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N 000	Initial Comments On 05/11/2026, with additional information gathered through 05/26/2026, Surveyors conducted 6 complaint investigations at Apple Creek Place III in Appleton. Three (3) of 6 complaints were substantiated. Four (4) deficiencies were identified. Census: 19	N 000		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, record review, and interview, the Administrator (Executive Director A) did not supervise the daily operation of the CBRF and ensure 1 of 1 resident reviewed (Resident 1) received proper care and treatment, that his/her health and safety was protected and promoted and that his/her rights were respected. Findings include: The provider is licensed to serve up to 22	N 214		

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

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residents who may be physically disabled, terminally ill, of advanced age, and/or have irreversible dementia/Alzheimer's. At the time of survey, 19 residents resided at the facility.

On 05/05/2026 and 05/06/2026, the department received 3 of 6 complaints alleging resident neglect, wounds, and care needs not being met.

On 05/11/2026 through 05/26/2026, Surveyors conducted 6 complaint investigations.

On 05/11/2026 9:30 AM, Surveyors interviewed Executive Director (ED) A who verified s/he was the Administrator of the facility. ED-A said s/he was a licensed practical nurse (LPN). ED-A said s/he oversaw the daily operations of the facility, but had been "removed" from clinical by the provider's regional team when Wellness Coordinator (WC) B was hired in mid-March. Surveyors inquired whether WC-B was a nurse and ED-A said no, WC-B was a medical assistant (MA).

Surveyor inquired about ED-A's awareness of the care and services for Resident 1 and ED-A said yes, but s/he was not involved in much of it until Resident 1's wounds were identified on 04/29/2026. ED-A said when s/he saw the wounds, s/he then decided s/he "needed to reinsert [him/herself] back into the clinical side of things." Surveyor inquired what re-inserting him/herself back into things meant and s/he said s/he ensured Resident 1 was signed onto hospice. ED-A said on 05/08/2026, a meeting was held with Resident 1's guardian, hospice, managed care team, and nurse practitioner to discuss Resident 1's care.
***Surveyor note: No increased oversight by ED-A was referenced, documented or shared from

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N 214	Continued From page 2 04/29/2026-05/08/2026. ED-A acknowledged there were concerns with Resident 1's care. In summary, on 04/09/2026, Resident 1 had an unwitnessed fall and sustained a a lower leg and foot/ ankle fracture, and received orders to be non-weight bearing. On 04/17/2026, Resident 1's left leg was placed in a walking boot. S/he received orders to ice and elevate, to be non-weight bearing, and to transfer with a 2-person pivot. On 04/19/2026, Resident 1 sustained a fractured humerus as a result of 1 caregiver transferring him/her contrary to his/her care plan. On 04/20/2026, Resident 1 had increased pain and was prescribed a change in PRN medications. On 04/22/2026, Resident 1 had shortness of breath and low oxygen levels. On 04/26/2026, Resident 1 had increased fevers and a change in condition. On 04/27/2026, Resident 1 was sent to the emergency room (ER). Resident 1 was discharged back to the facility with orders for a twice daily antibiotic and cream to be applied to the rash on his/her leg. On 04/29/2026, a caregiver took Resident 1's boot off and observed significant skin breakdown on his/her lower left leg stretching to the top of his/her foot, skin breakdown on the bottom of his/her left foot, and blackened areas on his/her heel and bottom of his/her big toe and pad of foot. On 04/30/2026, Resident 1 was admitted to hospice. Resident 1 was diagnosed with 4 necrotic wounds. On 05/11/2026, Resident 1's condition progressed to 7 necrotic wounds on his/her foot, 1 large necrotic wound stretching from Resident 1's foot to his/her ankle, and 1 necrotic wound up his/her leg. All wounds were black in color. Resident 1 was identified as being near end-of-life by Nurse Practitioner F and Hospice RN- G. On 05/22/2026, additional wounds on Resident 1's	N 214		

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N 214	Continued From page 3 leg have appeared from where the top of the boot was located, as well as skin breakdown on his/her coccyx and both pelvic prominences on his/her buttocks. Resident 1 was removed from the facility and transferred to a sister facility with direct-RN onsite oversight. As of 05/26/2026, Resident 1 is no longer declining and determined as being end-of-life. On 05/18/2026 at 1:00 PM, Surveyors interviewed ED-A, WC-B, Regional Director E, and Regional Director of Wellness X. Surveyors' findings were acknowledged and no additional information was provided. On 01/30/2025, the facility went through a change of ownership (CHOW) and new licensee affiliates and management group started. The provider received their standard license on 02/01/2026. From standard license date through 05/26/2026, 3 of 6 complaints were substantiated. As a result of ED-A and WC-B not ensuring Resident 1 received proper care and treatment, s/he was neglected at the facility. Cross Reference: N0352 83.32(3)(h) Rights of Residents: Right to Receive Medication N0353 83.23(3)(i) Rights of Residents: Adequate Treatment N0388 83.32(3)(c) Implement, Follow The Individual Service Plan	N 214		
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	N 352		

