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 09/30/2024

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

(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 08/20/2024, with additional information gathered through 08/27/2024, Surveyors conducted 8 complaint investigations and a verification visit. On 09/25/2024, with additional information gathered through 09/30/2024, Surveyor conducted 2 new complaint investigations at Apple Creek Place I. Nine of 10 complaints were substantiated. One complaint was unsubstantiated. Thirteen deficiencies were identified. Five of 13 deficiencies were repeat violations. See Statements of Deficiency (SOD) DGJM11, dated 02/11/2021, 0NUA12, dated 07/11/2023 and SOD 0NUA13, dated 03/06/2024. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 16	{N 000}		
{N 158}	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form	{N 158}		

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

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{N 158}	Continued From page 1	{N 158}		

provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did investigate and document an allegation of abuse by a caregiver for 1 of 1 (Resident 3) residents reviewed.

Caregiver C was alleged to have held down Resident 3's hands and forced Resident 3 to take medications. Director A did not have documentation or an investigation into the allegation.

This is a repeat citation. See Statement of Deficiency (SOD) 0NUA13 dated 03/06/2024.

Findings Include:

On 08/05/2024 and 08/09/2024, the department received complaints regarding allegations of caregiver misconduct.

On 08/20/2024, Surveyors conducted an onsite investigation. Surveyors requested all investigations of caregiver misconduct from the provider. Surveyors did not receive any investigations while onsite.

On 08/21/2024 at approximately 11:30 AM, Surveyor emailed Director A requesting any investigations of caregiver misconduct related to Caregiver C.

On 08/21/2024 at approximately 3:30 PM,

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{N 158}	Continued From page 2 Director A replied via email stating, "No investigation took place as we were unaware that these allegations occurred." On 08/21/2024 at approximately 3:52 PM, Surveyor interviewed APS (Adult Protective Service) Worker D who investigated a referral for a resident being physically forced to take his/her medications. APS Worker D stated it was reported to him/her on 08/09/2024 that the facility was short staffed and the caregiver was working alone. The staff called management for assistance due to Resident 3 being restless and attempting to get out of bed with a fracture. Caregiver C arrived to the facility to assist and Resident 3 continued to refuse his/her medications. Caregiver C physically pushed Resident 3's hands away and forced the medications, morphine and lorazepam, into his/her mouth. APS Worker D went to the facility on 08/09/2024 and spoke with Director of Nursing (DON) E who acknowledged awareness of the allegation. APS Worker D stated s/he was unable to determine harm from his/her perspective, but s/he definitely discussed the situation and followed up on the allegation with DON E. On 08/27/2024, Caregiver J provided information that Caregiver J witnessed Caregiver C pull Resident 3's hands away from his/her mouth and force-fed him/her medications. Caregiver C reported this incident to Director A but nothing was done about it. On 08/27/2024 at 10:00 AM, Surveyor interviewed DON E. DON E indicated s/he was unaware of any allegations involving Caregiver C. DON E stated Adult Protective Services was in the building but did not mention anything to DON E about their investigation.	{N 158}		

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{N 158}	Continued From page 3 Cross Reference: N0170 DHS 83.12(5)(b) Notification: Abuse and Neglect Allegations	{N 158}		
N 159	83.12(2)(b) Non-caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Non-caregiver or resident. When there is an allegation of abuse or neglect of a resident, or misappropriation of property by a non-caregiver or resident, the CBRF shall follow the elder abuse reporting requirements under s. 46.90 Stats., or the adult at risk requirements under s. 55.043, Stats., whichever is applicable. This Rule is not met as evidenced by: Based on record review and interview, the provider did not follow the elder abuse reporting and adult at risk requirements when there was an allegation of abuse by a resident to another resident. On 08/17/2024, Resident 8 alleged on 08/14/2024, s/he had sexual intercourse with Resident 7 in exchange for cigarettes and his/her debit card. Law enforcement and Resident 7 and Resident 8's managed care organizations (MCO) were not notified until 08/19/2024. Resident 8's MCO contacted Adult Protective Services (APS) after notification from the facility. Findings include: On 08/20/2024, the department received	N 159		

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N 159	Continued From page 4	N 159		

complaint information alleging sexual abuse between two residents.

On 08/20/2024, Surveyors conducted a complaint investigation.
At approximately 11:36 AM, Surveyor interviewed Director of Nursing (DON) E who stated on 08/19/2024, s/he contacted law enforcement, Resident 7's MCO, and Resident 8's MCO. Resident 8 went to the hospital for a sexual assault nurse exam (SANE) on 08/19/2024. Surveyor inquired when DON E was notified of Resident 7's allegation and s/he said s/he was notified by phone on 08/17/2024.

On 08/22/2024, Surveyor reviewed Resident 8's record and noted s/he was admitted to the facility on 04/10/2024 with diagnoses of bipolar disorder, major depressive disorder, chronic post-traumatic stress disorder, anxiety disorder, and borderline personality disorder. Resident 8 had an activated Power of Attorney for Healthcare. Surveyor note: Resident 8's face sheet listed Lakeland Care Inc as his/her MCO; Community Care was referenced as his/her MCO contact in documentation by the provider in error.
Surveyor reviewed Resident 8's provider observation notes and noted on 08/19/2024 at 3:00 PM, DON E wrote "Writer received call on 08.17.29 [sic] stating resident was trading sexual favors for cigarettes. Writer arrived at the community and interviewed resident, who stated that on 08.14.24, [s/he] had given [his/her] debit card to a peer [Resident 7] to get [him/her] cigarettes. The peer returned with the cigarettes but would not give them to [Resident 8] until [s/he] received sexual favors, and [s/he] agreed. Resident stated that [Resident 7] approached [him/her] again on 08.17.24, offered resident chicken for sexual favors to which [s/he] refused.

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N 159	Continued From page 5 Resident states [s/he[did not cause physical pain or injury at any time and [s/he] is not afraid of [Resident 7]. Writer discussed [his/her] choices and possible negative outcomes and health issues. Resident advised to avoid peer and update staff if approached by peer at any time. POA [Power of Attorney for Healthcare] ...APNP [nurse practitioner], Community Care CM [Care Manager] updated. Police contacted to file complaint. Resident sent to TC [Theda Care] Appleton to have rape kit completed and meet with a Special Investigator ....Community Care will contact APS and forward writers contact information." On 08/22/2024, Surveyor reviewed Resident 7's record and noted s/he was admitted to the facility on 11/01/2022 with diagnoses of alcohol abuse, atherosclerotic heart disease, and respiratory disorder. Resident 7 was his/her own person. Surveyor note: Resident 7's record did not list a MCO, which s/he was enrolled with Community Care. On 08/27/2024 at approximately 10:00 AM, Surveyors interviewed DON E who acknowledged law enforcement was not notified until 08/19/2024 and the provider did not contact APS. Cross Reference: N0426 83.38(1)(b) Supervision	N 159		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a	N 165		

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N 165	Continued From page 6	N 165		

resident.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure they reported an incident or accident resulting in serious injury requiring emergency room treatment for Resident 2.

