STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015847	A. BUILDING: _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DARBOY ASSISTED LIVING	N9520 SILVER CT APPLETON, WI 54915

(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 11/14/2024, Surveyor conducted a complaint investigation at Darboy Assisted Living. On 11/25/2024, the department received an additional complaint and it was investigated on 11/25/2024, with additional information gathered through 12/18/2024. The 2 complaints were substantiated. Six deficiencies were identified. One deficiency was a repeat violation (see SOD 0M9R11, dated 10/25/2022). Census: 8	N 000		
N 370	83.34(3) More than $200 personal funds from resident Funds in excess of $200. A CBRF receiving more than $200 of personal funds from a resident shall deposit funds in excess of $200 in an interest-bearing account in the resident ' s name in a savings institution insured by an agency of, or a corporation chartered by, this state or the United States. This Rule is not met as evidenced by: Based on record review and interview, the provider received and maintained more than $200 of Resident 1's personal funds without depositing funds in excess of $200 in an interest-bearing account in the resident's name in a savings institution insured by an agency of, or a corporation chartered by, this state or the United States. Findings include: On 08/12/2024, the department received complaint information alleging Administrator A mismanaged residents' personal funds.	N 370		

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

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N 370	Continued From page 1 On 11/14/2024, Surveyor conducted a complaint investigation. On 11/18/2024, Surveyor reviewed provider's "Policy and Procedure on Petty Cash:" "Darboy Assisted Living will keep up to two hundred dollars ($200.00) of petty cash for Residents living at Darboy Assisted Living. An ongoing log will be kept on the spending of this petty cash ..." Surveyor reviewed Resident 1's petty cash report dated 08/01/2024-11/15/2024 provided by Administrator A with a listed "Total On Hand: $436.76." Surveyor noted total counts of cash exceeding $200 for the entirety of the timeline with the highest amount on 08/23/2024 of $1,223.76 and the lowest count being $436.76. On 11/15/2024 at approximately 8:40 AM, Surveyor interviewed Guardian D who stated s/he sent a $200 check to Administrator A for Resident 1's petty cash account as Resident 1 went shopping regularly. Surveyor inquired whether Guardian D was aware of Administrator A having up to $1300.00 at one point in Resident 1's petty cash and s/he indicated s/he believed that sounded right. Surveyor inquired whether Administrator A or Owner C had explored opening an interest-based account in Resident 1's name for any cash exceeding $200 and Guardian D stated no. On 11/14/2024 at approximately 9:15 AM, Surveyor interviewed Administrator A who acknowledged s/he had over $200 in Resident 1's personal funds in cash.	N 370		

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N 427	Continued From page 2	N 427		
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 and interview, the provider did not follow a daily activity program to meet the interests and capabilities of the residents. Employees did not encourage and promote resident participation in the activity program. Findings include: The provider is licensed to provide services for up to 8 residents who may be developmentally disabled, physically disabled, emotionally disturbed/mentally ill, of advanced age, terminally ill, have traumatic brain injury, and/or have Alzheimer's/dementia. At the time of survey, the provider was licensed as a class C, non-ambulatory facility. On 11/14/2024 at approximately 8:40 AM, Surveyor observed a living room with Resident 1, Resident 3, Resident 4, Resident 5, and Resident	N 427		

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6 sitting and watching television.
At approximately 12:00 PM, Surveyor observed the same residents remained in the same seats watching television.

At approximately 9:20 AM, Surveyor observed an activity calendar posted on the wall near the living room.
At approximately 9:27 AM, Surveyor interviewed Caregiver B about activities provided to residents. Caregiver B stated they "sometimes" did activities. Surveyor inquired whether they followed the activity calendar or an activity program and s/he said no. Surveyor inquired what kinds of activities were done with residents since the calendar was not referenced and s/he said residents sometimes walked around the building or colored, but otherwise "they just watch TV all day."

Surveyor reviewed Resident 1's individualized service plan and noted, "ACTIVITY PARTICIPATION MONITORING ...Daily@ 10:00 AM, 2:00 PM, 7:00 PM, As Needed..Keep [him/her] busy with gardening, build a bird house, taking out the garbage, give [him/her] little jobs around the house ...To ensure they are participating in activities daily to maintain both mental and physical health."
"Resident at times is very anxious, keeping [him/her] busy to settle down [his/her] anxiety work. Working with the garden, watering flowers, pulling weeds helps."
"[S/he] loves to talk to other residents, go for walks helps [sic] cut [his/her] anxiety down, planting plants, water plants helps [his/her] anxiety."

On 11/14/2024 at approximately 9:09 AM, Surveyor interviewed Resident 1 who stated s/he

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N 427	Continued From page 4	N 427		

was glad s/he worked so s/he could get out once in a while. Resident 1 indicated s/he did not have much to do at the facility.

On 11/15/2024 at approximately 9:24 AM, Surveyor interviewed Community Care Inc Care Manager (CM) F who stated s/he had never witnessed activities being initiated or done with residents during his/her visits. CM F indicated Resident 1 enjoyed gardening and helping out as s/he liked to be "busy, busy."

On 11/25/2024 at approximately 9:10 AM, Surveyor interviewed Resident 3 who stated s/he got bored often and wished there was more to do at the facility.

Surveyor reviewed Resident 3's record and noted s/he was his/her own person, able to make his/her needs known, and had frequent contact with his/her family. Resident 3's individualized service plan with print date 11/15/2024 listed "ACTIVITY PARTICIPATION MONITORING ...To ensure they are participating in activities daily to maintain both mental and physical health."

On 11/25/2024 at approximately 9:00 AM, Surveyor interviewed Caregiver E who stated s/he developed the activity program. Surveyor inquired whether staff provided activities to the residents and Caregiver E stated they were supposed to, but s/he doesn't know what others do.

On 11/25/2024 at approximately 9:18 AM, Surveyor interviewed Administrator A who acknowledged a daily activity program was not followed and staff did not provide, encourage, and promote participation in activities.

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N 427	Continued From page 5 Cross Reference: Y3234 50.09(1)(e) Treatment	N 427		
N 637	83.59(1)(g) Proper exit locations, sidewalks, driveways. All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also meets this requirement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 2 exits was maintained to have a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building. The facility had 2 exits to the outside. One of the 2 exits, the back patio exit, had multiple obstructions, limiting the ability to exit in an emergency to the designated safe	N 637		

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N 637	Continued From page 6 space. This is a repeat deficiency. See Statement of Deficiency (SOD) 0M9R11, dated 10/25/2022. Findings include: The provider is licensed to provide services for up to 8 residents who may be developmentally disabled, physically disabled, emotionally disturbed/mentally ill, of advanced age, terminally ill, have traumatic brain injury, and/or have Alzheimer's/dementia. On 11/14/2024 through 12/18/2024, Surveyor conducted complaint investigations. On 11/25/2024, Surveyor conducted a second onsite visit. At approximately 8:45 AM, Surveyor drove into the facility parking lot and observed the back of the facility which was fenced in. Surveyor noted the gate of the fence was visibly misaligned from his/her vehicle while driving in. At approximately 8:54 AM, Surveyor exited out the back door of the building identified as an exit. Surveyor observed a cement patio with a sitting area and a grass yard surrounded by a wooden fence. The cement patio stretched from the door to the fence gate. Surveyor observed the following completely obstructing the path from the door to the fence gate: -an approximate 6 foot by 4 foot indoor black rug that was partially rolled up -3 metal patio chairs -a patio table with a folded-up patio umbrella on top of it and laying into the pathway -a seat cushion on the ground -a rake on the ground	N 637		

