STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 07/20/2023, with additional information gathered through 08/03/2023, Surveyor conducted 2 complaint investigations, a self-report review, and a verification visit at Apple Creek Place II. Two complaints were substantiated. Seven deficiencies were identified. Five of 8 previous deficiencies were corrected. Two deficiencies were repeat violations, see Statements of Deficiency (SOD) SYDX11 (dated 01/10/2022) and SOD SYDX12 (dated 10/21/2022). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 19	{N 000}		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide Resident 1 with the ability to make decisions related to his/her care, daily routines, and other aspects of life which enhanced and supported his/her self reliance, autonomy, and decision making. Findings include:	N 355		

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
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 355	Continued From page 1	N 355		

On 07/10/2023, the department received complaint information alleging residents did not have say in their daily routines.

On 07/24/2023, Surveyor reviewed Resident 1's individual service plan (ISP) with print date 09/03/2021, and noted s/he was admitted to the facility on 07/09/2020 with diagnoses of multiple sclerosis, morbid obesity, lymphedema, and spinal stenosis. Surveyor noted:
"Limited ROM [range of motion] due to MS [multiple sclerosis] diagnosis. Hoyer lift for safety ... Endurance/strength vulnerability interventions are: has MS diagnosis Hoyer lift for safety."
"Resident will receive bathing/showering assistance once a week on Thursday morning. Would like a bed bath daily at HS [bedtime] ...Resident will receive bathing/showering (SPECIFY NUMBER) time(s) a week."
"Needs full 2 assist for dressing."
"Is able to make self understood ....Oriented and able to recall or retain information ...Is able to make self understood."

On 07/20/2023 at approximately 3:14 PM, Surveyor interviewed Caregiver F who stated Resident 1 received a bed bath two times a week by night shift. Surveyor inquired whether Resident 1 ever requested a bath or shower and Caregiver F stated yes, but s/he was told Resident 1 was "too large" for the shower and whirlpool. Surveyor inquired whether s/he had ever tried to assist Resident 1 into the shower and s/he said no.

Caregiver F stated Resident 1 was easy to assist and get along with, "as long as you listen to [him/her]." Caregiver F stated some staff rush him/her and "belittle" him/her and that's when Resident 1 gets frustrated. Caregiver F stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 355	Continued From page 2	N 355		

staff transfer Resident 1 to his/her recliner in the afternoon and s/he sits in it until the following morning. Staff are to check on him/her and change his/her insertable pad. Surveyor inquired whether Resident 1 slept in his/her bed. Caregiver F stated s/he believed s/he used to and would probably be more comfortable, but s/he was always told by other staff Resident 1 slept in his/her recliner.

On 07/20/2023 at approximately 12:30 PM, Surveyor interviewed Resident 1 and Resident 2. Resident 1 stated s/he had not received a bath or shower "in ages" and really wished s/he could get something more than a bed bath. S/he could not recall the last time s/he was in a shower. Surveyor observed a walk- in 60x30 shower in Resident 1's bathroom. Resident 1 stated s/he was told on a regular (multiple times a week) basis by staff "I'm the only one here" when they say why they can't assist him/her. S/he said most of the time there was only 1 staff overnight, so "I don't have a choice but to stay in my recliner."

Resident 1 stated s/he will not sleep in his/her bed anymore for a number of reasons. S/he shared the bed was uncomfortable because the head and foot of the bed no longer move and the mattress was uncomfortable. S/he stated however the main reason to not sleep in his/her bed was because s/he had been left in his/her bed numerous times for longer than s/he preferred. Resident 1 stated s/he had MS and it made him/her very stiff and in pain. Resident 1 stated, "I would be stuck there." Resident 1 stated s/he felt s/he had to beg staff to do anything for him/her. Resident 1 shared s/he came to the realization that if s/he was assisted to his/her recliner between 1:30 PM and 2:00 PM then s/he doesn't have to depend on staff to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 355	Continued From page 3	N 355		

transfer him/her again. S/he stated it wasn't necessarily his/her preference, but the bed was uncomfortable for long periods of time and s/he can't depend on staff to get him/her out "timely or at all." Resident 1 said "they [staff] decide if I get up or not."
Resident 1 stated "I have not had my cares done my way for freaking months!"

