daily for Eczema at 8:00 AM and 8:00 PM
Venlafaxine ER 150MG Cap ER: Take one capsule by mouth in the morning for depression at 8:00 AM
Vitamin D3 1000IU (25MCG) Tab: Take 1 tablet by mouth twice daily for supplement at 8:00 AM and 8:00 PM
Vitamin D3 2000IU (50MCG) Tab: Take one tablet by mouth once a day at 8:00 AM
Vitron-C Tab 65-125: Take 1 tablet by mouth once daily for health at 8:00 AM
Zinc Gluc 50MG Tab: Take 1 tablet by mouth

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N 415	Continued From page 13 once daily for supplement at 8:00 AM" Resident 1's MAR had missing entries on the following dates: 03/15/2023-03/16/2023,03/18/2023, 03/20/2023-03/23/2023, 03/24/2023-03/30/2023, and 04/01/2023-04/08/2023. On 07/07/2023, Surveyor reviewed Resident 2's 04/06/2023-05/05/2023 MAR. Resident 2's MAR had a total of 79 blank entries for administering his/her medications. Surveyor noted the following blank entries for Resident 2's medication administration: Gabapentin 300 mg cap: Take one capsule by mouth twice daily for neuropathy at 8:00 AM and 8:00 PM - 04/06, 04/07, 04/08, 04/26, 04/28, 05/02, 05/04, 05/05, 05/06 8:00 AM and 04/04, 04/09, 04/10, 04/14, 04/21, 05/02, 05/04, 05/05, 05/06 8:00 PM Nystatin Sus 100000: Swish 5 mL in the mouth four times daily for 14 days for thrush (03/31/2023-04/14/2023) at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM - 04/06/2023-04/14/2023 at all 4 times. Miconazole 2% antifungal powder: apply to chest until skin heals at 8:00 AM and 8:00 PM: 04/09, 04/26, 04/27, 04/28, 04/30, 05/01, 05/02, 05/03, 05/04, 05/05, 05/06 at 8:00 AM and 04/07, 04/09, 04/14, 04/21, 04/26, 04/28, 04/29, 04/30, 05/01, 05/02, 05/03, 05/04, 05/05, 05/06 at 8:00 PM. On 07/10/2023 at approximately 2:30 PM, Surveyors interviewed Director A about blank entries in the MAR. Director A stated that staff should be initialing the paper MAR when medications were given and acknowledged blank spaces on Resident 1 and Resident 2's MARs.	N 415		

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N 427	Continued From page 14	N 427		
N 427	83.38(1)(c) Leisure time activities. 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on record review, observation and interview, the provider did not ensure a daily activity program was provided to meet the interests and capabilities of the residents. While present at the facility from approximately 9:30 AM to 4:30 PM, Surveyors did not observe residents engaged in activities. Findings include: On 04/10/2023 and 04/25/2023, the department received complaint information that alleged there were no activities at the facility. On 06/27/2023, Surveyors conducted a complaint investigation. Surveyors requested a copy of the provider's activity schedule and made observations. During a tour, at approximately 11:00 AM, Surveyors observed one caregiver helping a resident curl his/her hair in the salon.	N 427		

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N 427	Continued From page 15	N 427		

Surveyors did not observe any activity programs taking place besides this. While present at the facility from approximately 9:30 AM to 4:30 PM, Surveyors observed residents sitting in the dining room, walking around the facility and spending time in their own rooms watching television and sleeping. Surveyors noted an activity schedule was not posted and was not provided to the Surveyors on 06/27/2023.

On 06/27/2023 at approximately 12:00 PM, Surveyor interviewed Resident 3 who stated there were no activities and nothing to keep them (residents) busy each day. Surveyor inquired whether there was an activity calendar, in which Resident 3 stated if there was one, s/he had never seen it.

On 06/27/2023 at approximately 1:15 PM, Surveyors interviewed Resident 2 who shared there were no activities offered, which Resident 2 described as "disappointing." S/he stated s/he wasn't sure s/he would always attend them, but would appreciate if anything was even offered or available. Resident 2 shared there was no activity staff and the caregivers either refused or didn't have the staff to do activities.

On 06/28/2023 at approximately 11:00 AM, Surveyors interviewed Community Director A. Surveyors asked Community Director A if there was a daily activity program to follow. Community Director A stated they were working on a better activity program and right now staff were trying to do "one-on-ones" with the residents.