Findings Include:

On 08/11/2024, the department received an allegation of a fall resulting in a serious injury.

On 08/20/2024, at approximately 10:30AM, Surveyor interviewed Resident 2 regarding a reddish-brown stain on the floor between the bed and chair. Resident 2 reported it was blood from when s/he experienced a fall on 07/04/2024.

On 08/21/2024, Surveyor reviewed Resident 2's record and noted an observation note dated 07/04/2024 regarding a fall. The observation noted stated the following:

6:00PM: "Staff called triage to report when they went to wake [Resident 2] for dinner, found [him/her] in bed with a swollen and bruised left eye and a bleeding laceration above [his/her] left eyebrow. [Resident 2] states [s/he] tripped over the cord for [his/her] fan and fell within the last hour .... Instructed staff to call EMS (emergency medical services) for evaluation ..."

6:45PM: "Staff called to report [Resident 2] was transported to the ED (emergency department) via EMS.

10:45PM: "[Resident 2] returned from Theda

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N 165	Continued From page 7 Care (AMC) @ approximately 2200 hrs. after being sent out via Gold Cross for a fall with head injury and laceration. discharge [sic] summary as follows ...Diagnosis include periorbital contusion of left eye, initial encounter Tests: CT HEAD AND CEREVICAL SPINE W/O CONTRAST ..." On 08/21/2024 at approximately 3:00PM, Surveyor reviewed the department's files and noted there was no self-report submitted regarding the injury with emergency room treatment that occurred on 07/04/2024. On 08/27/2024, at approximately 10:00AM, Surveyor interviewed Director A. Director A stated s/he was not sure if the incident was self-reported to the department and would look into it. No further information was provided prior to the exit of the survey. Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes	N 165		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s legal representative within 72 hours when there is an allegation of misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify a resident's legal representative when there was an allegation	N 170		

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N 170	Continued From page 8 of abuse for 1 of 1 (Resident 3) residents reviewed. On 08/09/2024, the provider was made aware of an allegation of caregiver misconduct involving Resident 3 and Caregiver C. The provider did not notify Resident 3's legal representative of the allegation. Findings Include: On 08/05/2024 and 08/09/2024, the department received complaints regarding an allegation of caregiver misconduct involving Caregiver C. On 08/20/2024, Surveyors conducted an onsite investigation. Surveyors requested all investigations of caregiver misconduct from the provider. Surveyors did not receive any investigations while onsite. On 08/21/2024 at approximately 11:30 AM, Surveyor emailed Director A requesting any investigations of caregiver misconduct related to Caregiver C. On 08/21/2024 at 12:45 PM, Surveyor interviewed Guardian F. Guardian F verified s/he was the legal responsible party for Resident 3. Guardian F indicated s/he was unaware of any allegations involving Caregiver C forcing medications on Resident 3. Guardian F stated no one from the facility had mentioned anything to him/her regarding misconduct allegations and Resident 3. On 08/21/2024 at approximately 3:30 PM, Director A replied via email stating, "No investigation took place as we were unaware that these allegations occurred."	N 170		

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N 170	Continued From page 9 On 08/27/2024 at 10:00 AM, Surveyor interviewed DON E. DON E indicated s/he was unaware of any allegations involving Caregiver C. DON E stated Adult Protective Services was in the building but did not mention anything to DON E about their investigation. DON E and Director A verified Guardian F was not notified of the allegations as the facility was unaware of the allegations. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect	N 170		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. Nine of 10 complaints investigated from 08/01/2024 through 09/30/2024 were substantiated. Thirteen deficiencies were identified, including 5 repeat violations. See Statements of Deficiency (SOD) DGJM11, dated 02/11/2021, 0NUA12, dated 07/11/2023 and SOD 0NUA13, dated 03/06/2024. Findings include:	N 196		

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N 196	Continued From page 10 The provider is licensed to serve up to 22 residents who may be physically disabled, of advanced aged, terminally ill and/or have irreversible dementia or Alzheimer's disease. On 08/20/2024, Surveyors conducted 8 complaint investigations and a verification visit. On 09/25/2024, with additional information gathered through 09/30/2024, Surveyor conducted 2 new complaint investigations. At the time of the investigations, the census was 16 residents. On 08/20/2024, Surveyor reviewed the department provider records for Apple Creek Place I and noted the facility has been licensed by Licensee O with PPRC LLC since 03/19/2020. Upon complaint investigations, Surveyors were made aware the facility was managed by Cornerstone Management Services since February 2022. The department had conducted 5 investigations resulting in deficiencies since February 2022. See Statements of Deficiency (SOD) 0NUA11, dated 11/02/2022, SOD 0NUA12, dated 07/11/2023, SOD Y74H11, dated 01/30/2024, and SOD 0NUA13, dated 03/06/2024. On 09/09/2024, the department received correspondence from Cornerstone Vice President of Clinical Operations P and Cornerstone Chief Operating Officer Q stating Cornerstone Management Services had retained Health Dimensions Group (HDG) as a consultant group and Interim Director N with HDG would be the acting interim Administrator. On 09/26/2024, the department received correspondence from HDG identifying a change in management group from Cornerstone Management Services to Health Dimensions	N 196		

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Group effective 10/01/2024. Upon notification, the department also received documentation of agreement between Health Dimensions Group and Penta Investments, LLC. The department was made aware that Licensee O had no longer owned and operated Apple Creek Place I and its 2 sister facilities on the same campus. The department had not been notified and an application for change in ownership had not been submitted by Penta Investments, LLC as of 09/30/2024.

As a result of Licensee O not upholding his/her responsibilities as the licensee, 9 of 10 complaints investigated from 08/01/2024 through 09/30/2024 were substantiated and the following 13 deficiencies were identified (5 of 13 deficiencies were repeat violations):

N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect
Based on record review and interview, the provider did investigate and document an allegation of abuse by a caregiver for 1 of 1 (Resident 3) residents reviewed.
This is a repeat deficiency. See Statement of Deficiency (SOD) 0NUA13 dated 03/06/2024.