Resident 2 shared Resident 1 had yelled for around 2 hours one morning because Resident 1 was stuck in bed.
Resident 2 stated 2 weeks ago Resident 1 was in his/her recliner for over 12 hours. Staff had not checked on Resident 1 and his/her pad had not been changed. S/he was soiled with bowel. Resident 1 had his/her call light on, but it was not working. Resident 2 shared s/he told staff that if they didn't come to assist Resident 1 s/he would call 911. Resident 2 stated s/he felt staff meant well, but s/he was tired of having to beg them to help Resident 1.

On 07/21/2023 at approximately 1:39 PM, Surveyor interviewed Resident 1 who stated it would "only take 2 people to spend some devoted time to listen to what I want and then they can be rid of me for many hours - I don't know why they can't give me a little dedicated time since I can't do things myself."

On 08/01/2023 at approximately 1:00 PM, Surveyor interviewed Director A who acknowledged Resident 1 was not always given the opportunity to make his/her own decision related to his/her care and daily routines.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 355	Continued From page 4 N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable Y3244 Wis. Stat. Ch 50.09(1)(l) Care	N 355		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) was reviewed with him/her and included his/her signature acknowledging his/her involvement in, understanding of and agreement with the ISP. Findings include: On 02/13/2023, the department received complaint information that residents were not involved in their plan of care. On 07/24/2023, Surveyor reviewed Resident 1's most updated ISP with print date 09/03/2021.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 389	Continued From page 5 Surveyor noted Resident 1 was his/her own person and able to make his/her needs known. Surveyor noted there were no signatures by provider staff, Resident 1's care team, and Resident 1 acknowledging discussion and development of his/her care plan. On 07/20/2023 at approximately 12:30 PM, Surveyor interviewed Resident 1. Resident 1 stated s/he had not gone over his/her care plan in at least a year and was unsure what it said. On 08/01/2023 at approximately 1:00 PM, Surveyor interviewed Director A who acknowledged Resident 1 had not had a recent care plan review. S/he stated s/he was unable to find any additional documentation for past ISP reviews. Director A indicated they were in the process of updating all care plans and would be completing reviews. Cross Reference: Y3244 Ch 50.09(1)(l) Care	N 389		
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	N 427		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 427	Continued From page 6 to residents. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure a daily activity program to meet the interests and capabilities of residents was provided. The CBRF did not post the activity schedule in an area available to residents. Findings include: On 02/13/2023, the department received complaint information alleging there were no activities at the facility. On 07/20/2023 at approximately 10:40 AM, Surveyor toured the facility. Surveyor did not observe any activities being held. Surveyor observed no activity calendar posted in any common areas. On 07/20/2023 at approximately 1:00 PM, Surveyor interviewed Resident 1 and Resident 2 who both stated there were no activities offered in the facility and very little to do. Resident 2 stated s/he would participate in almost anything as long as it was offered. Resident 1 indicated s/he would be selective on what s/he would participate in, but it would be nice if s/he had a choice on things to do. On 07/20/2023 at approximately 12:21 PM, Surveyor interviewed Resident 4 who stated there was nothing to do at the facility. S/he shared s/he loved crafts and would really like it if they offered crafts.	N 427		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 427	Continued From page 7 On 08/01/2023 at approximately 1:00 PM, Surveyor interviewed Director A who acknowledged activities were not held in the facility. Director A verified an activity calendar was not posted in the facility.	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}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 431}	Continued From page 8	{N 431}		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not montior Resident 3's health and make arrangements for physical health services when s/he was experiencing urinary tract infection (UTI) symptoms timely. Resident 3 moved out of the facility without being tested and treated 7 days after caregiving staff recognized Resident 3's change in condition.

