STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019634	A. BUILDING: _____ B. WING _____	R-C 10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEK SIDE MANOR	8841 S 13TH STREET 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 10/14/2024, Surveyors completed a verification visit at Creek Side Manor and 1 complaint investigation. As result, 3 of the previous 5 deficiencies were corrected. Two of the previous deficiencies were re-cited with 2 new deficiencies; therefore, 4 total deficiencies identified. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 17	{N 000}		
{N 353}	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review, observation and interview, the provider did not ensure the resident right to prompt treatment appropriate to resident needs when 1 of 1 resident's call pendant and/or emergency pull cord was not answered timely. Between 08/15/2024-09/06/2024, Resident 4 experienced 19 episodes of call pendant/and or emergency pull cord wait times exceeding 20 minutes. This is a repeat deficiency. See Statement of Deficiency (SOD) NNFI11, dated 01/22/2024. Findings include:	{N 353}		

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

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{N 353}	Continued From page 1 On 09/16/2024, at approximately 11:00 AM, Surveyors reviewed Resident 4's record. Resident 4 was admitted on 04/03/2023 with diagnoses including congestive heart failure, bilateral osteoarthritis of knee, morbid obesity, and hypertension. Resident 4's individual service plan (ISP), dated 09/13/2023, reported Resident 4 required complete assistance with mobility and transfers, medication administration, bathing, dressing, grooming, transferring, laundry, housekeeping, and ongoing health monitoring. Resident 4's call pendant/emergency pull cord logs between 08/15/2024-09/06/2024 reported the following times greater than 20 minutes: 08/15/2024 8:12 PM - 26 minutes 08/17/2024 6:15 PM - 22 minutes 08/17?2024 6:39 PM - 41 minutes 08/21/2024 5:53 AM - 21 minutes 08/22/2024 10:21 AM - 21 minutes 08/23/2024 7:37 PM - 34 minutes 08/25/2024 2:45 AM - 28 minutes 08/25/2024 7:07 AM - 33 minutes 08/25/2024 2:22 PM - 24 minutes 08/26/2024 2:43 AM - 23 minutes 08/26/2024 11:09 PM - 50 minutes 08/27/2024 12:56 AM - 23 minutes 08/29/2024 10:48 AM - 49 minutes 08/30/2024 8:55 AM - 1 hour 19 minutes 08/31/2024 10:23 PM - 31 minutes 09/02/2024 4:45 PM - 39 minutes 09/02/2024 8:05 PM - 22 minutes 09/02/2024 6:30 PM - 50 minutes 09/05/2024 5:54 PM - 20 minutes On 09/16/2024, at approximately 12:00 PM, Surveyors toured and observed the facility. Pull cords were in all resident bathrooms and call	{N 353}		

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{N 353}	Continued From page 2 pendants were worn by residents. On 09/16/2024, at approximately 12:15 PM., Surveyors interviewed Resident 4. Resident 4 reported s/he often experienced long wait times for staff to help with personal cares. Resident 4 reported staff turned off his/her call light and it took staff an hour to come back. Resident 4 reported his/her legs should be moisturized twice a day due to having cellulitis. Resident 4 reported s/he does not ask for help with putting lotion on his/her legs due to shortage of staff and long wait times. On 10/14/2024, at approximately 2:30 PM, Surveyors interviewed Director of Operations (DO) C regarding the long wait times for staff to help with cares. DO C reported call pendants should be answered within 5 to 10 minutes at most. DO C reported call pendant reports should be pulled and reviewed daily by directors. DO C reported that call pendant reports would be pulled and reviewed daily going forward. DO C recognized the significant wait times and reported plans were in place to address the issue.	{N 353}		
{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	{N 389}		

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{N 389}	Continued From page 3 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 2 residents (Resident 2's and Resident 3's) individual service plans (ISP) were updated when there was a change in service needs. Resident 2 and Resident 3 had falls with injuries and there were no updates to their ISPs. This is a repeat deficiency. See Statement of Deficiency (SOD) NNFI11, dated 01/22/2024. Findings include: On 09/16/2024, at 11:00AM, Surveyors reviewed resident files and identified the following: Resident 2 was admitted on 10/08/2021, with diagnoses including chronic lymphocytic leukemia, hypertension, Parkinson's disease, diverticulosis, and osteoarthritis. Surveyors reviewed a fall report for Resident 2's unwitnessed fall on 05/13/2024. Resident 2 hit his/her head and obtained a cut to the forehead and left knee. Resident 2 was sent to the emergency room on 05/13/2024. Surveyors reviewed a copy of the self-report sent to the department. The self-report indicated Resident 2 was sent to the emergency department and returned with staples to her/his head. The self-report reported to increase checks and two-hour toileting, to ensure Resident 2's	{N 389}		

