STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017918	A. BUILDING: _____ B. WING _____	R-C 09/26/2023

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APPLE CREEK PLACE III	5117 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 06/27/2023, Surveyors conducted an onsite visit at Apple Creek Place III for 8 complaints, 2 self-report reviews, and a verification visit. The department received 1 additional complaint on 08/04/2023 that was also investigated. Additional information was gathered through 09/26/2023. Eight of 9 complaints were substantiated. One complaint was unsubstantiated. Three of 6 previous deficiencies were corrected. Fourteen deficiencies were identified. Three of 14 deficiencies were repeat violations, see Statements of Deficiency (SOD) P4Z911 (dated 01/17/2022) and SOD F8JP11 (dated 01/21/2021). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 15	{N 000}		
N 185	83.13(2)(b) Resident records retained for 7 years. Resident records shall be retained for 7 years following the date of a resident ' s final discharge. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure resident records were maintained at the facility. The provider did not maintain various documents of Resident 2, Resident 4, Resident 5, Resident 6, Resident 8, and Resident 9's records, and did not maintain any of Resident 7's record. Findings include: On 02/21/2022, 05/04/2022, 05/31/2022, 06/21/2022, 11/09/2022, 11/16/2022, 08/04/2023 the department received complaint information	N 185		

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

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that alleged resident files were not up to date and resident needs were not being met.

On 08/18/2023, the department received self-report information from provider that reported Resident 9 had 10 missing Lorazepam.

On 06/27/2023 at approximately 3:00 PM, Surveyors interviewed Director A and Corporate Administrator C who stated they were in between electronic member record systems and documents from Point Click Care (PCC) were not saved. Director A stated s/he did not have access to past resident documents. Corporate Administrator C indicated there was no plan in place to maintain and retain documentation in PCC by provider when termination of the record system contract was made.

On 06/27/2023, 07/07/2023, and 07/11/2023, Surveyors requested Resident 2, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9's records. Additional requests were made on 08/08/2023 for additional documentation from Resident 2's record. The following records were not available to provider and/or could not be found and provided to Surveyors:
Resident 2 - incident reports, progress notes, provider assessments
Resident 4 - progress notes and incident notes related to incident on 11/07/2023, previous individual service plan (ISP)
Resident 5 - provider assessments, previous ISP, progress notes, medication administration records (MARs)
Resident 6 - face sheet, previous ISP, progress notes, ER visit documentation, provider assessments, MARs
Resident 7 - face sheet, current ISP, previous

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N 185	Continued From page 2 ISP, progress notes, incident reports, MARs Resident 8 - face sheet, fall reports, incident reports, MARs Resident 9 - face sheet, MAR, incident report/investigation, progress notes Director A and Corporate Administrator A stated they had no awareness or indication Resident 7 had ever resided at the facility. Director A indicated s/he had never heard the name and had not come across any documentation referencing Resident 7. On 07/10/2023 at approximately 10:54 AM, Surveyor contacted Family Member Q who verified Resident 7 had resided at the facility for approximately 2 weeks from 9/17/2022-9/27/2022 before discharging. On 07/11/2023 at approximately 2:00 PM, Surveyor interviewed Director A who verified s/he did not have access to many past resident documentation and current residents' past documentation, but they were now working on getting access back from PCC. Corporate Administrator B verified the provider did not have access to PCC since prior to March 2023.	N 185		
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	N 196		

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the CBRF.

Eight of 9 complaints investigated from 06/27/2023 through 09/26/2023 were substantiated and 14 deficiencies were identified, including 3 repeat violations. See Statements of Deficiency (SOD) P4Z911, dated 01/17/2022 and SOD F8JP11, dated 01/21/2021.

Findings Include:

The provider is licensed to provide services for up to 22 residents who may be physically disabled, of advanced age, terminally ill, and/or have Alzheimer's/dementia.

On 08/22/2023 at approximately 11:00 AM, Surveyor interviewed Regional Director of Operations J who acknowledged licensee responsibilities were not being upheld.

As a result of Licensee R not upholding his/her responsibilities as the licensee, 8 of 9 complaints investigated from 06/27/2023 through 09/26/2023 were substantiated and the following 14 deficiencies were identified (3 of 14 deficiencies were repeat violations):

N0185 DHS 83.13(2)(b) Resident Records Retained for 7 Years
Based on observation, record review, and interview, the provider did not ensure resident records were maintained at the facility. The provider did not maintain various documents of Resident 2, Resident 4, Resident 5, Resident 6, Resident 8, and Resident 9's record, and did not maintain any of Resident 7's record.

N0200 DHS 83.14(2)(e) Notify Within 7 Days Of Administrator Change

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N 196	Continued From page 4 Based on record review and interview, the licensee did not notify the Department within 7 days after there was a change in administrator. N0346 DHS 83.32(3)(b) Rights of Residents: Confidentiality Based on observation and interview the provider did not ensure resident information was kept secured and confidential. Surveyor observed multiple sources of resident private health information left open, unattended, and unsecured from unauthorized access in the common area of the facility. This is a repeat deficiency, see Statement of Deficiency P4Z911, dated 01/17/2022. N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment Based on record review and interview, the provider did not ensure Resident 2 received prompt and adequate treatment that was appropriate to meet his/her needs. N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule Based on record review and interview, the provider did not maintain a current written schedule for staffing the CBRF. The schedules did not include each employee's full name, job assignment, and time worked. The schedules included staff assigned to different CBRFs, but didn't identify which CBRF the staff were assigned to on a given day. N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet Based on observation and interview, the provider did not ensure medications were securely stored. The medication cart (which contained Schedule II medications) was not secured to the wall or within	N 196		

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N 196	Continued From page 5 a locked area when not in use, was left in the common spaces of the facility unsecured, and not within caregivers' visual control. This practice was not changed or corrected since previous visit. This is a repeat deficiency, see Statement of Deficiency P4Z911, dated 01/17/2022. N0426 DHS 83.38(1)(b) Supervision Based on record review and interview, the provider did not ensure Resident 4 received supervision to meet his/her needs. This requirement is being cited for a third time, see Statements of Deficiency (SOD) P4Z911 (dated 01/17/2022) and SOD F8JP11 (dated 01/21/2021). N0427 DHS 83.38(1)(c) Leisure Time Activities Based on observation, record review, and interview, the provider did not provide a daily activity program to meet the interests and capabilities of the residents. The provider did not ensure the activity schedule was posted in an area available to residents. While present at the facility from approximately 9:30 AM to 12:00 PM and 2:30 PM to 4:30 PM, Surveyors did not observe residents engaged in activities and staff providing activities. N0431 DHS 83.38(1)(g) Health Monitoring Based on record review and interview, the provider did not ensure Resident 5 was receiving proper health monitoring related to his/her wound care. N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable Based on observation and interview, the provider did not ensure the CBRF provided a living environment that was safe, clean, comfortable and homelike.	N 196		

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N 196	Continued From page 6 N0499 DHS 83.45(3) Toxic Substances Based on observation and interview, the provider did not ensure cleaning compounds, polishes, and toxic substances were labeled and stored in a secure area. N0525 DHS 83.47(2)(d) Fire Drills Based on record review and interview, the provider did not ensure fire evacuation drills were conducted for 3 of 4 quarters in 2022, and 1 of 2 quarters thus far in 2023. N0526 DHS 83.47(2)(e) Other Evacuation Drills Based on record review, the provider did not ensure tornado, flooding, or other emergency or disaster evacuation drills were conducted at least semi-annually in 2022.	N 196		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not notify the department within 7 days after there was a change in administrator. Findings include: On 06/27/2023 at approximately 9:30 AM, Surveyors interviewed Community Director A and Corporate Administrator B. Surveyors asked when Community Director A took over and noted Community Director A was not listed on the facility facesheet and the department did not have any records of a change. Community Director A	N 200		

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N 200	Continued From page 7 stated s/he had taken over sometime in March of 2023 and wasn't sure if the previous director had sent in the information. Corporate Administrator B stated s/he was unsure if there was notification either and that s/he would check with the corporate office. On 06/27/2023 at approximately 2:30 PM, Surveyors requested to have information sent via email. Surveyors never received documentation of an administrator change as of 07/10/2023.	N 200		
{N 346}	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure resident information was kept secured and confidential. Surveyor observed multiple sources of resident private health information left open, unattended, and unsecured	{N 346}		

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from unauthorized access in the common area of the facility.