On 07/10/2023 at approximately 2:00 PM, Surveyor interviewed Community Director A who stated s/he was contracted with an activity programming system and s/he was working with

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N 427	Continued From page 16 staff on following the program. Community Director A indicated s/he would send the activity schedule to the Surveyors. As of 07/11/2023, Surveyors did not receive a copy of the provider's activity schedule.	N 427		
{N 450}	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure reasonable adjustments to the menu were made for individual resident's food likes, habits, customs, conditions and appetites. Deviations from the planned menu were not documented on the menu. This is a repeat deficiency. See Statement of Deficiency (SOD) 0NUA11, dated 11/02/2022. Findings include: On 06/27/2023, Surveyors conducted a verification visit. On 02/19/2023, 03/20/2023, 04/10/2023, the department received complaint information that alleged adjustments were not made to the menu for residents' food preferences.	{N 450}		

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{N 450}	Continued From page 17 On 06/27/2023, Surveyor reviewed January 2023 - June 2023 menus. Surveyor noted no menus were provided for February and March. Surveyor reviewed a sample of days and noted noon meals included an entree, a side dish, a starch, a dessert and milk. The evening meal included an entree, a side dish, fruit, and milk. Surveyor noted no alternatives, options, or additions were made to the menu for special diets, requests, or accommodations. On 06/27/2023 at approximately 3:00 PM, Surveyor interviewed Director A who stated Cook D was on leave for a while between February and March and Director A was unsure what was done in that timeframe for meals and alternatives as s/he was not employed with the facility yet. On 06/27/2023 at approximately 11:50 AM, Surveyor interviewed Resident 4 who stated the food quality was very poor. S/he stated there were no options or alternatives if they didn't like what was being served. On 06/27/2023 at approximately 12:00 PM, Surveyor interviewed Resident 3 who reported being on a renal diet, which meant s/he had to monitor his/her intake of sodium, phosphorous, and potassium. Resident 3 stated there were no options or alternatives to what was on the menu for each meal. S/he referenced Resident 2 as only wanting to eat vegetables. Resident 3 stated Resident 2 should be supported by the provider to keep up with that diet preference. On 06/27/2023 at approximately 1:13 PM, Surveyors interviewed Resident 2 who reported having the preference of eating a vegetarian diet. S/he stated s/he was not provided vegetarian	{N 450}		

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alternatives daily. Surveyor inquired whether anyone had spoken with him/her about his/her diet preferences or options when planning meals. Resident 2 stated no. Resident 2 shared staff bring him/her the food that was listed on the menu and did not ask if s/he wanted something different. S/he said s/he was told by a staff member that they do not make enough money to make Resident 2 something different.

On 07/07/2023 at approximately 10:00 AM, Surveyor interviewed LPN C who reported Cook D was responsible for meal prepping and providing alternatives. S/he shared resident restrictions and preferences were listed on notes in the kitchen. LPN C stated other staff do not know what the alternatives were, only Cook D did and s/he was supposed to provide the alternatives to staff. Surveyor inquired how staff know what the alternatives that Cook D provides. LPN C stated s/he believed Cook D would tell them. Surveyor inquired how staff know what alternatives were available when Cook D was not in the facility like in the evening and weekends and LPN C stated s/he did not know. Surveyor inquired what staff were supposed to do if a resident requests or needs an alternative and there wasn't one prepared. LPN C stated s/he did not know and would have to check. LPN C did not provide additional information about menu alternatives being communicated from Cook D to other staff. Surveyor inquired about Resident 2 requesting vegetarian options. LPN C stated it was the staff's best bet to ask Resident 2 what s/he wanted at each meal as sometimes s/he would want what was on the menu. Surveyor inquired whether staff were aware to ask Resident 2 as well; LPN C stated s/he did not know, but it was what s/he did.