N0159 83.12(2)(b) Non-Caregiver: Investigating Abuse & Neglect
Based on record review and interview, the provider did not follow the elder abuse reporting and adult at risk requirements when there was an allegation of abuse by a resident to another resident.

N0165 83.12(3)(b) Reporting Incidents With Serious Injury
Based on record review and interview, the provider did not ensure they reported an incident

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or accident resulting in serious injury requiring emergency room treatment for Resident 2.

N0170 83.12(5)(b) Notification: Abuse And Neglect Allegations
Based on record review and interview, the provider did not immediately notify a resident's legal representative when there was an allegation of abuse for 1 of 1 (Resident 3) residents reviewed.

N0223 83.18(1) Employee Records Maintained And Current
Based on record review and interview, the provider did not maintain Caregiver H's employee record to at minimum to include a written job description including duties, responsibilities and qualification, caregiver background checks, and documentation of training or exemption verification.

N0306 83.28(7) Advanced Directives
Based on record review and interview, the provider did not maintain copies of legal documents (Do Not Resuscitate orders) as required which could affect the care and treatment for 3 of 3 sampled resident records (Resident 10, Resident 11, and Resident 12).

N0326 83.31(4)(a) Notice of Facility Initiated Discharge
Based on record review and interview, the provider did not give Resident 8's legal representative a 30-day written advance notice of involuntary discharge.

N0352 83.32(3)(h) Rights Of Residents: Receive Medication
Based on record review and interview, the provider did not ensure residents received

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medications as ordered by a practitioner for Resident 1. This is a repeat deficiency. See SOD (Statement of Deficiency) 0NUA11 dated 11/02/2022 for and SOD 0NUA13 dated 03/06/2024.

N0389 83.35(3)(d) Service Plans Updated Annually Or On Changes
Based on record review and interview, the provider did not ensure individual services plans (ISP) were reviewed and updated annually or upon change for Resident 2. This requirement is being cited for a fourth time. See Statements of Deficiency (SOD) DGJM11, dated 02/11/2021, SOD 0NUA12, dated 07/11/2023 and 0NUA13, dated 03/06/2024.

N0426 83.38(1)(b) Supervision
Based on record review and interview, the provider did not ensure residents were provided supervision appropriate to the residents' needs.

N0481 83.43(1) Environment Safe, Clean, And Comfortable
Based on observation and interview, the provider did not ensure the living environment was safe, clean, comfortable, and home like. This is a repeat deficiency. See SOD (Statement of Deficiency) 0NUA13 dated 03/06/2024.

Y3244 50.09(1)(L) Care
Based on observation, record review and interview, the provider did not ensure 1 of 1 (Resident 13) residents reviewed received adequate and appropriate care within the capacity of the facility. This is a repeat deficiency. See Statement of Deficiency (SOD) 0NUA12, dated 07/11/2023.

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N 223	Continued From page 14	N 223		
N 223	83.18(1) Employee records maintained and current. A separate record for each employee shall be maintained, kept current, and at a minimum, include: (a) Written job description including duties, responsibilities and qualifications required for the employee; (b) Beginning date of employment; (c) Educational qualifications for administrators; (d) Completed caregiver background check following procedures under s. 50.065, Stats., and ch. HFS 12; (e) Documentation of training, or exemption verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain Caregiver H's employee record to at minimum to include a written job description including duties, responsibilities and qualification, caregiver background checks, and documentation of training or exemption verification. Findings include: On 07/02/2024, the department received complaint information alleging employee records were not maintained. On 08/20/2024, Surveyors conducted a complaint investigation. Surveyor requested Caregiver H's employee record. At approximately 2:00 PM, Surveyors interviewed Regional Director I who stated Caregiver H was no longer an employee at the facility and they were unable to locate Caregiver H's employee record.	N 223		

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N 223	Continued From page 15 On 08/27/2024 at approximately 10:00 AM, Surveyors interviewed Director A who acknowledged Caregiver H's record was not maintained.	N 223		
N 306	83.28(7) Advanced directives. Advanced directives. At the time of admission, the CBRF shall determine if the resident has executed an advanced directive. An advanced directive describes, in writing, the choices about treatments the resident may or may not want and about how health care decisions should be made for the resident if the resident becomes incapacitated and cannot express their wishes. A copy of the document shall be maintained in the resident record as required under s. HFS 83.42(1)(s). A CBRF may not require an advanced directive as a condition of admission or as a condition of receiving any health care service. An advanced directive may be a living will, power of attorney for health care, or a do-not-resuscitate order under chs. 154 or 155, Stats., or other authority as recognized by the courts of this state. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain copies of legal documents (Do Not Resuscitate orders) as required which could affect the care and treatment for 3 of 3 sampled resident records (Resident 10, Resident 11, and Resident 12). Resident 10 voiced decision of being a "Do Not Resuscitate" (DNR) order, but facility records and documentation did not provide evidence of his/her decision.	N 306		

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N 306	Continued From page 16 Resident 11 and Resident 12 were listed as "Do Not Resuscitate" on their individual face sheets, but no DNR paperwork was maintained by the provider. Findings include: The provider is licensed to serve up to 22 residents who may be physically disabled, of advanced aged, terminally ill and/or have irreversible dementia or Alzheimer's disease. On 09/17/2024, the department received complaint information alleging resident records did not contain DNR paperwork. Surveyor note: According to Wisconsin Department of Health Services, "A DNR order is something a doctor writes. It tells EMS (Emergency Medical Services) practitioners and emergency medical responders not to perform CPR (cardiopulmonary resuscitation) if your heart stops or you can't breathe. If you don't have a DNR order, the care team will try CPR... It's most helpful to set up a DNR order before you have an emergency. DNR orders only focus on CPR. The purpose of the DNR order is to make sure that your wishes are honored, no matter what facility you go to in an emergency." https://www.dhs.wisconsin.gov/ems/dnr.htm#:~:text=What%20is%20a%20DNR%20order,care%20team%20will%20try%20CPR. Retrieved 09/30/2024. On 09/25/2024, Surveyor conducted a complaint investigation. Surveyor reviewed sample resident records for Resident 10, Resident 11, and Resident 12.	N 306		

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Surveyor reviewed Resident 10's record and noted s/he was admitted to the facility on 09/28/2023 with diagnoses to include type 2 diabetes, depression, anxiety and hypokalemia. Surveyor noted Resident 10's face sheet indicated Resident 10 was a "DO NOT RESUSCITATE." Surveyor could not locate DNR paperwork in Resident 10's file.
At approximately 1:30 PM, Surveyor interviewed Resident 10 who stated s/he wished to be DNR.