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N 352	Continued From page 4 medications in the dosage and at intervals prescribed by a practitioner. The resident has the 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 Resident 1 received all medications as prescribed. Resident 1 had a fractured ankle, fracture arm, and necrotic wounds. S/he was receiving comfort cares and had orders for Morphine. Resident 1 did not receive his/her Morphine as ordered. Findings include: On 05/05/2026 and 05/07/2026, the department received complaint information alleging residents were not receiving pain medication as ordered. On 05/11/2026, Surveyors conducted complaint investigations. Surveyor reviewed Resident 1's record and noted s/he moved to the facility on 09/27/2023. Resident 1 was of advanced age and had diagnoses of schizoaffective disorder, bipolar disorder, paranoid personality disorder, anxiety disorder, sleep disorder, insomnia, major depressive disorder, Parkinson's disease, dementia, mild protein- calorie malnutrition, low body mass index, and osteoporosis. Resident 1 had a legal guardian. Resident 1 had an order dated 05/07/2026 for Morphine Sulfate Solution (concentrate) 100mg(milligrams)/5mL(milliliters) give 0.25mL by mouth every 6 hours for pain.	N 352		

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N 352	Continued From page 5 Surveyor reviewed Resident 1's May 2026 Medication Administration Record (MAR). The following was noted: -05/10/2026 at 0000 (midnight) Resident 1's Morphine was not marked with staff initials indicating Resident 1 received the medication, the space was blank. Surveyor reviewed a progress note dated 05/10/2026 by Wellness Coordinator (WC) B, "Hospice notified myself and [Executive Director (ED) A] that resident did not get [his/her] scheduled morphine at midnight. Writer checked to see staff schedule and the med tech on the schedule was agency. This staff member will be a DNR [do not return]." On 05/11/2026 at 1:48 PM, Surveyor interviewed Hospice RN-G who said Resident 1 did not receive his/her pain medication or get checked on the overnight of 05/09/2026, so s/he went at least 12 hours without pain medication, changes, and repositioning. On 05/11/2026 at 12:53 PM, Surveyor interviewed WC-B who said an agency staff worked on Saturday night and evidently did not do what s/he was supposed to and Resident 1 did not get his/her medications. On 05/18/2026 at 1:00 PM, Surveyors interviewed ED-A, WC-B, Regional Director E, and Regional Director of Wellness X. Surveyors' findings were acknowledged and no additional information was provided. Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 352		

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N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 1 received prompt and adequate treatment that was appropriate to Resident 1's needs. Resident 1 sustained a left ankle and foot fracture requiring a walking boot be placed, orders to be non-weight bearing and to ice and elevate the extremity. From 04/17/2026 to 04/29/2026, Resident 1's walking boot was not removed by provider staff and Resident 1 developed 9 wounds with necrotic tissue on his/her left foot, ankle, and leg. Resident 1's condition worsened and s/he was admitted to hospice and removed from the facility. Findings include: The facility is licensed to provide services for up to 22 residents who may be physically disabled, of advanced age, terminally ill, and/or have irreversible dementia/Alzheimer's. On 05/05/2026 and 05/07/2026, the department received complaint information alleging prompt and adequate treatment. Surveyor reviewed Resident 1's record and noted	N 353		

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s/he moved into the facility on 09/27/2023. Resident 1 was of advanced age and had diagnoses of Parkinson's disease, dementia, mild protein-calorie malnutrition, low body mass index and osteoporosis. Resident 1 had a legal guardian. S/he was able to use his/her call light and verbalize his/her needs and preferences. Surveyor reviewed Resident 1's ISP dated 09/28/2024. Resident 1's ISP stated Resident 1 "required staff assistance" with mobility in wheelchair, transfers with 1 staff pivot, bathing, dressing and toileting.

Surveyor reviewed self-report information sent to the department by Wellness Coordinator (WC) B on 04/14/2026:
On 04/09/2026 Emergency Room (ER) for fall - Left foot fracture: "At approximately 10:30 AM, while caring for another resident, staff ... heard [Resident 1] yelling from [his/her] bedroom for help ...Upon staff member ...entering the room staff saw resident sitting on the floor in [his/her] bathroom on [his/her] bottom with [his/her] pants partway down. Resident stated that [his/her] knees hurt (pain 10/10) ...Staff ...asked resident what happened and resident stated that [s/he] was getting off of the toilet and [his/her] knees gave in and [s/he] fell, resident also stated that [s/he] kicked the wall when [s/he] fell ...Resident was sent out to the hospital for medical treatment/intervention. Staff to assist resident with toileting when resident calls using call pendant."