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{N 450}	Continued From page 19 On 07/10/2023 at approximately 2:00 PM, Surveyor interviewed Director A who acknowledged options for meals were not always available and changes to the menu were not always updated on the menu.	{N 450}		
{N 454}	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and	{N 454}		

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{N 454}	Continued From page 20 therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure resident records were maintained at the facility. This is a repeat deficiency, see Statement of Deficiency 0NUA11, dated 11/01/2022.	{N 454}		

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{N 454}	Continued From page 21 Findings include: On 11/01/2022 and 12/16/2022, the department received complaint information that alleged resident needs were not being met. On 06/27/2023, Surveyors conducted a verification visit. On 06/27/2023 at approximately 3:00 PM, Surveyors interviewed Director A and Corporate Administrator B who stated they were in between electronic member record systems and documents from Point Click Care (PCC) were not saved. Director A stated s/he did not have access to resident past documents. Corporate Administrator B indicated there was no plan in place to maintain and retain documentation in PCC by provider when termination of the record system contract was made. On 06/27/2023, 07/07/2023, and 07/11/2023, Surveyors requested Resident 5 and Resident 6's records for review. On 07/11/2023 at approximately 7:45 AM, LPN C reported Surveyor that they were unable to provide any of Resident 5's medication administration records (MAR) prior to 03/17/2023, face sheet, and individual service plan (ISP) due to not having access to PCC. Resident 5 was admitted to the facility on 11/28/2022. LPN C reported to Surveyor s/he was unable to provide Resident 6's face sheet, ISP, MAR, and any progress notes beyond one handwritten page due to not having access to PCC. Resident 6 was admitted to the facility on 10/07/2022 and had since moved from the facility. On 07/11/2023 at approximately 2:00 PM,	{N 454}		

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{N 454}	Continued From page 22 Surveyor interviewed Director A who verified s/he did not have access to past resident documentation or current resident's past documentation, but they were now working on getting access back from PCC. Corporate Administrator B verified the provider did not have access to PCC since prior to March 2023.	{N 454}		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire evacuation drills were conducted in 2022, and 1 of 2 quarters thus far in 2023. Findings include: On 03/27/2023, the department received	N 525		

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N 525	Continued From page 23 complaint information that alleged fire drills were not conducted. On 06/27/2023, Surveyor reviewed provider's documentation for a fire drill on 05/22/2023 (quarter 2 of 2023). Surveyor noted there was no evidence of any fire drills being conducted in 2022 and in quarter 1 of 2023. On 06/27/2023 at approximately 2:45 PM, Surveyor inquired with Community Director A whether any other fire drills were conducted in 2022 and 2023 than the 1 documented drill provided. Director A stated s/he did not believe so, but would look for additional documentation. On 07/10/2023 at approximately 2:00 PM, Surveyors interviewed Community Director A who verified no additional fire drill documentation was found.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure other emergency or disaster evacuation drills were conducted at least semi-annually. Findings include: On 06/27/2023, Surveyor reviewed provider's drills and noted there was no evidence of other evacuation drills being conducted in 2022.	N 526		

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N 526	Continued From page 24 On 06/27/2023 at approximately 2:45 PM, Surveyor inquired with Community Director A whether other evacuation drills were conducted in 2022. Director A stated s/he did not know and there was no additional documentation available for him/her to reference or provide.	N 526		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received adequate and appropriate care. Findings include: The provider is licensed to provide services for up to 22 residents who may be physically disabled, of advanced age, terminally ill, and/or have Alzheimer's/dementia.	Y3244		

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Y3244	Continued From page 25 On 11/01/2022, 12/16/2022, 02/19/2023, 03/27/2023, and 04/25/2023, the department received complaint information that alleged resident needs were not being met and long call wait times. On 07/07/2023, Surveyor reviewed Resident 2's individual service plan (ISP) and noted s/he was re-admitted to the facility on 01/11/2023 (original admission date unknown by provider) with medical diagnoses of paresthesia, hyperglycemia, obesity, osteoarthritis, bipolar mood disorder, chronic pain, and fibromyalgia. Resident 2 was his/her own decision maker and able to make his/her needs known. Resident 2 was identified as a fall risk. Resident 2 had a history of skin breakdown and had prescription topical treatment. "Is Incontinent of bladder ...Resident wishes to have good skin health ... Remind resident to move carefully due to bruising easily." "Bathes with one assist or may sponge bathe as needed ...Check skin with bath/shower and report any reddened /open areas to Nurse." "Safety Checks for Falls: [Resident 2] will be on safety checks every two hours." On 06/27/2023 at approximately 1:15 PM, Surveyors interviewed Resident 2. Resident 2 stated s/he asked repeatedly for assistance from staff with showers every week and rarely got one. S/he said s/he would sometimes shower by him/herself and was very nervous and limited to do so. Resident 2 reported being incontinent of urine and soiling him/herself frequently, which s/he described as embarrassing. S/he described his/her hygiene and skin integrity as being important to him/her.	Y3244		