Surveyor reviewed Resident 11's record and noted s/he was admitted to the facility on 05/10/2023 with diagnoses to include anemia, type 2 diabetes, end stage renal disease, dependence on renal dialysis, major depressive disorder and hyperlipidemia. Surveyor noted Resident 11's face sheet listed him/her to be "DO NOT RESUSCITATE." Surveyor did not find evidence of DNR order documentation in Resident 11's record. Surveyor attempted to interview Resident 11, but Resident 11 was out of facility for dialysis.

Surveyor reviewed Resident 12's record and noted s/he was admitted to the facility on 05/06/2023 with diagnoses to include hypertension, restrictive lung disease, and chronic kidney disease, stage 3. Surveyor noted Resident 12's face sheet listed him/her to be "DO NOT RESUSCITATE." Surveyor did not find evidence of DNR order documentation in Resident 12's record. Surveyor attempted to interview Resident 12, but Resident 12 was out of the facility with family.

On 09/25/2024 at approximately 11:45 AM, Surveyor interviewed Caregiver L who stated s/he would look at the resident's face sheet in the electronic medical record to know whether the

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N 306	Continued From page 18 resident was a DNR or Full Code status. On 09/25/2024 at approximately 1:00 PM, Surveyor interviewed Wellness Director Consultant M. Wellness Director Consultant M verified resident records were not maintained with DNR order documentation. Wellness Director Consultant M indicated s/he came on board around 09/10/2024 as a consultant to help the Director of Nursing E. Shortly after coming on board, Director of Nursing E left the facility. Wellness Director Consultant M indicated at that time, s/he started to audit resident records and noticed some residents did not have DNR order documentation.	N 306		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not give Resident 8's legal representative a 30-day written advance notice of	N 326		

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involuntary discharge.
Resident 8 was admitted to the hospital with suicidal ideation. Upon hospital discharge, Resident 8 was not accepted back to the facility and was not given a 30-day notice of involuntary discharge.

Findings include:

On 09/17/2024, the department received complaint information alleging residents were not accepted back to the facility from the hospital.

On 09/16/2024, the department received self-report information from Interim Director N reporting on 09/12/2024, Resident 8 had reported attempting to break the window in his/her room to cut his/her wrists with the glass. Resident 8 voiced a desire to find a way to end his/her own life. Law enforcement was contacted and Resident 8 was admitted to the behavioral health unit of the hospital. When Resident 8 was ready to discharge from the hospital on 09/17/2024, the provider determined Resident 8 was not appropriate to return to the facility and did not accept him/her back.

On 09/25/2024, Surveyor conducted a complaint investigation.

Surveyor reviewed Resident 8's record and noted s/he was admitted to the facility on 04/10/2024 with diagnoses of bipolar disorder, major depressive disorder, anxiety disorder, post-traumatic stress disorder (PTSD), binge eating disorder, insomnia due to other mental disorder, borderline personality disorder, epilepsy, cerebral infarction, suicidal ideations, suicide attempt, and personal history of self-harm. S/he had an activated Power of Attorney for

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Healthcare.

Surveyor reviewed Resident 8's individual service plan (ISP) with print date 09/25/2024 and noted: "SUICIDAL TENDENCIES ...Resident has a history of suicidal tendencies ...Resident has suicidal thoughts/tendencies. Requires staff to redirect and education resident on resources [s/he] can use when having these feelings ... BEHAVIOR MONITORING ...Provide supervision and assistance in preventing and redirecting suicidal thoughts and behaviors. Report and document incidents for proper provider ...Resident requires supervision for all behaviors. Resident does have a history of suicidal tendencies, bipolar disorder, PTSD, anxiety, depression, and borderline personality disorder that require redirection. Resident does know that [s/he] can call and speak with family when having behaviors."

Surveyor reviewed Resident 8's facility progress notes written by Wellness Director Consultant M: 09/12/2024 "Writer was notified that resident had plan to commit suicide, resident yelled to staff that [s/he] was going to 'break the glass in my room and cut my wrists' [sic] resident was witnessed by writer to be screaming in dining room stating 'I want to get the [profanity] out of this place.' Resident has history of suicidal ideation without a 'plan.' Staff informed writer this is the first time resident has had a plan to hurt [him/herself]. Staff contacted POA [Power of Attorney] who was agreeable to contact 911 due to plan to commit suicide. Resident willingly went with Police and was admitted to St. Elizabeth behavioral health."
09/12/2024 "Writer spoke to Lakeland Case Manager ...about events that lead up to resident being admitted ...resident had a 'change in

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N 326	Continued From page 21 condition' due to having a plan in place for self harm. [sic] [Lakeland Care] in agreement that resident is not safe in community due to mental health needs." 09/16/2024 "Writer and [Interim Director N] spoke to ...Case Manager at St Elizabeth for discharge. Writer and [Interim Director N] informed them that due to resident plan for self harm community [sic] would not be able to readmit due to the change in condition." On 09/25/2024 at approximately 2:00 PM, Surveyor interviewed Wellness Director Consultant M and Interim Director N regarding the discharge. Interim Director N verified the facility did not accept Resident 8 back due to Resident 8's ongoing mental health needs and felt the facility was not a suitable placement for Resident 8. Interim Director N indicated the facility did reach out to the MCO (Managed Care Organization) to obtain funding for 1:1 care that Resident 8 would require if s/he did return. Interim Director N indicated they had not heard anything back from MCO regarding funding for the 1:1 care. Interim Director N and Wellness Director Consultant M indicated they understood they would be receiving a citation due to not accepting Resident 8 back at the facility, however, felt they made the right decision due to Resident 8's ongoing mental health needs.	N 326		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the	{N 352}		

