STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014863	A. BUILDING: _____ B. WING _____	C 08/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CREEK CQS LLC	8035 S CECILY DRIVE 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 08/18/2026, Surveyor completed 3 complaint investigations at Autumn Creek CQS. As a result, 2 deficiencies were identified. Two complaints were substantiated, and 1 complaint was unsubstantiated. Census: 8	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on observations, record review and interview, the provider did not take immediate steps to ensure the safety of residents or conduct and document an investigation after receiving allegations of neglect and abuse for 2 of 2	N 158		

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

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N 158	Continued From page 1 incidents. House Manager C received allegations Caregiver D was sleeping during her/his shift. House Manager C received a picture of a resident without clothing on. Findings include: The Wisconsin Caregiver Program Manual defines abuse and neglect to include the following: "Abuse is any of the following acts committed by a caregiver ...A course of conduct or repeated acts by a caregiver which serve no legitimate purpose and which, when done with intent to harass, intimidate, humiliate, threaten, or frighten a client, causes or could be reasonably expected to cause the client to be harassed, intimidated, humiliated, threatened, or frightened .... Neglect means an intentional omission or intentional course of conduct by a caregiver or a non-client resident including, but not limited to, restraint, isolation, or confinement that is contrary to the entity's policies and procedures, is not part of the client's treatment plan, and - through substantial carelessness or negligence - does any of the following ...Substantially disregards a client's rights under either Wis. Stat. chapters 50 or 51 or a caregiver's duties and obligations to a client. Causes or could reasonably be expected to cause mental or emotional damage to a client, including harm to the client's psychological or intellectual functioning that is exhibited by anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation, fear of harm or death, or a combination of these behaviors. This paragraph does not apply to permissible restraint, isolation, or confinement implemented by order of a court or as permitted by statute. Neglect is the	N 158		

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N 158	Continued From page 2 intentional carelessness, negligence, or disregard of policy or care plan which causes --- or could reasonably be expected to cause --- pain, injury, or death ..." On 04/30/2026 and 08/05/2026, the Department received complaints alleging caregiver misconduct. Example 1 On 08/17/2026, at 10:10 AM, Surveyor reviewed Caregiver D's record. Caregiver D was hired on 02/05/2026. Caregiver D was terminated from employment on 06/22/2026. Caregiver was brought back and worked on 06/30/2026, 07/02/2026, 07/03/2026, 07/04/2026, and 07/05/2026. A document in Caregiver D's file, was identified by House Manager C as a document s/he typed up for reasons of termination of Caregiver D. The document reported, "[Caregiver D] was caught several times sleeping on the job, fell asleep cooking lunch [sic] burnt the food ...retaliation against the residents because [Licensee A] called and has a talk with [her/him] about being mean to [Resident 1] [sic] it continued even after this talk [sic] there was an incident where [s/he] slammed [Resident 1] plate on the counter so [Resident 1] told [her/him] you break it you buy me a new one ..." "Policy and Procedure All shifts are working shifts at no time is sleeping while on duty permitted. The appearance of sleeping or sleeping while on duty will be grounds for automatic termination and will be reported to caregiver misconduct for further investigation." The policy was signed by Caregiver D on 02/04/2026.	N 158		

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N 158	Continued From page 3 On 08/17/2026, at 10:20 AM, Surveyor interviewed House Manager C. House Manager C reported residents would report they caught Caregiver D sleeping during the shift. House Manager C reported s/he reported the allegations to Nurse B and was told it was the house manager's responsibility to complete drop in visits during 3rd shift for the allegations. House Manager C confirmed s/he did not complete drop in visits and did not complete an investigation. House Manager C reported the document was a list of reasons why Caregiver D was terminated from employment. House Manager C reported all residents required 24-hour supervision and care. House Manager C reported Caregiver D was brought back to employment due to s/he was in the hospital, and they needed staff to cover the open shifts. House Manager C reported Caregiver D was terminated again on 07/08/2026 due to a video which was sent to House Manager C in regards to threats of violence from Caregiver D. On 08/17/2026, at 11:39 AM, Surveyor interviewed Licensee A. Licensee A reported Nurse B was to handle any investigations regarding staff members. Licensee A reported if a caregiver was brought back into employment, there was a need for staffing. On 08/18/2026, at 9:20 AM, Surveyor interviewed Nurse B. Nurse B reported s/he received a text message from Licensee A about 3 months ago which indicated Licensee A would handle staffing issues and concerns. Nurse B reported s/he was not responsible for conducting the investigations and s/he was unsure if any investigations were completed. Nurse B reported s/he was responsible for nursing services.	N 158		

