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	0013397	A. BUILDING: _____ B. WING _____	C 12/20/2024

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MCKINLEY HOUSE	75 N PARK ST CLINTONVILLE, WI 54929

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N 000	Initial Comments On 12/05/2024, Surveyor conducted a standard survey and complaint investigation at McKinley House. Additional information was collected through 12/20/2024. The complaint was substantiated and resulted in 2 deficient practices. 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 record review and interview, the provider did not ensure allegations of caregiver misconduct were immediately investigated when brought to their attention.	N 158		

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

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N 158	Continued From page 1 After initially being made aware of an allegation of caregiver misconduct the provider did not conduct an investigation until a 2nd allegation was made and reported approximately 6 months after the first allegation was reported. Subsequent provider investigations were conducted in November 2024 after the 2nd allegation was reported, and December 2024 after allegations were discovered during the state survey process. The resulting internal investigation findings included new allegations of caregiver misconduct reported in the November investigation and new allegations within the December investigation. The provider did not recognize the new allegations of caregiver misconduct within their own investigation findings and did not take steps to investigate the new allegations. Resident 1's record contained multiple documented instances and allegations of caregiver misconduct. The provider was responsible for reviewing the record and the allegations of caregiver misconduct contained within were not investigated. Findings include: On 06/28/2024, the Department received a complaint alleging caregiver misconduct occurred at the facility. Surveyor reviewed former Resident 1's medical record and noted Resident 1 resided at the facility from 11/07/2023 through 05/02/2024. May 2024 -Initial Outside Agency Misconduct Reporting to the Provider	N 158		

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N 158	Continued From page 2 On 12/09/2024 at 9:48 AM, Surveyor received and reviewed an e-mail from the Managed Care Organization representative (MCO I.) The e-mail noted on 05/13/2024 concerns regarding the nature of Resident 1 and Lead D's relationship were brought to Director B's attention. The note concludes, "... IDT consulted with supervisor re [sic] [Lead D]. Contacted [Lead D's] supervisor [Director B] at Clarity Care re [sic] situations at HH [sic] and [Director B] states [s/he] will have conversation with [Lead D] about this. IDT to continue care management." This was the first source of documentation from an outside provider confirming the provider was made aware there were concerns related to Lead D's conduct. On 12/10/2024 at 1:12 PM, Surveyor interviewed Director B with Administrator A present. Director B confirmed the MCO discussion summary indicating when the provider was made aware of the caregiver misconduct concerns in May of 2024. Director B stated s/he had a conversation with Lead D at the time it was brought to his/her attention but did not conduct a formal investigation into the allegations. Director B stated a formal investigation did not begin until November 2024 after allegations of caregiver misconduct by Lead D were brought to the provider's attention a second time via a report to Human Resources (HR.) November 2024- Initial Provider Caregiver Misconduct Investigation On 12/06/2024 at 10:47AM, Surveyor interviewed Director B. Director B stated Lead D was internally investigated in November for caregiver misconduct and had recently been allowed back to work. Surveyor requested the investigation documentation, employee record, and Resident 1's medical record including his/her observation	N 158		

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notes and any incident reports/ investigations related to the resident. After review of the initial complaint allegation, and additional allegations that were brought forth during the state survey process, Director B stated s/he had been aware of some of the allegations and that they had been addressed in the investigation conducted in November. Director B stated s/he had not been aware of the extent of the allegations brought forward during the survey investigation and stated a new provider investigation into the additional allegations would begin.

November 2024 provider investigation interview notes:

On 12/19/2024 at 9:35 AM, Surveyor was sent the requested documentation from the investigation conducted in November of 2024. Documentation of the investigation sent to Surveyor did not contain the date the investigation began, the names of the employee/s conducting the investigation, a summary of the findings, or any actions taken by the provider. The investigation consisted of 4 documented employee interviews (Caregiver E, Caregiver G, Caregiver K, and Caregiver AA.)

Caregiver E, " ... [Lead D] was having an inappropriate relationship with a former client - [sic] [Resident 1.] [Caregiver F] reported concerns about this too ... it was very obvious favoritism going on ... [Resident 1] was a Hoyer lift and [s/he] would lift [him/her] into [his/her] car and they would go off together in [his/her] car ... they watch movies in [his/her] room together in [his/her] bedroom ... [S/he] would do [his/her] showers and [s/he] would want [Lead D] to help [him/her.] ... [Resident 1] would put [his/ her] hands on [Lead D] in private areas and [s/he]

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would not redirect [him/her] appropriately ... One time [Lead D] even called [Resident 1] a [explicative] ..."

Caregiver G, " ... [Caregiver F] reported these concerns to somebody before [s/he] left. Uncomfortable vibe with [Resident 1.] [Lead D] will say, 'Isn't [s/he] hot?'"