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{N 352}	Continued From page 22 right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents received medications as ordered by a practitioner for Resident 1. This is a repeat deficiency. See SOD (Statement of Deficiency) 0NUA11 dated 11/02/2022 for and SOD 0NUA13 dated 03/06/2024. Findings Include: On 05/07/2024, 07/03/2024 and 08/11/2024, the department received allegations of medications not being administered as ordered. On 08/20/2024, at approximately 8:30AM, Surveyor reviewed Resident 1's medication administration record for June, July, and August 2024. The documentation noted Resident 1 was not administered medications due to being out or waiting on refills. The medications and dates missed were as follows: Senna Lax 8.6mg - Take 2 tabs every other day in the evening. Patient supplies. 06/24/2024: not on cart; waiting on refill Hydrocodone/APAP 5/325mg - Take one tab by mouth twice daily for chronic pain. >AM Dose 07/07/2024: Waiting for delivery 07/08/2024: on order 07/09/2024: Waiting on pharmacy drop off - Pain Level 6 08/09/2024: Waiting on order >PM Dose	{N 352}		

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{N 352}	Continued From page 23 07/06/2024: Out of meds 07/07/2024: Waiting for delivery 07/08/2024: Out On 08/27/2024, at approximately 10:00AM, Surveyor interviewed Director of Nursing E. Director of Nursing E reported s/he double checks medications and re-orders as necessary. Director of Nursing E explained if a caregiver notices a medication is getting low, they should inform him/her so it can be addressed, and there are also times the medication passer will be instructed to follow up.	{N 352}		
{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 individual services plans (ISP) were reviewed and updated annually or upon change for Resident 2.	{N 389}		

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{N 389}	Continued From page 24 This requirement is being cited for a fourth time. See Statements of Deficiency (SOD) DGJM11, dated 02/11/2021, SOD 0NUA12, dated 07/11/2023 and 0NUA13, dated 03/06/2024. Findings Include: On 08/11/2024, the department received an allegation a resident fell due to lack of supervision. On 08/20/2024, at approximately 10:30AM, Surveyor interviewed Resident 2 in his/her room. Resident 2 confirmed s/he fell on 07/04/2024 due to tripping over his/her fan causing facial injuries. Resident 2 wanted to finish the interview outside. Surveyor accompanied Resident 2 to the back patio. Surveyor observed Resident 2 used a 4 wheeled walker. On 08/21/2024, Surveyor reviewed Resident 2's observation for 07/04/2024. The observation note stated the following: 6:00PM: "Staff called triage to report when they went to wake resident for dinner, found [him/her] in bed with a swollen and bruised left eye and a bleeding laceration above her left eyebrow. [Resident 2] states [s/he] tripped over the cord for [his/her] fan and fell within the last hour. Staff report [Resident 2] has been drinking and is intoxicated, slurring [his/her] words .... Instructed staff to call EMS for evaluation ..." Further review of the observation note revealed Resident 2 was transported to the emergency department for evaluation and treatment. On 08/20/2024, at approximately 10:10AM, Surveyor interviewed Caregiver B. Caregiver B reported Resident 2 drinks alcohol regularly and	{N 389}		

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{N 389}	Continued From page 25 his/her preference is beer. On 08/21/2024, at 5:02PM, Surveyor reviewed Resident 2's ISP signed on 06/12/2024. The ISP noted Resident 2 has a diagnosis of alcohol abuse. The ISP further noted Resident 2 ambulates independently and does not mention any assistive devices. The ISP did not document Resident 2's preference to drink beer or how s/he should be supported during that time or that s/he uses a walker. On 08/27/2024, at approximately 10:00AM, Surveyor interviewed Director A and Director of Nursing E. No further comment or information was provided at the survey exit. Cross Reference N0165 DHS 83.12(4)(c) Reporting Incidents with Serious Injury	{N 389}		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision 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 residents were provided	N 426		

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supervision appropriate to the residents' needs. On 08/17/2024, Resident 8 alleged having sexual relations with Resident 7 in return for his/her credit card and cigarettes on 08/14/2024. Resident 7 allegedly reapproached Resident 8 to have relations in return for chicken on 08/17/2024. Outside agencies were not notified of the allegations timely and increased supervision was not implemented to protect Resident 8 and other residents for 2 days following the allegation.

Findings include:

The provider is licensed to serve up to 22 residents who may be physically disabled, of advanced aged, terminally ill and/or have irreversible dementia or Alzheimer's disease.

On 08/20/2024, the department received complaint information alleging sexual abuse between residents.

On 08/20/2024, Surveyors conducted a complaint investigation.

Surveyor reviewed self-report information sent to the department by Director A on 08/22/2024, which stated "[Director of Nursing (DON) E] received call on 08.17.24 stating [Resident 8] was trading sexual favors for cigarettes. [DON E] arrived at the community and interviewed [Resident 8] who stated that on 08.14.24, [s/he] had given [his/her] debit card to [Resident 7] to get [him/her] cigarettes. When [Resident 7] returned with the cigarettes but [sic] would not give them to [Resident 8] until [Resident 7] received sexual favors, and [Resident 8] agreed. [Resident 8] stated [Resident 7] approached [him/her] again on 08.17.24, offered [Resident 8]

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chicken for sexual favors to which [Resident 8] refused. [Resident 8] stated other resident did not cause physical pain or injury at any time and [Resident 7] is not afraid of [Resident 8] ...Police contacted to file complaint. Resident sent to TC-Appleton [hospital] to have rape kit completed and meet with a Special Investigator ...Community Care [Managed Care Organization] contacted Adult Protective Services [APS] who placed [Resident 7] on 1:1. APS will be in contact with [Resident 8] ...[Resident 8] was sent to ER [emergency room] for rape kit to be completed. Resident is being referred to behavioral health. Increase checks on [Resident 8], education completed."

Surveyor reviewed self-report information sent to the department by Director A on 08/22/2024, which stated "[DON E] was contacted 8/17/24 regarding [Resident 7] requesting sexual favors from [Resident 8] in return of getting other resident cigarettes, [sic] other resident gave consent but due to [his/her] POA [Power of Attorney for Healthcare] activation [s/he] is unable to consent. [Resident 7] approached other resident again on 08/17/2024 requesting sexual favors in exchange for chicken but other resident declined ...Police contacted. APS [Adult Protective Services] contacted. Community Care contacted.

RECORD REVIEWS
On 08/22/2024, Surveyor reviewed Resident 7's record and noted s/he was admitted to the facility on 11/01/2022 with diagnoses of alcohol abuse, atherosclerotic heart disease, and respiratory disorder. Resident 7 was his/her own person. Surveyor note: Resident 7's record did not list a MCO, which s/he was enrolled with Community Care, which caused delay in contact with them.

