STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012503	A. BUILDING: _____ B. WING _____	R-C 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREATIVE LIVING ENVIRONMENTS CLARION MANOI	21325 CLARION LN WAUKESHA, WI 53186

(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 12/10/2025, Surveyor conducted a verification visit at Creative Living Environments Clarion Manor. One deficiency was identified. One of 1 deficiency was a repeat violation. See Statement of Deficiency (SOD) CFM914, dated 07/28/2021 and SOD CFM913, dated 03/03/2021. All previous violations from deficiencies from SOD 7MMZ12, dated 06/25/2025 were substantially corrected. Under statutory provisions of Wis. Stat. ch. 50 a $200 revisit fee is being assessed. Census: 7	{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 observation, record review and interview, the provider did not ensure 2 of 2 residents reviewed received his/her medications as prescribed. Resident 4's sliding scale insulin, was not administered as prescribed. Additionally, both	N 352		

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

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N 352	Continued From page 1 residents did not have their blood glucose tested prior to eating lunch on 12/10/2025 as prescribed. Resident 5 did not receive his/her polyethylene glycol as prescribed resulting in emergency room treatment. This is a repeat deficiency. See Statement of Deficiency (SOD) CFM914, dated 07/28/2021 and SOD CFM913, dated 03/03/2021. Findings include: On 12/10/2025, Surveyor conducted a verification visit and reviewed resident records. The following was found: Example 1: Resident 4 On 12/10/2025 at 12:30 PM, Surveyor observed Resident 4 eat a meal from fast food restaurant that his/her brother/sister brought to the facility. At 12:59 PM, Caregiver E gathered supplies to test Resident 4's blood glucose at the dining room table. Caregiver E asked Program Director D about Resident 4's insulin instructions. Program Director D stated Resident 4's blood glucose should be tested and insulin given prior to eating. Caregiver E stated s/he thought Resident 4 received his/her insulin after lunch. Program Director D reviewed the provider's electronic health record and confirmed Resident 4 was to have his/her blood glucose tested and receive insulin prior to lunch. At 1:10 PM, Caregiver E tested Resident 4's blood glucose which read 391. Program Director D proceeded to call Resident 4's physician to determine next steps with his/her insulin.	N 352		

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N 352	Continued From page 2 On 12/10/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility on 02/12/2024 with diagnoses including schizophrenia and type 2 diabetes. Resident 4's medication administration record (MAR) dated December 2025 included staff initials indicating staff were responsible for administering medications. Resident 4's physician orders included: "-Fiasp Flextouch 100 unit/ ML (3ML) insulin aspart (niacinamide), with instructions to inject 5 units subcutaneously 3 times day in the morning, noon, and evening with meals. Hold if blood sugar is less than 70 or if patient is not eating or eating less than 25%. Prime 2 units before each dose. Start date 08/05/2025." Example 2: Resident 5 On 12/10/2025 at 11:15, Surveyor interviewed Guardian F. Guardian F reported concerns with Resident 5 becoming constipated and having to go to the emergency room (ER). Guardian F reported Resident 5 does refuse his/her medications, but staff should try to reapproach. Guardian F stated Resident 5 was seen in the ER at the end of November and was full of bowel movement. Guardian F stated s/he was unsure if staff were giving Resident 5's his/her constipation medication due to the frequency of him/her reporting stomach issues. On 12/10/2025 at 12:00 PM, Surveyor observed Resident 5 eat lunch at the dining room table. At 12:59 PM, Caregiver E gathered supplies to test Resident 5's blood glucose at the dining room table. Caregiver E asked Program Director D about Resident 5's blood sugar checks. Program Director D stated Resident 5's blood glucose	N 352		

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N 352	Continued From page 3	N 352		

should be tested prior to eating. Program Director D reviewed the provider's electronic health record and confirmed Resident 5 was to have his/her blood glucose tested prior to lunch. At 1:10 PM, Caregiver E tested Resident 5's blood glucose.

On 12/10/2025, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the facility on 02/26/2009 with diagnoses including bipolar and type 2 diabetes. Resident 5's individual support plan (ISP) dated 01/20/2025 indicated staff were responsible for administering his/her medications. Resident 5's physician orders included:
"-Blood sugar checks: Caregiver to check resident's blood sugar 3 times per week before lunch, with a start date of 12/23/2022.
-Polyethylene Glycol with instructions to take 17G by mouth, stir and dissolve in 4-8 oz of liquid at noon and at 5pm, with a start date of 08/05/202 to 11/07/2025 & 11/13/2025."

On 12/10/2025 at 12:00 PM, Surveyor observed the provider's medication closet with Program Director D. Surveyor observed the following: Resident 5's polyethylene glycol container noted a manufacturer's label including the container originally held 30 once-daily dose of 17 grams. The container included a pharmacy label including Resident 5's practitioner's prescription for polyethylene glycol including, "Dissolve 17 gm by mouth stir and dissolve in 4-8 oz of liquid at noon and at 5pm." The pharmacy label included a delivery date to the facility of 11/10/2025. Surveyor observed approximately 1/4 of the medication remained in the container. Program Director D observed and verbally confirmed 1/4 of the medication remained in the container.

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N 352	Continued From page 4 Surveyor reviewed Resident 5's November to December 2025 MAR and identified the following: Resident 5 was administered 51 doses of polyethylene glycol between 11/13/2025 to 12/09/2025 from a 30-dose container, based on Resident 5's practitioner's order (2x/day), with 1/4 of the medication remaining in the container. Resident 5's progress notes documented: "-11/28/2025: resident complaining about stomach pain resident [sister/brother] came took resident to ER. Resident not back. Will notify 2nd shift." Resident 5' medical after visit summaries documented: "-11/28/2025: Instructions-Increase MiraLAX for next 2 doses to 4 caps from 1 cap. Diagnoses: Generalized abdominal pain, constipation. Imaging tests: CT abdomen pelvis w contrast. -09/10/2025: Reason for visit: Abdominal pain. Diagnosis: Blood in stool. Instructions: You have been diagnosed with episode of blood in the stool/diaper at care facility. There was no evidence of blood in the stool or urine here. Your labs are overall reassuring. Please follow-up with your doctor." On 12/10/2025 at 1:30 PM, Surveyor interviewed Program Director D. Program Director D acknowledged concerns with Caregiver E not checking blood glucose prior to lunch and not administering Resident 4's insulin as prescribed. Program Director D confirmed Caregiver E was delegated by the provider's nurse but would provide retraining. Surveyor questioned why Resident 5's poly glycol medication still had ¼ of the medication remaining in the container if given 2x/day. Surveyor shared if given as prescribed,	N 352		

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N 352	Continued From page 5 Resident 5 would have run out of his/her poly glycol on approximately 11/28/2025. Program Director D stated s/he thought Resident 5 refused this medication regularly but acknowledged staff continued to document as given. Program Director D stated s/he would work with the provider's nurse to correct the issue.	N 352		