This is a repeat deficiency, see Statement of Deficiency SYDX12, dated 10/21/2022.

Findings include:

On 11/22/2022, the department received complaint information that residents were not receive appropriate and adequate care to meet their needs.

On 07/20/2023, Surveyor conducted a verification visit.

On 07/31/2023, Surveyor reviewed Resident 3's record and noted s/he was admitted to the facility on 05/22/2018 with diagnoses of cerebral infarction, stage 3 kidney disease, peripheral vascular disease, low back pain, benign prostatic hyperplasia with lower urinary tract symptoms, type 2 diabetes mellitus, diabetic polyneuropathy, and depression.

Surveyor reviewed Resident 3's individual service plan (ISP) dated 10/25/2021 and noted s/he required assistance from staff with bathing and dressing. Surveyor noted Resident 3 was able to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 431}	Continued From page 9	{N 431}		

self-propel in his/her wheelchair and pivot transfer independently. Resident 3 had a history of falling and impaired mobility related to cerebral infarction. Surveyor noted Resident 3's ISP was silent to toileting needs.

On 08/02/2023 at approximately 5:00 PM, Surveyor reviewed written information from Guardian D who reported being notified on 11/11/2022 Resident 3 was having UTI symptoms. Guardian D shared s/he had requested they obtain a urine sample in-house versus sending Resident 3 to the hospital. On 11/14/2022, Guardian D spoke with LPN B who verified s/he had also heard Resident 3 was experiencing UTI symptoms and would have staff get a urine sample. On 11/16/2022, LPN B reported to Guardian D "staff was still trying to get a clean sample from [him/her] for the [urinary analysis] UA." On 11/18/2022, Guardian D asked LPN B in person whether the UA was completed, and s/he stated no. Guardian D stated s/he observed Resident 2 with staff twice in the bathroom within a 10-minute span (urine frequency and urgency).