This is a repeat deficiency, see Statement of Deficiency P4Z911, dated 01/17/2022.

Findings Include:

On 06/27/2023, Surveyors conducted a verification visit.

On 06/27/2023, at approximately 10:35 AM, Surveyors toured the facility with Director A. Surveyors and Director A observed 8-10 boxes of documents and multiple stacks of papers on the floor of the activity room. Resident names and resident personal and health information was clearly vislble on the documents in piles and when the unsecured boxes. Surveyor noted the activity room was located directly off the main dining room and the doors were open and unlocked between the two spaces. Surveyor noted at least 3 residents to be in the vicinity of the activity room while Surveyors observed the documents.

On 06/27/2023 at approximately 11:00 AM, Surveyor noted a binder on the medication cart located in the common space of the facility. The binder was left unattended and Surveyor noted the binder included Resident 1's fall charting, a note regarding a new identified wound, supervision checks, and a list of his/her medications. Surveyor noted the binder remained on the top of the medication cart for the entirety of Surveyors' visit from approximately 9:30 AM to 12:00 PM and 2:30 PM to 4:30 PM.

At approximately 11:12 AM, Surveyor observed a 4-slot filing system attached to the medication

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{N 346}	Continued From page 9 room door, located in the common space of the facility. Surveyor noted multiple documents with resident name, date of birth, medications, and other identifying information on them. Surveyor noted one of the documents was dated 06/23/2023, 3 days prior to Surveyors' visit. Documents remained in the file folders for the entirety of Surveyors' visit. On 07/10/2023 at approximately 2:00 PM, Director A acknowledged resident information was not stored securely or confidentially.	{N 346}		
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 record review and interview, the provider did not ensure Resident 2 received prompt and adequate treatment that was appropriate to meet his/her needs. Resident 2 required assistance for all activities of daily living (ADLs), was wheelchair dependent, incontinent, and had a history of poor skin integrity. S/he was identified to have skin breakdown on his/her left buttocks to family in early May 2023. On 07/03/2023, the new hospice team observed a pressure ulcer on Resident 2's left buttocks and a decline in Resident 2's condition. On 07/22/2023, Resident 2 was admitted to the hospital following new management's awareness and observation of the	N 353		

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pressure ulcer on his/her buttocks. Resident 2 presented to the emergency room ill-appearing, soaked in urine, curled in the fetal position, and moaning in pain. Resident 2 was diagnosed with delirium, urinary tract infection, sepsis, and having a stage 4 pressure ulcer on his/her left buttocks measuring 8-10 centimeters with a significant amount of exposed bone, odor, and large black eschar (dead skin). Resident 2 was placed on comfort measures and passed away in the hospital on 07/27/2023 with cause of death listed as Stage 4 pressure ulcer. The measure of time between the onset of the injury and the time of death was stated to be months.

According to Johns Hopkins Medicine, "Bedsores can happen when a person is bedridden or otherwise immobile, unconscious, or unable to sense pain. Bedsores are ulcers that happen on areas of the skin that are under pressure from lying in bed, sitting in a wheelchair, or wearing a cast for a prolonged time. Bedsores are also called pressure injuries, pressure sores, pressure ulcers, or decubitus ulcers. Bedsores can be a serious problem among frail older adults. They can be related to the quality of care the person receives. If an immobile or bedridden person is not turned, positioned correctly, and given good nutrition and skin care, bedsores can develop. People with diabetes, circulation problems, and poor nutrition are at higher risk...
Bedsores are divided into 4 stages, from least severe to most severe... Stage 4. The area is severely damaged and a large wound is present. Muscles, tendons, bones, and joints can be involved. Infection is a significant risk at this stage. " Retrieved from: https://www.hopkinsmedicine.org/health/conditions-and-diseases/bedsores. Retrival date 10/02/2023.

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N 353	Continued From page 11 Findings include: On 08/04/2023, the department received complaint information that alleged residents did not receive appropriate wound care. The provider is licensed to provide services for up to 22 residents who may be physically disabled, of advanced age, terminally ill, and/or have Alzheimer's/dementia. PROVIDER DOCUMENTATION: On 08/22/2023, Surveyor reviewed Resident 2's record. Surveyor noted Resident 1 was admitted to the facility on 04/02/2021 with diagnoses of dementia, chronic pain, heart failure, cerebrovascular disease, dysphagia, and atrial fibrillation. Resident 2 was advanced age. Resident 2 was admitted to hospice services on 06/22/2022 for congestive heart failure. Surveyor reviewed Resident 2's individual service plan (ISP) with print date 07/11/2023. Surveyor noted Resident 2 required full assistance from staff for all ADLs and was identified as requiring assistance from one staff with transfers using a mechanical lift. "Bathing Needs - Needs full help with bathing / showering - little or no participation from resident .... Dressing Needs - Special - No special dressing needs - Note: Resident does have special wound care wraps done by hospice 3x weekly and facility staff on opposite days as resident allows ... Mobility - Bed - Needs help to sit up - Note: Resident does not sleep in [his/her] bed. Resident chooses to sleep in [his/her] Broda chair. Nutritional / Hydration Status - Nutritional Status -	N 353		

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N 353	Continued From page 12 Note: Resident intake has decreased ... Toileting Needs - Other provider orders supply of incontinent products ...Needs help with peri-care ... Bladder incontinence - Note: Yes ... Weight Gain / Loss ...unknown, unable to obtain wt [weight] ..." "Pain - Treatment of pain - pharmacological, specify: - Note: Tylenol 3x daily, resident noted to refuse. Also, Morphine PRN [as needed]." "Skin - Other skin issues - specify ... skin breakdown d/t [due to] weepy edema to bilat. LE [lower legs]." Skin - Wound Assessment 1-3 "No wound present" "Behavior - Self Isolation ... Stays in room most of the day, does not socialize with others .... Mental Illness ... Dementia." Surveyor reviewed Resident 2's "WOUND - WEEKLY OBSERVATION TOOL" documents completed by LPN B. Surveyor noted 3 assessments and all included documentation of Resident 2's lower extremities. No assessment of Resident 2's ischial/buttocks wound was identified or addressed. Surveyor noted the assessments did include that Resident 2 had an air mattress, was to be encouraged to raise and reposition his/her legs, and was to be provided Tylenol for pain, all of which were listed as Resident 2 refused. Surveyor reviewed 2 shower sheets provided for Resident 2 and noted skin checks on both. The shower sheet dated 03/04/2023 identified Resident 2 as refusing the shower due to his/her legs being wrapped. The shower sheet dated 06/09/2023 identified blisters on his/her legs and weepiness, but did not identify other skin breakdown. Surveyor reviewed provider progress notes dated	N 353		

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04/06/2023-05/18/2023. Surveyor noted a progress note dated 05/08/2023 LPN B "Resident having increased pain today. [S/he] sat in recliner and was screaming and yelling out in pain. [His/her] legs were elevated and so legs were brought down and this seemed to help some. Legs were wrapped ..." No other progress note provided listed documentation about Resident 2's bed sore.

Surveyor reviewed a note to LPN B regarding Resident 2 dated 04/25/2023:
"[Resident 2] has very red irritated skin between legs almost rash looking/ kind of close to peri area. Cleaned with soap and water, dried and applied calamazine cream. Past few nights working with [him/her] I've seen a difference in his/her attitude, a lot calmer and more quiet, seems a lot more confused as to what [s/he's] doing and what's going on. [S/he] told me [s/he] doesn't know how to use [his/her] pendant which I thought was very odd, maybe UTI? Just thought I'd let you know." Surveyor noted the correspondence form included "Nurse Response" which was blank. No additional documentation was found related to these concerns reported to LPN B.

Surveyor reviewed Resident 2's May-July MARs and noted Resident 2 had orders for nystatin powder for his/her groin, wound care orders for his/her legs, and topical treatments related to itchy areas. No orders were listed for Resident 2's pressure ulcer on his/her buttocks.

Surveyor reviewed Bluestone Physician Services and provider correspondence documentation and noted:
06/20/2023 LPN B "Increased pain. Will not take morphine prior to leg wrap changes. More

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confusion noted ...Refusing medications ..."

