STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014863	A. BUILDING: _____ B. WING _____	C 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CREEK CQS LLC	8035 S CECILY DRIVE OAK CREEK, WI 53154

(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 10/31/2024, Surveyors completed a standard survey and 2 complaint investigation at Autumn Creek Cqs. As a result, 6 deficiencies were identified. Two complaints were unsubstantiated. Census: 8	N 000		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees (House Manager A, Caregiver D, and Caregiver E) reviewed received the annual training in client groups. Findings include: This facility was licensed as a semiambulatory community based residential facility (CBRF) on 12/18/2013 to serve up to 8 individuals in the client groups of irreversible dementia/Alzheimer's, advanced age, and developmentally disabled.	N 277		

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

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N 277	Continued From page 1 On 09/30/2024, at 10:15 AM, Surveyors reviewed employee records and identified the following: -House Manager A was hired on 06/15/2021. House Manager A's record identified his/her continuing education for 2023 totaled 18 hours but did not include continuing education hours for client group. -Caregiver D was hired on 08/05/2014. Caregiver D's record identified his/ her continuing education for 2023 totaled 18 hours but did not include continuing education hours for client group. -Caregiver E was hired on 07/03/2022. Caregiver E's record identified his/ her continuing education for 2023 totaled 18 hours but did not include continuing education hours for client group. On 10/31/2024, at 10:00 AM, Surveyors interviewed Facility Nurse B and Administrator C. Facility Nurse B reported they utilized an in-service binder to ensure all trainings were completed. Facility Nurse B did not report why client group training was missed.	N 277		
N 283	83.26(1) Documentation of required employee training The CBRF shall maintain documentation of all employee training under s. DHS 83.21 and task specific training under s. DHS 83.22 and shall include the name of the employee, the name of the instructor, the dates of training, a description of the course content, and the length of the training.	N 283		

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N 283	Continued From page 2	N 283		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not maintain documentation of all employee training under Wis. Admin Code § DHS 83.21 and task specific training under Wis. Admin Code § DHS 83.22 in 3 of 3 staff records reviewed. House Manager A's, Caregiver D's, and Caregiver E's records did not contain documentation of the date(s) of the training, the length of the training, or a description of the course content for training under Wis. Admin Code § DHS 83.21 and applicable task specific training under Wis. Admin Code § DHS 83.22.

Wis. Admin Code § DHS 83.21 states, "All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: (1) Resident Rights...(2) Client Group...(3) Recognizing, preventing, managing and responding to challenging behaviors."

Wis. Admin Code § DHS 83.22 states, "Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: (1) Assessment of residents...(2) Individual service plan development...(3) Provision of personal care...(4) Dietary training."

Findings include:

On 09/30/2024, at 10:15 AM, Surveyors reviewed employee records and identified the following:

-House Manager A was hired on 06/15/2021. House Manager A's record contained an employee orientation packet with the following trainings in list form: resident rights training, challenging behavior training, personal care

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N 283	Continued From page 3	N 283		

training, and dietary training. House Manager A's record did not have documentation in his/her record which identified the dates of the training, the length of the training, or a description of the course content of those trainings.

-Caregiver D was hired on 08/05/2014. Caregiver D's record contained an employee orientation packet with the following trainings in list form: resident rights training, challenging behavior training, personal care training, and dietary training. Caregiver D's record did not have documentation in his/her record which identified the dates of the training, the length of the training, or a description of the course content of those trainings.

-Caregiver E was hired on 07/03/2022. Caregiver E's record contained an employee orientation packet with the following areas in list form: resident rights training, challenging behavior training, personal care training, and dietary training. Caregiver E's record did not have documentation in his/her record which identified the dates of the training, the length of the training, or a description of the course content of those trainings.

On 10/31/2024, at 10:00 AM, Surveyors interviewed Facility Nurse B and Administrator C. Facility Nurse B reported s/he was aware of the requirement due to a previous survey at another facility. Facility Nurse B reported s/he had started to update the documentation to reflect this data. Facility Nurse B reported s/he did not update older employee checklists, but had made changes to ensure all new employees' training documentation would have all required documentation.