On 07/31/2023, Surveyor reviewed Resident 3's physician orders and virtual communication between Resident 3's physician and LPN B.
Virtual communication - 11/14/2022 LPN B "Resident is having some increased confusion, burning with urination, and abdominal pain. Resident planning to move on the 18th, I was just informed of this. I do not have any information on where [s/he] is going."
Physician Assistant (PA) D " ...[Resident 3 was recently treated for UTI after [his/her] latest ER visit. [S/he] may still have the same infection. Have staff attempt to collect a new UA, please. Thanks"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 431}	Continued From page 10 Physician order dated 11/14/2022 for a urinary analysis/urine culture due to altered mental status. On 08/02/2023 at approximately 5:00 PM, Surveyor reviewed written information from Guardian D who reported on 11/14/2022 s/he requested a tuberculosis (TB) test to be completed as Resident 3 was moving out of the facility on 11/18/2022. LPN B verified s/he had the testing supplies in house, and s/he would complete it his/herself. On 11/16/2022, Guardian D inquired with LPN B if the TB test was completed, and s/he received the response "I attempted TB test yesterday and [s/he] was not compliant. Maybe a chest x-ray is a better avenue to try?" On 11/18/2022, LPN B still had not completed a TB test or obtained a chest x-ray for Resident 3's move to a new facility. On 07/31/2023, Surveyor reviewed Resident 3's virtual communication between PA D and LPN B. 11/18/2022 at 9:00 AM- "Resident is leaving today and refused [his/her] TB test, could we have an order for a chest x-ray please." PA D "What time is [s/he] leaving? It might be too late for BTW [x-ray service] to come out on such short notice." LPN B "It is, [s/he] has left but if I can still have the order encase [sic] the other AL [assisted living] needs it?.." On 08/01/2023 at approximately 1:00 PM, Surveyor interviewed Director A who stated LPN B was no longer an employee at the facility. S/he stated it was his/her understanding that there were issues with obtaining the UA and TB test from Resident 3 but was unable to say more as s/he was not with the company at that time.	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 431}	Continued From page 11 Director A acknowledged Resident 3 did not receive a UA and TB test timely. In conclusion, Resident 3 developed urinary tract infection symptoms that went untested and untreated. On 11/11/2022, provider staff recognized a change in Resident 3's baseline and reported it to Guardian D and LPN B. A UA order was obtained, but urine sample was never collected for testing. Resident 3 moved to a new facility with continued symptoms of UTI. Additionally, on 11/14/2022, Guardian D had requested a TB test be completed for Resident 3's move to a new facility and LPN B stated s/he would complete it. Resident 3 moved to a new facility on 11/18/2022 and the TB test was never completed.	{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 provide a living environment that was safe, clean, comfortable, and homelike. Findings include: On 02/13/2023, the department received complaint information alleging the facility and resident rooms were unclean.	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 481	Continued From page 12 On 07/20/2023 at approximately 12:21 PM, Surveyor interviewed Resident 4. Resident 4 stated there was "very bad housekeeping." Resident 4 stated s/he was told rooms were going to be cleaned weekly and "they are absolutely not cleaned weekly." S/he shared s/he needed assistance with laundry, and when staff bring in laundry, his/her clothes were always damp. Resident 4 said s/he always has to hang them up to dry after they were brought back to his/her room. On 07/20/2023 at approximately 12:30 PM, Surveyor interviewed Resident 1 in his/her room and observed multiple large soiled spots on his/her carpeting, debris throughout the floor of the room, approximately 1 inch piece of moldy sausage on the floor, a pile of cracker crumbs on the floor, a soiled napkin in the corner next to Resident 1's recliner, debris on the bathroom floor, multiple days-worth of hand soap dried to the bathroom floor, and 3 of 4 garbages were overflowing. Resident 1 stated "once in a while the staff vacuum." Resident 1 stated the napkin next to his/her recliner had been on the floor for weeks and s/he couldn't reach the floor to pick it up. Surveyor observed Resident 1's laundry basket to be almost full with dirty laundry. Resident 1 shared s/he had to remind staff weekly to wash his/her clothes. Surveyor observed Resident 1 to be in a power wheelchair and have limited range of motion, affecting his/her ability to reach to the floor. On 07/20/2023 at approximately 2:54 PM, Surveyor interviewed Caregiver F who stated resident rooms were to be cleaned on their shower days and if they need it whenever staff were in there. Caregiver F was unsure when	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 481	Continued From page 13 Resident 1's room was last cleaned. S/he stated s/he noticed the carpeting needed to be shampooed in Resident 1's room for sure. On 08/01/2023 at approximately 1:00 PM, Surveyor interviewed Director A who acknowledged concerns about housekeeping. Director A stated s/he had implemented housekeeping sheets, but it was a work in progress. S/he verified Resident 1 and Resident 4 required assistance from staff with housekeeping and laundry. Cross Reference: N0669 DHS 83.60(2) Insect-Proof Screens On Openable Windows Y3244 Wis. Stat. Ch 50.09(1)(l) Care	N 481		
N 669	83.60(2) Insect-proof screens on openable windows Screens. All required openable windows shall have insect-proof screens. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all required openable windows had insect-proof screens and were free of holes. Findings include: On 02/13/2023, the department received complaint information alleging window screens on the facility were in poor condition. On 07/20/2023 at approximately 10:40 AM, Surveyor observed 2 of 3 window sets on the side of the building facing the parking lot to have multiple (at least 5) dime sized to golf ball sized	N 669		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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 669	Continued From page 14 holes in the window screens. Surveyor observed 1 of 3 window sets to have a missing screen on the window. On 08/03/2023 at approximately 1:00 PM, Surveyor interviewed Director A who acknowledged there being holes in the screens of resident windows and a screen being missing. Cross Reference: N0481 DHS 83.43(1) Environment Clean, Safe, and Comfortable	N 669		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1, Resident 2, and Resident 4 received adequate and appropriate care to meet their needs.	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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
Y3244	Continued From page 15	Y3244		

Findings include:

The provider is a class CNA non-ambulatory CBRF 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 02/13/2023 and 07/10/2023, the department received complaint information alleging residents needs were not being met.