Surveyor reviewed ER discharge paperwork and noted Resident 1 was sent to the emergency room on 04/10/2026 for leg pain, and diagnosed with closed nondisplaced fracture of left talus, unspecified portion of talus, initial encounter. "Splint until follow-up with the orthopedic team

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then as per orthopedic team ...Tylenol 650 mg by mouth every 6 hours as needed for the next 5 days."

On 04/10/2026, Resident 1's ISP was updated to state, Resident 1 "requires assistance for all transfers with 1 staff pivot transfers, no weight bearing on left foot due to fracture of left talus [ankle bone]." The ISP was again revised on 04/10/2026 to state Resident 1, "requires assistance for all transfers with 2 staff pivot transfers, no weight bearing on left foot due to fracture of left talus." In addition, staff are now "to assist resident with toileting when resident calls using call pendant. Staff to provide pivot transfer without weight bearing on left foot. Staff to complete peri care after elimination and change briefs as needed. The ISP also reflected a change in dressing for Resident 1, which stated, "Staff to ensure resident has left boot on until resident is seen by doctor." Lastly, the ISP updated on 04/10/2026 indicated a change in bathing for Resident 1. It was noted for staff, "to wrap boot in plastic bag to avoid boot getting wet."

Surveyor reviewed Resident 1's orthopedic physician orders dated 04/17/2026. "[Resident 1] was seen in our office today. Patient was diagnosed with a nondisplaced fracture of medial malleolus of left tibia and nondisplaced avulsion fracture of left talus. These are the current recommendations:
-Wear tall walking boot at all times
-Avoid weightbearing as much as possible
-OTC [over-the-counter] Tylenol arthritis 650 mg x 2 tablets Q8 [every 8 hours] PRN[as needed]
-Avoid NSAIDs given CKD[chronic kidney disease]
-Icing affected area 20 min on/20 min off/ 20 min

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on, and elevation of affected limb when sitting or laying flat
Follow up in 3 weeks for repeat left ankle X-rays. (05/08/2026 at 10:00 AM)."

On 04/19/2026, Resident 1 sustained a shoulder fracture during a transfer. Resident 1's ISP was updated on 04/30/2026 to reflect the following changes. Resident 1 required "assistance for all transfers with 2 staff Hoyer transfer." In addition, the ISP was revised to include: Resident 1 requires assistance for dressing and undressing; is incontinent of bladder; care staff will report any new complaint of pain; resident prefers to use call pendant for help. Aside from that staff to provide 2 hour checks with repositioning; staff to reposition every 2 hours and encourage resident to get out of bed, chart all refusals; care staff will report any changes in ability to bath/shower; resident may choose to have meal trays delivered; reminders for meals; assistance for meals: total feed; resident prefers to eat in [his/her] room by [him/herself], staff to assist [him/her] with meals fully; hospice services initiated - RN daily visits for wound care and CNA twice weekly visits for bathing assistance and emotional wellbeing.

Surveyor reviewed provider progress notes related to changes in Resident 1's condition. The following was noted:
-04/09/2026 Caregiver S wrote "Resident unable to bear weight on left foot or in general. Writer and other staff member did not feel it was safe to put any weight on resident's foot due to resident having a fall earlier today and because of the inability to bear weight at baseline. Writer and other staff member assisted resident back into the bed and suggested [s/he] be sent to the ER for evaluation, resident in agreement, spoke with

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facility on-call and advised, writer also called guardian ...Resident sent to [hospital]."
-04/10/2026 CC-C wrote "called the ER to obtain the status of Resident 1. ER staff stated Resident 1 had fractured his/her ankle and was not able to bear any weight on that ankle. "Writer gave OK for resident to be sent [back to] the facility due to [ER staff] stating resident is able to two-assist transfer pivot to their wheelchair. Writer made [WC-B] aware of this injury, [WC-B] states for writer to email [Regional RN D]."
***Surveyor note - no relevant progress notes or additional documentation noted between 04/10/2026-04/17/2026. No documentation of resident checks, repositioning, if/how pain was being monitored and managed, and any information regarding Resident 1's splint or bearing of weight.
-04/18/2026 9:50 AM CC-C wrote "Resident seems to be very "out of it" today. Resident can barely hold their head up and cannot bear any weight when standing to transfer. Writer had to call for assistance to stand resident up from the toilet. Resident seems to be slurring their words and cannot speak clearly at this time."
-04/20/2026 2:00 PM Care Coordinator (CC) C wrote "Writer faxed primary to possibly get resident stronger pain medication rather than acetaminophen. Per resident's request."
-04/20/2026 1:13 PM WC-B wrote "Writer went and saw resident this afternoon. Resident was laying in [his/her] bed. Discussed yesterday's incident with [him/her] and also was able to complete a skin check. Resident had no visible bruising to [his/her] arms, there was what appeared to be an old bruise (brown and yellow in color) on [his/her] left knee along with a small scrape."
-04/22/2026 1:30 PM DW-D wrote "ISP updated to reflect new orders for transfer and feeding in