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N 637	Continued From page 7 Surveyor observed the fence gate was misaligned with the fence around it. The gate was at an approximate 20-degree angle from the fence creating a gap on each side of the fence on the bottom and top of the gate. Surveyor observed a fully rusted bolt lock that was unable to be moved halfway through the 4x4 wood fence post. Surveyor was unable to move the bolt, pull the gate shut, or open the gate. Surveyor noted wear on the 4x4 of where the bolt path scraped the wood. At approximately 8:58 AM, Surveyor and Caregiver E went to the back patio. Caregiver E verified the patio furniture and other items were obstructing the path and s/he moved the rake to get to the gate. Surveyor inquired how long the furniture and other items were obstructing the path to the gate and Caregiver E stated s/he was not sure. Surveyor inquired how long the gate had been misaligned and Caregiver E stated s/he was not sure. Caregiver E attempted to open the gate with the bolt lock and was unable to move the lock, close the gate, or pull the gate shut to realign the gate and fence. Caregiver E stated "oh that's nice." Caregiver E indicated s/he did not think the gate was like that the last time s/he would worked, but could no confirm. Caregiver E verified the gate was the second exit in the case of an emergency. On 11/25/2025, Surveyor reviewed the emergency exit plan and facility map and verified an exit at the front of the facility and an exit at the back of the facility were the only 2 exits from the facility. Surveyor verified the back exit plan route was out the back door through the fence gate and to the parking lot. On 11/25/2025 at approximately 9:18 AM,	N 637		

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N 637	Continued From page 8 Surveyor interviewed Administrator A who stated s/he was not aware of the gate being unable to be opened and would get it fixed. Administrator A acknowledged the obstructions to exit the facility to a designated safe place in the case of an emergency. Cross Reference: N0639 83.59(2)(a) One-Hand, One-Motion Door Operation	N 637		
N 639	83.59(2)(a) One-hand, one-motion door operation All doors shall have latching hardware to permit opening from the inside with a one-hand, one-motion operation without the use of a key or special tool. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all doors had latching hardware to permit opening from the inside with a one-hand, one-motion operation without the use of a key or special tool. Six of 8 resident rooms did not have one-hand, one-motion operating door handles. Findings include: The provider is licensed to provide services for up to 8 residents who may be developmentally disabled, physically disabled, emotionally disturbed/mentally ill, of advanced age, terminally ill, have traumatic brain injury, and/or have Alzheimer's/dementia. On 11/14/2024 at approximately 9:18 AM, Surveyor and Caregiver B toured the facility. Surveyor sampled resident room 2's door handle to verify one-hand, one-motion when locked from	N 639		

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N 639	Continued From page 9 the inside and observed the door handle was not one-hand, one-motion. Surveyor tested the door handles on each resident door and observed rooms 3, 4, 5, 6, and 7 also did not have door handles that were one-hand, one-motion. Caregiver B acknowledged observation of Surveyor locking the doors from the inside and being unable to unlock the doors from the inside with the one-hand, one-motion for 6 of the 8 resident rooms. On 12/18/2024 at approximately 3:06 PM, Surveyor reviewed email correspondence from Administrator A who acknowledged not all resident door handles were one-hand, one-motion. Cross Reference: N0637 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways	N 639		
Y3234	50.09(1)(e) Treatment (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: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact.	Y3234		

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This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure Resident 1 and Resident 2 were treated with courtesy, respect and full recognition of their dignity and individuality, by all employees of the facility.
Resident 1's room as well as majority of the facility was malodorous of urine due to Resident 1's incontinence and him/her urinating in his/her room. Resident 1's room was not cleaned regularly.
Resident 1 slept on a dirty bed without a bed frame and on top of a blue tarp without blankets or sheets.
Resident 1 and Resident 2's personal belongings were not kept in their rooms.
Resident 1 was required to empty his/her pockets and be searched upon re-entry to the facility. His/her room was to be searched at staff's discretion.
The kitchen was locked "because of Resident 1."

Findings include:

The provider is licensed to provide services for up to 8 residents who may be developmentally disabled, physically disabled, emotionally disturbed/mentally ill, of advanced age, terminally ill, have traumatic brain injury, and/or have Alzheimer's/dementia. At the time of survey, the provider was licensed as a class C, non-ambulatory facility.

On 08/12/2024 and 11/25/2024, the department received complaint information alleging residents were searched, did not have access to their

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personal belongings, and were not treated with dignity and respect.

On 11/14/2024 and 11/25/2024, Surveyor conducted complaint investigations.

INCONTINENCE & ODORS
On 11/14/2024, upon entry to the facility at approximately 8:35 AM, Surveyor noted a significant malodorous scent of urine which continued throughout the facility.

At approximately 8:40 AM, Caregiver B said within earshot of Resident 1, Resident 3, Resident 4, Resident 5, and Resident 6 (who were later identified), "it smells like pee because of [Resident 1]," and pointed to Resident 1.

On 11/15/2024, Surveyor reviewed Resident 1's record and his/her face sheet indicated s/he had diagnoses of schizophreniaand anxiety. S/he had a legal guardian and was admitted to the facility on 01/23/2023.

Surveyor reviewed Resident 1's individualized service plan (ISP) with print date 11/14/2024 indicated s/he was independent with mobility and required assistance with bathing as well as prompting and cueing with dressing and toileting. Surveyor noted the following care needs and behaviors related to toileting/incontinence care: "TOILET CHECK - SCHEDULED ...Follow their toileting schedule and assist in monitoring and assisting. [sic] Wears a depends at night with a bed pad on [his/her] bed every night. [S/he] needs to changed [sic] [his/her] depends every night. Staff (PM shift) should also be making sure resident uses the restroom, properly makes [his/her] bed with disposable bed pads, ensures resident puts on [his/her] depend *UNDER

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Y3234	Continued From page 12 [HIS/HER] UNDERWEAR NOT OVER* all before resident goes to bed for the night. ((((YOU CAN NOT DOUBLE BREIF [sic] [HIM/HER] THAT IS AGAINST RESIDENTS RIGHTS)))) ...Daily @ 1:00 AM, 3:00 AM, 5:00 AM, 7:00 AM, 9:00 AM, 11:00 AM, 1:00 PM, 3:00 PM, 5:00 PM, 7:00 PM , 9:00 PM, 11:00 PM." "BATHING - AS NEEDED ASSISTANCE ...Monitor and provide assistance as needed with bathing/showering. Resident needs to be timed/supervised while in the shower. Writer recommends letting resident know staff is close by and timing how long resident is in the shower and also making sure resident is all the way in using soap and hand towel to properly clean [him/herself]. Staff will also spend the weekend washing residents clothes which will then be kept in the locked closet across from residents room. A new set off [sic] clean clothes can be given to resident each day to ensure [s/he] has a fresh set of clothes for work/ outings. [S/he] needs to be a 1 assist with all shower from now on. Staff can be in the shower room with resident, giving [him/her] cues how to shower, how to change clothes, how to clean [his/her] room, change [his/her] sheets, etc ....Make sure that [his/her] clothes are clean before [s/he] goes to work as work complains [s/he] smells." Surveyor note: Resident 1's ISP was silent to Resident 1's history of behaviors related to urination outside of his/her briefs and the toilet, the use of a urinal, guidance to staff on cleanliness related to incontinence, where his/her clothes were stored, and interventions related to behaviors. Surveyor reviewed Resident 1's observation note from 08/02/2024 at 4:45 PM written by	Y3234		

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Administrator A. "Make sure that [Resident 1] is toileted every 2 hrs [hours] at night, in the am [morning] make sure [his/her] room is clean and dry and doesn't smell like urine, [s/he] likes to hide wet urine soaked clothes in drawers, closets, plastic containers in [his/her] room ...Please make sure that [s/he] is up and out of bed by 7:30 on mon, Tues, Thurs, Fri for work that [sic] [s/he] showers and has clean clothes on and clean pulls ups. I don't want [him/her] going to work or any where smelling like urine. Also makes [sic] sure that [his/her] urinal is cleaned out in the am. Don't let [him/her] drink out of it either. Any questions please give me a call."

