STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014654	A. BUILDING: _____ B. WING _____	C 05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK PLACE	**3829 S CHICAGO AVE SOUTH MILWAUKEE, WI 53172**

(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 05/07/2024, Surveyor conducted 3 complaint investigations at Oak Creek Place in South Milwaukee. One deficiency was indentified. One complaint was substantiated. Two complaints were unsubstantiated. Census: 42	N 000		
N 356	83.32(3)(l) Rights of Residents: Least restrictive env In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Least restrictive environment. Have the least restrictive conditions necessary to achieve the purposes of the resident ' s admission. The CBRF may not impose a curfew, rule or other restriction on a resident ' s freedom of choice. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure the least restrictive conditions necessary to achieve the purpose of Resident 1's return to facility after a hospital stay. Provider did not ensure 1 of 1 resident (Resident 1) was free from rules or other restrictions on his/her freedom of choice. The provider attempted to impose restrictions on Resident 1's freedom of choice by requiring a 1 to 1 staffing ratio, prior to his/her return from the hospital. Resident 1 did not want or agree to this plan of care. Findings include:	N 356		

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

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N 356	Continued From page 1 On 04/03/2024, the Department received a complaint alleging the provider "put [Resident 1] on a 1:1 [staffing ratio] without having a doctor's order for increased supervision. [Provider] was going to charge [Resident 1] for the additional [staffing]. Complainant alleges they did not receive an agreement for additional charges." On 05/07/2024, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted on 10/16/2023 with a diagnosis of bipolar disorder, depression, anxiety, hypertension, chronic renal insufficiency, sleep apnea, and narcolepsy. Resident 1's Individual Service Plan (ISP), dated 03/10/2024, identified Resident 1 required assistance with medication management and no other activities of daily living. Resident 1 was his/her own decision maker. Progress note, dated 01/06/2024, documented the following: "[Resident 1] told med[ication] passer [s/he] wished [s/he] was dead. [Resident 1] is own responsible party and [s/he] notified daughter that [s/he] was leaving by ambulance [to St Lukes South Shore for evaluation]. St Lukes South Shore did a workup on [Resident 1]. S/he had pneumonia which they said was most likely the cause of change in behaviors. They ordered an antibiotic and sent him/her to ... for psychiatric clearance." Progress note, dated 03/08/2024, stated: [Resident 1] readmitted to facility. Patient medications were adjusted. On 05/07/2024, Surveyor reviewed staffing schedules and identified the following dates had 1:1 staffing scheduled for Resident 1:	N 356		

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N 356	Continued From page 2 03/13/2024 6:00 AM - 6:00PM 03/21/2024 3rd shift 10:00 PM - 6:00 AM 03/25/2024 2nd shift 2:00 PM - 10:00 PM 03/26/2024 2nd shift 2:00 PM - 10:00 PM 03/29/2024 2nd shift 2:00 PM - 10:00 PM 04/02/2024 2nd shift 2:00 PM - 10:00 PM Interviews On 05/07/2024 at approximately 1:30 PM, Surveyor interviewed Registered Nurse (RN) B. RN B confirmed there had never been a doctor's order for 1:1 care for Resident 1. RN B reported Former Executive Director (FED) A initiated 1:1 care when Resident 1 returned from a hospital stay. FED A wanted coverage for all 3 shifts, but they were not successful in finding willing caregivers. Resident 1 was very upset about having care staff watching him/her all the time and became very upset with the situation. On 05/07/2024 at approximately 2:00 PM, Surveyor interviewed Resident 1. Resident 1 confirmed that FED A would come into their apartment uninvited. Resident 1 stated, "They would knock but not wait for an answer just coming right in. I was very upset about [FED A] making caregivers stay in my apartment." Surveyor asked Resident 1 if they had a choice in care staff being assigned to them. Resident 1 replied "No." On 05/07/2024 at approximately 3:00 PM, Surveyor interviewed Lead Caregiver (LC) E. LC E reported they had witnessed FED A come into Resident 1's apartment even though s/he did not want them to come in. LC E described a cardboard sign Resident 1 constructed that read, 'Talk to my lawyer.' LC E sated, "[FED A] just	N 356		

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N 356	Continued From page 3 wouldn't listen and did what they wanted." On 05/08/2024 at 2:40 PM Surveyor spoke with Interim Administrator (IA) D who agreed if the situation occurred as described by staff and Resident 1, it was an infringement on Resident 1's rights.	N 356		