STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019661	A. BUILDING: _____ B. WING _____	C 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE I	5102 N CHERRYVALE AVE 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 05/28/2026, with additional information gathered through 06/02/2026, Surveyors investigated 4 complaints at Apple Creek Place 1. Four (4) of 4 complaints were substantiated and 4 new deficiencies were identified. One (1) of the 4 deficiencies is a repeat deficiency. See statement of deficiency (SOD) JBCN11, dated 11/06/2025 for additional details. Census: 19	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents received medications in the dosage and intervals prescribed by the practitioner for 3 of 3 (Resident 1, 2 and 3) residents reviewed. Findings Include: On 05/07/2026 and 05/26/2026, the department received a complaint regarding administration of medications. RESIDENT 1 On 05/28/2026, Surveyor reviewed Resident 1's	N 352		

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

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individual support plan (ISP) dated 05/28/2026. The ISP identified the following:

MEDICATION: "Will be able to maintains medication management assistance from care staff Date Initiated: 02/19/2026. Revision on: 02/28/2026."

On 05/28/2026, at 10:35AM, Surveyor interviewed Resident 1. Resident 1 reported s/he was upset that s/he did not receive his/her antibiotic until days after it was prescribed. Resident 1 reported the medication was not in the cart and was found later, but s/he did not know any specifics.

On 05/28/2026, Surveyor reviewed Resident 1's order dated 05/04/2026 for cephalexin 500mg - 1 cap every 8 hours for 10 days. The order was accompanied with a note written by the pharmacy that stated, "We delivered cephalexin on 5/5/26. Received a call on 5/6 from Apple Creek asking if we received the order and if we were going to send the medication). I let them know it was delivered on 5/5. They said they were going to look for it then they called back and asked us to send them the order. I emailed it to them ..."

On 05/08/2026, Surveyor reviewed Resident 1's May 2026 medication administration record (MAR). The MAR noted Resident 1 did not begin receiving the medication until 05/07/2026.

On 06/02/2026, at 9:00AM, Surveyor interviewed Regional Registered Nurse E (RRN-E) and Regional Director-A. RRN-E reported the medication was delivered to one of the other buildings. RD-A advised one the medication was located it was administered accordingly. RD-A confirmed caregivers and nursing staff are

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receiving re-education on the process of receiving medication and ensuring it is in the correct location for administration.

RESIDENT 2

On 05/28/2026, Surveyor reviewed Resident 2's ISP, dated 05/27/2026. The ISP identified Resident 2 was diagnosed with chronic kidney disease, chronic gout, and osteoarthritis. The ISP noted the following:

PAIN: "Resident has general all over pain ... Date Initialed: 12/17/2024." Staff to administer medication per PCP orders ...If pain is not relieved by the medication notify PCP ... Date Initiated: 09/26/2024. Revision on 05/27/2026."

MEDICATION MANAGEMENT: "Requires Assistance for: medication administration; ordering of medications; communication with pharmacy Date Initiated: 09/24/2024.

On 05/28/2026, Surveyor interviewed Resident 2. Resident explained s/he had issues receiving his/her pain medication 2 days ago. Resident 2 reported s/he needed the "hydro" pain medication on 05/26/2026 but was told s/he ran out of the medication, and it needed to be re-ordered. Resident 2 identified the facility re-orders his/her medication and communicates with the pharmacy. Resident 2 reported yesterday (05/27/2026), someone told him/her the medication was at the facility, but no one could find it. Resident 2 confirmed s/he finally received the medication in the afternoon.

On 05/28/2026, Surveyor reviewed Resident 2's progress notes. The progress notes identified the

