

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016351	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/07/2026
NAME OF PROVIDER OR SUPPLIER AMERICAN GRAND ASSISTED LIVING SUITES		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MEADOW LN NEENAH, WI 54956		
(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 07/01/2026, with additional information gathered through 07/07/2026, Surveyor conducted a verification visit and investigated 3 complaints. One of 1 previous deficiency was corrected. Two of 3 complaints were substantiated and 1 new deficiency was identified. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census 67	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure one of one resident's (Resident 13's) physician was notified when there was a significant change in physical condition for Resident 13. On 10/05/2025, caregivers noted Resident 13 had an open wound on the buttocks. The	N 169		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016351	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/07/2026
NAME OF PROVIDER OR SUPPLIER AMERICAN GRAND ASSISTED LIVING SUITES		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MEADOW LN NEENAH, WI 54956		
(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 169	Continued From page 1 physician was not notified until 11 days later on 10/24/2025. This is a repeat violation. See Statement of Deficiency (SOD) QP0C16 dated 04/17/2023. Findings Include: On 11/03/2025 and 11/12/2025, the department received a complaint regarding resident changes in conditions. On 07/02/2026, Surveyor reviewed Resident 13's Individual Service Plan (ISP), dated 09/01/2025. The ISP specified Resident 13 required the following: ASSISTANCE REQUIRED IN MANAGING BOWEL/AND OR BLADDER CARE (Toileting) " ...Staff to monitor skin for signs of breakdown and report any concerns to Administrator." On 07/02/2026, Surveyor reviewed Resident 13's observation notes. The observation notes were as follows: Observation Note - 10/05/2025 at 2:30PM: "Writer gave [Resident 13] a shower, when resident got out of shower staff noticed that [Resident 13's] behind was broken and [s/he] was observing signs that [his/her] wound had broken open. Staff noticed when [Resident 13] lifted up to have [his/her] depend lifted to waist, there was blood on the toilet seat. Staff cleaned and did wound care on [him/her]." Observation Note - 10/24/2025 at 3:00PM by Registered Nurse B: "[Physician] notified: [Resident 13] has a stage II open area to intergluteal cleft. Staff currently are keeping the	N 169		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016351	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 07/07/2026
NAME OF PROVIDER OR SUPPLIER AMERICAN GRAND ASSISTED LIVING SUITES			STREET ADDRESS, CITY, STATE, ZIP CODE 900 MEADOW LN NEENAH, WI 54956		
(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 169	Continued From page 2 site clean and dry and applying scheduled cream and PRN until [Physician] provides different orders." Surveyor Note: There was no further documentation in the observation notes regarding the wound until 10/24/2025. On 07/07/2026, at 2:00PM, Surveyor interviewed Registered Nurse B and South Resident Director T, North Director U and Operations Administrator A. Registered Nurse B reported s/he was not aware of the wound until 10/24/2025. During the interview, Registered Nurse B acknowledged the observation note on 10/05/2025 that identified the wound. Registered Nurse B advised moving forward observation notes will be closely reviewed. South Resident Director T reported it is standard practice that caregivers report changes in condition immediately. All reported they would ensure increased monitoring of caregiver communications moving forward so notifications would be made more timely.	N 169			