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N 158	Continued From page 4 Example 2 Observation On 08/17/2026, at 10:42 AM, Surveyor observed House Manager C's phone. Surveyor observed a picture message from Caregiver E to House Manager C, on 06/30/2026 at 9:15 PM, which showed the left side of a resident without clothing on. The resident's face was not in the picture and the picture showed her/his shoulder to her/his thigh. The picture showed a large red rash, located under the skin fold of her/his stomach area on the left side of her/his body. Record Review On 08/17/2026, at 10:10 AM, Surveyor reviewed Caregiver E's record. Caregiver E was hired on 04/27/2026. Caregiver E was terminated from employment on 07/24/2026. A document in Caregiver E's file, was identified by House Manager C as a document s/he typed up for reasons of termination of Caregiver E. The document reported, " ...June 30th [9:15 PM] - I received a naked picture of one of the residents [sic] [Resident 2] where no consent was given to take picture of a rash on [her/his] body ...". The document indicated House Manager C terminated Caregiver E on 07/20/2026 by text message. Caregiver E was given a 2nd chance on 07/20/2026 by Licensee A. Surveyor reviewed staff schedules and identified Caregiver E worked the following shifts after 06/30/2026: 07/01/2026 3:00 PM - 11:00 PM	N 158		

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N 158	Continued From page 5 07/02/2026 3:00 PM - 11:00 PM 07/06/2026 3:00 PM - 11:00 PM 07/09/2026 3:00 PM - 11:00 PM 07/10/2026 3:00 PM - 11:00 PM 07/13/2026 3:00 PM - 11:00 PM 07/16/2026 3:00 PM - 11:00 PM 07/22/2026 3:00 PM - 11:00 PM 07/23/2026 3:00 PM - 11:00 PM A policy for cell phones was located in Caregiver E's file. The policy reported, " ... Absolutely no cell phones in the homes at any time period the house phone number should be given to any people who may need to contact you for emergent purposes while you are at work ...". The policy was signed by Caregiver E on 04/20/2026. On 08/17/2026, at 11:15 AM, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 08/12/2025 with diagnoses including bipolar disorder. Resident 2 had an activated power of attorney (POA) which was activated in March 2024. Resident 2's record contained a "Photograph Release and Waiver" which was signed by Resident 2. Resident 2's "Photograph Release and Waiver" was not signed by Resident 2's POA. Interviews On 08/17/2026, at 10:20 AM, Surveyor interviewed House Manager C. House Manager C reported Resident 2 was in the photo. House Manager C reported Caregiver E sent her/him the picture to show the rash on Resident 2's body. House Manager C reported s/he was in the hospital at the time the text message was sent. House Manager C reported s/he was unsure if an investigation was completed because s/he was in the hospital.	N 158		

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N 158	Continued From page 6 On 08/17/2026, at 11:39 AM, Surveyor interviewed Licensee A. Licensee A reported Nurse B was to handle any investigations regarding staff members. Licensee A reported if a caregiver was brought back into employment, there was a need for staffing. Licensee A reported s/he was unaware of the picture taken of Resident 2 and sent to House Manager C. On 08/18/2026, at 9:20 AM, Surveyor interviewed Nurse B. Nurse B reported s/he received a text message from Licensee A about 3 months ago which indicated Licensee A would handle staffing issues and concerns. Nurse B reported s/he was not aware of the picture of Resident 2 until after Caregiver E was terminated. Nurse B reported staff should not be taking pictures of the residents. Nurse B reported s/he was unsure if the incident constituted as caregiver misconduct and needed to be reported. Nurse B acknowledged Surveyor's concerns.	N 158		
N 357	83.32(3)(m) Rights of Residents: Recording and filming In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Recording, filming, photographing. Not be recorded, filmed or photographed without informed, written consent by the resident or resident ' s legal representative. The CBRF may take a photograph for identification purposes. The department may photograph, record or film a resident pursuant to an inspection or investigation under s. 50.03(2), Stats., without his or her written informed consent.	N 357		

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N 357	Continued From page 7 This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure each resident had the right to not be photographed without informed, written consent by the resident or resident's legal representative for 1 of 1 resident (Resident 2). Resident 2 was photographed by a staff member without written consent. Findings include: On 08/17/2026, at 10:42 AM, Surveyor observed House Manager C's phone. Surveyor observed a picture message from Caregiver E to House Manager C, on 06/30/2026 at 9:15 PM, which showed the left side of a resident without clothing on. The resident's face was not in the picture, and the picture showed her/his shoulder to her/his thigh. The picture showed a large red rash, located under the skin fold of her/his stomach area on the left side of her/his body. On 08/17/2026, at 11:15 AM, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 08/12/2025 with diagnoses including bipolar disorder. Resident 2 had an activated power of attorney (POA) which was activated in March 2024. Resident 2's record contained a "Photograph Release and Waiver" which was signed by Resident 2. Resident 2's "Photograph Release and Waiver" was not signed by Resident 2's POA. On 08/17/2026, at 10:20 AM, Surveyor interviewed House Manager C. House Manager C reported Resident 2 was in the photo. House Manager C reported Caregiver E sent her/him the picture to show the rash on Resident 2's body.	N 357		

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N 357	Continued From page 8 House Manager C confirmed Resident 2 was not her/his own person. House Manager C acknowledged Surveyor's concerns.	N 357		