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N 352	Continued From page 3 following: 05/27/2026 at 12:26AM: "Staff updated writer this afternoon (05/26/2026) that [Resident 2] was upset that [s/he] did not have [his/her] hydrocodone. Writer contacted [pharmacy name] to see if medication was ordered ... received with shipment this evening (05/26/2026) and given to the med tech to put away in the cart." 05/27/2026 at 4:10PM: "[Resident 2] upset about hydrocodone. Writer called Omnicare back and they report that medication was signed and shipped urgent overnight. Writer had med tech check the cart and medication was in cart ...Regional RN also provided writer with [pharmacy name] login information for writer to be able to order medication on their website and see all orders and medications due. Writer to get account setup and sign up for the training in the next upcoming weeks ..." On 05/28/2026, Surveyor reviewed Resident 2's MAR. The MAR noted Resident 2 was prescribed the following: Start date: 04/23/2026 - End date 05/26/2026: hydrocodone-acetaminophen 10-325 - take 1 tab 3 times daily as needed for pain. The MAR showed Resident 3 utilized the as needed pain medication multiple times daily. The MAR reflected no usage after 5:02AM on 05/26/2026. Start date: 05/27/2026 and entered at 1:26PM: hydrocodone-acetaminophen 10-325 - take 1 tab 3 times daily as needed for pain. The MAR reflected Resident 2 received his/her requested as needed dose at 3:32PM. On 06/02/2026, Surveyor interviewed RD-A.	N 352		

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N 352	Continued From page 4 RD-D advised there was an issue with the re-ordering process by a day and a half. RD-A reported they were also waiting for the physician to approve the new script, but s/he was not responding. RD-A reported s/he obtained pharmacy login set up for RRN-E and training was provided to ensure timely re-order of medications. RESIDENT 3 On 05/28/2026, Surveyor reviewed Resident 3's resident record. Resident 3 was admitted to the facility on 05/20/2026. Resident 3's individual support plan (ISP) dated 05/20/2026, identified the following: MEDICATION MANAGEMENT: "Requires Assistance for: medication administration; ordering of medications; communication with [name of pharmacy] pharmacy. Date Initiated: 05/18/2026" Resident 3's admission orders, dated 05/20/2026 and signed by Resident 3's nurse practitioner, indicated Resident 3 was to receive the following medication: -Nexletol 180mg(milligrams) tablet give 1 tablet by mouth once daily for high amounts of fat in the blood On 05/28/2026, Surveyor reviewed Resident 3's progress notes. The following was noted: -05/21/2026 Nexletol Oral Tablet 180mg give 1 tablet by mouth one time a day for high amounts of fat in the blood "unavailable" -05/23/2026 Nexletol Oral Tablet 180mg give 1 tablet by mouth one time a day for high amounts of fat in the blood "not available will attempt to locate/order" On 05/28/2026, Surveyor reviewed Resident 3's	N 352		

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N 352	Continued From page 5 May 2026 medication administration record (MAR). The MAR noted Resident 3 had an order for Nexletol Oral Tablet 180mg give 1 tablet by mouth one time a day for high amounts of fat in the blood with a start date of 05/21/2026. Resident 3's MAR noted the following: -05/21/2026-05/24/2026 there was the number 13 in the date box indicating "Med Not Available (F/U[follow up] required)" -05/25/2026, 05/26/2026 and 05/28/2026 there was a number 14 in the date box indicating "Med Not Available (F/U NOT Required)" -05/27/2026 there was a check mark indicating Resident 3 received the medication. On 06/01/2026, at 1:50 PM, Surveyor received an email from Regional Director A regarding Resident 3's Nexletol medication. Regional Director A stated, "The medication was not delivered. The pharmacy states that they did not have an active order. This was clarified and a new order was sent to [name of pharmacy] Pharmacy by the NP[Nurse Practitioner]." Regional Director A verified the error was discovered on 05/31/2026 and Resident 3 had not received the Nexletol medication since admission on 05/20/2026.	N 352		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately.	N 410		

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N 410	Continued From page 6 Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure they reported to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after a resident refuses a medication for 2 consecutive days and did not notify them immediately of an error in administration of a medication for 2 of 2 (Resident 1 and 3) residents reviewed. Findings Include: On 05/07/2026 and 05/26/2026, the department received complaints regarding medication administration. On 05/28/2026, Surveyors conducted an onsite visit to the facility. A sample of residents was selected, including the records of Resident 1 and 3. RESIDENT 1 On 05/28/2026, Surveyor reviewed Resident 1's individual service plan (ISP) dated 05/28/2026. The ISP documented Resident 1 had the following diagnosis: type 2 diabetes mellitus, dry eye syndrome, chronic obstructive pulmonary disease, hypertension and hypertensive chronic kidney disease. The ISP identified:	N 410		

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MEDICATION: "Will be able to maintains medication management assistance from care staff Date Initiated: 02/19/2026. Revision on: 02/28/2026."