At approximately 8:50 AM, Surveyor interviewed Administrator A on the phone. S/he described Resident 1 as "needing a lot of redirection and having incontinence issues."

On 11/14/2024, at approximately 8:56 AM, Surveyor interviewed Caregiver B. S/he indicated Resident 1 peed on the floor in his/her room. Surveyor and Caregiver B observed Resident 1's bedroom floor to have a discolored sediment, sticky, and visibly dirty. Resident 1's room was pungent with urine odor. Surveyor inquired when the last time the floor was specifically cleaned and Caregiver B said s/he didn't know as Resident 1 would just pee on it again after it was cleaned. Caregiver B said Resident 1 wore briefs only at night, as s/he was continent during the day, but very incontinent at night or would urinate in various places or on his/her belongings at night. Surveyor inquired whether Resident 1 had a urinal and Caregiver B said yes, but s/he did not know where it was. Caregiver B indicated s/he did not know what the cleaning schedule was or where the housekeeping list was. Caregiver B stated s/he worked at the facility on rotation, but

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was there regularly.

Surveyor and Caregiver B observed where Resident 1 slept. Caregiver B stated the facility provided Resident 1 with his/her furniture. There was no bed frame; a twin box spring was on the floor covered in a misfitting bed skirt that had light brown stains throughout it; a dirty twin box spring on top of the other; a twin extra-long (exceeded the length of the 2 box springs) all foam mattress that had a microfiber covering which was cream in color, but had large brown stains throughout it. One of the stains on the mattress was in the shape of a large graduated streak measuring approximately 2 ½ feet in length and 1 ½ feet width, the entire thickness of the mattress. On top of the mattress was a large blue tarp (approximately 7 foot), 2 disposable chux (incontinence) pads, and a brown-tinged pillow without a pillow case. (Photo 1) The bed did not have any bedsheets or blankets. Caregiver B verified Resident 1 slept on the bed including the tarp at night. S/he said Resident 1 had to sleep on the tarp because s/he was so incontinent. Caregiver B said there were usually bedsheets and that they were likely in the wash. Surveyor asked if s/he took bedsheets and blankets off the bed that morning to be washed and s/he said no.

At approximately 9:09 AM, Surveyor interviewed Resident 1 who was able to clearly communicate and converse. S/he presented awareness and was forthcoming of his/her impulses and tendencies. Resident 1 and Surveyor went into his/her room and Resident 1 stated s/he had tarp on his/her mattress because it was less likely for the urine to get to the mattress. Resident 1 stated the manager told staff to put it there. Surveyor inquired whether Resident 1 liked sleeping on a tarp and s/he stated "no, it's not the

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best." Resident 1 stated s/he would be getting a rubber mattress with a protector at his/her new home as it was "cleaner." Surveyor inquired whether s/he had sheets, a pillowcase or blankets at night time and s/he said not always, but sometimes. Resident 1 indicated s/he wore briefs at night, but often urinated through them because s/he was "big time" incontinent and sleep through the "bed wetting." Resident 1 stated s/he can use the toilet, but also had a urinal to urinate in. Surveyor asked where the urinal was and Resident 1 said s/he did not know. Surveyor asked if s/he could recall the last time s/he had the urinal in his/her room and Resident 1 said s/he could not remember. Resident 1 stated that his/her room and the facility "smelled really bad" because of his/her urine and incontinence, and s/he wished that there was an air scent in the outlet. Resident 1 did not know the last time his/her room was cleaned. S/he stated that staff would tell him/her that s/he "can be a lot."

On 11/27/2024 at approximately 9:00 AM, Surveyor reviewed written information from Power of Attorney for Healthcare (for Resident 2) G who stated s/he had concerns about the care of the facility and said "one resident has a blue tarp on [his/her] bed as a sheet."

On 11/15/2024 at approximately 9:24 PM, Surveyor interviewed Community Care Inc. Managed Care Organization Care Manager (CM) F who stated upon their assessment, Resident 1 required more supervision and support than the provider gave him/her and they were choosing to relocate him/her. CM F stated Resident 1's room had a super strong odor and often smelled like urine upon all visits to the facility.

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Y3234	Continued From page 16 On 11/15/2025 at approximately 8:39 AM, Surveyor interviewed Guardian D who indicated s/he did not like how Resident 1 was treated at the facility by staff and management. Guardian D stated Resident 1 required more cares and autonomy than what was being provided. Guardian D indicated the facility especially Resident 1's room was unclean and odorous of urine. Guardian D said Resident 1 had a history of not showering, to the point that his/her work had to send him/her home for being odorous. The facility would not ensure s/he was showering, cleaning up, and free of odors. S/he said Resident 1 had a history of heavy incontinence, refusing to use the bathroom, hiding soiled depends and clothes, and urinating in areas other than the toilet. S/he indicated Resident 1 had been evaluated multiple times for various underlying causes, but it was found to be behavioral. Guardian D voiced awareness of the bed not having a bed frame and the mattress, box springs being heavily soiled and odorous. Guardian D was not aware Resident 1 had been sleeping on a tarp and sleeping without bedsheets, a pillowcase and blankets. Guardian D voiced disbelief and upset learning that Resident 1 had been sleeping on a tarp. On 11/25/2025 at approximately 9:18 AM, Surveyor interviewed Administrator A who stated Resident 1 urinated "all over the place." S/he said Resident 1 was on 2 hour checks for staff to get him/her up overnight to go to the bathroom, but Resident 1 would refuse and refuse to change his/her depends. Administrator A verified Resident 1's bed was provided by the facility. Administrator A acknowledged awareness of Resident 1 sleeping on the tarp and stated the tarp was to protect the bed from getting any more stained. S/he said Resident 1 would pull apart	Y3234		

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the bedding and take off the mattress protectors. Surveyor voiced his/her personal opinion that Resident 1 having to sleep on a tarp was heartbreaking and Administrator A said "it is heartbreaking."

ACCESS TO PERSONAL BELONGINGS
On 11/14/2024, at approximately 8:56 AM, Surveyor interviewed Caregiver B who showed Surveyor a locked "linen" closet in the hallway. Surveyor inquired whether the closet door was always kept locked and s/he said yes. Caregiver B stated Resident 1 and Resident 2's clothes and some other personal belongings were kept in the closet. Surveyor noted laundry baskets filled with clothing as well as shelves that wrapped around the walk-in closet filled with clothing, linens and other belongings.

RESIDENT 1
While in the linen closet, Surveyor and Caregiver B noted 3 urinals on the top shelf of the closet. Surveyor noted Surveyor and Caregiver B were not able to reach the top shelf. Caregiver B said "oh, those (urinals) are [Resident 1's]." Caregiver B stated Resident 1 "pees on everything and then will put it on the floor," or mix his/her clean and dirty clothes, so "we don't let [him/her] have [his/her] clothes in [his/her] room anymore. S/he said the 3 baskets on the floor were Resident 1's. S/he said the closet had to be kept locked because otherwise Resident 2 would go into it and "take everything." Caregiver B also stated Resident 1 had a history of property destruction, so they had to remove almost all of his/her items from his/her room. Caregiver B indicated they would not fix or replace any items due to Resident 1's behavior.