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N 389	Continued From page 4	N 389		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents' (Resident 1 and Resident 2) Individual Service Plans (ISP) were updated with changes and signed by the resident or resident's legal representatives acknowledging their involvement in, understanding of, and agreement with the ISP. Resident 1 utilized pain management. Resident 2 utilized wound care. Resident's 1 and Resident 2's ISPs did not contain signatures from their legal representatives for the ISP reviews in 2022, 2023, and 2024. This is a repeat deficiency. See Statement of Deficiency (SOD) YOYL11, dated 02/01/2019. Findings include: On 09/30/2024, at 11:35 AM, Surveyors reviewed	N 389		

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N 389	Continued From page 5 resident records and identified the following: Example 1 Resident 1 was admitted on 08/20/2018 with diagnoses including Alzheimer disease, depression, osteoporosis, chronic pain, rheumatoid arthritis, anxiety, and psychosis. Resident 1's ISP, dated 04/24/2024, under section titled, "Other pain management", indicated the following: "Current status: Tylenol for pain or fever Frequency of service and service provided: Staff to administer pain medications as prescribed. Goal/Outcome: Patient to remain free of pain and rate pain on a 0-10 verbal pain scale as 0 with 0 [sic] being the least amount of pain and 10 being the most pain. Service Provider Responsible: Caregiver [Registered Nurse] Resident" Resident 1's record contained an after-visit summary, dated 05/29/2024, for pain management. The after-visit summary indicated Resident 1 was seen for chronic right shoulder pain, lumbar radicular pain, left hip pain, and sacroiliac pain. Resident 1 received an order for physical therapy. Resident 2 was admitted on 02/28/2014 with diagnoses including chronic obstructive pulmonary disease, diabetes, anxiety, depression, paranoid schizophrenia, and nocturnal hypoxia seizures. Resident 2's ISP, dated 01/09/2024, under section titled, "Skin conditions", indicated the following: "Care area needs/strengths: skin war, dry + intact.	N 389		

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Interventions: Staff to inspect skin on shower day and report any redness, skin breakdown or open areas.
Staff responsible: Caregiver, [Resident], [Registered Nurse]
Resident desired outcomes/goals: [Resident] skin to remain clean, warm, dry, and intact."

On 09/30/2024, at 12:45 PM, Surveyors interviewed House Manager A. House Manager A reported Resident 1 attended occupational therapy weekly. House Manager A reported Resident 2 started wound care in March 2024 and had visits twice a week.

On 10/31/2024, at 10:00 AM, Surveyors interviewed Facility Nurse B and Administrator C. Facility Nurse B reported s/he updates the ISPs. Facility Nurse B reported the resident ISPs had been updated with the outside agencies. Facility Nurse B reported resident ISPs have listed residents may attend PT as an option under the section of fall prevention. Surveyor informed them the ISPs should contain information if the resident was utilizing an outside agency and should identified what outside agency they were utilizing.

Example 2

Resident 1 was admitted on 08/20/2018 with diagnoses including Alzheimer disease, depression, osteoporosis, chronic pain, rheumatoid arthritis, anxiety, and psychosis. Resident 1 had a guardian. Resident 1's ISP, had review dates written on top of the page which indicated Resident 1's ISP was reviewed on 08/02/2018, 07/16/2020, 06/09/2021, 05/17/2022, 04/18/2023, 04/24/2023, 04/04/2024, 04/18/2024 and 04/24/2024. Resident 1's ISP reviews were not signed by Resident 1's guardian.

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N 389	Continued From page 7 Resident 2 was admitted on 02/28/2014 with diagnoses including chronic obstructive pulmonary disease, diabetes, anxiety, depression, paranoid schizophrenia, and nocturnal hypoxia seizures. Resident 2 had an activated power of attorney. Resident 2's ISP had review dates written on top of the first page which indicated Resident 2's ISP was reviewed on 01/10/2021, 01/10/2022, 12/15/2022, 01/04/2023 and 01/09/2024. Resident 2's ISP reviews were not signed by Resident 2's power of attorney. On 10/31/2024, at 10:00 AM, Surveyors interviewed Facility Nurse B and Administrator C. Facility Nurse B reported the house manager was responsible for the ISP reviews. Facility Nurse B confirmed the ISPs should have been signed by all parties.	N 389		
N 420	83.37(3)(d) Medication storage: refrigeration Refrigeration. Medications stored in a common refrigerator shall be properly labeled and stored in a locked box. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all medications were securely stored in the common refrigerator for 1 of 1 refrigerator. Resident 1's Humira injection pens, Resident 2's Risperdal injection pens, Resident 3's Ozempic and progesterone injection pens, Resident 4's Novolog and Ozempic injections, and Resident 5's capsules were stored in an unlocked box in the common refrigerator. Findings include:	N 420		