On 05/28/2026, at approximately 9:45 AM, Surveyor interviewed Caregiver B. Caregiver B identified s/he administers medications. Caregiver B reported Resident 2 refuses medications often.

On 05/28/2026, Surveyor reviewed Resident 1's March, April and May 2026 medication administration record (MAR). The MAR identified several medications refused by Resident 1 for 2 consecutive days. The medication and dates of refusals were as follows:

Artificial Tears Ophthalmic Solution - instill 1 unit in both eyes in the morning every morning. Order date: 02/20/2026.

03/08, 03/09 and 03/10 (3 consecutive)
03/14, and 03/15 (2 consecutive)

Artificial Tears Ophthalmic Solution - instill 1 unit in both eyes in the morning every Monday, Wednesday and Friday for dry eye syndrome. Order date: 03/19/2026

Wednesday: 03/25 and Friday: 03/27 (2 consecutive)
Wednesday: 04/01, Friday: 04/03 (2 consecutive)
Wednesday: 04/08, Friday: 04/10, Monday: 04/13, Wednesday: 04/15, and Friday: 04/17 (5 consecutive)
Wednesday: 04/22, and Friday: 04/24 (2 consecutive)
Friday: 04/08, Monday: 05/11, Wednesday: 05/13 and Monday: 05/18 (4 consecutive)

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N 410	Continued From page 8 Friday: 05/22, Monday: 05/25 and Wednesday: 05/27 (3 consecutive) Artificial Tears Ophthalmic Solution - instill 1 unit in both eyes in the morning every Tuesday, Thursday, Saturday and Sunday for dry eye syndrome. Order date 03/20/2026 Saturday: 03/21, Sunday: 03/22, Tuesday: 04/24 and Thursday 04/26 (4 consecutive) Thursday: 04/09 and Saturday: 04/11 (2 consecutive) Tuesday: 04/14, Thursday: 04/16 and Saturday: 04/18 (3 consecutive) Tuesday: 04/28 and Thursday: 04/30 (2 consecutive) Carboxymethylellul - instill 1 drop in both eyes one time a day every Monday, Wednesday and Friday for dry eye syndrome. Order date: 03/20/2026 Wednesday: 04/01 and Friday 04/03 (2 consecutive) Wednesday: 04/08, Friday: 04/10, Monday: 04/13, Wednesday: 04/15 and Friday: 04/17 (5 consecutive) Friday: 05/08, Monday: 05/11 and Wednesday 05/13 (3 consecutive) Friday: 05/22, Monday: 05/25 and Wednesday 05/27 (3 consecutive) Carboxymethylellul - instill 1 drop in both eyes one time a day every Tuesday, Thursday, Saturday and Sunday for dry eye syndrome. Order date: 03/21/2026 Saturday: 03/21, Sunday: 03/22 and Tuesday: 03/24 (3 consecutive)	N 410		

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N 410	Continued From page 9 Tuesday: 04/14, Thursday 04/16 and Saturday: 04/18 (3 consecutive) Tuesday 04/21 and Thursday: 04/23 (2 consecutive) Atorvastatin Calcium 20mg - 1 tab daily at bedtime for hypertensive chronic kidney disease with state 5 kidney disease. Order date: 02/19/2026 03/15 and 03/16 (2 consecutive) 04/10 and 04/11 (2 consecutive) Spiriva Respimat Aerosol Solution 2.5mcg/ACT - inhale orally 2 times on Monday, Wednesday and Friday for chronic obstructive pulmonary disease. Order date: 03/20/2026 Wednesday PM: 03/15 and Friday AM: 03/17 (2 consecutive) Wednesday AM: 04/22, Wednesday PM: 04/22 and Friday: 04/24 (3 consecutive) Friday AM: 05/08, Friday PM: 05/08, Monday AM: 05/11, Monday PM: 05/11 and Wednesday AM: 05/13 (5 consecutive) Spiriva Respimat Aerosol Solution 2.5mcg/ACT - inhale orally 2 times on Tuesday, Thursday, Saturday and Sunday for chronic obstructive pulmonary disease. Order date: 03/21/2026 Tuesday PM: 04/07 and Thursday AM: 04/09 (2 consecutive) Thursday PM: 04/16 and Saturday AM: 04/18 (2 consecutive) On 06/02/2026 at 9:00 AM, Surveyor interviewed Regional Director (RD-A). RD-A acknowledged the consecutive refusal of medications should be	N 410		

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reported to the physician and confirmed s/he would ensure the refusals were reported to the prescribing physician.