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room in bed. Resident needs to be fed."
-04/23/2026 2:12 PM DW-D wrote "LATE ENTRY ...[CC-C] and I met with [Resident 1], [Guardian H], and [Care Manager (CM) R] to review [Resident 1's] needs and communication. We reviewed the information received from the incident last weekend resulting in a humerus fracture ...We acknowledged that our follow up/investigation may not be completed, but we will share what we have and provide additional information as we ...obtain it ...[Resident 1] also requested to be fed in [his/her] bed at this time. [S/he] can transfer with 2 assist and gait belt to [his/her] wheelchair as well."
-04/23/2026 WC-B wrote "Per MD [physician]: Check O2 sats [oxygen saturation] every 4 hours, MAR [medication administration record] updated. PCP [primary care physician] placed STAT order for chest X-ray [for hypoxemia]."
-04/23/2026 4:46 PM WC-B wrote "Staff reports that resident was in a lot of pain today but did want to get out of bed for a little while. Staff also reported some redness to [his/her] bottom and also a change in [his/her] skin color as [s/he] appears to look a bit more pale/grey. Resident eat all of [his/her] breakfast but only a little bit of [his/her] lunch as [s/he] stated that [s/he] was full. Staff have been pushing fluids with success. Vitals were taken 143/59, 80% (staff had [him/her] take a few breaths and it went up to 88%) P 93, R 16 T 97.8 ...Writer updated [NP-F] and requested orders for barrier cream and the hospice eval."
04/24/2026 5:14 PM Caregiver S wrote "Check oxygen every 4 hours per MD every 4 hours for low O2 [oxygen] Resident sleeping - requested earlier not to be woke if [s/he] is sleeping d.t [due to] difficulty falling back asleep - writer accepted resident's request and did not complete task."
-04/26/2026 12:54 PM DW-D wrote "Notified that

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resident was c/o SOB [shortness of breath] O2 stats are 89-92% Temp is 99.2. Message left for [Guardian H] about symptoms and what [s/he] would like for next steps."
-04/26/2026 6:00 AM Caregiver T wrote "During Cares [sic] staff noticed resident wincing in pain to movement."
-04/26/2026 1:41 PM Caregiver K "pain all over body."
-04/27/2026 9:04 AM WC-D wrote "Resident returned from the hospital. UA came back with possible infection. Labs within normal limits. EKG within normal limits. Right foot xray within normal limits. Chest xray completed. New Orders: Cipro 250 mg: take 1 tab po [by mouth] BID [twice daily] x3 days 2. Metronidazole 1% cream; apply topically twice daily as needed for rash ...Task placed in resident's chart to remove boot and clean left leg twice daily. STAFF PLEASE MAKE SURE YOU ARE DOING THIS!"
-04/27/2026 12:14 pm Director of Wellness (DW) D wrote "assisted aide with changing [Resident 1]- noted quarter size skin shear on upper L [left] buttocks, almost at [his/her] hip. Area cleaned and salve applied to site. Notified [NP-F] and requested an order for Hospice."
-04/27/2026 5:47 PM DW-D wrote "Spoke with guardian ...discussed the open area on [his/her] bottom and the difficulty of trying to keep [him/her] on [his/her] side and off that hip."
-04/29/2026 10:41 AM WC-B wrote "LATE ENTRY ...Staff reported that when they removed resident's boot they noticed an open area on resident's top left foot along with an open area on that heel. Writer and [ED-A] checked on resident and noted that there is what appears to be an open (broken) blister on the top of foot. The area extends over the majority of the bridge of [his/her] left foot. Resident also has redness on the bottom of [his/her] foot. There are two areas that