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N 426	Continued From page 28 On 08/22/2024, Surveyor reviewed Resident 8's record and noted s/he was admitted to the facility on 04/10/2024 with diagnoses of bipolar disorder, major depressive disorder, chronic post-traumatic stress disorder, anxiety disorder, and borderline personality disorder. Resident 8 had an activated Power of Attorney for Healthcare. On 08/27/2024, Surveyor reviewed a questionnaire provided to residents on 08/19/2024 and 08/20/2024: "Do you feel safe in this facility?...Has anyone approached you for sexual favors of any kind?...Do you know who to contact if you feel uncomfortable in any situation?" Eight of 16 residents were interviewed. Surveyor noted Resident 8 and Resident 9 were not included in the eight residents that had already been interviewed. INTERVIEWS On 08/20/2024 at approximately 10:28 AM, Surveyor interviewed Caregiver B who stated Resident 7 has had consensual sexual relations with 2 residents and had also had sexual relations with Resident 8 in return for cigarettes and his/her debit card. Caregiver B stated Resident 8 had been observed openly talking about sex which introduced Resident 7 in having interest in Resident 8. Caregiver B said s/he was made aware on 08/17/2024 of Resident 8 giving Resident 7 sexual favors in return for him/her picking up cigarettes for him/her from the store as Resident 7 was able to drive. S/he reported Resident 8 had an activated POAHC and Resident 7 and Resident 8 have had sexual relations at least twice. Caregiver B said s/he contacted DON E as soon as s/he learned of the allegation on 08/17/2024.	N 426		

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N 426	Continued From page 29 At approximately 11:36 AM, Surveyor interviewed DON E who stated s/he was notified on 08/17/2024 of the allegations and provided education to Resident 8 about making safe choices. S/he said s/he spoke to Resident 7 on 08/19/2024 advising him/her of police involvement and recommended staying away from Resident 8. DON E stated a referral was made for behavioral health to support Resident 8 on 08/19/2024. At approximately 2:27 PM, Surveyor interviewed Resident 8 who stated s/he had a history of being sexually assaulted and did not always make the best choices. Resident 8 said "I had sex [with Resident 7] for cigarettes" and now Resident 7 "wants it more." Resident 8 stated Resident 7 keeps "bugging me," as s/he sat next to him/her at activities and Resident 7 continues to ask for sexual favors in return for items. Surveyor inquired whether Resident 8 felt safe at the facility and s/he said s/he did as long as Resident 7 didn't bother him/her. At approximately 2:45 PM, Surveyor interviewed Resident 9 who stated fear for Resident 8 and the "pressure" that Resident 7 was putting on him/her. Resident 9 voiced feelings of anxiety and concern that Resident 7 was still at the facility where residents, especially Resident 8 were exposed to Resident 7 and his/her solicitation. Resident 9 stated s/he did not feel the provider and police were doing enough to keep the residents safe. S/he said s/he had an anxiety attack following the incident as s/he was so worried about Resident 8. Resident 9 described Resident 8 as being his/her best friend and felt a need to protect him/her and babysit him/her. Resident 9 said Resident 8 did not always make good choices and would still talk to Resident 7.	N 426		

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N 426	Continued From page 30 S/he felt Resident 8 was giving Resident 7 the wrong impression because s/he just wanted to be nice. Resident 9 reported Resident 7 still seeks Resident 8 out and will sit next to him/her any chance s/he could. Resident 9 said Resident 8 was told s/he could not go out to have a cigarette if Resident 7 was out there and Resident 9 stated that s/he felt that was not fair to Resident 8. Resident 8 said s/he noticed a staff member sitting outside Resident 8's door starting on the evening of 08/19/2024, but nothing else was done to protect Resident 8 from 08/17/2024 to 08/19/2024. Resident 9 stated s/he did not feel safe at the facility with Resident 7 residing there. On 08/21/2024 at approximately 3:18 PM, Surveyor interviewed APS Worker K who stated s/he had investigated an allegation where Resident 7 took Resident 8's debit card to pick up cigarettes for him/her. When Resident 7 returned to the facility with the cigarettes, s/he would not give Resident 8 the cigarettes or his/her debit card unless s/he had oral sex and intercourse with him/her, in which s/he complied. APS Worker K stated s/he was notified by Lakeland Care Inc on 08/19/2024 at 4:00 PM. APS Worker K stated Resident 8 was very vulnerable as s/he was easily taken advantage and did not have a lot of safety awareness. APS Worker K indicated Resident 7 had a history of being a victim of sexual assault. APS Worker K voiced concern that interventions were not implemented until APS' presence on 08/19/2024 evening which was days after the allegation was reported to Caregiver B and DON E. S/he said when s/he arrived to the facility at lunch time on 08/20/2024, Resident 8 was sitting next to Resident 7. S/he said it did not feel that they were protecting Resident 8 or other residents from Resident 7.	N 426		

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N 426	Continued From page 31 On 08/27/2024 at approximately 10:00 AM, Surveyors interviewed DON E who stated 1:1 supervision of Resident 7 was initiated after APS' visit on 08/19/2024 evening. DON E acknowledged law enforcement and managed care organizations were not contacted until 08/19/2024, and the MCO had contacted APS. In conclusion, Resident 8 alleged having sexual relations with Resident 7 in return for getting his/her debit card and cigarettes from him/her. Caregiver B and DON E were made aware of the allegation on 08/17/2024. Increased supervision, referrals to outside agencies, and other interventions were not implemented to meet the residents' needs until late afternoon 08/19/2024. Cross Reference: N0159 83.12(2)(b) Non-Caregiver: Investigating Abuse & Neglect	N 426		
{N 481}	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the living environment was safe, clean, comfortable, and home like. This is a repeat deficiency. See SOD (Statement of Deficiency) 0NUA13 dated 03/06/2024.	{N 481}		

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{N 481}	Continued From page 32 Findings Include: On 08/11/2024, the department received an allegation of rooms and carpets being dirty and stained. RESIDENT 2'S ROOM: On 08/20/2024, at approximately 10:30AM, Surveyor was in Resident 2's room and observed a reddish-brown stain between the bed and recliner next to the wall. Resident 2 advised this was blood from when s/he fell on 07/04/2024. Resident 2 explained the housekeeper attempted to clean it up but did not get it all. Resident 2 stated s/he does his/her own laundry and the door is always unlocked. Resident 2 also stated one of the dryers is not working. Note: See the section below titled, "LAUNDRY ROOM" regarding unlocked chemicals. RESIDENT 4'S ROOM: On 08/20/2024, at 1:45PM, Surveyor observed the carpet in Resident 4's room. The carpet 6 large reddish-brown stained aeras in the following locations: one next a chair by the window, one next to the foot of the recliner, one near the head of the bed, two at the foot of the bed and one in front of a table. RESIDENT 5'S ROOM: On 08/20/2024, at 2:25PM, Surveyor observed the carpet in Resident 4's room. The carpet had a large reddish pink near the door. RESIDENT 6'S ROOM: On 08/20/2024, at 1:44PM, Surveyor observed the carpet in Resident 6's room. The carpet had 2 large reddish-pink stains and one smaller reddish-pink stain near the door.	{N 481}		