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N 420	Continued From page 8 On 09/30/2024, at 9:10 AM, Surveyors observed the common refrigerator. There was 1 black toolbox on the shelf. The box was equipped with a padlock locking mechanism. The locking mechanism was not engaged. Surveyors removed the padlock from the box. The box contained 1 box of Humira injections pens for Resident 1, 1 box of Risperdal injection pens for Resident 2, 1 box of Ozempic injection pens for Resident 3, 1 box of Novolog flex pens and 1 box of Ozempic injection pens for Resident 4, 1 box of medroxyprogesterone acetate injections and Florajen capsules for Resident 5. Surveyors observed residents moving freely around the facility. On 10/31/2024, at 10:00 AM, Surveyors interviewed Facility Nurse B and Administrator C. Facility Nurse B confirmed the medications should have been securely stored. Facility Nurse B reported staff were trained to ensure medications were securely stored.	N 420		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until	N 452		

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N 452	Continued From page 9 serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored and served under sanitary conditions. Frozen chicken was thawing at room temperature on the kitchen counter for approximately 2 hours. Findings include: On 09/30/2024, between 9:10 AM and 10:55 AM, Surveyors observed a bag of Great Value chicken breast thawing in the kitchen sink. Surveyors touched the chicken through the plastic bag and noted some of the chicken was not frozen. Surveyors took the temperature of the chicken. The temperature was 54° Fahrenheit. According to the SERVSAFE 7th Edition Coursebook ©2017 National Restaurant Association Educational Foundation chapter 8, page 3 refers to thawing frozen food and states, "When frozen food is thawed and exposed to the temperature danger zone, pathogens in the food will begin to grow. To reduce this growth, NEVER thaw food at room temperature." On 09/30/2024, at 10:55 AM, Surveyors interviewed House Manager A. House Manager A reported the chicken was pulled out of the freezer. Surveyors informed House Manager A the chicken was observed sitting in the sink for	N 452		

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N 452	Continued From page 10 approximately 2 hours. House Manager A reported s/he was not aware of how to properly thaw chicken based on food and safety code requirements. On 10/31/2024, at 10:00 AM, Surveyors interviewed Facility Nurse B and Administrator C. Facility Nurse B reported they taught staff food safety during training. Facility Nurse B reported the food should have only been thawed in the refrigerator.	N 452		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible materials were not placed within 3 feet of 1 of 1 furnace and 1 of 1 water heater. There were furnace filters, a fabric covered metal folding chair and garbage can all stored less than 3 feet from the furnace and water heater. This is a repeat deficiency. See Statement of Deficiency (SOD) YOYL11, dated 02/01/2019. Findings include: On 09/30/2024, at 9:00 AM, Surveyors toured the facility. Surveyors observed the utility room. There were 2 furnace filters in a plastic bag stored in between the furnace. A green chair fabric folding metal chair and black garbage can were stored next to the water heater. The chair was stored within 3.75 inches of the water heater	N 507		

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N 507	Continued From page 11 and the garbage can was stored within 5 inches of the water heater. On 09/30/2024, at 10:15 AM, Surveyors interviewed House Manager A. House Manager A unaware of the code requirement that required combustible materials to not be stored within 3 feet of furnaces or water heaters. House Manager A reported they would stop storing items in the furnace rooms. On 10/31/2024, at 10:00 AM, Surveyors interviewed Facility Nurse B and Administrator C. Facility Nurse B confirmed the code requirement. Facility Nurse B reported staff were aware items were not to be stored near the furnace and water heater. When Surveyors inquired about the floor plan indicating the laundry room and furnace room were separate rooms, Administrator C reported the house was built with the laundry room and furnace room being combined and was unsure why the change in the build happened.	N 507		