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are open on the bottom as well. Resident's PCP [primary care nurse practitioner] aware and hospice to evaluate in the morning."
-04/29/2026 1:51 PM Caregiver K wrote "Was doing full care[s] on [him/her] and took [his/her] [boot] off [his/her] fractured foot and noticed a big blood blister and a couple of black spots."
-04/29/2026 9:41 PM Caregiver J wrote "Writer heard yelling from residents room. Writer was doing checks. Writer asked resident what can I assist with. Resident stated [his/her] button is broke. Writer push resident button to check. The button worked. Writer had showed resident it worked. Writer asked resident to try it. Writer observed that resident has gotten weaken to press button. Writer had told other lead and we agreed to do frequent checks on resident due to [him/her] not able to press button us lead's also agreed to pass onto next shift. Writer is going to notify nursing management. [sic all]"
-04/30/2026 10:57 AM WC-B wrote "Resident was admitted to St. Croix Hospice this morning with the diagnoses of Cerebral Atherosclerosis and Vascular Dementia."
-04/30/2026 2:32 PM Caregiver O wrote "Resident stated [s/he] is in level 10 pain to another caregiver and requested something for pain."
-04/30/2026 8:06 PM WC-B wrote "Change of Condition completed ...Resident is now to be transferred by 2 staff with a Hoyer lift. Repositioning every 2 hours. Floating the left heel. Staff to report any changes to management and hospice.
-05/01/2026 10:56 AM WC-B wrote New Orders: 1. Wound care daily (to be done by hospice) 2. Morphine 0.25 mL every 4 hours 3. Lorazepam 0.5 mg 1 tab by mouth every 4 hours PRN 4. Hyoscamine 1 tab every 6 hours PRN"
-05/02/2026 2:00 PM Caregiver N wrote PRN

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Administration was: Ineffective (tramadol "
resident stated [s/he] is in pain, asked for prn
Follow-up pain scale was: 7"
-05/03/2026 7:45 PM Caregiver M wrote "requested for pain described at 9/10"
-05/02/2026 Caregiver L wrote PRN Administration was: "Unknown"
-05/03/2026 10:00 AM Caregiver L wrote "requested for buttock pain. Pain level 10"
-05/04/2026 WC-B wrote "New Order from hospice to increase morphine PRN every hour"
-05/04/2026 12:47 PM Caregiver K wrote "morphine PRN Administration was: Ineffective"
-05/04/2026 10:45 AM Caregiver K wrote "a lot of pain in back and legs"
-05/05/2026 3:27 PM Caregiver J wrote "Residents hospice nurse had came to staff about residents morphine and writer answered call light. Hospice showed writer about bed inflator was off it wasn't on. Writer notified nursing staff."
-05/05/2026 9:59 PM Caregiver J wrote "Resident call light went for little over 30 mins cause staff were with another resident. [sic all]"
-05/06/2026 1:55 PM PRN lorazepam administered "climbing out of bed"
-05/08/2026 2:16 PM CC-C wrote "Writer added 2-hour documentation in a binder put at residents' bedside table. Staff have been made aware of this documentation being so important."
-05/09/2026 9:20 AM "betadine to all wound areas on left leg and foot once daily through the weekend one time a day for wounds Hospice RN to complete wound care once daily, staff to contact hospice if soiled or with any changes and document."
-05/09/2026 at 9:21 AM, Caregiver I wrote "Sign Detailed Log Every 2 Hours and PRN [as needed] (Located in resident's room) 1. Repositioning, 2. Feeding, 3. Getting resident up, 4. Cares (Bed bath) 5. BM [bowel movement] and ALL refusals

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with # of attempts & approach noted every 2 hours for Resident Care Monitoring/ Skin Checks".

Resident 1's ISP was updated on 05/08/2026 to reflect the following changes: turning and reposition q [every] 2 hr[hour] checks; broken areas on bilateral ankles and buttock from limited mobility will be evaluated frequently; staff to check bilateral legs daily and will report any change to MD[physician]; 5/1/2026 hospice to complete wound care daily to left leg, staff to call hospice if bandage is soiled; requires assistance for transferring in and out, washing body, washing hair, drying, 5/1/26 if resident is in too much pain staff to assist with bed bath; diet-pureed diet and necthar[sic] thick liquids.
***Surveyor note: repositioning, feeding, transfers, care, and pain management was not documented, monitored, or tracked prior to implementation of paper document added to Resident 1's bedside table on 05/08/2026.

On 05/11/2026 at approximately 9:15 AM, Surveyor visited Resident 1 in his/her room. Resident 1 presented fatigued, eyes open, and his/her mouth was open. Resident 1's mouth and lips were visibly free from moisture. Surveyor interviewed Resident 1 and observed Resident 1 to attempt to pull his/her blankets off. S/he said "hot." Resident 1's right arm was visibly bruised and swollen and his/her left foot and leg was bandaged from his/her toes to his/her knee. Resident 1's right foot was bare and resting on the uncovered part of the vinyl mattress. Surveyor observed Resident 1 open and close his/her mouth slowly and say in a raspy voice, "water." Surveyor went to the hall and asked ED-A if s/he knew where Surveyor could find a staff and that Resident 1 wanted water. ED-A said s/he would