RESIDENT 1:

On 07/24/2023, Surveyor reviewed Resident 1's individual service plan (ISP) with print date 09/03/2021, and noted s/he was admitted to the facility on 07/09/2020 with diagnoses of multiple sclerosis, morbid obesity, lymphedema, and spinal stenosis.
Surveyor noted:
"Monitor resident for pain. Update nurse if new pain noted."
"Limited ROM [range of motion] due to MS [multiple sclerosis] diagnosis. Hoyer lift for safety ... Endurance/strength vulnerability interventions are: has MS diagnosis Hoyer lift for safety."
"Needs full 2 assist for dressing."
"Is able to make self understood ....Oriented and able to recall or retain information ...Is able to make self understood."
"Continent of bowel ...Is incontinent of bladder. Uses incontinent products ...Dispose of used incontinent products every shift."

Surveyor reviewed Resident 2's most recent individual service plan (ISP) with print date 07/20/2023 with diagnoses of diabetes mellitus, bipolar disorder, congestive heart failure, and COPD. Resident 2 was his/her own person and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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
Y3244	Continued From page 16	Y3244		

able to make his/her needs known.

On 07/20/2023 at approximately 12:30 PM, Surveyor interviewed Resident 1 and Resident 2. Resident 1 shared s/he was not checked on by staff. S/he said it was rare if anyone came in even once on the overnight shift.

Resident 2 stated a few weeks ago it was 6:30 AM when staff came in to assist Resident 1 and s/he needed to be changed 4 hours prior to that. Resident 2 reported Resident 1 has sat in his/her own feces for hours before even though s/he was continent of bowel. Resident 1 verified this reporting.

Resident 1 reported having sporadic leg pain and spasms. Surveyor observed Resident 1 being unable to physically lift and reposition his/her legs independently. Surveyor inquired whether s/he reported the pain to staff and s/he stated "yeah, they don't help with it."

On 07/20/2023 at approximately 2:54 PM, Surveyor interviewed Caregiver F who stated, "I feel bad for [Resident 1]." Caregiver F described Resident 1 as needing assistance from 2 staff to transfer with a mechanical Hoyer lift. S/he said the remote for the Hoyer has broken a number of times. Surveyor inquired whether Resident 1 was on any specific checks. Caregiver F stated s/he did not know if s/he was on scheduled checks, but s/he didn't think so. S/he said s/he usually checked with Resident 2 around 2 hours to see if his/her pad needed to be changed. Caregiver F stated s/he knew some staff did not answer Resident 2's call light or check on him/her. Caregiver F stated s/he had heard from Resident 1 and Resident 2 that staff do not check on Resident 1 overnight. S/he stated s/he had come

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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
Y3244	Continued From page 17	Y3244		

in multiple mornings with Resident 2's call light on all night. Surveyor inquired whether s/he knew if Resident 1 had any pain and Caregiver F stated s/he knew s/he was stiff and had troubles lifting his/her extremities.

On 07/20/2023 at approximately 3:14 PM, Surveyor interviewed Caregiver G who stated Resident 1 will either call or they need to check on him/her to see if his/her insertable pad needed to be changed. Caregiver G stated s/he had heard that staff avoid answering Resident 1's call light and checking on him/her so they don't have to go by him/her. Caregiver G indicated s/he volunteered to work with Resident 1 more because of his/her size and demeanor, and because s/he knew other staff were resistant. Caregiver G stated at times there was only 1 staff in the facility and Resident 1 needed 2-staff assist. This would cause both staff and Resident 1 to have to just "sit there and wait."

On 08/01/2023 at approximately 1:00 PM, Surveyor interviewed Director A who stated having challenges with caregivers assisting Resident 1 due to his/her behaviors and size. Director A voiced s/he was not aware of Resident 1 having pain and not always being checked on. S/he verified Resident 1 had MS which affected his/her range of motion and needed full assistance from staff.