Surveyor note: No other facility documentation was provided to Surveyor.

HOSPICE DOCUMENTATION:

On 10/02/2023, Surveyor reviewed Resident 2's hospice records. Surveyor noted the following on Resident 2's Routine Visit Summaries completed by Hospice RN E:
07/03/2023 - "Patient was sleeping in Broda chair upon arrival. Patient was having labored breathing, short and shallow breathing. Patient was not alert, [s/he] would become startled very easily and confused. [S/he] was unable to stay awake. [S/he] would repeat saying that [s/he] was cold. [Resident 2] did not want writer to stay. [S/he] kept saying 'don't stay, go away, I don't feel good.' [Resident 2] would become very fearful when startled and screamed 'Who are you?' ...Patient was not able to tolerate getting up from [his/her] chair. Patient refused lunch has had a decreased appetite. [S/he] did drink an entire ensure and ate an applesauce ...[S/he] did deny pain but anytime [s/he] was startled by touch, [s/he] would start shrieking as if [s/he] were in pain. Wound care not completed today, due to patient condition. Noticeable decline in cognition and alertness, and ability to stay awake, but did began [sic] to wake a little more once [his/her] family came to visit. RN will continue to monitor."
"Facility had notified hospice RN that patient has a pressure sore on [his/her] buttocks. Writer discussed this with staff member [unidentified staff] and it was reported to RN that this was cleaned and changed already today. Writer did provide wound care supplies and a new bottle of barrier cream to help protect the skin as well."
"Wound #3 - Posterior right buttock ...Wound

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N 353	Continued From page 15 Status Active Date Identified 07/03/2023 ... Wound Type Pressure Injury Goal Closure Pressure Injury Stage Stage [blank] ...1 Mattress Overlay or Specialized Mattress 1. Cleanse affected area with soap and water or no-rinse cleanser, if available. 2. Gently pat dry and apply protective ointment such as petroleum jelly or zinc oxide. 3. Cover with bandage. 4. Repeat after each episode of incontinence ...Wound is worsening and becoming larger. There is a fleshy tone to the wound with some blackening and yellow drainage from the wound. Due to the location, it becomes soiled easily, and patient is often soiled from urine and feces and refuses cares. Patients legs are warm to the touch. Due to the nature of the wound and the location, there are some concerns that infection may occur. No fever noted. Wound cleaned, antibiotic ointment applied, gauze placed on wound and large bandage secured to keep gauze in place. Patient was in pain during wound care, [s/he] screamed and verbalized [his/her] discomfort." Surveyor note: Upon review of other documentation, "posterior right buttock" is a discrepancy for wound location. Pressure ulcer was located on Resident 2's left buttocks. 07/05/2023 - "Wound #3 - Pressure Injury ... Facility will complete during peri care and BM episodes. Writer delivered larger bandages for wounds." 07/11/2023 - "Wound #3 - Pressure Injury ... Facility performs when patient is toileted and soiled." 07/14/2023 - "Patient in pain during visit. Patient administered PRN morphine by facility staff, prior to wound care and toileting per writer's instruction. Writer assessed wound on left	N 353		

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buttocks area, it appears to be a pressure ulcer, no bleeding noted. Writer cleansed and applied ointment, gauze and bandage to wound ...Facility staff called RN earlier on this day and requested that patient receive a new Broda chair that can recline ... two staff members, and also patient stated [s/he] will not recline [his/her] legs up due to pain ...Patient has several options to offload pressure, IE recliner, hospital bed, or pillows to reposition with. Patient typically refuses bed and recliner due to pain on the of [his/her] calves and heels. Writer did bring additional large bandages for patient's buttocks sore. And provided update to facility staff."

07/18/2023 - "Care conference completed today for patient with RN from Community Care, facility staff, Bristol [hospice] SW [Social Worker], and Chaplain and this writer ....Patient refused to use any DME [durable medical equipment] that elevates and reclines [his/her] legs due to pain from [his/her] calves and back of [his/her] heels from [his/her] venous stasis ulcers. Patients family addressed concerns of pain medication, writer and Bristol SW reminded them that comfort and reducing pain is our priority with patient ...Writer did encourage staff to use cushion that [s/he] currently has, and will plan to bring something to help prevent cushion from sliding. Writer did encourage staff to do a Q 2 [2 hour checks] schedule to check patient's brief and alternate pillows to help offload pressure due to [his/her] refusal to lay in [his/her] alternating air mattress bed or to recline ...
Writer assessed wound on buttocks. There was not any dressing on the wound when writer assisted facility staff to toilet patient. Wound appears to be worsening from pressure due to patient consistent [sic] sitting in [his/her] Broda chair and refusing to lay or recline. This would

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benefit from alternating pillows/cushions under [his/her] buttocks to help offload pressure..."

07/19/2023 visit completed by Hospice RN I - "Call received to come out to change dressings on legs. Upon arrival staff wanted leg dressing and buttock dressing changed ...Resident refused writer to look at buttocks dressing, primary hospice case manager nurse for resident was updated and will come out tomorrow to reassess and redress bandages."

07/20/2023- "Buttock wound unable to be assessed due to patient remaining in Broda chair during entire assessment. Writer did however provide education to facility staff on method of dressing this wound at this time. Upon last assessment, pressure sore on [his/her] left buttock is black in color. Due to patients reported frequent refusal of cares to facility staff, this would continue to go undressed at times, and appears to be worsening due to it being in an open area of constant pressure and moisture related to urine and feces. Buttock wound appears to be stage 2 pressure sore, with some blackened areas and some yellow slough. RN encouraged facility to be addressing this wound every time patient is soiled. Writer did provide facility with orders of wound care of all three wounds. Writer also provided additional supplies for wounds ..."

On 08/22/2023, Surveyor reviewed hospice "Clinical Summary" documentation and noted: 07/18/2023 "WOUND PROTOCOL Wound #3 - Pressure Injury ...1. Cleanse affected area with soap and water or no-rinse cleanser, if available. 2. Gently pat dry and apply protective ointment such as petroleum jelly or zinc oxide 3. Cover with bandage. 4. Repeat after each episode of

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incontinence ...ELIMINATION: Assist with toileting Every visit ...RN notified of any refused care. Tidy patient's immediate area. RN notified of any changes. Adult brief changes. Keep patient clean and dry. MOBILITY: Transfer using mechanical lift. Sift to stand with 2 assist ...PARTIAL/COMPLETE BATH: Bed bath Every Tuesday. Partial Bath Every visit. PERSONAL CARE: Perineal Care Every visit. Apply barrier cream to peri area after cares ..."

HOSPITAL DOCUMENTATION:

On 10/02/2023, Surveyor reviewed Resident 2's hospital discharge documentation and noted s/he was brought to the emergency room (ER) on 07/22/2023, admitted into the hospital on 07/23/2023 and passed away on 07/27/2023.

07/22/2023 ER documentation
"Assessment/Plan: After I [physician] left the room nurse noted pt [Resident 2] moaning more, pca [intravenous pain medication] increased, also foley placed due to retention. Continue comfort measures."
"Delirium presumed to be due to Stage IV pressure ulcer and Acute cystitis [urinary tract infection], Mild cognitive impairment"
"[Resident 2] comes in confused. [S/he] lives at an assisted living center. [S/he] is reported to be on hospice but has been refusing all of their services. [S/he] is a DNR. [S/he] has a POA but it has not been activated. [S/he] has been declining since [s/he] was initiated on hospice and is not confused. EMS was called. [S/he] was soaked in urine and has significant pressure ulcer in the ischial area. [S/he] is confused. [S/he] is awake and responds to questions but [his/her] responses do not make sense. Nursing staff has been trying to contact family for future

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information."
"The patient is awake and curled up in a fetal position. [S/he] is not able to give reliable answers to any questions.
Skin: [S/he] has an Unna boot on each lower extremity. [S/he] also has a large decubitis ulcer in the left ischial area which is about 8 to 10 cm in diameter. It appears to be at least a stage III pressure ulcer with significant discharge and foul odor ....
Extremities: [S/he] has erythema around the feet and ankles bilaterally. The Unna boot on the right was removed, I did not see any significant skin breakdown. The Unna boot on the left was adherent to the skin and will need to be soaked before removal.
Neurological: [S/he] is awake but responses are nonsensical. [S/he would not comply with the neurological exam ..."
"Differential diagnosis would include sepsis, decubitis ulcers, acute mental status, stroke, urinary tract infection, metabolic abnormality. Multiple other diagnoses were considered as well."
ER physician consulted with Family Member G. "I explained to [him/her] that [Resident 2's] decubitus ulcer likely would never fully heal, and with [his/her] urinary tract infection this could be an end-of-life issue. [Family Member G] indicated that [s/he] would like us to pursue all treatment modalities. [S/he] said that [s/he] would want us to treat [Resident 2's] for urinary tract infection, treat [his/her] pressure ulcers, and provide any additional care that we possibly could." Resident 2 was admitted to the hospital.
"Additional Recommendations: ...Per family wants to fix ulcer, will likely require multiple surgeries, long term IV abx [intravenous antibiotics] and would require intense pt/ot [physical/occupational therapies], and frequent shifting."