RESIDENT 3

On 05/28/2026, Surveyor reviewed Resident 3's resident record. Resident 3 was admitted to the facility on 05/20/2026 with diagnoses to include type 2 diabetes mellitus with other diabetic kidney complications, obesity, mixed hyperlipidemia and hyperkalemia. Resident 3's individual support plan (ISP) dated 05/20/2026, identified the following: "MEDICATION MANAGEMENT: Requires Assistance for: medication administration; ordering of medications; communication with [name of pharmacy] pharmacy...Staff to administer antidiabetic medications (oral hypoglycemics or insulin) as prescribed and monitor for effectiveness and side effects."

On 05/28/2026, Surveyor reviewed a facility "Medication Error" report dated 05/21/2026 and prepared by Wellness Coordinator F. The report stated, "Writer found [s/he] had administered 54 units of LANTUS this morning IN ERROR; Per MD[physician] orders, resident was to receive 54 units of LISPRO (not in med cart/not yet delivered). Writer immediately notified management of error and obtained vitals (b/p[blood pressure] 120/69, pulse 70, pulse ox[oxygen] 95%[percent], temp 98.7 [degrees], respirations 17, blood sugar 267. Resident did not receive noon dose of insulin (Lispro) due to insulin not being delivered yet. Resident appears comfortable with no concerning symptoms following this error. Resident's blood sugar sensor stating it needs to be replaced, writer informed management of this need as well, until

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N 410	Continued From page 11 this sensor is changed writer utilized true matrix meter/test strips to obtain blood sugar readings. Writer will also inform oncoming shift of error." The report goes on to state, "Writer was informed of this incident around 1500 [3:fpm]. Resident contacted PCP[primary care physician] via email and PCP advised that blood sugar checks be done every 3 hours for the next 24 hours. Writer assisted staff with getting a working dexacom on resident and MAR [Medication Administration Record] was updated." The report indicated the physician was updated on 05/21/2026 at 19:00[7:00 PM]. ***Surveyor note: It should be noted Wellness Coordinator F is a MA(Medical Assistant), s/he does not hold a nurse or physician license. On 06/01/2026 at 8:45 AM, Surveyor interviewed Nurse Practitioner (NP) G. NP G verified s/he is the NP for Resident 3. NP G stated the facility sent an email around 7:30 PM about the medication error for Resident 3. NP G stated s/he called Wellness Coordinator F and told him/her that that length of time was not appropriate. NP G stated s/he made adjustments to insulin and to have staff check blood sugars every 3 hours, including overnight. NP G stated Resident 3 did not get sent out to hospital and NP G saw Resident 3 at the facility next day. NP G stated blood sugars had come down and Resident 3 was doing better.	N 410		
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	N 431		

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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.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not monitor the health of residents or make arrangements for physical health for Resident 1.

Resident 1 had several refusals for blood sugar monitoring. The physician was not contacted regarding the refusals.

Findings Include:

On 05/28/2026, Surveyor reviewed Resident 1's individual service plan (ISP) dated 05/28/2026. The ISP documented Resident 1 had a diagnosis of type 2 diabetes mellitus. The ISP identified the

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(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
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following:

MEDICATION: "Will be able to m maintains medication management assistance from care staff Date Initiated: 02/19/2026. Revision on: 02/28/2026."

INSULIN & BLOOD SUGAR MANAGEMENT: "Requires Assistance for daily injection of insulin, blood sugar checks once [sic] time daily ... Date Initiated 02/19/2026."

On 05/28/2026, Surveyor reviewed Resident 1's March 2026 through May 2026 medication administration record (MAR). Review of the MAR showed several instances of Resident 1 refusing to have his/her blood sugar taken by caregivers. The dates of refusals were as follows:

>Blood Glucose Monitoring Supplies (glucometer) - daily for Type 2 Diabetes. Order start date: 02/20/2026.
03/01, 03/02, 03/09, 03/10, 03/12, 03/14, 03/15, 03/17, 03/19.

>Blood Glucose Monitoring Supplies (glucometer) - every morning on Monday, Wednesday and Friday for Type 2 Diabetes. Order start date: 03/20/2026.
>Blood Glucose Monitoring Supplies (glucometer) - every morning on Tuesday, Thursday, Saturday and Sunday for Type 2 Diabetes. Order start date: 03/21/2026.