CALL LIGHTS:

On 07/20/2023 at approximately 2:54 PM, Surveyor interviewed Caregiver F who stated at times there were issues with the call lights because of the Internet connectivity, the pendants not always working, and the IPads not being able to be carried because of their size. Caregiver F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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
Y3244	Continued From page 18	Y3244		

said call lights were connected to a computer in provider's sister facility, but would alarm on the app on the IPads, so staff have to check the IPads for call lights going off. Caregiver F stated, "It really worries me. Call lights will go a long time sometimes." Caregiver F said the Internet doesn't work regularly, which affects the call light system and phone lines. When the Internet was down, staff don't know and don't know if anyone was paging for assistance.

On 07/20/2023 at approximately 12:30 PM, Surveyor interviewed Resident 1 and Resident 2 who stated the call lights never work.
Resident 1 stated s/he had turned his/her call light on, on and off all night long some nights and staff wouldn't come until the morning.
Resident 2 stated s/he had fallen a few weeks ago and staff did not answer his/her call light, so s/he had to yell for help until someone came to assist him/her.

On 07/20/2023 at approximately 1:00 PM, Surveyor observed Caregiver F check in with Resident 1 to see if s/he wanted to be transferred to his/her recliner. Resident 2 had stated s/he had pressed his/her call light approximately 10 minutes earlier. Caregiver F stated s/he didn't have the IPad as it was on the charger. S/he did not know Resident 2's call light was on.
Surveyor observed Caregiver F return with the IPad and saw that Resident 1 and Resident 2's call lights were on. Resident 2's call light was able to be reset, but Resident 1's was not. Resident 1's call light appeared to have been on since 11:46 AM that day (approximately an hour and a half). Caregiver F took Resident 1's call light out of the room to see if s/he could fix it. Caregiver F returned approximately 5 minutes later with Resident 1's pendant and it appeared to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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
Y3244	Continued From page 19	Y3244		

be working again. Caregiver F stated the battery needed to be changed. Surveyor inquired when the last time the IPads were checked that day, 07/20/2023, and Caregiver F said s/he wasn't sure.

On 07/20/2023, Surveyor reviewed Resident 4's ISP and noted s/he required assistance from staff with most activities of daily living (ADLs). Resident 4 had diagnoses of congestive heart failure, bipolar disorder, anxiety, and rheumatoid arthritis. S/he was able to make his/her needs known.

On 07/20/2023 at approximately 12:21 PM, Surveyor interviewed Resident 4 who Surveyor observed open the drawer in his/her nightstand to show him/her his/her call light pendant. Resident 4 stated s/he didn't wear it because "no one answers it anyways." S/he stated s/he would prefer to have something to call for help and something to help make him/her feel more comfortable. Resident 4 stated s/he had to walk out to the hallway to find someone to help him/her.

On 07/24/2023, Surveyor reviewed a sample call light log and noted from 07/16/2023-07/23/2023, the average response time was 40 minutes and 32 seconds.

On 08/01/2023 at approximately 1:00 PM, Surveyor interviewed Director A who verified issues with the Internet and call light system. Director A stated they now have pagers and were working on enhancing the system in other ways. S/he also said they just upgraded their WIFI. Director A acknowledged call light times exceeded their expectation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017917	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE II	5118 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
Y3244	Continued From page 20 In conclusion, the call light system was not always in proper functioning order allowing for residents the ability to call for assistance when needed. Staff did not carry the proper equipment, in the form of IPads to be able to acknowledge and respond to call lights timely. Resident 1's ISP did not identify Resident 1's needs related to checks or toileting. Resident 1's ISP indicated s/he could make his/her needs known, however with a call light that did not always work and staff not knowing how often Resident 1 should be checked on and/or changed, but Resident 1 fully dependent on staff for ADL's, Resident 1 was not always assisted when needed. Cross Reference: N0355 DHS 83.32(3)(k) Rights Of Residents: Self-Determination N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable	Y3244		