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N 353	Continued From page 20 History & Physical Examination in ER "[Family Member H] states that patient was placed on hospice so that [s/he] could get a Broda chair since [s/he] has severe orthopnea and dislikes laying down in bed. [Family Member H] states that about 2 weeks ago [Resident 2] complaining of pain with urination, but states that nothing was done about this. [Family Member H] states that they were unaware of how severe the pressure ulcer was, does not feel patient was getting adequate care from facility and/or hospice services." "Appearance: [S/he] is ill-appearing. Comments: Patient laying on side, moaning, visibly in pain, clothes/bedding smell of urine .... Musculoskeletal: General: Signs of injury present. Right lower leg: Edema present. Left lower leg: Edema present ... Skin: General: Skin is dry. Findings: Bruising, erythema and lesion present. Comments: Left ischial pressure ulcer covered with bandage with significant surround ecchymoses. Removing bandage revealed stage IV pressure ulcer with significant amount of exposed bone. Skin bilateral lower extremities below knees dry with flaking, erythema, open areas of skin. Large black eschar present on left lateral heel." "Osteomyelitis ...Assessment/Plan: Large stage IV pressure ulcer with exposed bone approx. 8-10 cm in diameter on left ischial area. Patient has history of previous pressure ulcers. Family states this ulcer started in May. Family states they were unaware of ulcer severity ... Family has often found patient soaked in own urine." 07/27/2023 Discharge Summary "Brief Hospital Summary: Pt [patient] admitted with acute delirium thought to be due to stage IV ulcer and cystitis. Family indicated preference for comfort care and so pt was admitted to hospice	N 353		

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and treated with comfort care measures until [s/he] ultimately expired.
Cause of death and interval between onset and time of death: Stage 4 pressure ulcer - months"

INTERVIEWS:

On 06/27/2023 at approximately 2:53 PM, Surveyor interviewed Caregiver F and inquired which residents had open areas and/or wounds. Caregiver F mentioned Resident 2 had open areas on his/her legs from lymphedema and they were weepy. Caregiver F did not have any other information related to Resident 2's wounds. S/he stated Resident 2 "sometimes" required two-staff assistance. Surveyor inquired whether it was ever reported to Caregiver F that Resident 2 had a wound on his/her butt, Caregiver F stated s/he knew s/he had some skin breakdown on his/her butt, but there were not any formal orders for it. Surveyor inquired how caregivers would know about a change in resident's care. Caregiver F stated that changes in residents' condition and medication changes would be listed in the shift change binder by LPN B and shared at shift change report. S/he said that staff are to report changes to residents they recognize to LPN B using a form kept in the tray on his/her office door. Caregiver F stated s/he did not know what was done with medication changes on weekends as LPN did not work weekends and was responsible for updating the medication administration records (MAR).

On 08/21/2023 at approximately 9:00 AM, Surveyor interviewed Hospice Executive Director (HED) D and Hospice RN (HRN) E. HRN-E described Resident 2 as confused, disoriented, and in pain. S/he felt that the facility would confuse Resident 2's pain as Resident 2 being

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resistive to care, when s/he really needed to be further assessed for pain. S/he said facility would mistake Resident 2 as being resistive when actually Resident 2 was just confused as to who they were and why they were there. When HRN-E would address concerns of Resident 2 being soaked with urine, s/he stated LPN B would approach the conversation as trying different approaches with Resident 2 was in violation of his/her rights. S/he felt that some staff didn't seem to try too hard to redirect Resident 2 being resistive to cares. It was reported that the hospice caregiver would go in weekly and Resident 2's incontinence product would always be "exploding from being so full." HRN-E shared it was not uncommon for Resident 2 to be soaked with urine through his/her clothes and the chucks (incontinence pad) on the chair. HRN-E shared communication with the facility was always a challenge due to there being high turnover in staff. Resident 2 was identified as being susceptible to skin breakdown, as s/he had open sores all along his/her feet, legs, and heels, with the most problematic spot being his/her left leg. Resident 2 was receiving wound care for weeping lymphedema of his/her legs. HRN-E stated Resident 2 did not like to recline in his/her recliner and refused to sit in the reclining Broda that was provided. S/he refused to elevate his/her legs as well as lay in bed, and subsequently, Resident 2 remained in his/her non-reclining Broda chair around the clock. HRN-E reported s/he recommended provider staff place pillows under Resident 2's thighs to alleviate pressure, but was unsure how often that happened. Resident 2 reportedly was too weak to utilize a sit-to-stand lift, and would refused to be lifted up using a mechanical Hoyer lift.
HRN-E reported s/he had inconsistency with who s/he would report to because it would depend

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who was onsite. S/he said if LPN B was present, s/he would talk to him/her, but after s/he quit, there was a lack of documentation, so staff didn't know much about Resident 2. HRN-E stated s/he had been communicating with LPN B, but after s/he left, it varied by the day due to what caregiver was working.
HRN-E stated Resident 2's visible signs of pain were when wound care was being completed and when s/he was moved around. Resident 2 was prescribed a fentanyl patch for the pain, but the pain was believed to be centralized on his/her legs wounds. HRN-E reported s/he had started working with Resident 2 in June, with more visits occurring in July. Since the previous hospice RN was a contracted RN, there was not any transfer conference regarding Resident 2's care. HED-D and HRN-E stated they were not aware of the wound on Resident 2's left buttocks until July 3rd. S/he were made aware that staff were washing and rebandaging it and suddenly provider staff had told him/her that it was worsening really bad. HRN-E stated s/he would have categorized the wound as a stage 3. S/he stated s/he received formal training on wound care recently/since the incident.

On 06/30/2023 at approximately 10:00 AM, Surveyor interviewed LPN B who stated his/her protocol for wound care was that s/he would oversee and provide guidance to staff on any wound care that was basic antibiotic ointment or similar to Kerlex, and anything with silver or other medication needs, s/he would refer to an outside service like hospice or home care for wound care management.
Surveyor inquired which residents had open skin areas or pressure ulcers. LPN B referenced Resident 2 as having open and weepy legs due to his/her edema.LPN B stated Resident 2's hospice

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nurse would provide wound care to his/her legs 3 times a week. S/he stated Resident 2 had a history of refusals of many things, including wound care. When Surveyor inquired about any wounds Resident 2 had, LPN B stated "only the lower legs".
Surveyor inquired about how caregivers communicate skin issues to LPN B and how LPN B communicates to caregivers. LPN B indicated s/he just updated shower sheets and staff have been trained to utilize them to complete skin checks. If change in skin or change in condition, it would be documented on the shower sheet or in the shift change binder. LPN B stated s/he looked at shift changes binders daily and if something bigger needed to be addressed, there was a separate binder for documentation to the him/her to provide concern and there is room for nurse response as well so follow up was shown.
Surveyor note: Surveyor only received one nurse correspondence note and there was no nurse follow- up listed.
S/he stated staff should document on the sheet if residents refuse and if there were any changes. If someone refuses over and over again, LPN B indicated s/he would go and talk with the resident about changes in shower options, such as time of day or day, male vs female caregiver, whirlpool, and find out what the reasoning was. Surveyor inquired whether Resident 2 ever refused to be cleaned up and LPN B stated yes. LPN B stated it was the approach with him/her. S/he said it was important to talk through what needed to be done and Resident 2 would be more willing to be moved and assisted. Surveyor inquired whether s/he had shower sheets to show Resident 2's refusals and LPN B stated s/he would look for them.
Surveyor note: Surveyor received 2 shower sheets for the past 6 months; 1 refusal by a

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caregiver, and 1 shower sheet completed by LPN B. There was no documentation to determine when Resident 2's last shower was.
Surveyor note: LPN B's employment ended prior to Resident 2 passing.