Refusal Dates: 03/20, 03/21, 03/22/, 03/24, 03/25, 03/26, 03/27, 03/28, 03/29, 03/31, 04/01, 04/03, 04/04, 04/05, 04/08, 04/10, 04/11, 04/12, 04/13, 04/14, 04/15, 04/17, 04/18, 04/22, 04/23, 04/24, 04/28, 04/29, 04/30, 05/01, 05/03, 05/07, 05/08, 05/09, 05/10, 05/11, 05/13, 5/14, 05/15,

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	0019661	A. BUILDING: _____ B. WING _____	C 06/02/2026

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N 431	Continued From page 14 05/16, 05/17, 05/18, 05/19, 05/20, 05/22, 05/23, 05/25, 05/26, 05/27 and 05/28. On 02/28/2026, Surveyor reviewed Resident 1's March 2026 through May 2026 progress notes. The progress notes noted some comments from Resident 1 for his/her refusals. The notes are as follows: 05/26/2026: Glucose Monitoring Supply Device: "[Resident 1] stated [s/he] only allows [his/her] dialysis team to check [his/her] blood sugars. 05/20/2026: Glucose Monitoring Supply Device: "[Resident 1] refused bs reading stating it is always good and dialysis keeps a close eye on it also." 04/30/2026: Glucose Monitoring Supply Device: "Said [s/he] does not want it done." 04/21/2026: Glucose Monitoring Supply Device: "REFUSES TO LET STAFF TAKE BS SAYS IT GETS DONE ENOUGH AT THE DOCTOR BUT WILL TAKE INSULIN." 03/20/2026: Glucose Monitoring Supply Device: "stated [s/he] gets his glucose checked at dialysis and refused cluse to get checked." On 05/28/2026, at 10:35AM, Surveyor interviewed Resident 1. Resident 1 explained s/he does not want to complete the blood sugar checks because it is also done at his/her dialysis appointments. Resident 1 added his/her physician also monitors the blood sugar through blood work. Resident 1 further stated his/her fingers get sore from repeated pricks from the lancets.	N 431		

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N 431	Continued From page 15 On 05/28/2026, at approximately 9:00AM, Surveyor interviewed Regional Director A (RD-A). RD-A could not confirm it was reported, but stated s/he would ensure the physician was notified. No further information was provided. Resident 1 has a diagnosis of diabetes type 2 and required blood sugar monitoring daily. Resident 1 continuously refused to have his/her blood sugar checked for 60 days during the months of March, April and May 2026. The provider did not monitor Resident 1's blood sugar or report his/her refusals to the physician.	N 431		
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	Y3244		

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provider did not ensure adequate and appropriate care within the capacity of the facility was provided for Resident 1.

Resident 1 had an order for dressing changes on the right arm daily and as needed. The order was written on 05/08/2026 but not added to the MAR until 05/13/2026. The written order and MAR did not match. The MAR noted several dates when the dressings were not changed. The MAR reflected refusals for the dressing changes but was no evidence of follow-ups or re-approaches to ensure the dressing was changed as ordered.

This is a repeat deficiency. See statement of deficiency (SOD) JBCN11, dated 11/06/2025.

Findings Include:

On 05/07/2026, the department received a complaint alleging concerns with wound care not being provided.

On 05/28/2026, Surveyor reviewed Resident 1's individual support plan (ISP), dated 05/28/2026. The ISP noted the following:

SKIN CONDITION: "Skin will be free from signs of breakdown or infection. Date Initialed: 02/19/2026 Revision on: 02/28/2026 .... [Resident 1] will notify staff of new of worsening skin conditions Date Initiated 02/19/2026 Revision on: 05/28/2026."

On 05/28/2026, Surveyor interviewed Resident 1. Resident 1 reported s/he has a dialysis port in his/her right arm. Resident 1 explained it became infected and now needs wound dressing changes. Resident 1 confirmed s/he received wound care services, but the dressing needed to

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be changed often. Resident 1 reported the staff would tell him/her the dressing changes were, "not their job." Resident 1 stated his/her family members were assisting with dressing changes.