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look for staff. Surveyor located staff coming out of another resident's room and notified them Resident 1 was asking for water. Caregiver V told Surveyor s/he was "just in there." Surveyor said s/he was just sitting with Resident 1 and s/he had requested it. Surveyor asked if s/he had a straw and Caregiver V grabbed a straw from the dining room and said, "Maybe [s/he] will drink better with this." Surveyor observed Caregiver V give Resident 1 water from a cup on his/her bedside table using the straw. Resident 1 requested more and more water. Caregiver V left the room 3 times as Resident 1 drank four 16 ounce glasses of water. Caregiver V said, "You were thirsty." Surveyor asked Caregiver V how often staff were to check on Resident 1 and s/he said they tried to often. Surveyor inquired whether Resident 1 was to be repositioned or if s/he had any special orders and Caregiver V said not that s/he was aware of. Surveyor inquired whether Resident 1 had any wounds and s/he said s/he didn't know. Surveyor inquired whether there were any updates shared between night shift staff and AM shift staff that day regarding Resident 1's cares and repositioning and s/he said no. Surveyor observed a handwritten, ripped notepad paper with "Reposition & Check Brief every 2 hours!!" on the bedside table next to Resident 1. Also, on the bedside table was a binder with papers for staff to fill out every 2 hours "Two-Hour Documentation of Resident Checks" for 05/08/2026-current. Surveyor reviewed the binder and noted staff were to document time of check, their initials, and comments. Surveyor noted no documentation of checks, repositioning, etc. from 05/09/2026 after 6:45 PM through 05/10/2026 6:00 AM.

On 05/11/2026 at 12:14 PM, Surveyor interviewed Caregiver Q who said Resident 1 had

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almost-open areas near each hip and also observed a bandage on his/her coccyx.

On 05/11/2026 at 1:45 PM, Surveyor interviewed Caregiver U who said s/he was one of the staff who observed Resident 1's leg and foot for the first time on 04/29/2026. S/he said his/her foot was turning black under his/her heel and on top of his/her foot. S/he said both areas looked like "big blood blisters had burst." Caregiver U indicated s/he had never seen wounds like it before.

On 05/11/2026 at 9:30 AM, Surveyors interviewed ED-A who said Resident 1 had significant changes in condition over the past few months. S/he said on 04/29/2026, s/he visibly observed and was made aware of Resident 1's left foot and leg. S/he said that s/he had an open blister on the top of his/her ankle and foot and discoloration on the bottom of his/her foot. ED-A said when talking with Hospice RN-G, s/he had indicated the necrotic skin was related to circulation issue in Resident 1's foot. ED-A said s/he was aware of Resident 1 having a fall and sustaining a foot fracture and sustaining a humerus fracture during a transfer. ED-A said his/her regional team "took [him/her] out of clinical" and so s/he had not been involved in Resident 1's orders and care directives until the 29th. ED-A said when s/he observed the wounds, s/he decided at that time it was time for him/her to interject into clinical. Surveyor inquired whether staff removed Resident 1's walking boot and ED-A said it was his/her understanding they had not. Surveyor inquired what the orders were following the wounds being found and s/he said Resident 1 was then admitted to hospice and have since taken over wound care and resident care. ED-A said s/he had met with hospice, Resident 1's

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guardian, managed care organization (MCO) staff, and Nurse Practitioner (NP) F on 05/08/2026 and it was determined to have a physical sheet be added to Resident 1's room to ensure staff are signing off on continuous checks every 2 hours, changing him/her, feeding him/her, and bowel movements.

On 05/11/2026 at 12:12 PM, Surveyor interviewed CC-C who said it was an expectation between shifts to talk about updates and resident care. Surveyor inquired whether it was passed along to staff to reposition, feed, check-on, change, provide water, and cares for Resident 1 and s/he said yes, it was an expectation. Surveyor inquired whether staff documented any of that anywhere and s/he said not until 05/08/2026. CC-C said 2-hour checks had always been an expectation, for Resident 1, the documentation binder in his/her room to document repositioning, checks, and feeding was implemented this past Friday. Surveyor inquired whether this was messaged to staff to follow through the weekend and to present and s/he said yes. CC-C indicated there had been some recent confusion from staff about who to report to and where information was coming from since WC-B started in his/her new role in March. Surveyor inquired whether there was any meal tracking for Resident 1 and CC-C said there was not prior to Friday. Surveyor inquired whether Resident 1 was able to press his/her call light to call for assistance and CC-C said s/he did not believe so. CC-C who stated "[Resident 1's] wounds are bad. That doesn't just happen. It is heartbreaking."