On 08/09/2023 at approximately 11:09 AM, Surveyor interviewed Regional Director of Operations (RDO) J . RDO-J had started with the company in the past few months, and was newly arriving to this facility for compliance oversight. RDO-J reported having a meeting with Resident 2's care team and hospice team in July, and was told Resident 2's wound didn't look that bad and wasn't open. It was shared that it was being monitored.
RDO-J stated s/he had documentation to support that staff notified hospice about the pressure ulcer, as well as correspondence between LPN B and hospice regarding the wound and direction to apply triple antibiotic ointment, clean, and apply mepilex to cover it.
Surveyor note: Documentation to support these statements was not found or provided.

RDO-J stated s/he personally physically observed the wound on 07/20/2023 and contacted hospice right away. RDO-J described the wound to be very significant and pushed for new wound care orders. Since new orders did not come and Resident 2's condition continued to worsen, RDO-J made the decision to send Resident 2 to the hospital. RDO-J stated Director A had communication with Family Member G on 07/18/2023 about him/her seeing the wound the first time, and RDO-J said s/he spoke with Family Member G on 07/21/2023 about how substantial the pressure ulcer was.

On 08/04/2023 at approximately 1:22 PM,

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Surveyor interviewed Family Member H. Family Member H shared Resident 2 was admitted to hospice strictly to get a Broda chair and indicated s/he was never dying as s/he was doing well for his/her age. Family Member H said it was difficult for Resident 2 to lay in bed following his/her stroke due to difficulty swallowing, so s/he was up in his/her chair primarily. Family Member H said there were some struggles with getting a chair that Resident 2 liked and met his/her needs right, and s/he had finally gotten the chair s/he needed 2 weeks prior to his/her passing. Since Resident 2 was always in his/her chair, Resident 2 was on his/her bottom almost 24/7.

Family Member H stated there had been a large turnover in caregivers and no consistency in cares. S/he said there had also been change in management that affected who to communicate with and it was evident that there was not communication from past to new.

Family Member H voiced concern that Resident 2 was never showered, would sit in urine for hours and never taken to the bathroom to be changed.

Family Member H recalled multiple incidents where s/he witnessed concerning events related to Resident 2's care:

On 02/14/2023, s/he reported Resident 2 waited over 3 hours sitting in his/her bowel movement. It was his/her birthday.

One time, Resident 2 had waited for hours to go to the bathroom. Family Member H had told staff Resident 2 had to go to the bathroom. They waited 15 more minutes. Family Member Had had to go back out and find a staff to assist Resident 2.

Resident 2 voiced to Family Member G and Family Member H, s/he had waited for hours on numerous occasions to be assisted to the bathroom.

Family Member H said it was always very difficult

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to find staff to assist Resident 2, and they would rarely answer his/her call light timely.
Family Member H reported on the second week of July, s/he witnessed a staff member pull a pillow out from behind Resident 2 in his/her Broda chair. The pillow was soiled and dripping with urine, Resident 2's brief was soaked through, and his/her chair was soaked in urine. It was unknown the last time Resident 2 had been changed.
Family Member H reported being made aware of what s/he was told, a bed sore on Resident 2's left buttocks in the beginning of May. S/he voiced hospice and LPN B were aware of it. Family was visiting Resident 2 when s/he was taken to the bathroom. Resident 2 had yelled out in pain and the bed sore on his/her buttocks was discovered. Family Member H stated "the only thing they were putting on it was what you put on cuts; we trusted them because they're supposed to be experts and dictate the care. We trusted them. There was a lot of neglect." We later learned that hospice had provided the facility with large bandages for it. "Why weren't they using them?" Family Member H stated they had no idea how bad the sore was on Resident 2's buttocks. When s/he would ask LPN B or hospice about it, they would tell him/her "it was fine." S/he indicated there were multiple conversations with hospice and LPN B about Resident 2's legs, but never about his/her buttocks.
Family Member H reported on 07/17/2023, Resident 2 was taken to the bathroom while him/her and Family Member G were there, and Resident 2 was visibly shaking in pain. Resident 2 said his/her butt was hurting and s/he thought s/he had a UTI. Family Member H reported this to LPN B and hospice, but no further follow up was done. Family Member H noted Resident 2 had tested positive for urinary tract infection in the

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hospital on 07/22/2023.
Family Member H reported on 07/18/2023, Director A had reported to Family Member H that s/he put eyes on Resident 2's pressure ulcer located on his/her left buttocks, and described it to Family Member H and Family Member G as the worst (wound) s/he had ever seen in his/her 18 years and that if s/he would have seen it 2 weeks earlier, s/he would have sent him/her to the hospital. Family Member H voiced concern that staff did not report this to Director A sooner. Family Member H described the pressure ulcer as being as big as his/her fist, "going in like a tornado right to [his/her] bone," and being infected.
Family Member H stated s/he felt that if the bed sore had been taken care of in May, Resident 2 would have still been alive today. "They didn't do anything about it." Family Member H reported upset that they were never made aware of how bad the pressure ulcer was. S/he said they saw Resident 2's buttocks 3 times a day at least and questioned how no one noticed and didn't say anything about the state of the bed sore.
Surveyor inquired whether s/he was aware of Resident 2 refusing assistance with cares or moving. Family Member H stated not that s/he was aware of beyond not taking pain medication. S/he indicated if Resident 2 would refuse, it was because s/he was in pain. Family Member H referenced Resident 2 as being "tortured with pain. [S/he] was in pain every single day."
Family Member H stated Resident 2 had a very fast decline. When Resident 2 was in the hospital, Family Member G and Family Member H were told there was nothing more they could do as even with an extensive amount of surgeries and therapies on the pressure ulcer, it would never fully heal, so they decided it was best for Resident 2 to be comfortable.

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N 353	Continued From page 29 On 08/22/2023 at approximately 11:00 AM, Surveyor interviewed RDO-J and COO-K. RDO-J verified Resident 2 had a stage 4 pressure ulcer that should have been identified, addressed, and monitored prior to getting to that outcome. S/he stated they were working on retraining and reeducating staff on what to look for with skin integrity, change in condition, involving third parties, reporting, and staff monitoring. S/he also stated they were working on RN staff delegation. COO-K stated wound management was difficult, but something s/he was very particular about. S/he verified wound care was something they would refer for third parties, but it was important to have a checks and balances for these services in place, as it was something they should be managing. In conclusion, Resident 2 was identified as being at risk for skin breakdown: Resident 2 had a history of skin related concerns requiring intervention, had a diagnosis of dysphagia impacting nutrition intake, was chair-bound and preferred to remain in his/her wheelchair 24/7, was incontinent of bowel and bladder, was of advanced age, was on hospice related to congestive heart failure, had chronic pain, and was dependent on staff for ADLs including repositioning, dressing, toileting, bathing, and transferring. There was staff turnover in hospice services, caregiving staff, and provider management staff, in addition to documentation not being found which were factors in communication breakdown of Resident 2's plan of care. Resident 2 sustained a pressure ulcer on his/her buttocks that was reportedly identified at an early stage, but not addressed, treated promptly and adequately, and monitored until it worsened into a stage 4 pressure ulcer, leading	N 353		

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N 353	Continued From page 30 to Resident 2's untimely death. Cross Reference: DHS 83.13(2)(b) Resident Records Retained for 7 Years DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 353		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain a current written schedule for staffing the CBRF. The schedules did not include each employee's full name, job assignment, and time worked. The schedules included staff assigned to different CBRFs, but didn't identify which CBRF the staff were assigned to on a given day. Findings include: On 06/27/2023, Surveyor reviewed a sample of provider's schedules with dates between February 2023-June 2023. Surveyor noted multiple calendars of the same month with one calendar for every shift (3 shifts). Surveyor noted employee first names and/or employee first names and the first letter of their last names. Surveyor noted 2-6 staff listed on any given day. On 07/07/2023 at approximately 9:30 AM,	N 399		

