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{M 000}	INITIAL COMMENTS On 05/21/2024, Surveyor conducted a standard survey, verification visit and complaint investigation at Creative Community Living Services River Drive. Data collection continued through 06/11/2024. The complaint was substantiated. The deficiencies identified in Statement of Deficiency (SOD) FWMB11, dated 06/17/2021, were corrected. Four deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure smoke detectors were tested monthly. Findings include:	M 336		

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

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M 336	Continued From page 1 On 05/21/2024, Surveyor requested smoke detector test documentation for 2022 and 2023 from Supervisor B. Supervisor B provided Surveyor with smoke detector tests conducted on the following dates: -September and December of 2022 -February, March, April, August, and September of 2023 -May of 2024 At 11:20 AM, Surveyor discussed the above findings with Supervisor B. Supervisor B stated smoke detector tests were scheduled but they did not always get done. Supervisor B stated it was on the staff task list. The provider did not ensure smoke detector tests were conducted monthly when 17 months were not documented as checked in 2022 and 2023, and 4 months had passed in 2024, with 1 documented test completed.	M 336		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following: This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the individual service plan (ISP) contained descriptions of services to meet the assessed needs of each resident. The	M 410		

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M 410	Continued From page 2 ISP did not fully address diabetic care needs and oxygen supplementation for Resident 1. Findings include: The provider is licensed to care for 4 residents in the client groups advanced aged, emotionally disturbed/mental illness, developmentally disabled, physically disabled, and advanced age. On 05/21/2024, at 11:53 AM, Surveyor observed Caregiver D assist Resident 1 with eating lunch. Resident 1 was in his/her bedroom with his/her bed elevated. Caregiver D stated Resident 1 typically ate lunch in bed. Caregiver D stated Resident 1 required repositioning every couple of hours. Caregiver D completed a medication pass for Resident 1. When asked about Resident 1's medications, Caregiver D stated Resident 1 had insulin in the refrigerator and received insulin injections at night. At approximately 12:20 PM, Surveyor reviewed Resident 1's records. Resident 1 was admitted to the facility on 04/27/2021. Resident 1's most recent ISP, dated 05/14/2024, included the following: -A general summary stating the following: "[Resident 1's] primary diagnosis: Paranoid Schizophrenia [sic] one leg is amputated. [Resident 1] has many fantom pains from this. [Resident 1] is a Type 2 Diabetic." The ISP indicated Resident 1 had guardian. -Under the Medications Management section, it stated Resident 1 required staff to administer medications. Under the subsection titled, "How does client/resident take medications?" a box was selected indicating Resident 1 took medications whole. There was no information related to nightly insulin injections or insulin	M 410		

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M 410	Continued From page 3	M 410		

storage recommendations.
-Under Illnesses section, there was a subsection titled, "What are client/resident's diabetic needs?" There was one box checked that indicated, "Client requires blood sugar monitoring and protocol." Surveyor could not locate information on signs or symptoms of abnormal blood sugar levels or parameters for reporting abnormal blood sugar results to the physician on Resident 1's ISP.
-Under the Illnesses section, was a subsection titled, "Does client/resident have difficulty breathing and needs oxygen monitoring or supplemental oxygen?" there was one box under that section, checked "Yes." Surveyor could not locate information related to Resident 1's oxygen usage and monitoring, including when to wear the oxygen, what level of assistance was needed from staff, what liters were ordered by the physician, how often oxygen levels should be checked, or any parameters for reporting abnormal oxygen levels to the physician. The ISP did not contain information for staff for when it was appropriate to administer Resident 1's as needed breathing treatments.

On 05/24/2024, Surveyor received additional records for Resident 1 from Director C via email that included the following physicians orders:
-Basaglar, 13 units, with an initial start date of 01/24/2023. Orders stated to inject 13 units subcutaneously once a day at 8:00 PM for Type 2 diabetes.
-Trulicity, .75mg/0.5ml dose, scheduled at 8:00 AM, with a "last updated" date of 12/14/2023. Orders stated, "Inject 1 dose into subcutaneous (abdomen or upper arm fatty tissues) tissue 1 time weekly."
-Blood Glucose, with an initial start date of 07/21/2021. Orders stated, "Take blood glucose

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level every morning before any oral intake. IF BG (Blood Glucose) is over 400 call [Provider's] office.
-Oxygen Check, with an initial start date of 05/04/2021. Orders stated, "[Resident 1] is on Oxygen at 2 liters with nasal cannula at night and is totally dependent on staff to make sure [his/her] oxygen stays on throughout the night. Staff must check every 2 hours overnight to make sure it is still properly positioned in [his/her] nose."
-Albuterol/Ipratropium Solution, 3ml, as needed, with an initial start date of 07/21/2021. Orders stated, "3 ML as needed 4 times daily inhalation (DO not use with Combivent) (every 6 hours)."