Surveyor and Caregiver B observed Resident 1's

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room located in the same hallway as the linen closet and noted 2 articles of clothing hanging in his/her closet, a 6 drawer dresser that had broken/misaligned drawers and multiple marks and dings throughout, 3 toy vehicles, a computer monitor, a missing closet door, and broken blinds. At approximately 9:09 AM, Surveyor inquired with Resident 1 where his/her clothes were. Resident 1 stated that s/he could ask for his/her clothes and staff would get them from the closet. Surveyor inquired whether s/he would like to have access to his/her clothes whenever s/he wanted and Resident 1 stated "it would be nice, they're locked usually." Resident 1 voiced frustration with not having personal belongings in his/her room and said that many of his/her items were missing, specifically naming his/her clock radio.

On 11/15/2024 at approximately 9:09 AM, Surveyor interviewed Guardian D who stated s/he was not aware of Resident 1's clothing being kept in the closet in the hallway or locked.

On 11/15/2024 at approximately 9:24 AM, Surveyor interviewed CM F who indicated Resident 1 had a history of hoarding, but s/he noticed Resident 1 did not have many personal belongings at the facility upon his/her most recent visit.

Surveyor reviewed Resident 1's observation note from 11/12/2024 at 5:45 PM, written by Administrator A. "Resident will be moving on Friday. Please get all [his/her] clothes out of the closet and put together in bags. Friday [s/he] will stay at home from work so [s/he] can be ready to move. Friday after am meds please put all [his/her] medication [sic] together. Count all [his/her] meds print a face sheet and put on there how many meds [s/he] has in the cards, bottles

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and put on med list. Have [him/her] sign all the meds [s/he] is taking so [s/he] can't say we didn't send [his/her] medications with [him/her]. Check all prn's [as needed medications] also. Friday am pack up [his/her] room and have [him/her] ready after 12noon [sic]. They will pick [him/her] up at 1pm. Make sure [s/he] doesn't take anyone else['s] stuff please. Have [his/her] boxes of pads also ready too. Thank you."

RESIDENT 2
On 11/14/2024 at approximately 9:00 AM, Surveyor interviewed Caregiver B about Resident 2 and toured his/her room. Caregiver B described Resident 2 as having dementia and being known to put multiple layers of clothing on at a time. Surveyor noted Resident 2 had a tall dresser and a long, shorter dresser with many drawers in his/her room. Resident 2's tall dresser had a drawer with approximately 2 pairs of pajamas in it. All other drawers in the tall dress and short dresser were empty. Caregiver B indicated Resident 2's clothes were kept in the locked linen closet in the hallway. S/he said s/he didn't understand why they kept Resident 2's clothes in there because "it's not right to not have access to clothes." Caregiver B indicated Resident 2 "can't change [his/herself] anymore anyways."

On 12/02/2024, Surveyor reviewed Resident 2's ISP with print date 11/29/2024 and noted s/he had an activated Power of Attorney for Healthcare and diagnoses of Alzheimer's disease, mood disorder, and peripheral vascular disease. Resident 2's ISP listed Resident 2 required as needed assistance with dressing and also 1 assist at all times with dressing. "Requires monitoring and assistance as needed with dressing and undressing as well as choosing

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proper attire ...Resident's Desired Goals & Outcomes: To maintain proper attire for the day and receive assistance if necessary to complete dressing. Service Provider Responsibilities: Staff to monitor and observe and update a manager/nurse if any changes. Resident is a assist of 1 for dressing at all times. [S/he] resists cares but keep trying different ways to get [him/her] dressed or undressed."

On 12/16/2024 at approximately 11:35 AM, Surveyor reviewed email correspondence from Power of Attorney for Healthcare (POAHC) G. POAHC G stated Resident 2 required assistance from staff for all dressing needs and stated confusion with his/her clothes not being kept in his/her room. "They threw everyone's belonging into the same closet and mixed everything together and not in separate bins. This was not ok with me, as many items were lost along with some bedding."

On 11/25/2024 at approximately 9:18 AM, Surveyor interviewed Administrator A who verified Resident 1's clothes were kept in the linen closet in the hallway when s/he resided there "per the guardian's wishes of Resident 1 having a clean outfit." Administrator A said that Resident 1 should have always had access and it shouldn't have been locked.
Administrator A stated s/he was not aware Resident 2's clothes were kept in the linen closet.

BODY & ROOM CHECKS
On 11/14/2024 at approximately 8:50 AM, Surveyor interviewed Administrator A on the phone. S/he said Resident 1 "putzes" with things and has been known to steal from work and stores, so s/he was asked to empty his/her pockets by staff. Surveyor inquired whether there

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was a Client Rights Limitation or Denial (CRLD) with the MCO or county and Administrator A said no, it was listed in his/her ISP that "they s/he should empty [his/her] pockets and could search [his/her] room" at staff's discretion.

Surveyor reviewed Resident 1's ISP and noted the following regarding body and room checks: "30 MIN CHECKS ...Document behaviors ... [Resident 1] has a hx [history] of starting fires/burning holes in [his/her] blankets. [S/he] will also collect/take apart items to put them together which results in the potential for fire/explosion. [S/he] will also take apart most electronic items apart [sic] to use various wires and reattach hem making alternative items - same potentials. Staff will complete room searches with [Resident 1] present at random times for safety. [Resident 1] has put others at risk due to him taking/putting items that are at risk for starting fires/Explosions [sic]. [Resident 1] will also use smoking materials to burn items."

"DESTRUCTIVE/ABUSIVE - INDEPENDENT ...Displays no destructive/abusive behaviors. Resident has tried to start [his/her] blanket on fire in [his/her] room. So lighters need to be in the med cart for safety ...
RESIDENT SMOKES ...Cigarettes' [sic] and Lighter need to be in the med cart at all times. Resident can come get a cigarette from staff in med cart for safety reasons ...[S/he] has been smoking in [his/her] room and opening [his/her] windows and crawl out to smoke. [S/he] has tried to light items on fire while having a lighter in [his/her] room."

"RESIDENT IS A HOARDER CHECK ROOM OFTEN FOR SAFETY ...Ask resident if [s/he] can show you what [s/he] has brought from work,

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store. Ask if [s/he] has anything new in [his/her] room that [s/he] may who [sic] you."

"COMMUNITY CONTACTS ...Resident has one to multiple contacts throughout the community. May be visited or visit them on occasion. Guardian, Community Care, MD. [S/he] does have a shopper on every other Wednesdays that takes [him/her] shopping. [S/he] needs to be watched at all times shopping due to history of shop lifting."

"EMPLOYED ...Needs to be supervised at work due to impulsiveness. [S/he] will walk off the floor and be distracted at a drop of the hat."

"ATTITUDE - SUPERVISE/INTERVENE ...To receive complete assistance and care from staff redirecting negative attitudes. Be firm, [sic] with [him/her] but don't raise your voice, or disrespect [him/her], or go against [his/her] rights in any way with [him/her]. [S/he] gets very nervous and will pace if [s/he] thinks [s/he] is in trouble."

Surveyor reviewed Resident 1's observation note from 08/02/2024 at 4:45 PM written by Administrator A. " ...[S/he] also likes to collect garbage and take and put it under [his/her] bed or pillow. [S/he] has a history of hoarding so [s/he] will hide things in [his/her] room, creqt [sic] things, crawl out of [his/her] windows and smoke. Make sure all smoking materials are in the med cart. Have [him/her] empty [his/her] pockets after work as [s/he] likes to steal things and bring them home. Keep a close eye on [him/her] ..."