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N 399	Continued From page 31 Surveyor interviewed Director A who stated all 3 CBRF employees were listed on the calendars. Surveyor inquired how it was known what building they were working in and what the staff member's job title was on any given day as they were not identified. Director A stated s/he was unsure as s/he had just taken over the scheduling. On 07/10/2023 at approximately 2:00 PM, Surveyor interviewed Director A who verified the schedule had not been maintained with employees' full names, job assignments, time worked, and what building they were working in.	N 399		
{N 419}	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications were securely stored. The medication cart (which contained Schedule II medications) was not secured to the wall or within a locked area when not in use, was left in the common spaces of the facility unsecured, and not within caregivers' visual control. This practice was not changed or corrected since the previous visit. This is a repeat deficiency, see Statement of Deficiency P4Z911, dated 01/17/2022. Findings include: On 05/04/2022, the department received complaint information that alleged the medication carts were not secured.	{N 419}		

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{N 419}	Continued From page 32 On 06/27/2023 at approximately 9:30 AM, Surveyors toured the facility. Surveyor observed a medication cart in the front common space located in direct access of the front entrance. At approximately 11:00 AM, Surveyor viewed the contents of the medication cart. The cart contained Schedule II prescription narcotics within the cart, in addition to other prescription medication and treatments. Surveyors were onsite on 06/27/2023 from approximately 9:30 AM to 12:00 PM and 2:30 PM to 4:30 PM, and the medication cart was not secured to the wall or moved to a secure room for the entirety of the visit. Caregivers and management left the vicinity of the medication cart numerous times throughout the visit. Surveyors observed residents and visitors were present near the cart when staff were not present or within visual control approximately 5 times. On 06/30/2023 at approximately 10:00 AM, Surveyor interviewed LPN B who stated s/he had never seen the medication cart in the medication room or secured to the wall. Surveyor inquired whether there had been changes to the medication cart storage since the previous visit. LPN B stated s/he was not aware of any changes. On 07/10/2023 at approximately 2:30 PM, Surveyors interviewed Director A who verified the medication cart which contained Schedule II narcotics was not secured to the wall or kept in the secure medication room. Director A stated s/he would move the cart into the medication room.	{N 419}		

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{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 Resident 4 received supervision to meet his/her needs. Resident 4 recently moved into the facility and was identified as being an elopement risk. Resident 4 had diagnoses of dementia and his/her primary language was Spanish. On 11/07/2022, Resident 4 eloped from the facility undetected and was found at an assisted living down the road. The assisted living down the road contacted police to try and locate where Resident 4 resided as Resident 4 was unsure. The assisted living contacted provider to inquire whether Resident 4 resided at the facility, which is when the facility was made aware that Resident 4 was missing. This requirement is being cited for a third time, see Statements of Deficiency (SOD) P4Z911 (dated 01/17/2022) and SOD F8JP11 (dated 01/21/2021).	{N 426}		

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Findings include:

The provider is licensed to provide services for up to 22 residents who may be physically disabled, of advanced age, terminally ill, and/or have Alzheimer's/dementia.

On 11/09/2022, the department received complaint information alleging residents were not receiving appropriate supervision to meet their needs.

On 11/08/2022, the department received self-report information from provider reporting on 11/07/2022 at approximately 6:30 AM, Resident 4 had eloped from the building undetected, walked up the road to a neighboring assisted living facility. The other facility contacted police and provider to report Resident 4's whereabouts. Provider staff picked Resident 4 up from the other facility.

Surveyor note: According to Google Maps, Apple Creek Place III and Care Partners was located approximately 0.6 miles away, which was approximately 13 minutes walking distance from the facility with 1 of the 2 connecting roads to be Highway JJ with a speed limit of 55 MPH. Neither connecting roads had sidewalks, so Resident 4 had walked on the road. https://www.google.com/maps/dir/Apple+Creek+Place,+North+Cherryvale+Avenue,+Appleton,+WI/Care+Partners,+North+French+Road,+Appleton,+WI/@44.3143278,-. Retrieved 07/12/2023.

On 07/05/2023, Surveyor reviewed Resident 4's record and noted s/he was admitted to the facility on 10/28/2022 with diagnoses of vascular dementia, insomnia, aphasia following cerebral infarction, history of urinary tract infection (UTI),

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{N 426}	Continued From page 35 and anxiety. Surveyor reviewed Resident 4's individual service plan (ISP) and noted s/he was independent with activities of daily living (ADLs) with cueing and reminders, however preferred to remain as independent as possible. S/he was ambulatory without any assistive devices. Surveyor noted the following related to supervision needs: "COGNITION/MOOD ...Agitated, resident recently noted to become upset and agitated when asked to leave other residents rooms when wandering or having to return items that are not [his/hers]. At times can be verbally aggressive with resident and staff. Staff redirects with one to one, snack, or activity ....Wandering Concerns ...Has mild to moderate disorientation or difficulty recalling/retaining information. Needs cueing." "SAFETY ...24 hour supervision and visual checks in Memory Care ...Century system with door alarm." Surveyor reviewed provider's "Physician Update" document which stated "11-7-22 Resident eloped from community. [S/he] traveled on foot from 5117 N Cherryvale Ave to Care Partners on French Rd. Currently [s/he] is a two hour safety check. Sign will be placed at exit for staff to stop and look for residents." Surveyor reviewed Resident 4's incident notes and noted "Nursing Description: Community received call from Care Partners asking if a Spanish speaking [racial identifier] resided within our [note was cut off] ...Care Partners confirmed [his/her] name was [Resident 2]. Staff checked [Resident 2's] room. [S/he] was not there. [note was cut off] pick up resident ... Care Partners did contact the police prior to resident being picked up. Guardian was updated,	{N 426}		

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MCO, and PCP." Surveyor noted Resident 4's attire was not identified in notes to understand attire appropriateness for weather condition.

Surveyor note: According to AccuWeather, weather conditions on 11/07/2023 in Appleton, Wisconsin was listed as a high of 43 degrees Farenheit and a low of 32 degrees Farenheit with sunrise at 6:40 AM. https://www.accuweather.com/en/us/appleton/54911/november-weather/331517?year=2022. Retrieved 07/12/2023.

On 06/27/2023 at approximately 9:48 AM, Surveyor interviewed Director A who described Resident 4 as a sweet and easy going person. S/he felt Resident 4 had adjusted well and enjoyed being around others at the facility. Surveyor inquired whether Resident 4 was exit seeking and Director A stated s/he wandered, but was easily redirected from exit doors, and it was primarily after family members left.

On 06/27/2023 at approximately 2:53 PM, Surveyor interviewed Caregiver F who described Resident 4 as a very private and independent person. S/he stated s/he did not really exit seek, but did wander. Caregiver F stated the most challenging thing with Resident 4 was providing him/her cares because s/he was primarily Spanish speaking and Resident 4 was easily embarrassed when s/he was changing. Surveyor inquired whether Caregiver F had heard about Resident 4 eloping in the past and Caregiver F stated s/he had heard that, but didn't witness Resident 4 making any attempts recently.

On 06/30/2023 at approximately 10:00 AM, Surveyor interviewed LPN B who had just started at the facility when the incident with Resident 4

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occurred. LPN B stated Resident 4 was assessed as being an elopement risk, especially since s/he had just moved in and wasn't familiar with his/her surroundings yet. LPN B stated s/he though that Resident 4 would always be an elopement risk as s/he had eloped a few times prior to LPN B started at the facility too. Related to the incident on 11/07/2022, LPN B thought Resident 4 must have gotten out the back door undetected as it was near his/her room and a lot of staff go in and out to the parking lot utilizing that door. S/he stated it was unknown when Resident 4 was last seen at the facility prior to him/her being found at the other facility. LPN B stated Resident 4 was found to have a UTI after the incident and was doing better after starting on an antibiotic. Surveyor noted on the provider's self-report that a wanderguard was placed on Resident 4. LPN B denied this and said that Resident 4 did not have a wanderguard, but they did have alarmed, egress doors. S/he stated knowing that Resident 4 was an elopement risk and was still a wanderer, it was important to make sure to know where s/he was at all times. Surveyor inquired how often Resident 4 was to be checked on and LPN B stated at least every 2 hours. Surveyor inquired whether residents who are elopement risks are checked on more than residents who were not, and LPN B stated the facility was a memory care, so all residents were checked on. LPN B stated there was a sign on the exit door to remind staff and visitors to make sure there is not a resident behind them and that Resident 4 was on frequent checks. Surveyor inquired about the provider's supervision policy specific to elopement. LPN B stated s/he would send it to Surveyor. As of 08/03/2023, Surveyor did not receive a policy related to supervision or elopement.