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{N 481}	Continued From page 33 RESIDENT 13'S ROOM: On 09/25/2024 at approximately 1:00PM, Surveyor observed the bathroom in Resident 13s room. Surveyor observed the shower head laying on the shower bench. The shower head was not attached to the hose which was attached to the faucet. Resident 13 stated the shower head broke off about 2 weeks ago when Resident 13 was taking a shower and started to fall and grabbed the hose to stop from falling. Resident 13 stated staff said they will fix it but its still broke. Resident 13 said s/he is still taking showers just using the hose with no shower head on it. Resident 13 said now staff are telling him/her s/he can use the shower in room next door since no resident is in that room. LAUNDRY ROOM: On 08/20/2024, at approximately 11:00AM, Surveyor observed several chemicals were stored in the unlocked laundry room. Chemicals observed were as follows: >Signet Heavy duty Floor Cleaner/Detergent >Lemon Fresh Premium Pot Pan Detergent: Label stated, "CAUTION: Harmful if swallowed. Irritating to eyes. KEEP OUT OF REACH OF CHILDREN." >TMA Quaternary Sanitizer: Label stated, "DANGER: CORROSIVE. Harmful if swallowed. Injurious to eyes and skin. >KEEP OUT OF REACH OF CHILDREN." >Mulit-Clean Pre Treat-Carpet Spray: Warning label stated, "IMPROPER USE POSES RISK OF PHYSICAL INJURY OR PROPERTY." >Zep All-Purpose Carpet Shampoo: Label stated," KEEP OUT OF REACH OF CHILDREN AND PETS." >TMA Bio-Suds: Label stated, "CAUTION: Harmful if swallowed. Irritating to eyes and skin.	{N 481}		

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{N 481}	Continued From page 34	{N 481}		

KEEP OUT OF REACH OF CHILDREN."
>Hot Shot ant, Roach, and Spider Killer (Pesticide): Label stated, "CAUTION: Harmful if swallowed, inhaled or absorbed through skin."
>Terro Carpenter ant and Termite Killer (Pesticide): Label stated, "KEEP OUT OF REACH OF CHILDREN."
>TMA Completely Fresh Disinfectant: Label stated, "CAUTION. Harmful if absorbed through the skin. Avoid contact with skin, eyes or clothing. Wash thoroughly with soap and water after handling. KEEP OUT OF REACH OF CHILDREN."
>Comet Disinfecting-Sanitizing Bathroom Cleaner: Label stated, "KEEP OUT OF REACH OF CHILDREN. May be harmful if swallowed."
>TMA ChemWorx 256Worx Disinfectant: Label stated, "DANGER KEEP OUT OF REACH OF CHILDREN CORROSIVE ..."
>Spray bottle labeled "glass cleaner" - no label
>Spray bottle labeled "pre spot" - no label
>Two bottles of opened laundry detergent
>TMA H-Cling Thickened HCL Toilet Bowl Cleaner: Label stated, "Keep containers tightly closed in a dry and well-ventilated place. Keep out of reach of children."
>TMA Glass & Mulit-Purpose Cleaner: Label stated, "DANGER: CORROSIVE. Harmful if swallowed. Injurious to eyes and skin. KEEP OUT OF REACH OF CHILDREN."

On 08/20/2024, at approximately 11:05AM, Surveyors observed 2 of 2 dryers did not have rigid venting. One dryer had a sign that stated, "Broken Do Not Use." The second dryer had broken door handle and tape securing the handle to the door. The tile flooring was soiled with red and black smudges.
The door handle of the laundry room was not

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{N 481}	Continued From page 35 one-hand, one-motion when attempting to open the door from the inside when the door was locked from the outside. BACK PATIO: On 08/20/2024, at approximately 2:20PM, Surveyor observed the back patio and noted two pots and a plastic cup with cigarette butts floating in water. On 08/20/2024, at approximately 9:51AM, Surveyor observed the following in the kitchen: >Open bottle of Oasis Multi Quart Sanitizer with black specs resembling mold and hair stuck to the bottle. >Open bottle of TMA Mechanical Dish Detergent-CS >Open bottle of TMA Premium Rinse Additive Note: Kitchen does not remain locked. >Sticky, greasy substance around metal shelving where cooking sheets and pans were stored. Debris and crumbs were noted on the shelf and on the cooking sheets pans. >Under the stainless-steel sink: plumbing pipes and wall were covered in a black speckled substance resembling mold. The sink had many areas of a white substance streaking down the front surface. The floor surrounding the sink had food and debris stuck to the floor. There were 2 heavily soiled rags next to on the floor, next to the sink. >Under and next to the dishwasher there were six dishwashing cleaning products with two connected to the dishwasher. The dishwashing products had black splotchy debris resembling mold on them. The surrounding floor was covered with food debris and a greasy black substance. The wall under and behind the cleaning products had dried streaks of black liquid and the plumbing pipes were covered in a splotchy substance	{N 481}		

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{N 481}	Continued From page 36 resembling mold. >The refrigerator and the wall next to it had a dried, liquid substance splatted on them. The floor between the wall and refrigerator was covered in a black greasy substance. >The refrigerator door was covered in a whitish colored dried liquid and the handle was broken and secured with tape. >A large stainless steal cooktop was covered in food debris and had approximately 5 flattened cardboard boxes stored in a cubby underneath the grill. On 08/27/2024, at approximately 10:00AM, Surveyors interviewed Director A and Regional Registered Nurse G regarding the cleanliness of the environment. Regarding the stains on the carpet, Director A advised they typically let the housekeeper know it needs to be cleaned. Director A explained the housekeeper has attempted to get the stains out multiple times. Regional Registered Nurse G reported if the stains cannot be removed, they will contract with a 3rd party professional cleaner. There was no further information provided regarding the unlocked chemicals in the laundry room or the cleanliness of the kitchen. On 09/25/2024, at approximately 2:00PM, Surveyor interviewed Interim Director N. Interim Director N stated s/he is with a new management company that will be taking over on 10/01/2024. Interim Director N stated s/he came on board around 09/10/2024 as a consultant until the new management company takes over. Interim Director N stated s/he along with a maintenance person are putting together a list of environmental concerns to start working on when the new management company takes over on 10/01/2024, the shower head in Room 12 is on the list.	{N 481}		