On 05/30/2024, Surveyor received additional records for Resident 1 via email from Director C that included the following:
-A physician's report, dated 03/15/2024, with orders stating, "Apply nasal cannula, oxygen 1-3 L per minute to maintain O2 saturation, 88-89%. If 87% or less, turn up. If 93% or greater, turn down. Maintain this as a standing order."

On 06/10/2024, at 10:00 AM, Surveyor interviewed Supervisor B via Microsoft Teams Meeting. Surveyor asked Supervisor B if Surveyor had the most recently updated ISP for Resident 1. Supervisor B affirmed and stated that they just had Resident 1's staffing. When asked if Resident 1's blood glucose checks and parameters were identified on his/her ISP, Supervisor B stated s/he would have to look, and they may not be. Supervisor B stated the ISP may direct staff to look in another location to obtain that information. When asked if Supervisor B was aware Insulin injections were not identified on the ISP, Supervisor B stated there were 3 different ways to do anything. Supervisor B stated there was a matrix plan and a linear plan. When asked

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M 410	Continued From page 5 if Resident 1's oxygen protocols were in his/her ISP, Supervisor B stated s/he would imagine they were not. Supervisor B stated they would keep the protocol in the protocol section. Surveyor shared concerns that those medical needs were not captured on Resident 1's ISP. Supervisor B stated they can add those areas to the ISP.	M 410		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure it provided or arranged for the provision of individualized services specified in the individual service plan (ISP) for Resident 1 and Resident 2. Findings Include: The provider is licensed to care for 4 residents in the client groups advanced aged, emotionally disturbed/mental illness, developmentally disabled, physically disabled and advanced age. On 05/21/2024, Surveyor reviewed Resident 1's records. Resident 1 was admitted to the facility on 04/27/2021. Resident 1's most recent ISP, dated	M 436		

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05/14/2024, indicated Resident 1 required full assistance with toileting and repositioning, utilized incontinence products, and was at risk for skin breakdown.

On 05/24/2024, Surveyor received additional records for Resident 1 from Director C via email that included the following observation notes:

-On 12/01/2023, at 7:30 AM, "[Resident 1] had a large BM (Bowel Movement) in [his/her] brief this morning when staff woke [him/her] up/BM was stuck to [his/her] skin and had to be scrubbed off. [Resident 1] was cleaned up."
-On 12/08/2023, at 6:30 AM, "Client had about 1 cup of feces in brief this morning, mouth covered with dried food, client scheduled for shower today. Client was cleaned up and changed. Unsure if client was ever changed during 2nd and 3rd shift. Care ongoing."
-On 12/08/2023, at 7:15 AM, "Client's wound care looked exactly the same as I left it yesterday, there were no wound dressings or abd [sic] pads used, unsure if 2nd shift did wound care last night. Client was asked if they remember and they said no. Wound care was done this morning following doctor notes. Care ongoing."
-On 02/25/2024, "[Caregiver E] was caught sleeping again by this staff. Client had hard dried up feces in brief. Client was changed and cleaned up. Care ongoing."

On 06/10/2024, at 10:00 AM, Surveyor interviewed Supervisor B via a Microsoft Teams meeting. Director C was informed of the meeting but could not attend. When asked if any concerns were brought to the provider's attention regarding Caregiver E, Supervisor B stated yes. Supervisor B stated Caregiver E was reported to have been sleeping at work and was terminated. Supervisor

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B stated an investigation was not completed as Caregiver E did not deny the allegations. When asked why Caregiver E was terminated, Supervisor B stated it was for reasons related to policy and procedure, conduct, and client neglect. Supervisor B stated Caregiver E was found to be sleeping on the overnight awake shift and did not complete duties or cares according to resident care plans. Supervisor B stated Caregiver E's termination was effective on 02/29/2024. When asked if the neglect allegations were reported, Supervisor B stated Director C would have the answer to that.

At 3:25 PM, Surveyor emailed Supervisor B and Director C. Surveyor asked if Caregiver E's neglect allegations were reported to the department and requested any documentation related to Caregiver E's neglect allegations.

On 06/11/2024, at 2:16 PM, Director C responded via email with the following documentation related to Caregiver E's neglect allegations:

-An employee termination form, with a termination reason identified to be, "Conduct/client neglect." The termination date was 02/29/2024.
-An internal investigation summary, that read, in part, "Neglect - sleeping during awake shift resulting in clients not being assisted with repositioning, toileting, and changing ...[Resident 2's] brief, pajama pants, mattress pad and bedding were soiled with urine, and [s/he] had feces in [his/her] brief ...[Caregiver D] also stated [Resident 1's] oxygen tubing was on the floor. [Resident 1] sleeps with oxygen tubing and staff are to make sure [s/he] is wearing it when completing the routine checks ...Review of the first shift observation notes from January and February indicate [Caregiver E] often may not

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M 436	Continued From page 8 assist residents during the night as required. There were several notes from after [his/her] 3rd shifts that clients were soiled and had dried feces on them upon waking...It is believed that [Caregiver E] was neglectful by falling asleep during an awake shift and not assisting clients with personal cares resulting in two clients being left in soiled clothing and bedding. It is also believed that this was not an isolated incident as evidenced by the progress notes written by the first shift staff. [Caregiver E's] employment was terminated." -On 02/27/2024, an email from the provider was sent to the Office of Caregiver Quality with details of the allegations. -On 03/01/2024, a misconduct incident report, was signed and submitted to the department. The provider did not ensure it provided or arranged for the provision of individualized services specified in Resident 1 and Resident 2's ISP. The provider identified Caregiver E had not been providing personal cares during the overnight shift and was terminated for resident neglect.	M 436		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency.	M 582		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 1 received all prescribed medications in the dosage and interval prescribed by Resident 1's physician.

