STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015802	A. BUILDING: _____ B. WING _____	R-C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREATIVE LIVING ENVIRONMENTS HAVEN BA	225 E BROWN DEER BAYSIDE, WI 53217

(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 01/23/2024, Surveyor conducted a verification visit and complaint investigation at Creative Living Environment Haven Bayside. As a result, deficiencies identified in ECQJ13 were corrected. One new deficiency was identified and the complaint was substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 17	{N 000}		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more.	N 397		

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

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N 397	Continued From page 1	N 397		

This Rule is not met as evidenced by:
Based on interview and record review, the provider did not ensure there was at least 1 qualified resident care staff in charge and on the premises of the Community-Based Residential Facility (CBRF) when one or more residents were present. On 11/20/2023, Caregiver B left the facility and the residents. The residents were alone for approximately 45 minutes. This had the potential to affect 17 of 17 residents.

Findings include:

On 11/28/2023, the Department received a complaint alleging on 11/20/2023 a caregiver left the residents alone.

On 01/23/2024, at 1:00 PM, Surveyor interviewed Caregiver B. Caregiver B reported s/he was scheduled to work on 11/20/2023, from 2:00 PM until 10:00 PM. Caregiver B reported the 3rd shift staff did not arrive to the facility and s/he left at 10:45 PM. Caregiver B reported Administrator A was coming in to care for the residents. Caregiver B reported s/he had to leave as s/he utilized public transportation. Caregiver B confirmed s/he left the facility and the residents alone.

On 01/23/2024, at Surveyor interviewed Director C of the staffing agency Caregiver B worked for. Director C confirmed Caregiver B left the facility and the residents alone. Director C reported Caregiver B was dismissed immediately after the incident. Director C reported s/he would provide, via email, the on-call report for 11/20/2023.

On 01/23/2024, at 3:00 PM, Surveyor reviewed the staffing agency's on-call report for the night of 11/20/2023, and identified the following:
-At 10:06 PM, Caregiver B notified the staffing

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N 397	Continued From page 2	N 397		

agency's on-call staff the 3rd shift staff had not arrived.
-At 10:09 PM, The staffing agency on-call staff notified Administrator A the 3rd shift did not arrive.
-At 10:11 PM, Administrator A followed up with the staffing agency on-call staff and reported the 3rd shift caregiver would arrive around 10:30 PM.
-At 10:25 PM, Administrator A updated the staffing agency on-call staff the 3rd shift caregiver had a flat tire and would arrive by 10:45 PM.
-At 10:30 PM, The staffing agency on-call staff notified Caregiver B of the new arrival time of 10:45 PM. The report indicated Caregiver B "was very upset" but agreed to stay until 10:45 PM.
-At 10:47 PM, Caregiver B notified the staffing agency on-call staff the 3rd shift staff had not arrived.
-At 10:53 PM, Administrator A called the staffing agency on-call staff and reported the staff member would not be in, as s/he was waiting for a tow truck. Administrator A reported s/he would go to the facility.
-At 10:54 PM, Caregiver B was updated s/he had to stay until Administrator A arrived. Caregiver B reported s/he was not waiting any longer. The staffing agency on-call staff informed Caregiver B it was resident abandonment if s/he left the residents alone. Caregiver B left at approximately 11:00 PM.
-At 10:55 PM, Administrator A was informed by the staffing agency on-call staff Caregiver B was leaving.

On 01/23/2024, at 4:30 PM, Surveyor reviewed the facility's self-report for the incident on 11/20/2023, when Caregiver B left the residents alone. The provider's self-report indicated the residents required 24-hour supervision and were left alone for approximately 35-45 minutes.

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N 397	Continued From page 3 On 01/23/2024, at 4:40 PM, Surveyor interviewed Administrator A. Administrator A confirmed Caregiver B left the residents alone on 11/20/2023, at approximately 11:00 PM. Administrator A reported s/he arrived at the facility at approximately 11:30 PM to care for the residents.	N 397		