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Y3244	Continued From page 26 On 06/30/2023 at approximately 10:00 AM, Surveyor interviewed LPN C. LPN C stated Resident 2 did require assistance from staff with showers. S/he said when Resident 2 would allow for staff to assist with showers they are on Monday and Thursday PM shifts. LPN C stated, "It's the approach with [Resident 2]; [s/he] has refused at times." Surveyor inquired where shower completion was documented. LPN C stated staff were to fill out shower sheets and put them under his/her door when complete. S/he indicated that shower sheets were completed with all showers and refusals would be documented on the shower sheets. On 07/07/2023, Surveyor reviewed Resident 2's shower sheets dated 04/27/2023, 05/11/2023 (documented as refused), 05/18/2023, and 05/25/2023. No other shower sheets were found by LPN C. 14 showers did not have evidence of being completed or offered and refused by Resident 2 on Mondays and Thursdays since 04/27/2023. On 07/07/2023, Surveyor reviewed provider's shower schedule and noted Resident 2 listed as having a shower on Mondays and Thursdays. "Shower sheet needs to be completed for each shower even if resident is independent. Vitals, weight, strip the bed and wash linens. HOUSEKEEPING SHEET TO BE FILLED OUT." On 06/27/2023 at approximately 1:15 PM, Surveyors interviewed Resident 2 who stated s/he needed assistance with his/her room being cleaned, sheets changed, and laundry. S/he said s/he was still waiting for towels to be washed so s/he could take a shower since s/he didn't get one on Monday, 06/26/2023. Surveyor observed	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017916	A. BUILDING: _____ B. WING _____	R-C 07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE I	5102 N CHERRYVALE AVENUE APPLETON, WI 54913

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Y3244	Continued From page 27	Y3244		

Resident 2's carpeting to have visible debris, his/her bed unmade, his/her bathroom and room garbage cans overfilled with garbage and soiled incontinence products, and his/her bathroom floor to be sticky in feeling.

On 06/30/2023 at approximately 10:00 AM, Surveyor interviewed LPN C who stated housekeeping was to be done the day of resident's showers and housekeeping forms were to be filled out upon cleaning. Surveyor inquired when the most recent time Resident 2's room was cleaned and LPN C stated s/he did not know and did not have any housekeeping sheets for Resident 2.

On 06/27/2023 at approximately 1:15 PM, Resident 2 referenced the call light system as "never working." S/he stated, "I don't bother with it [wearing his/her call light] because it's a waste of time. They [staff] don't come anyways." Resident 2 stated if s/he needed something s/he would just yell and hope someone heard him/her. Surveyor inquired with Resident 2 how often staff check on him/her, and Resident 2 said rarely. Resident 2 stated s/he was sick of asking for help and not getting it. Surveyor observed Resident 2 to present upset, soft spoken, and using descriptives that presented as an expression of defeat.

On 06/30/2023 at approximately 10:00 AM, LPN C stated, "Pretty much everyone is independent in this building, so everyone should have a call light pendant." LPN C indicated 10 minutes wait time would be his/her maximum standard expectation of staff. LPN C indicated the building was primarily independent, but "it still warrants 2 staff on the AM shift and PM shift because of showers, call lights, and meal times,

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Y3244	Continued From page 28	Y3244		

hands down."

On 07/07/2023, Surveyor reviewed a sample call light report dated 06/28/2023-06/29/2023 and noted an average call wait time of 31.86 minutes wait time with the longest wait times being 108 minutes and 236 minutes.

On 07/11/2023 at approximately 2:00 PM, Surveyors interviewed Director A who acknowledged long call wait times and a need to better the system. Director A stated 10 minutes and less was the standard expectation for call light response time. Director A acknowledged Resident 2 was not receiving showers, being monitored for skin integrity, being checked on per his/her plan of care, and having his/her room cleaned to meet his/her needs.

In conclusion, Resident 2 required assistance with bathing, housekeeping, skin checks, and was not being checked on as listed in his/her ISP as a fall intervention. Call light time was on average triple the wait time than the provider's expectation. Resident 2 had stopped utilizing his/her call light due to staff not responding timely and was not receiving adequate care to meet his/her needs.

Cross Reference:
N0389 DHS 83.35(3)(d) Services Plans Updated Annually Or On Changes