On 11/14/2024 at approximately 9:09 AM, Surveyor interviewed Resident 1. Surveyor asked Resident 1 what his/her routine was upon returning from work or shopping trips and s/he

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said that staff searched him/her and made him/her empty his/her pockets. Resident 1 stated "I don't feel good about that," but expressed acceptance as s/he shrugged his/her shoulders. Resident 1 stated s/he did have a tendency and impulse to grab things without paying while at stores.

On 11/14/2024 at approximately 8:56 AM, Surveyor interviewed Caregiver B. Surveyor inquired about other behaviors Resident 1 had. Caregiver B indicated Resident 1 was known to steal things when he was away from the facility at work or at stores. Caregiver B recalled a time where Resident 1 stole from the local gas station. S/he stated when Resident 1 comes home from work or being out in the community, staff are to ask him/her to empty his/her pockets and search him/her. Surveyor inquired whether they ever looked in his/her room and Caregiver B said yes, we are to search his/her room whenever we need to because s/he hides things and has been known to do risky things with items, such as cigarettes and lighters.

SECURE AREA "BECAUSE OF" RESIDENT 1
On 11/14/2024 at approximately 9:27 AM, Surveyor and Caregiver B toured the dining area and kitchen. Surveyor noted the kitchen door was a sliding door that had a 2x4 of wood attached to it spanning the height of the door. On the 2x4 of wood was a key locking safety hasp on both sides of the door with the reciprocating hardware on the adjoining wall for both locks. Surveyor noted with a key lock being on either side, the door could be locked from the outside and inside. Surveyor observed Caregiver B lock it upon leaving the kitchen. Surveyor inquired why the kitchen door was locked and Caregiver B indicated s/he wasn't sure, but s/he thought it was

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"because of" Resident 1 and a previous resident who no longer resided there. Surveyor inquired what Resident 1 did to not be able to go in the kitchen and Caregiver B stated s/he did not know and that's just what s/he was told. Surveyor asked whether Resident 1 was independent with getting beverages or coffee as Surveyor observed Resident 1 to be drinking a cup of coffee. Caregiver B stated yes, Resident 1 could get his/her own coffee and reached over the counter to pour him/herself a cup since the kitchen door was locked.

On 11/14/2024 at approximately 9:09 AM, Resident 1 stated to Surveyor s/he wished s/he could have more coffee, beverages, and snacks.

On 11/15/2024 at approximately 9:09 AM, Surveyor interviewed Guardian D and inquired whether there was an incident with the kitchen or whether Resident 1 was unsafe in the kitchen/getting his/her own coffee. Guardian D stated s/he was not aware of any. Guardian D stated s/he did not know the kitchen being locked was "for [Resident 1]."

On 11/15/2024 at approximately 9:24 AM, Surveyor interviewed CM F who stated Resident 1 "really likes [his/her] snacks and coffee."

On 11/25/2024 at approximately 9:05 AM, Surveyor interviewed Caregiver E who was observed leaving the kitchen and not locking the sliding door. Surveyor inquired whether the kitchen door was regularly locked and Caregiver E stated it used to be, but isn't anymore because Resident 1 didn't live there anymore. S/he indicated that Resident 1 was "a lot."

On 11/25/2024 at approximately 9:18 AM,

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DARBOY ASSISTED LIVING	N9520 SILVER CT APPLETON, WI 54915

(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
Y3234	Continued From page 25 Surveyor interviewed Administrator A who stated the kitchen should not have been locked. S/he said s/he wasn't aware of any incidents regarding the kitchen and Resident 1. Surveyor asked why the locks were on the doors and why staff locked the doors and Administrator A stated s/he would have the locks removed. On 11/18/2025, Surveyor reviewed the provider's Program Statement: "Darboy Assisted Living's philosophy is to offer its Residents a warm place to live that feels like home and the opportunity to continue to live in our home as you progress towards the end of life" "[Residents] will have their needs met emotionally, spiritually, socially, and medically with a strong team of professionals. The Darboy Assisted Living Team will work closely with these residents and their families, Physicians or Psychiatrists to ensure that their quality of life is maintained as much as possible" "Darboy Assisted Livings [sic] Ultimate goal is to provide a warm, safe and carefree home for you. To accomplish this, Grand Horizons Darboy [sic; previous provider] will look at you as a whole person and work as a team to develop your plan of care." "D. Darboy Assisted Living will have caregivers - They will provide 24 hour awake staff to care, assist and supervise you with all your activities of daily living including: bathing, toileting, feeding, assist with medication administration, meal preparation, or housekeeping." "F. Darboy Assisted Living will provide three (3) meals a day and have snacks available 24 hours a day." "G. Darboy Assisted Living will have internal laundry facilities for personal clothing. Darboy Assisted Living will launder personal items as needed and bed linens on a weekly basis."	Y3234		

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"H. Housekeeping is done by staff on a daily basis to keep the facility neat and clean at all times."

On 11/15/2025 at approximately 8:39 AM, Surveyor interviewed Guardian D who described Resident 1 as having "high needs" and reported a need for Resident 1 to have more responsive staff and management. Guardian D indicated Resident 1 was moving to a different facility that day, on 11/15/2025 per Guardian D and Care Manager F's decision.

On 11/25/2024 at approximately 9:18 AM, Surveyor interviewed Administrator A. S/he verified Resident 1 was relocated to an alternative facility on 11/15/2024. Administrator A described Resident 1 as needing a lot of cueing and being improperly medicated for his/her "high anxiety."

On 12/18/2024 at approximately 3:06 PM, Administrator A acknowledged concerns with Resident 1 and Resident 2's care and treatment at the facility.

In conclusion, Resident 1 was identified as having behaviors that affected his/her daily living and had the potential of affecting the daily living of other residents. The provider did not implement or follow through on interventions to support the resident and mitigate behaviors.
Resident 1's incontinence and toileting needs were not met, creating an unsanitary and odorous environment, which had the potential to affect all 8 residents residing in the facility.
Resident 1 was not treated with dignity and respect as staff referenced him/her as "being a lot," talked about his/her urine odor in front of him/her and others, searched him/her in front of others, had room searches at staff's discretion,

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Y3234	Continued From page 27 was sleeping on a tarp, and was not provided unbroken furniture, a clean room, a clean bed and consistent clean bedding. Resident 1 and Resident 2 were not provided with autonomy as they did not have access to their personal belongings. All residents were limited access to the kitchen due to assumed behaviors by Resident 1. Cross Reference: N0370 83.34(3) More Than $200 Personal Funds From Resident N0427 83.38(1)(c) Leisure Time Activities N0639 83.59(2)(a) One-Hand, One-Motion Door Operation Y3244 50.09(1)(L) Care	Y3234		
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.	Y3244		

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This Rule is not met as evidenced by:
Based on record review, observation and interview, the provider did not ensure Resident 2 received adequate and appropriate care within the capacity of the facility.

Findings include:

The provider is licensed to provide services for up to 8 residents who may be developmentally disabled, physically disabled, emotionally disturbed/mentally ill, of advanced age, terminally ill, have traumatic brain injury, and/or have Alzheimer's/dementia. At the time of survey, the provider was licensed as a class C, non-ambulatory facility. At the time of survey the census was 8 residents.

On 08/12/2024 and 11/25/2024, the department received complaint information alleging resident care needs were not being met.