On 05/11/2026 at 12:53 PM, Surveyor interviewed WC-B and CC-C who confirmed Resident 1 had an unwitnessed fall on 04/09/2026 and sustained left ankle and foot fractures. Surveyor inquired

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what the orders were for Resident 1 post-fracture. WC-B indicated Resident 1 was put in a boot after his/her orthopedic appointment and was non-weightbearing. Surveyor requested to review Resident 1's physician orders for his/her fractures. WC-B, CC-C, and Surveyor reviewed Resident 1's orthopedic physician orders dated 04/17/2026. WC-B said s/he needed to clarify Resident 1 having to wear the boot indefinitely or just with ambulation. Surveyor requested documentation of correspondence requesting clarification on the orders. Surveyor inquired whether staff iced Resident 1's ankle as ordered and WC-B and CC-C said they did not know. Surveyor inquired what Resident 1's change in care needs were and WC-B said s/he did not know as s/he was off on the days surrounding the incident. WC-B said s/he was on PTO (paid time off) over the time Resident 1 fell, went to the hospital and returned to the facility.
***Surveyor note: As of 05/18/2026, no evidence of correspondence requesting clarification on physician orders was received.

On 05/11/2026 at 1:48 PM, Surveyor interviewed Hospice RN-G who said Resident 1 required full assistance with transfers, incontinence care, dressing, bathing, eating, and repositioning. Hospice RN-G said Resident 1's arm was his/her dominant arm and due to weakness, s/he could not sit up on his/her own, requiring staff to feed him/her. Hospice RN-G said there was no evidence that staff were feeding Resident 1 from their observation. RN-G stated after Resident 1's ankle fracture, s/he could be getting up and instead staff kept him/her in bed and aren't repositioning as often as they should, and s/he has developed skin breakdown on the top of his/her pelvis on both sides as well as a coccyx wound. Hospice RN-G continued to state, s/he

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observed Resident 1's left foot and leg on 04/29/2026 and observed a very large popped blister on the top of Resident 1's ankle indicating visible necrotic tissue, the top of 2 toes, his/her heel was black, 2 wounds on the bottom of his/her foot were black, and a wound on his/her lower calf totaling 9 spots. Surveyor inquired whether all the areas had necrotic skin and s/he said yes. Hospice RN-G stated "this was absolutely neglect."

Surveyor reviewed hospice notes. The following was noted:
-04/30/2026 admission note: patient currently presents with bruising to the left dorsal ankle that is 13 x 6 cm[centimeters], left dorsal foot that is 2 x 3cm. Bruising to right plantar food that is 6 x 5 cm and right dorsal foot that is 9 x 6 cm. Patient has what appears to be a healing blister on [his/her] left dorsal foot. 1 area is 4 x 3 cm and 1 areas 1 x 3 cm. Writer has phone call out to PCP[primary care provider] regarding wound care orders. PCP will be on site on 5/1 for assessment.

On 05/26/2026 at 10:27 AM, Surveyor interviewed Nurse Practitioner (NP) F who said s/he visited the facility at least every other week and had witnessed on multiple occasions where Resident 1 was not checked on, remained in the same position during his/her visit, and not fed. NP-F said s/he fed Resident 1 on the evening of 05/15/2026 as staff dropped his/her food off in his/her room and did not feed him/her. NP-F said Resident 1 had declined pretty rapidly since his/her leg fracture on 04/09/2026, humerus fracture on 04/19/2026, and since the wounds on his/her foot and leg developed. NP-F said s/he had signs of nearing end of life, such as the Kennedy ulcer that had developed on Resident

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N 353	Continued From page 21 1's coccyx. NP-F said now that Resident 1 was relocated on 05/22/2026, s/he had been making a physical turn around. On 05/14/2026 at 11:00 AM, Surveyor interviewed APS Supervisor W who said they were in the midst of their investigation, but neglect and harm was evident. APS Supervisor W discussed making a referral to law enforcement for the case. On 05/18/2026 at 1:00 PM, Surveyors interviewed Executive Director (ED) A, WC-B, Regional Director E, and Regional Director of Wellness X. Surveyor inquired whether any of them knew what splint Resident 1 had prior to wearing the walking boot and what care needs s/he had related to it and no answer was provided. Surveyors' findings were acknowledged and no additional information was provided. Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation N0388 83.35(3)(c) Implement, Follow The Individual Service Plan	N 353		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) was implemented to meet his/her needs.	N 388		

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N 388	Continued From page 22 After Resident 1 sustained a fractured ankle, Resident 1 required assistance from 2-staff for transferring and ambulation. Resident 1 was transferred contrary to his/her ISP, resulting in Resident 1 sustaining a shoulder fracture. Findings include: On 05/05/2026 and 05/07/2026, the department received complaint information alleging resident care needs were not met. On 05/11/2026, Surveyors conducted complaint investigations. Surveyor reviewed Resident 1's record and noted s/he moved to the facility on 09/27/2023. Resident 1 had a legal guardian. S/he was able to use his/her call light and verbalize his/her needs. Resident 1 was of advanced age and had diagnoses of Parkinson's disease, dementia, mild protein- calorie malnutrition, low body mass index, osteoporosis, urge incontinence, chronic kidney disease (CKD), and hypertension. Surveyor reviewed self-report information sent to the department by Wellness Coordinator (WC) B on 04/14/2026. The self report indicated on 04/09/2026 Resident 1 sustained a left foot fracture after a fall in Resident 1's room. On 04/10/2026, Resident 1's ISP was updated to state, Resident 1 "requires assistance for all transfers with 1 staff pivot transfers, no weight bearing on left foot due to fracture of left talus [ankle bone]." The ISP was again revised on 04/10/2026 to state Resident 1, "requires assistance for all transfers with 2 staff pivot transfers, no weight bearing on left foot due to fracture of left talus." In addition, staff are now "to	N 388		