Findings include:
The provider is licensed to care for 4 residents in the client groups advanced aged, emotionally disturbed/mental illness, developmentally disabled, physically disabled and advanced age.

On 04/17/2024, the department received a complaint regarding medication administration and documentation.

On 05/21/2024, at 12:45 PM, Surveyor interviewed Supervisor B. When asked about any recent staff misconduct, Supervisor B stated Caregiver A was involved in a medication error that led to a written notice of improper work performance being issued to Caregiver A. Supervisor B stated Caregiver A went back and tried to cover up the medication error. Supervisor B stated there was some forging of documentation as it related to medication counts. Supervisor B stated Caregiver A admitted s/he made a mistake and was afraid s/he would get in trouble.

Supervisor B provided a copy of the notice titled, "Written Notice of Improper Work Performance," that read, in part, "On 12/13/2023 [Caregiver A] signed that [s/he] administered a medication in ECP (Electronic Record) but failed to pass medication as scheduled. [Caregiver A] also failed to complete end of shift proof of use with oncoming staff ...Following [Caregiver A's] shift on 12/14/2023 it was discovered that the

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medications from the error had been removed from the bubble pack and the Proof of Use form had been altered to reflect the medications being given. There was no documentation of medications being destroyed. [Staff] made two phone calls to [Caregiver A] to determine what was done with the medication and the documentation. [Caregiver A] did not return the phone calls."

Supervisor B provided an investigation summary that read, in part, "12/19/2023 [Caregiver A] received a Written Notice of Improper Work Performance pertaining to med (medication) error on 12/13/2023 and [his/her] actions following. [Caregiver A] stated that [s/he] had a lot going on and is feeling some stress. When asked about the missing medication, [s/he] said [s/he] was not sure what [s/he] had done with it. [Caregiver A] admitted to changing the documentation to reflect the med (medication) being given. It was explained to [him/her] that the medication error was not the issue, these things do happen but the attempt to cover it up was a concern."

On 05/22/2024, Surveyor requested Resident 1's records via email from Supervisor B.

On 05/23/2024, Surveyor received Resident 1's records via email from Supervisor B. The following was included:
-A medication error report signed by Supervisor B on 12/15/2023. The date/time of error was 12/13/2024 at 8:00 PM. The error was found on 12/14/2023 at 6:00 AM and reported on 12/14/2023 at 7:00 AM. The medication involved was "Clozapine 25mg x 3 pills." It was identified as a missed medication. The description stated the following: "This staff arrived at 6:00 AM and was doing med count with 3rd shift. It was then

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noticed that last nights [sic] dose was not given and there was no audit done. This staff called [Program Director] and informed [him/her]. Spoke with nurse and [Program Director]. Doctor was call [sic] and care team was notified."

On 05/24/2024, Surveyor received Resident 1's records via email from Director C. The following was included:
-A December 2023 Medication Administration Record (MAR) showing, "Clozapine (25mg/tab) 75 MG (3 tabs)" was started on 04/18/2023, to be taken at bedtime. Clozapine was initialed by staff and appeared to have been administered on 12/13/2023, despite an internal investigation identifying it was not given as scheduled. The MAR provided to Surveyor did not capture the medication error.

On 06/10/2024, at 10:00 AM, Surveyor interviewed Supervisor B via a Microsoft Teams meeting. Director C was informed of the meeting but could not attend. When asked if any reports were made to the Office of Caregiver Quality (OCQ) regarding staff misconduct, Supervisor B stated s/he did not know and would need to ask Director C.

At 3:25 PM, Surveyor emailed Supervisor B and Director C. Surveyor asked if Caregiver A's incident was reported to OCQ.

On 06/11/2024, at 2:16 PM, Director C responded via email and stated, "[Caregiver A's] medication error was not reported to DHS (Department of Health Services) Office of Caregiver Quality."

On 06/13/2024, Surveyor provided resources to Supervisor B and Director C via email related to provider reporting requirements and resident

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M 582	Continued From page 12 misappropriation. Surveyor informed Supervisor B and Director C that in removing Resident 1's medication from the original packaging and not knowing where the medication went, that would be considered misappropriation of Resident 1's property and should have been reported to the department. The provider did not ensure Resident 1 received all medications as prescribed by his/her physician.	M 582		