On 05/28/2026, Surveyor reviewed Resident 1's progress notes. The note for 05/28/2026 stated, "writer was at the med cart and [Resident 1s] wound care specialist came up to writer. Wound care specialist told writer that wound on [his/her] arm is not being taken care of that [s/he] had put multiple order [sic] about changing dressing on [Resident 1's] wound that [Resident 1's] sleeve was soaked and that it should be changed daily ..."

On 05/28/2026, Surveyor reviewed Resident 1's wound care progress notes from 05/08/20206. Resident 1 was seen by the advanced practice nurse prescriber (APNP). The progress note identified the following:

" ...New surgical fistula site on right arm continues with significant redness, drainage, warmth, pain and pitting edema. Patient states this is still an improvement compared with at the beginning of the week when [s/he] was sent to the ER (emergency room) for further evaluation. In the ER ... [s/he] was given an IV dose of antibiotic along with continued oral course of antibiotic medications ...Concerns raised included right arm wound care, functional decline due to pain and edema ... Facility states they can be doing daily dressing changes with dry dressings but no skilled treatments..."

New Order: "Change dressing on right arm DAILY AND PRN ...If drainage comes through dressing then replace dressing."

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Y3244	Continued From page 18 On 05/28/2026, Surveyor reviewed Resident 1's May 2026 medication administration record (MAR). The MAR identified the following: Order added on 05/13/2026: Telfa on incision site, wrap with kerlix or comfort wrap, apply two layers of tubigrip. Change daily PRN (as needed). One time daily for wound care update management with any changes. Review of the MAR showed several dates with corresponding codes indicating why a dressing change was not completed. The dates and corresponding documented reasons were as follows: 05/14: "9" other/see nurse note 05/14 Progress Note: The note only stated the order. 05/15: "3" away from home 05/16: "2" refused 05/17: "2" refused 05/17 Progress Note: "The resident stated [Family Member] will come and change wrapping. 05/18: "2" refused 05/19: "9" other/see nurse note 05/19 Progress Note: "PER [RESIDENT 1] - [FAMILY MEMBER] AND [FAMILY MEMBER] COMING IN TO COMPLETE TASK ... Surveyor Note: There was no follow up in the documentation to verify the dressing was changed. 05/20: "3" away from home 05/21: "9" other/see nurse note 05/21 Progress Note: "Per [Resident 1] - [Family Member] or [Family Member] will be coming today to complete task. Surveyor Note: There was no follow up in the documentation to verify the dressing was changed. 05/22: "3" away from home 05/23: "3" away from home 05/24: "2" refused	Y3244		

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Y3244	Continued From page 19 05/25: "2" refused 05/27: "3" away from home 05/28: "9" other/see nurse note 05/28 Progress Note: The note only stated the order. Surveyor noted the wound care order written the APNP on 05/08/2026 was not on the MAR until 05/13/2026. Additionally, the 05/08/2026 order stated the dressing was to be changed daily and PRN. The MAR only indicated daily PRN. There was no documentation in the record to show the provider re-approached Resident 1 when dressing changes were refused, or to confirm his/her family members changed the dressing. On 06/01/2026, at 12:12PM, Surveyor interviewed Director of Clinical Services C (DCS-C) from the home health agency providing wound care services for Resident 1. DCS-C relayed Registered Nurse D (RN-D) was the case manager assigned to Resident 1. DCS-C explained RN-D expressed concerns regarding the facility not changing Resident 1's dressings. RN-D informed DCS-C Resident 1 asked his/her family members to change the dressings due to not getting assistance at the facility. On 06/02/2026, at 9:00AM, Surveyor interviewed Regional Director A (RD-A). RD-A acknowledged the MAR did not reflect the specifics of the 05/08/2026 order. RD-A confirmed caregivers should have re-approached Resident 1 when s/he refused the dressing changes. Additionally RD-A confirmed caregivers should have followed up with Resident 1 when s/he identified family would complete the task to ensure it was done. RD-A confirmed caregivers are receiving re-education regarding Resident 1's wound care orders.	Y3244		

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Y3244	Continued From page 20 Resident 1 had a wound with a fistula on the right arm that required daily dressing changes. The order for dressing changes was written on 05/08/2026 but was not added to the MAR until 05/13/2026. There were several documented occasions that reflected Resident 1 refused care or stated a family member would complete the task. There was no evidence of re-approaches or follow-up with Resident 1 to ensure the dressing was changed.	Y3244		