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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 observation, record review and interview, the provider did not ensure 1 of 1 (Resident 13) residents reviewed received adequate and appropriate care within the capcacity of the facility. Resident 13 developed a wound on left lower extremity on 08/26/2024. Resident 13 was prescribed an ointment for 14 days to be applied to the wound. After 14 days, no additional assessments or communication to the physician was documented. On 09/16/2024, Resident 13 was assessed by Wellness Director Consultant M to have 2 wounds on left lower extremity with redness around them. This is a repeat deficiency. See SOD (Statement of Deficiency) 0NUA12 dated 07/11/2023 for	Y3244		

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Y3244	Continued From page 38 additional details. Findings Include: On 09/17/2024, the Department received a complaint regarding wound care. On 09/25/2024, Surveyor conducted an onsite visit to the facility and a sample of residents was selected, including the resident record of Resident 13. Resident 13 was admitted to the facility on 03/30/2023 with diagnoses to include cerebral vascular accident, anemia, hypertension and aphasia. Surveyor reviewed Resident 13's resident record. The following was noted: 08/26/2024 - An observation note stated, "resident has a skin abrasion on [his/her] left back of leg, above the heel, called and updated PCP [Primary Care Physician], they are sending an ointment to pharmacy." Per MAR (Medication Administration Record)...Mupirocin 2% ointment to apply a pea size amount topically to affected area twice daily as needed for 14 days (08/26/2024-09/08/2024) Apply to back of left calf after cleansing. Resident 13 received this cream twice a day from 08/27/2024 through 09/08/2024. 08/27/2024 - "Area to left calf open with slight serous drainage noted. Periwound warm to touch. Resident afebrile, area tender to touch. Wound cleansed and Muprocin applied per MD orders. RCC working with resident to admit to Bluestone." 08/29/2024 - "Bluestone enrollment form emailed to Bluestone. Resident aware and in agreement." 08/29/2024 - "Emailed received from Bluestone stating Enrollment form received and processing." 09/04/2024 - "Bluestone to admit 09/26/2024."	Y3244		

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Y3244	Continued From page 39 09/16/2024 - "Nurse consultant did skin evaluation and noted 2 wounds on left lower extremity. 1 wound is 3cm[centimeters] in diameter and the second is 2.5cm in diameter. The wounds have redness around them. Resident does not complaint of pain. Nurse consultant reached out to Bluestone to obtain an order for skilled nursing to start wound care. Also requested PT [physical therapy]. Requested these orders be send out to Ascension." 09/17/2024 - "Writer reached out to Bluestone for a second time to request that the order for PT and SN[skilled nursing] be sent out to Ascension today. Writer spoke with [Bluestone employee] at Bluestone who is with the Wisconsin Clinical Team. [Bluestone employee] states that [s/he] can only relay a message to the overseeing MD [Medical Doctor] to request that this is completed..." 09/18/2024 - "Bluestone has never seen resident and will not sign orders for therapy. Resident aware and agreeable to switch providers to obtain home health orders." On 09/24/2024, Resident 13 was seen by home health agency for wound care. The following was noted in home health agency's assessment and notes. Wound #1 unstagable pressure ulcer on left posterior lower leg. Measures 1.5cm x 1.2cm x 0.2cm Wound #2 unstagable pressure ulcer on left posterior lower leg. Measures 1.7cm x 1.4cm x 0.2cm "Skilled reason for homecare: Wound care; Prior level of function: Patient mostly independent but has recently became wheelchair bount [sic]. Current level of function: Patient is wheelchair bound. Patient has reported that [his/her] health has deteriorated since moving from [SNF] to	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 09/30/2024

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Y3244	Continued From page 40	Y3244		

Apple Creek. Patient requires more assistance but does state [s/he] doesn't always get the assistance [s/he] needs. Home health services needed: SN - wound care and chronic disease management. PT - Strength and conditioning...patient reports that [s/he] does not currently have a PCP. Patient reports that [s/he] has not seen a doctor since [s/he] has moved to Apple Creek. Writer spoke with staff and stated they are in the middle of switching companies and patient was assigned a doctor and staff states that patient will "hopefully be seen soon." It appears that patient was seen via tele health with [Nurse Practitioner]. Patient was prescribed an antibiotic for wound and HH[home health] referral for wound care."

On 09/25/2024 at 1:00 PM, Surveyor interviewed Resident 13. Resident 13 was observed with a bandage on his/her left calf. Resident 13 indicated s/he had a wound on his/her lower leg which Resident 13 thought started in the last 2 weeks. Resident 13 said s/he woke up and legs were really swollen and there was this wound. Resident 13 stated initially s/he was putting cream on it. Resident 13 then showed Surveyor a bag which contained Mupirocin cream located on his/her nightstand. Resident 13 stated when s/he used the cream it would burn. Resident 13 then showed Surveyor another bottle which was labeled "skin protectant." Resident 13 stated this cream helped much more. Resident 13 then stated yesterday home health came and they are putting "honey" on it with a bandage over and reevaluate it in a few days/weeks. Resident 13 said the middle of the wound is "black, doesn't look very good." Resident 13 said initially there was one wound, and now there are two wounds, a new one above the older one. Resident 13 stated home health nurse said if the "honey"

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Y3244	Continued From page 41 doesn't work then they will have to go in and clean out the middle of it. On 09/25/2024 at approximately 2:00 PM, Surveyor interviewed Wellness Director Consultant M. Wellness Director Consultant M stated s/he works for the consulting agency that came on board around 09/09/2024. Wellness Director Consultant M indicated that when consulting agency came onboard, s/he attempted to update assessments and conducted a skin assessment on Resident 13 on 09/16/2024. Wellness Director Consultant M stated that is when s/he became aware of the lower left calf wounds. Wellness Director Consultant M stated s/he immediately notified Resident 13's PCP to obtain home health orders for wound care. Wellness Director Consultant M verified Resident 13 originally had orders for a cream to be applied starting 08/26/2024 through 09/08/2024 but no further assessments or communication with PCP was done until Wellness Director Consultant M made his/her observation on 09/16/2024.	Y3244		