On 11/14/2024 through 12/18/2024, Surveyor conducted complaint investigations.

On 11/14/2024 at approximately 9:03 AM, Surveyor and Caregiver B went into Resident 2's room. Surveyor noted a distinct urine like odor entering the room. Surveyor noted the window was open despite it being a cool weather November day. Surveyor observed Resident 2 was in a crouched over position with his/her head down, elbows tucked tight to his/her sides and sitting at the edge of his/her bed. S/he was wearing a short sleeve pajamas and did not have any shoes or socks on his/her feet. Surveyor observed Resident 2 to be very thin in stature. Caregiver B said "[Resident 2] lay down." Surveyor observed Caregiver B help Resident 2

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lay back down in bed. Caregiver B indicated Resident 2 sat up on the edge of his/her bed like this often. Surveyor inquired whether Resident 2 got up out of bed and Caregiver B said rarely and indicated s/he slept a lot and stayed in his/her room. Caregiver B described Resident 2 as having dementia that had been worsening over the past 2-3 months and was now on hospice. S/he said Resident 2 refused to get assistance often in the past and would do things like put multiple layers of clothes on, but s/he did not do that anymore and just slept a lot. Surveyor inquired whether Resident 2 was taken to the bathroom and s/he said s/he was incontinent, but had a commode in his/her room. Caregiver B indicated s/he would "come back" to change Resident 2.

RESIDENT 2'S PROVIDER RECORD
On 12/03/2024, Surveyor reviewed Resident 1's record and noted on his/her face sheet s/he moved to the facility on
02/23/2024 with diagnoses of Alzheimer's disease, peripheral vascular disease, mood disorder, and anxiety. Surveyor noted Resident 2 had a Guardian and was admitted to hospice on 09/25/2024.

Surveyor reviewed Resident 2's individualized service plan (ISP) with signed review date of 11/04/2024 and noted his/her care plan said: "BATHING - FULL ASSISTANCE ... Provide full assistance with bathing/showering. Assist with dressing and undressing, wash, shampoo and with all required physical assistance ...
DRESSING - AS NEEDED ASSISTANCE ...
Monitor and assist with dressing and undressing ...requires monitoring and assistance as needed with dressing and undressing ...Resident is a 1 assist of 1 for dressing at all times. [S/he] resists

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cares but keep trying different ways to get [him/her] dressed or undressed ...
EATING - AS NEEDED ASSISTANCE ...Assist as needed. [S/he] will refuse to come out to dining room at times. Take [him/her] meals to [his/her] room but sit with [him/her] to make sure [s/he] doesn't choke. Try to get [him/her] out to the dining room to eat with others and keep a close on [him/her] to make sure [s/he] doesn't choke ...
TOILET CHECK - SCHEDULED ...To have staff initiate and assist with toileting schedule on an ongoing basis. Staff will cue as needed and assist when required. Resident needs a slight push to use the bathroom every 2 hours. If [s/he] does not go, please reattempt every 30-45 minutes until [s/he] does as [s/he] often gets confused on where the bathroom is and if the bathroom is occupied, [s/he] does not always know to use the other half bathrooms. -[S/he] has a commode in [his/her] closet for [his/her] comfort ...
MOBILITY & WALKING - INDEPENDENT ... Can walk and ambulate independently. 9/20/24 Starting to have problems with ambulating, will sit on floor and scoot on the floor on [his/her] bottom. [S/he] will also get a pillow and blanket and sleep on the floor. [S/he] may need assistance at time[s] with ambulation for safety. 9/25/24 [S/he] is on hospice and they will try a walker with [him/her] for safety. [S/he] is refusing to us it [walker] at times and other times [s/he] will use it. Staff to assist [him/her] with walker ...
30 MIN [minute] CHECKS ...Please do 30 min checks to ensure [s/he] isn't putting [him/herself] on the floor and getting hurt."
Surveyor note: Resident 2's ISP was silent to incontinence care, sitting at the edge of his/her bed, symptoms of anxiety, fall risk, and fall interventions. No changes were made to Resident 2's ISP to reflect decline in

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independence with dressing, toileting, and a change in incontinence as discussed during the care plan review on 11/04/2024.

PROVIDER OBSERVATION NOTES
On 11/27/2024, Surveyor reviewed Resident 2's provider observation notes provided by Administrator A and noted observation notes for August and observation notes for November only.
08/02/2024 4:30 PM Administrator A wrote "Please make sure that resident is clean and dry at all times. If you approach [him/her] and [s/he] refuses let [sic] retry again. Be creative to get [him/her] to toilet every 2 hrs [hours] and wash up and change. Also make sure that you clean [his/her] room daily or even 2-3 times a day as [s/he] will urinate in [his/her] room [s/he] has a commode in [his/her] closet. Please check this every 2 hrs as well."

11/01/2024 2:00 PM Administrator A wrote "[Resident 2] needs to be toileted with [his/her] commode by [his/her] bed if [s/he] is having problems wih walking or [s/he] needs to be taken to the bathroom every 2 hours. When you take [him/her] to the bathroom on [his/her] 2 hr [hour] checks make sure you document if [s/he] went or [s/he] didn't go. Make [s/he] [sic] on your 30 min [minute] checks that you are actually checking [him/her] to make sure that [s/he] is dry or if [s/he] is we. If [s/he] is we make sure that you change [him/her] and clean [him/her[up so there isn't any big puddles on the floor and you don't have to do alo of laundry to do. [sic] Make sure your [sic] actually checking [him/her] every 30 min. If [s/he] is wet then take [him/her] to the bathroom and change [him/her] and wash [him/her] up. Make sure that you are cleaning [him/her] very carefully and applying powder so there is not break down. Also try to [his/her] out of [his/her] room more

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often especially with meals as [s/he] is a choke risk and I don't want [him/her] choking in [his/her] room and no one would even know [s/he] was choking. Please keep a better eye on the resident and make sure [s/he] is clean and dry and [his/her] room is taken care of as well."

PROVIDER TASK DOCUMENTATION
Surveyor reviewed Resident 2's sample task documentation for 11/01/2024 through 11/15/2024. Surveyor noted staff were to sign off on completing 30 minute checks 48 times a day and complete the prompt in the record, answering questions about his/her status:
"What assistance was required? Was there an incontinence accident? Skin Condition? If [s/he] was wet did you change [him/her] and clean [him/her] up Is [his/her] room odor free Did you change [his/her] clothes/bedding?"
Other tasks provider staff were to sign off on and answer prompted questions were for Toileting Checks, Bowel Movement Monitoring, Snack, Housekeeping, Eating - as needed assistance, Activity participation, Bathing, and Dressing.

As samples, on 11/01/2024, 47 of 48 30-minute checks were signed off on but the prompted questions were not answered. On 11/03/2024, 17 of 48 30-minute checks were signed off but the prompted questions regarding Resident 2's condition were not answered. On 11/12/2024, 20 of 48 30-minute checks were not answered.

Surveyor noted the task list included the date and time documentation was entered for the completed task. As samples, on 11/02/2024, documentation for tasks of 30 minute checks, toilet check, bowel movement monitoring was signed off on and prompted questions were completed by Administrator A on 11/28/2024 for

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11/02/2024. On 11/13/2024, documentation for all tasks except 6 tasks for the day were completed by Administrator A on 11/28/2024 and 11/29/2024 for 11/13/2024.

RESIDENT 2'S HOSPICE RECORD
On 12/16/2024 at approximately 2:06 PM, Surveyor reviewed Resident 2's hospice visit notes.