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assist resident with toileting when resident calls using call pendant. Staff to provide pivot transfer without weight bearing on left foot. Staff to complete peri care after elimination and change briefs as needed.

Surveyor reviewed Resident 1's progress notes:
-04/19/2026 3:50 PM Caregiver Q wrote "Writer went into [Resident 1's] room at 13:19 [1:19 PM] to administer medication. When writer was in there [Resident 1] informed writer that when another staff member was transferring [him/her] to the toilet [s/he] had slipped a little but did not fall and now [his/her] arm was hurting. Writer attempted ROM [range of motion] on [Resident 1] and was unable to complete with [Resident 1] showing signs of discomfort and vocalization that there is pain. The writer propped [Resident 1's] arm up with a pillow and gave [him/her] an ice pack. PRN was not given at this time as it was already administered before when [Resident 1] previously requested for pain in [his/her] ankle. Per [Guardian H] [Resident 1] is being sent out to have [his/her] right shoulder assessed."
-04/19/2026 10:14 PM WC-B wrote "Staff contacted writer this afternoon with concerns regarding the resident complaining of right shoulder pain. Writer advised staff to contact [Guardian H] to arrange transfer to the hospital for evaluation ...The resident returned from the hospital with a diagnosis of a closed right humerus fracture. [S/he] was instructed to wear a sling and continue Tylenol for pain management. Upon return, the resident reported that during a prior transfer, a staff member tripped and fell while assisting [him/her] and was still holding on to the resident's arm at this time. Writer notified [ED-A] and regional personnel. Writer and [ED-A] will follow up and investigate further on Monday morning."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019689	A. BUILDING: _____ B. WING _____	C 05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE III	5117 N CHERRYVALE AVE 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 388	Continued From page 24 Surveyor reviewed Resident 1's ER discharge paperwork from 04/19/2026 "Reason for visit : Shoulder pain ...Diagnosis: Closed nondisplaced fracture of surgical neck of right humerus, unspecified fracture morphology, initial encounter ...Instructions ... Keep arm in sling. Apply ice as often as needed but no more than 10-15 minutes each time. Continue taking your Tylenol as previously prescribed for pain control." Surveyor reviewed ED-A and WC-B's internal investigation: -WC-B wrote on 04/20/2026 RESIDENT INTERVIEW: "Mid-day [staff] transferred [him/her] ...from edge of bed. Staff stood in front of [him/her] to help [him/her] up, not sure if [s/he] use both or one hand just that [s/he] was in front of [him/her] when they stood up [s/he] felt a sharp pain and [s/he] said 'ow.' Staff put [him/her] back down and [laid] [him/her] back in bed. Resident then said when [s/he] fell [s/he] noticed the pain got worse. Writer asked at what point did you fall and [s/he] was unable to answer. Resident reports that [s/he] remembers being on the floor when asking [him/her] to explain [s/he] was unable. (bruising to knee and scratch) ...SPECIFY RECOMMENDATIONS / INTERVENTIONS ...Gait belt, staff alerts/education." Surveyor reviewed a "Team Member Counseling Record" written by ED-A on 04/28/2026, "On 04/19/26, staff transferred the resident as a one-person assist despite the resident's request for a second staff member. A gait belt was not utilized, and the resident was assisted by pulling on [his/her] right arm. During the transfer, staff lost balance and fell backward, causing both the staff member and resident to fall. The resident was sent to the ER and sustained a closed right	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 388	Continued From page 25 humerus fracture. This incident represents a significant deviation from the organization's core values. It reflects a lack of integrity, as the staff did not adhere to established care plans and safe transfer protocols, nor did they honor the resident's express need for additional assistance ...Expectations for staff are to consistently follow the resident's care plan, adhere to safe transfer protocols, and utilize appropriate equipment and assistance at all times." On 05/18/2026 at 1:00 PM, Surveyors interviewed ED-A, WC-B, Regional Director E, and Regional Director of Wellness X. Surveyors' findings were acknowledged and no additional information was provided. Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation N0353 83.23(3)(i) Rights of Residents: Adequate Treatment	N 388		