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{N 426}	Continued From page 38 On 07/10/2023 at approximately 2:00 PM, Surveyor interviewed Director A who verified s/he had heard Resident 4 had eloped from the facility undetected and walked to another facility. Director A verified Resident 4's supervision needs were not met. Director A indicated there had been turnover in staff since then and no other documentation was found specific to the incident.	{N 426}		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not provide a daily activity program to meet the interests and capabilities of the residents. The provider did not ensure the activity schedule was posted in an area available to residents. While present at the facility from approximately 9:30 AM to 12:00 PM and 2:30 PM to 4:30 PM, Surveyors did not observe residents engaged in activities and staff providing activities.	N 427		

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N 427	Continued From page 39 Findings include: The provider is licensed to provide services for up to 22 residents who may be physically disabled, of advanced age, terminally ill, and/or have Alzheimer's/dementia. On 05/04/2022 and 03/08/2023, the department received complaint information that alleged the provider did not have any activities. On 06/27/2023, Surveyors requested a copy of the provider's activity schedule and made observations. While present at the facility from approximately 9:30 AM to 12:00 PM and 2:00 PM to 4:30 PM, Surveyors observed residents to be sitting in the common areas and sitting in their rooms. Surveyor overheard a staff member state to the residents that the TV was not in working order in the common space and they may need to go to their rooms to watch TV. Surveyors noted an activity schedule was not posted and was not provided to the Surveyors on 06/27/2023. On 06/27/2023 at approximately 11:15 AM, Surveyors interviewed Director A. Surveyors asked Director A if there was a daily activity program to follow. Director A stated that they were working on a better activity program and right now staff were trying to do one on one's with the residents, especially since this building was identified as the memory care. Director A stated they had ongoing problems with the WiFi connection which affected the TV's intermittently ongoing. On 07/10/2023 at approximately 2:00 PM,	N 427		

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N 427	Continued From page 40 Surveyor interviewed Director A who stated they were contracted with an activity programming system and s/he was working with staff on following the program. Director A indicated s/he would send the activity schedule to the Surveyors. As of 07/11/2023, Surveyors did not receive a copy of the provider's activity schedule.	N 427		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	N 431		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 5 received proper health monitoring related to his/her wound care.

Findings include:

On 02/21/2022, the department received complaint information alleging residents' health was not being monitored.

On 07/17/2023, Surveyor reviewed Resident 5's record and noted s/he was admitted to the facility on 07/31/2021 with diagnoses of Alzheimer's disease with behavioral disturbance, osteoporosis, and history of other endocrine, nutritional and metabolic disease.

Surveyor reviewed Resident 5's physician orders:
01/21/2022, "Apply Betadine to patients left inner heel once daily and cover with gauze until resolved."
01/26/2022, "D/C [discontinue] Betadine daily with gauze. Start: Cleanse wound with saline. Pat dry. Cut small piece of hydrocellular foam dressing to [foot] wound bed. Apply skin prep around the edges of the wound. Wrap with kerlex. Change every other day and PRN [as needed]."
01/31/2022, "Cleanse wound with saline. Pat dry. Cut small piece of hydrocellular foam dressing to fit wound bed. Apply skin prep around the edges

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of the wound. Wrap with kerlex. Change every day and PRN."
02/09/2022, "Cleanse wound with saline. Pat dry. Cut small piece of hydrocellular foam dressing to fit wound bed. Apply skin prep around the edges of the wound. Wrap with kerlex. Change every day and PRN if soiled."
02/10/2022, "Mighty Shakes - Drink 1 shake TID [three times daily] with meals for nutritional support and to help promote wound healing."
02/11/2022, "CLEANSE HEEL WOUND WITH SALINE. PAT DRY. APPLY MEDIHONEY TO BLACK NECROTIC ESCHAR AT 11 TO 2'OCLOCK AND 3-5 O'CLOCK. CUT PIECE OF HYDROCELLULAR FOAM DRESSING TO FIT WOUND BED. APPLY SKIN PREP TO PERIOWOUND. WRAP WITH KERLEX. HOSPICE TO CHANGE DAILY."
02/11/2022, "Order for patient to be up only for meals. Patient to remain up 30 minutes after meals and then be placed in bed due to left heel wound."
02/11/2022, "Heel boots to remain on patients [sic] bilateral heels at all times besides for showers. Also - patient's bilateral heels are to be free floating at all times while in bed."
Surveyor reviewed written correspondence between Resident 5's physician assistant, nurse practitioner, hospice nurse, family, and facility:
01/12/2022 Physician Assistant (PA-C) L, "Please watch that area on [his/her] heel ..."
01/12/2022 LPN P "Found half-dollar sized blister on left medial heel. Does not come in contact with ground. Possibly new shoes caused this."
01/18/2022 Nurse Practitioner (NP) N - " ...Open left heel wound/previous blister noted on left heel."
01/21/2022 Hospice RN M - "Patient has a open blister on [his/her] left inner heel. Can I have an order to apply Betadine to patients left inner heel

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once daily and cover with gauze until resolved."
01/26/2022 Hospice RN M - "Patients left heel blister is not healing. Left heel wound now 5.0 x 5.7 cm with a moderate amount of slough [drainage]. Wound is warm to the touch and red around the outside. Patient does not have fever. I know patient is on Doxycycline currently, however I feel [s/he] needs a different antibiotic as this appears not to be helping. Can I have orders for: 1. D/C [discontinue] doxycycline and start new [antibiotic] as wound appears to have an infection. 2. D/C Betadine daily with gauze. Start: Cleanse wound with saline. Pat dry. Cut small piece of hydrocellular foam dressing to [foot] wound bed. Apply skin prep around the edges of the wound. Wrap with kerlex. Change every other day and PRN."
01/28/2022 PA-C L - " ...I am going to start [him/her] on a different antibiotic. [His/her] pressure ulcer on L [left] heel is stage 3 vs 4 at this point - not good. Heel protectors will be greatly appreciated as well. I ordered staff to change [his/her] bandages on days Hospice is not seeing [Resident 5]."
01/28/2022 from PA-C L to Power of Attorney for Healthcare (POAHC) O - " ...[his/her] left heel wound is pretty severe - I am starting [him/her] on a different antibiotic and have asked Hospice to send more wound care supplies. A wound of this severity often requires IV antibiotics and possibly even surgical attention ..."
02/03/2022 Hospice RN M - " ...I changed [Resident 5]'s left heel dressing yesterday. Size has increased to 5.2 x 8.6 cm. Wound has a large amount of Serosangenous drainage and is being changed more than once daily d/t [due to] drainage. Now black eschar present on wound bed. Sound has foul smelling odor present. I talked with facility and [POAHC O] yesterday. I feel it would be best for [Resident 5] to go to a

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SNF [skilled nursing facility] where they have 24 hour nursing care due to the stage of [his/her] wound. POA was agreeable and facility agreed also as they can't do wound care on weekends ..."
02/01/2022 LPN P "I changed wound dressing late yesterday afternoon. It was changed by staff this AM early after shower. Small amount of serosanguinous drainage. Sough covering wound bed. No warmth felt. Applied boot protectors today and up in broda ....I will change when hospice is not here during week and delegate to staff on weekend."
02/08/2022 Hospice RN M - "Left heel wound is 6.5 x 5.2 cm. Black eschar present on over 50% of the wound. Large amount of slough. Large amount of Purulent drainage. Foul smelling odor present. Wound is masserated."
02/09/2022 Hospice RN M - "I will be seeing [Resident 5] daily starting tomorrow including the weekends to do wound care until [s/he] moves."
02/09/2022 PA-C L - " ...Apple Creek Staff - please follow [orders]. Worst case scenario, if anyone is noticing [Resident 5] needs something please reach out and ask for it right away. We'd rather have to move our schedules around than have [Resident 5] not get the care [s/he] needs."

