STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014137	A. BUILDING: _____ B. WING _____	R-C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAN DYKE	1811 S VAN DYKE RD APPLETON, WI 54914

(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 04/09/2025 with addtional information gathered through 04/15/2025, Surveyor conducted two (2) complaint investigations and two (2) verification visits at Van Dyke for Statement of Deficiencies (SOD) B1O611 and Q3GL11. Two of 2 complaints were substantiated. Two deficiencies were identified. One of two deficiencies was a repeat deficiency. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 7	{N 000}		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not review or revise a resident's ISP (Individual Service Plan) when there was a change in needs, abilities or physical or mental condition.	{N 389}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014137	A. BUILDING: _____ B. WING _____	R-C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAN DYKE	1811 S VAN DYKE RD APPLETON, WI 54914

(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 389}	Continued From page 1 On 01/10/2024, an order was written for Resident 5 to receive nectar-thick liquids. Resident 5's ISP was not reviewed and revised to include the nectar-thick liquids until 10/03/2024, approximately 9 months later. This is a repeat deficiency. See SOD Q3GL11, dated 06/10/2024. Findings include: On 10/10/2024, the department received a concern regarding resident ISPs. On 04/09/2025, Surveyor reviewed Resident 5's medical record. Resident 5 was admitted to the facility on 11/03/2023 with diagnosis to include dysphagia, aphasia and cerebral infarction. A video swallow was completed for Resident 5 on 01/10/2024 which revealed, "A moderate oropharyngeal dysphagia...While there was no observed aspiration, [Resident 5] does remain at risk." The SLP (Speech Language Pathologist) treatment plan indicated, "Diet: Dysphagia 1 diet (Pureed) with Nectar-thick liquids." Review of Resident 5's signed ISP dated 11/14/2024 indicated, Resident 5 required full assistance with eating, was at risk for choking and was on a Pureed diet. The ISP did not include any revisions Resident 5 was to receive nectar-thick liquids. Review of Resident 5's signed ISP dated 04/24/2024 indicated, Resident 5 required full assistance with eating, was at risk for choking and was on a Pureed diet. The ISP did not include Resident 5 was to receive nectar-thick	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014137	A. BUILDING: _____ B. WING _____	R-C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAN DYKE	1811 S VAN DYKE RD APPLETON, WI 54914

(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 389}	Continued From page 2 liquids. ***Surveyor noted no revisions were made to Resident 5's ISP regarding nectar-thick liquids until 10/03/2024, approximately 9 months later. On 04/09/2025 at 3:00 PM, Surveyor interviewed MCO RN (Managed Care Organization Registered Nurse)-Q. MCO RN-Q stated, "On 10/03/2024, we had a care plan meeting for [Resident 5] at the facility with [DA (Division Administrator-D]. I pointed out [Resident 5's] ISP did not indicate [s/he] was supposed to be receiving nectar-thick liquids. I told [DA-D] the order had been in place for a while and [s/he] looked surprised. [DA-D] then entered the information regarding nectar-thick liquids into [Resident 5's] computerized ISP...I'm not aware of any choking or aspiration episodes." On 04/09/2025 at 11:30 AM, Surveyor spoke with DA-D and CMD (Care Management Director)-A regarding Resident 5's ISP. Both DA-D and CMD-A confirmed an order for nectar-thick liquids was written on 01/10/2024 for Resident 5 and the resident's ISP was not updated until 10/03/2024, almost 9 months later. DA-D stated, "I added the nectar-thick liquids to [Resident 5's] ISP on 10/03/2024 after [MCO RN-Q] pointed it out to me...The team lead is responsible to ensure all ISPs are updated and sent out for signatures... [CMD-A] and I are now checking all ISPs monthly to ensure updates and changes have been made." On 04/09/2025, Surveyor reviewed Resident 5's current ISP and noted the ISP included nectar-thick liquids.	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014137	A. BUILDING: _____ B. WING _____	R-C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAN DYKE	1811 S VAN DYKE RD APPLETON, WI 54914

(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 397	Continued From page 3	N 397		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not ensure at least one qualified resident care staff was present in the CBRF on 01/25/2025 when residents were present. Findings Include: The provider is licensed as a class CNA (non ambulatory) to provide care for up to 8 residents with traumatic brain injury, developmental disabilities, advanced aged, physical disabilities, irreversible dementia/Alzheimer's and emotionally	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014137	A. BUILDING: _____ B. WING _____	R-C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAN DYKE	1811 S VAN DYKE RD APPLETON, WI 54914

(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 397	Continued From page 4 disturbed and/or mental illness. On 02/04/2025, the department received a concern regarding staffing. On 01/27/2025, the department received a facility MIR (Misconduct Incident Report) which indicated, "On 01/25/2025 [DA(Division Administrator)-D] received a phone call from our scheduling department letting [her/him] know the members were left alone for a little over an hour. Scheduling stated at 7:55 AM the 8 AM-8 PM staff called into scheduling. Scheduling started working on getting coverage. Once coverage was found a call was placed to [DSP(Direct Support Provider)-P] letting [him/her] know relief staff were coming so [s/he] could leave. [DSP-P] took instructions literally and left the program." Additionally, the MIR indicated, "Residents were checked on and appeared fine and did not seem to be affected. [DSP-P] was pulled from all direct hours and disciplined. All care teams and guardians were made aware of the situation." An "Employee Warning Notice" for DSP-P dated 01/27/2025 indicated, "On the morning of 01/25/2025 you left work at 8:03 AM before a relief staff was able to arrive to the home. This puts member safety at risk and can not happen again. If you are the only staff on working, you must wait until another employee arrives before you can leave." On 04/09/2025 at 10:35 AM, Surveyor interviewed DA-D about the above facility MIR. DA-D explained on 01/25/2025, there was miscommunication between scheduling and DSP-P who was working the night shift. DA-D stated, "On 01/25/2025, the morning staff called in sick, and scheduling was looking for a	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014137	A. BUILDING: _____ B. WING _____	R-C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAN DYKE	1811 S VAN DYKE RD APPLETON, WI 54914

(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 397	Continued From page 5	N 397		

replacement, when scheduling notified [DSP-P] a replacement was on the way, [DSP-P] took it literally and left. Scheduling meant [DSP-P] wouldn't be stuck there and could leave when staff arrived." DA-D confirmed at the time of this incident seven residents were present in the facility and required care and supervision needs. DA-D also confirmed all seven residents were left alone, unattended in the building from 8 AM until 9 AM, because DSP-P left the facility without a replacement staff present. DA-D denied any negative affect to the residents.

On 04/09/2025 at 10:40 AM, Surveyor spoke with CMD (Care Management Director)-A regarding the above incident. CMD-A indicated the overnight staff left at 8 AM on 01/25/2025 and no staff came in until 9 AM leaving all the residents alone and unattended for an hour. CMD-A confirmed no negative outcome occurred to any of the residents during this time. CMD-A told Surveyor an all staff meeting was held and information was added to the new employee orientation training packet regarding, "Not leaving residents unattended" following this incident.

On 01/25/2025, DSP-P left the facility at 8 AM without any other staff present. The replacement staff did not arrive until 9 AM. Residents who required care and supervision needs were left alone, unsupervised for approximately one hour.