09/25/2024 10:15 AM Social Worker (SW) J visit "Documentation obtained from the assisted living facility for review outlines a sharp decline in [his/her] functional ability over the past 2 to 3 months. [S/he] was ambulating and verbal. [S/he] is now spending all day in bed, refusing to eat and drink at times and is increasingly confused. [S/he] had a recent visit to an emergency room, given the changes and it was reported that there were no reversible or treatable causes identified. The patient is currently refusing to be weighed but when [s/he] last permitted this [s/he] had a documented 8 pound weight loss in 4 months ....The patient began having memory concerns in 2016. [S/he] had not been able to drive for at least 2 years prior to that and was described as forgetful, confused, and paranoid. [S/he] is in the terminal stages of Alzheimer's Disease. MoCA [Montreal Cognitive Assessment] in 2019 was 11/30 and there is no reason to believe this has improved."

09/26/2024 2:44 PM Chaplain I visit "[Chaplain I] greeted [Resident 2] who was sitting in [his/her] night gown on [his/her] bed looking at a greeting card. [Resident 2] was not wearing shoes and at various times during our visit had a hard time articulating what [s/he] wanted to say."

09/26/2024 5:24 PM Hospice Nurse (RN) H visit

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"Writer met with ALF activity aide and CNA [certified nurse aide] [Caregiver E] prior to visit to obtain collateral information. [Caregiver E] shared [Resident 2] is having a good day, has been talkative and in good spirits. Activity aide reports [s/he] does not know much about [Resident 2] as [s/he] is covering for the day and that [Administrator A] would be able to provide background information.
Surveyor noted upon majority of written hospice visits by RN H, Chaplain I, and SW J, Caregiver B or Caregiver E were identified as working at the facility.

10/22/2024 9:00 AM RN H visit "[Resident 2] is sitting on bed in [his/her] room, [s/he] has no compression socks on, in [pajamas]. Smiles when greeted ...Writer attempted to ask some interview questions and [Resident 2] could not find the words and became physically anxious and stated, 'Stop talking about me" ....Conferenced with [Caregiver E], facility staff, and [Caregiver E] confirms that [Resident 2] has become weaker and is eating less and drinking less."

11/4/2024 2:00 PM Social Worker (SW) K visit "Writer stopped in [Resident 2's] room and observed [him/her] sitting on the edge of [his/her] bed with [his/her] head in [his/her] lap ...Care Conference was held regarding [Resident 2] ...Staff and [Guardian G] report noticeable decline lately due to progression of Alzheimer's. Reported [Resident 2] can no longer complete any cares independently, has incontinence of BM [bowel] and urine daily, and without prompting would not ask for food or to toilet. Concerns with skin irritation with a high risk of skin breakdown reported by [Guardian G] to [Administrator A]. Facility staff report that [Resident 2] is safely

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checked every ½ hour and toileted every 2 hours. Writer and [Guardian G] requested more frequent checking of and changing of incontinence products. [Administrator A] agreed to increase checking on this and possible use of barrier cream due to red rash/irritation in groin area present at times. Writer provided encouragement to [Guardian G] for [his/her] advocating for [Resident 2]."

11/6/2024 2:00 PM RN H "[Guardian G] returned call to writer on 11/06/24. [S/he] indicated [s/he] and [Administrator A] had a good conversation following the conference about care expectations. [Administrator A] voiced willingness to work with staff on this ...[Guardian G] is hopeful discussion of expectation will improve situation as [s/he] would like for [Resident 2] to remain in current facility as [s/he] likes the size of the facility and feels [Resident 2] got 'lost in the shuffle' when [s/he] was at larger facilities. Discussed plan to continue working together moving forward."

11/7/2024 2:15 PM Chaplain I visit "This Chaplain greeted [Resident 2] who was sitting on the edge of [his/her] bed ...[Resident 2] had no shoes on and was dressed with a long dress. Area smelled of urine and room was messy/floors dirty."

11/15/2024 1:00 PM SW J visit "SW [Social Worker] spoke with [Managed Care Organization (MCO)]Care Manager (CM) L prior to and following meeting today with Darboy Living Center [Assisted Living]. Informed action plan was developed to address concerns [at facility] presented. [Administrator A] will address concerns with staff members and provide a weekly document on Fridays to SW and [MCO] on toileting schedule and observations. ALF is requesting hospice provide a more substantial

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brief that will not allow so much leaking. [MCO] team has determined current needs may appropriately be met at CBRF [community based residential facility] level of care and do not warrant SNF [skilled nursing facility] level. CM L has sent listing to [Guardian G] and [SW J] for review and notes [s/he] is actively exploring alternative CBRF's."

11/18/2024 12:15 PM RN H visit "[Resident 2] is lying in bed sleeping, easily aroused and receptive to visit from writer. [Resident 2] has not eaten yet so we venture to the dining room. [Resident 2's] dress, and bedding are saturated. [Caregiver B] is available and we take [Resident 2] into the bathroom for clothing change and skin check ...[Resident 2] is walked with walker to dining room. [Resident 2] is only patient eating in the dining room."

On 12/12/2024, RN H visit "[Resident 2] has transferred to [another provider] from Darboy Assisted Living, [s/he] is pleasantly confused and cannot find words at times and lives in a different decade sometimes. [Resident 2] occasionally ambulates by self with walker and preferred with a standby assist. Since [s/he] moved facilities [s/he] has started using the toilet again and is still incontinent at times ...
At last [Social Worker] visit [Resident 2] is noted to be assisted to/from bathroom by ALF [assisted living facility] staff and using the toilet more regularly versus not being taken to the bathroom and changing soiled clothing/bedding [like at previous facility] ...[S/he] is completely dependent on ALF.

10/23/2024 9:00 AM Chaplain I wrote "[Chaplain I] greeted [Resident 2] who was sitting on [his/her] bed in [his/her] night gown, no shoes, slumped

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	0015847	A. BUILDING: _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DARBOY ASSISTED LIVING	N9520 SILVER CT APPLETON, WI 54915

(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 37 over looking down." 11/12/2024 4:00 PM Chaplain I visit "[Resident 2], usually sitting on the side of [his/her] bed appearing unkept, hair messy, at times urine smell and has intermittent twitches in [his/her] upper body ..." INTERVIEWS On 12/16/2024 at approximately 2:00 PM, Surveyor interviewed Hospice Health Information Specialist (HIS) N who indicated RN H was no longer with the agency, so was not available for interview regarding Resident 2's care. HIS N stated all documentation of visits and concerns regarding Resident 2's care would be identified in the visit notes. HIS N acknowledged known concerns of care at the facility for Resident 2, leading to his/her move to an alternative facility. On 11/27/2024 at approximately 9:00 AM, Surveyor received and reviewed email correspondence from Guardian G. "[Resident 2] has Alzheimer's and has entered the final stage and is now on hospice. [S/he] is supposed to be on thirty minute checks, which is not happening. [S/he] is being left soaked with urine and leaning on [his/her] side. On some days, [s/he] no longer has the strength to sit up and so is left leaning on [his/her] bed in awkward positions and staff leave [him/her] like this. When the smell of urine is too strong, they close [his/her] door and open [his/her] window to air out [his/her] room. I have found [him/her] soaked in urine, cold, and shivering like this. [His/her] hospice team has also found [him/her] like this. [Resident 2]'s room isn't being cleaned. They bring [his/her] food and leave [him/her] to eat on [his/her] own and often food is spilled/dropped on the floor by [him/her] and not picked up ...I have	Y3244		

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Y3244	Continued From page 38	Y3244		

asked for mopping supplies to clean [his/her] floor of sticky urine, juice, and food. I was then given the mopping supplies and the staff member walked away. So I ended up mopping [his/her] floor.
[S/he] is not being cleaned regularly and they are blaming [his/her] 'behaviors' on [him/her] not being cleaned. At one stage of [his/her] illness [s/he] was vocal about refusing cares, but this is no longer the case and hasn't been for three months. [S/he] has transitioned to a stage ...that [s/he] no longer refuses."