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{N 389}	Continued From page 4 safety. Surveyors reviewed Resident 2's ISP, dated 08/19/2024. Resident 2's ISP identified Resident 2 as a fall risk. Resident 2's fall risk goal was "Resident to have a decrease in the number of falls with no falls with serious injury. Intervention per fall risk intervention." Resident 2's ISP did not indicate what fall interventions were in place for Resident 2. Resident 3 was admitted on 03/28/2023, with diagnoses of Rheumatoid arthritis, hypothyroidism, bell's palsy, osteoarthritis, and chronic kidney disease. Surveyors reviewed a fall report for Resident 3's unwitnessed fall on 05/31/2024. Resident 3 was found on the floor next to his/her bed with an injury above the right ear. Resident 3 was sent to the emergency room on 05/31/2024. Surveyors reviewed a copy of the self- report sent to the department. The self-report indicated Resident 3 was sent to the emergency department and returned with staples to his/her head. The self-report reported to increase checks and for Resident 3 to remain in the common area during awake hours. Resident 3's ISP, dated 04/10/2024 identified Resident 3 as a fall risk. Resident 3's fall risk goal was "Resident to have a decrease in the number of falls with no falls with serious injury. Intervention per fall risk intervention." was not updated to reflect the fall or changes in supervision during awake hours. Resident 3's ISP did not indicate what fall interventions were in place for Resident 3.	{N 389}		

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{N 389}	Continued From page 5 On 10/14/2024, at approximately 2:30 PM, Surveyors interviewed Director of Operations (DO) C about the policy of ISP updates when there was a change in a resident's condition. DO C reported service plans should be updated by facility nurses. DO C reported ISPs were to be updated when there was a change in condition and medication changes. DO C confirmed a shortage of nursing staff and s/he was in the process of hiring a new nurse with plans of properly training him/her to address the ISP updates and to ensure ISPs were updated with details surrounding the change of condition and intervention details.	{N 389}		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 clothes dryer in the laundry room had vent tubing of rigid material, with a fire rating that exceeded the temperature rating of the dryer. The clothes dryer was observed to have the flexible foil type vent tubing. Findings include: On 09/16/2024, at 12:30 PM, Surveyors toured the laundry room. The clothes dryer had flexible	N 488		

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N 488	Continued From page 6 foil accordion style vent tubing, approximately 2 feet from the residential clothes dryer to the wall vent. On 09/16/2024, at approximately 4:00 PM, Surveyors reviewed the departments facility department file, no evidence was found requesting a waiver to use a dryer vent tube that was not of rigid material with a fire rating that exceeded the temperature rating of the dryer. On 10/14/2024, at approximately 2:30 PM, Surveyors interviewed Director of Operations (DO) C. DO C reported s/he thought the dryer vent was of rigid material. DO C confirmed the code requirement. DO C reported s/he was unaware of maintenance changing the dryer vent to flexible venting. DO C reported s/he would notify their maintenance team to address the dryer vent.	N 488		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were securely stored in 2 of 2 areas accessible to residents. Cleaning compounds and toxic substances were not securely stored in the laundry room area and in the bathroom area. Findings include:	N 499		

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N 499	Continued From page 7 The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to serve up to 23 residents in client groups of physically disabled, advanced aged, terminally ill, and irreversible dementia/Alzheimer's. On 09/16/2024, at 12:30 PM, Surveyors toured the facility and observed the following: The bathroom door contained a locking mechanism, which was not engaged. The bathroom door was wide open. On a stand was a bottle of Lysol Power clinging gel and a container of Lysol wipes. The laundry room contained a locking mechanism. The locking mechanism was engaged but the door would not latch. Surveyors were able to push the door open. Inside the laundry room, a cleaning cart contained 2 cans of Scrubbing Bubbles Disinfectant Cleaner, 2 cans of Spray way glass cleaner, a can of Old English Wood Protector, a bottle of Cloralen Bathroom Cleaner with bleach, a bottle of Lysol Power clinging gel, a can of Trueliving tropical nectar automatic spray refill, and a spray bottle labeled Mr. Clean which contained a green liquid. On the shelf there was a container of Arm and Hammer Sensitive Skin laundry detergent and a container of Purex Hypoallergenic Free and Clear laundry detergent. Surveyors observed residents moving freely throughout the facility. On 10/14/2024, at approximately 2:30 PM, Surveyors interviewed Director of Operations (DO) C. DO C confirmed toxic substances and cleaning compounds were to be securely stored.	N 499		

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N 499	Continued From page 8 DO C reported s/he would continue to educate staff on the importance of securely storing cleaning compounds in the proper areas of the facility.	N 499		