Surveyor reviewed Resident 2's hospice notes:
1/26/2022, "LEFT HEEL WOUND : LEFT HEEL WOUND SIGNIFICANTLY CHANGED IN THE LAST WEEK, WOUND NOW MEASURING 5.7 X 6.0 CM WITH A DEPT OF 0.3 CM. AREA IS WARM TO THE TOUCH AND HAS A MODERATE AMOUNT OF SLOUGH DRAINAGE WITH THE AREA AROUND THE WOUND BEING RED. PATIENT IS CURRENTLY DOXYCYCLINE FOR THE WOUND HOWEVER I FEEL THAT IS NOT WORKING. ORDER PLACED TO CHANGE ANTIBIOTIC ....STAFF

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ADVISED TO FREE FLOAT PATIENTS HEEL TRY TO NOT LET [HIM/HER] PUT ANY PRESSURE/WALK ON IT AND WE WILL GET BLUE HEEL BOOTIES ..." " ...PROVIDE AND INSTRUCT PATIENT/CAREGIVER WOUND CARE - DETAILS/COMMENTS: FACILITY RN VERBALLY INSTRUCTED ON WOUND CARE. [S/HE] VERBALLY DEMONSTRATED UNDERSTANDING."
02/10/2022, "DAILY VISITS FOR LEFT HEEL WOUND CARE DAILY."

Resident 5 discharged from the facility to a skilled nursing facility (SNF) on 02/21/2022.

On 06/27/2023 at approximately 9:48 AM Surveyor interviewed Director A who stated s/he had no awareness of Resident 5 as s/he had started at the facility in the past few months. Director A stated s/he provided Surveyor with any documentation s/he could find on Resident 5. S/he said there was a staff turnover and there wasn't anyone at the facility that would have known Resident 5. Director A stated s/he was unable to locate any documentation of Resident 5's medication administration record (MAR) as their access to Point Click Care (PCC) was ended.

On 06/30/2023 at approximately 10:00 AM, Surveyor interviewed LPN B who reported Resident 5 resided at the facility prior to him/her starting in fall 2022. LPN B referenced that it was his/her protocol to refer all wound care to third parties that s/he could not manage or train staff on. LPN B gave the examples of basic antibiotic ointment, Kerlex, and basic bandaging was something s/he could do, but otherwise if it was medicated, would make the referral and ensure there was clear directions on what to do for the

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N 431	Continued From page 46 wound in between home health or hospice visits. On 07/11/2023 at approximately 2:00 PM, Surveyor interviewed Director A who acknowledged there being physician orders and correspondence identifying Resident 5 to have a blister that worsened over time in relation to wound care orders not being followed. Cross Reference: DHS 83.13(2)(b) Resident Records Retained for 7 Years DHS 83.32(3)(i) Rights of Residents: Adequate Treatment	N 431		
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 CBRF provided a living environment that was safe, clean, comfortable and homelike. Findings include: On 11/16/2022 and 03/08/2023 the department received complaint information that alleged the facility was unclean. On 06/27/2023 at approximately 10:30 AM,	N 481		

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N 481	Continued From page 47 Surveyors toured the facility. Surveyors observed the following: -Resident 3's room floor had debris throughout the carpet and bathroom floor. -Multiple boxes and stacks of paper, activity supplies, decorations, and office supplies were on the floor, table, and chairs of the activity room making it difficult to walk into the space. -A dark gray marking measuring approximately 6-feet long and 1-foot wide was on the wall of the dining room. The corner of the same dining room wall had broken dry wall and chipped paint ranging from the base board to approximately 2-feet high. -A large, 8-frame wall hanging for identified for announcements and activities in the dining room had blank white pages and empty frames. -A 3-frame wall hanging identifying Daily Menu in the dining room had blank white pages. -2 lines of piping covered by black insulation and metal clamps stretching across the entirety of the common dining room lentil from the kitchen to the hallway. The piping was drooping in multiple places. -Visible thick dust on the dining room ceiling vent and surrounding it. -Dust on the air return vent on the dining room ceiling. -The 4-foot by 2-foot fluorescent light fixture in the kitchen had dead bugs and other debris throughout it. -Dust and debris on the 3-foot tall air return on the right wall of the left hallway next to the dining room. -The fish tank in the common space had a full (dirty) filter and grime build-up on the side and rocks of the tank. -Debris on the common space window sills, and the carpeting of the hallway, common space, and resident rooms.	N 481		

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N 481	Continued From page 48 -The furnace room located in the right hall from the entrance was unlocked and had visible debris and hard water stains on the floor. -The exit located on the right side of the entrance building had oversupply of incontinence products, personal protective equipment, extra furniture, extra clinical supplies, and other care items on a shelf and on the floor, spanning the proximity of the vestibule between the internal and external doors. On 07/10/2022 at approximately 2:15 PM, Surveyors interviewed Director A who stated housekeeping had come a long way, but was still a work in progress. Cross Reference: DHS 83.32(3)(b) Rights Of Residents - Confidentiality DHS 83.45(3) Toxic Substances	N 481		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds, polishes, and toxic substances were labeled and stored in a secure area. Findings include: On 06/27/2023, at approximately 9:45 AM, Surveyors toured the facility with Director A.	N 499		

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N 499	Continued From page 49 Surveyors observed a laundry room located in the hallway of resident rooms located to the left of the common space and main entrance. The laundry room door was unlocked. Surveyors observed: 3 bottles of glass cleaner, 2 bottles of disinfectant cleaner, 3 bottles of LSR Delimer, 7 bottles of Super Trump Cleaner, 2 bottles of Jet Dry, 8 bottles of fresh 100 cleaner, a bottle of Drain-O, 1 bottle of Non-Acid Coil Cleaner, 2 bottles of premium rinse additive, 8 bottles of hand sanitizer, 5 bottles of hand soap, 1 bottle of 256 Worx, 1 bottle of Mechanical Dish Detergent, 1 spray can of furniture polish and 1 bottle of Clorox Bleach. Surveyor noted a sign on the laundry room door that stated, "Please keep door closed at all times," and there was a keypad on the door. Further down the same hall, Surveyors observed an unlocked storage and ice machine room with 2 bottles of glass cleaner, 2 bottles of Mechanical Dish Detergent, 3 containers of Comet deodorizing cleanser, and 1 bottle of premium rinse additive. On 06/27/2023, at approximately 10:50 AM, Surveyors asked Director A if the laundry room and ice machine room was open at all times. Director A stated that they should be closed and locked at all times so memory care residents did not have access. Director A acknowledged the rooms were unlocked and contained toxic substances.	N 499		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time.	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017918	A. BUILDING: _____ B. WING _____	R-C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE III	5117 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 525	Continued From page 50	N 525		

Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure fire evacuation drills were conducted for 3 of 4 quarters in 2022, and 1 of 2 quarters thus far in 2023.

Findings include:

On 05/04/2022, the department received complaint information that alleged fire drills were not conducted.

On 06/27/2023, Surveyor reviewed provider's documentation for a fire drill on 06/10/2022 (quarter 2 of 2022) and a fire drill on 04/16/2023 (quarter 2 of 2023). Surveyor noted there was no evidence of fire drills being conducted in quarters 1, 3, and 4 of 2022, or quarter 1 in 2023.

On 06/27/2023 at approximately 2:45 PM, Surveyor inquired with Director A whether any other fire drills were conducted in 2022 and 2023 than the 2 documented drills provided. Director A stated s/he did not believe so.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017918	A. BUILDING: _____ B. WING _____	R-C 09/26/2023

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APPLE CREEK PLACE III	5117 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 525	Continued From page 51 On 07/10/2023 at approximately 2:30 PM, Surveyors interviewed Director A who verified no additional documentation of fire drills were found.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review, the provider did not ensure tornado, flooding, or other emergency or disaster evacuation drills were conducted at least semi-annually in 2022. Findings include: On 05/04/2023, the department received complaint information that alleged other evacuation drills were not conducted. On 06/27/2023, Surveyor reviewed provider's documentation for emergency drills. Surveyor noted there was no evidence of other emergency or disaster evacuation drills conducted in 2022. On 06/27/2023 at approximately 2:45 PM, Surveyor inquired with Director A whether any other evacuation drills were conducted in 2022. Director A stated s/he did not know and could not find any additional documentation. On 07/10/2023 at approximately 2:30 PM, Surveyors interviewed Director A who verified no additional documentation of evacuation drills were found.	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017918	A. BUILDING: _____ B. WING _____	R-C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE III	**5117 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