On 12/16/2024 at approximately 11:35 AM, Surveyor received and reviewed email correspondence with Guardian G, "I always found [Resident 2] in [his/her] room and often with [his/her] door closed. [S/he] would be folded over [his/her] lap and usually soaked and cold ...[S/he] would also slide/fall off the bed as a result."
"[S/he] was supposed to be on 30 minute checks, which I do not believe were happening. They were claiming that [s/he] refused the bathroom and that [s/he] 'just holds onto [his/her] urine and lets it all out at once,' This is per [Administrator A] ...
Very rarely did staff or I see [Resident 2] out of [his/her] room. [S/he] was always isolated and left sitting at the side of [his/her] bed.
[Resident 2] would refuse care when [s/he] first arrived [to the facility], but that stopped being an issue when 1) [s/he] was placed on Rexulti and 2) [His/her] disease has progressed markedly since the summer.
[S/he] became docile and was always willing for me and hospice to clean [him/her] ...I do not believe they were making attempts.

Since being moved [Resident 2] is showing remarkable improvement. Staff have zero

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difficulty bathrooming [sic] [him/her] or cleaning [him/her]. [His/her] room does not smell like urine as [s/he] is no longer sitting soiled. [S/he] is walked with [his/her] walker *which she does not refuse as [Administrator A] claimed) to other areas of the facility for meals, to the sitting room, and to activities. [S/he] is also more alert and communicative. Hospice has noticed this as well."

FALL
Surveyor reviewed an observation note from 11/21/2024 5:30 AM where Caregiver M wrote "[S/he] fell down last night [s/he] have a littel [sic] red spot on left forhead [sic] but no change in a resident"

Surveyor reviewed Resident 2's incident report from the fall on 11/21/2024. The report says the time of the unwitnessed fall was at 3:24 AM. Caregiver M wrote "While I was doing rounds, I found resident on the floor. [S/he] had a bruise on [his/her] forehead. I helped resident up back to bed ...Resident says [s/he] is okay, not feeling any pain ...Family or Representative Notified? No Supervisor Notified? Yes ...11/21/2024 06:24 AM ...Unite Hospic [sic] 11/21/2024 6:30 AM
Did resident sustain any injuries? Yes Notes: Bruise on the forehead Range of motion performed? No Did injuries require outside medical care? No Notes: Injury is superficial."\
Surveyor note: The time of the fall is not consistent from source to source.

Surveyor reviewed Resident 2's hospice notes: 11/21/2024 12:30 PM RN H visit "Arrived for RN PRN [as needed] visit post fall. [Resident 2] is in [his/her] room sitting on the bed, greets writer ...Writer can smell stool and [Caregiver B] states, "I was just going to change [him/her]." Writer

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assesses [Resident 2's] buttocks, hips, shoulder, elbows, all-over body check and [Resident 2] has a lump or 'goose egg' on the mid=upper part of forehead which has a darker than [Resident 2's] skin discoloration. [Resident 2] denies pain on palpation of lump, declines a cold pack and denies pain. [Resident 2 is able to stand up with gait belt assistance. [Caregiver B] reports that [s/he] checks on [Resident 2] every two hours and writer encourages [him/her] to check every 30 minutes due to disease progression. Educated [Caregiver B] on importance of calling [hospice] immediately after a fall ....[Caregiver B] reports that when [s/he] came to work this morning, [Caregiver M] reported that [Resident 2] had fallen at 11:00 PM on 11/20/24. [Caregiver M] reported that [s/he] was in another resident's room when [s/he] heard a loud bang and [s/he] went to seek out and found [Resident 2] sitting on the floor in [his/her] room in front of the bed. [Caregiver B] reports that [Caregiver M] did not call and that is why [Caregiver B] decided to call [hospice]. [Caregiver B] reports that [s/he] has not called [Guardian G]. [RN H] updated [Guardian G]."

11/27/2024 RN H wrote "Fall on 11/21 with head injury and facility staff did not report it to [hospice] until 7 hours later per [Caregiver B] with facility when I got to visit. [Guardian G] is also a nurse and is upset that [s/he] feels [Resident 2] is being neglected by staff. Planning to move to new facility on Friday."
On 12/16/2024 at approximately 11:35 AM, Surveyor reviewed a copy of correspondence between Administrator A and Guardian G via messaging:
Guardian G "I heard from the hospice nurse that [Resident 2] fell last night and nobody was called?"

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Y3244	Continued From page 41 Administrator A "[S/he] fell early this am [morning] around 3-4 am. I was not notified till [sic] around 6am I told them to call hospice right away. I did talk to staff about it this am and [s/he] was written up for not following protocol ...We have had [Resident 2] on 30 min checks since [his/her] fall and [s/he] is doing well. On 12/16/2024 at approximately 11:35 AM, Surveyor reviewed email correspondence from Guardian G from "[Resident 2] also had a fall that went unreported to me shortly before I moved [him/her]. Hospice was not called either until the following morning. It was [his/her] hospice nurse who informed me. They claim that [Resident 2] slid on [his/her] butt to the floor. And yet, [s/he] had a goose egg on [his/her] forehead. In Michele's [text] message.. regarding the fall that [Resident 2] was then put on 30 minute checks as a result. [S/he] was supposed to already be on 30 minute checks since the meeting in October." On 11/25/2024 at approximately 9:18 AM, Surveyor interviewed Administrator A. Administrator A stated Resident 2 had dementia. Administrator A said Resident 2 did not refuse cares anymore and s/he was easy to assist (now). S/he indicated s/he was on hospice. Administrator A acknowledged having to provide education to staff on ensuring Resident 2 was checked on frequently and his/her room not being cleaned as expected to eliminate odors. Administrator A verified Resident 2 had a fall, but stated s/he was not injured. Administrator A stated staff were provided education on notifying him/her, legal representatives, and hospice. On 12/18/2024 at approximately 3:06 PM, Administrator A acknowledged Resident 2 did not	Y3244		

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Y3244	Continued From page 42 receive care that met his/her needs. In conclusion, Resident 2 had a progression in his/her condition which impacted his/her ability to provide cares for his/herself and required staff assistance. Resident 2 was not checked on every 30 minutes, was left sitting up on the side of his/her bed multiple times a day, was left to eat by his/herself in his/her room despite concern for risk of choking, was not toileted per schedule, was left incontinent on causing odor in his/her room, was not encouraged and assisted to walk regularly, his/her room was not regularly cleaned causing odor, his/her care plan was not updated, his/her task documentation was not completed to verify completion, and s/he had a fall where Guardian G and RN H were not notified timely. Resident 2 sustained a bump on his/her head which was not initially reported. RN H, CM --, and Guardian G had discussions with Administrator A about staff not following Resident 2's care plan and Resident 2 not receiving the care s/he required. Administrator A, on more than one occasion per hospice notes and correspondence with Guardian G, Administrator A acknowledged opportunity for improvement and stated that s/he would work with staff to do more. As a result of Resident 2 not receiving adequate and appropriate care within the capacity of the facility, Guardian G relocated Resident 2 to an alternative facility. Cross Reference: Y3234 50.09(1)(e) Treatment	Y3244		