Caregiver K, "... [Lead D] would come into the house and go straight to [Resident 1's] room looking for [him/her] and not acknowledging others ... [Resident 2 and 3] noticed [Resident 1] got extra attention from [Lead D.] ... One time [Resident 1] put [his/her] hands on [Lead D's] thigh and [S/he] didn't even move [his/her] hand away. One time after leaving a shift I had to come back because I forgot something. I went back into the house and [Resident 1] and [Lead D] were getting ready to watch a movie in [his/her] bedroom ..."

Caregiver AA, "[S/he] talks about [Resident 1] every time I see [him/her.] It's always this and that about [Resident 1] and how [s/he] shares pictures with [him/her] and talks with [him/her] daily."

On 12/19/2024 at 11:05 AM, Surveyor interviewed Director B and interviewed Administrator A at 3:30 PM. Both administrators acknowledged the minimum required elements of investigation documentation were not present as they did not contain the date the investigation began, the names of the employee/s conducting the investigation, a summary of the findings, or any actions taken by the provider. The 4 caregiver interviews in the November investigation contained allegations of caregiver misconduct the new allegations of misconduct had not been

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individually investigated, and the investigation had not been reported to the Office of Caregiver Quality as required.

December 2024- 2nd Provider Caregiver Misconduct Investigation; Initiated by State Investigation
On 12/19/2024 at 11:05 AM Surveyor interviewed Director B. Director B stated Lead D was internally investigated on 12/11/2024, for allegations of caregiver misconduct after the state survey investigation brought additional allegations of caregiver misconduct to their attention on 12/06/2024.

December 2024 provider investigation interview notes:

Surveyor reviewed the documentation from the investigation conducted 12/11/2024. Documentation of the investigation sent to Surveyor did not contain the date the names of the employee/s conducting the investigation, a summary of the findings, or any actions taken by the provider. Director D stated HR H conducted the interviews. The investigation consisted of 12 employee interviews (Caregiver BB, Caregiver N, Caregiver V, Caregiver CC, Caregiver W, Caregiver M, Caregiver DD, Caregiver O, Caregiver X, Caregiver Q, Caregiver S, and Caregiver Y.) Some of the interviews contained new allegations of caregiver misconduct. Some statements made by caregivers in the interviews were not congruent with resident rights and would require the provider who was reviewing the investigation to recognize that the statements made require their own subsequent investigation.

Caregiver N, "I know there was [Lead D] and [another person with the same name; Caregiver

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G] at McKinley the other one had a bias against [him/her] because of [his/her] parents' religion. [Caregiver G] told me that God was punishing [Resident 1] and when I told [him/her] that's not OK to say [s/he] said 'Well [his/her] parents say the same thing' ... [Resident 1] was [sic] being treated well at all. 2nd shift gave [him/her] less attention due to behaviors. 3rd and 2nd shift ignored [him/her.] When [s/he] was ignored that's when [s/he] had behaviors ... [S/he] could have done really well at McKinley if [s/he] was treated better by staff ..."

Caregiver V, "... remembers [Resident 1] and recalls that some staff were nice to [him/her] and others were not nice."

Caregiver W, "[Resident 1] was cocky to all staff if [s/he] didn't want to do something [s/he] wouldn't and would throw [him/herself] on the floor."

Caregiver M, "[Resident 1] was a rough one ... it was [his/her] temper ... if [s/he] did not get [his/her] way [s/he] would make it [explicative] ... I told [him/her] no [s/he] didn't like being told no so [s/he] took me down ... [s/he] was allowed to have a phone but [his/her] [relative] took it away from [him/her] [sic] [s/he] would have behaviors ... [s/he] took [his/her] temper out on us if you did not have a backbone it would be hard ..."

Caregiver X, "[Resident 1] made it difficult ... it would be difficult to do the behaviors refusing to do things [s/he] couldn't talk much but would throw a tantrum ... we got through it even when [s/he] was a jerk."

Caregiver Q, "[s/he] had behaviors mostly because staff didn't take the time with [him/her] to get to know and understand [him/her] [s/he] had

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some bully tendencies but other consumers picked on [him/her] some staff put [him/her] on a back burner because [s/he] had behaviors ... some of the staff allowed Gabe to pick on [Resident 1] ... [Resident 1] did target [Caregiver M] only because [s/he] ignored [him/her.] I did have to address [Lead D] once because [s/he] was telling staff to ignore [Resident 1] and that's not OK."

Caregiver S, "I wrote a statement and talked with Administrator A and felt that [his/her] [Family member] was talking about restraints and [Lead D] not stand up for [Resident 1] and I said I was not going to restrain [him/her] I did not think it was OK to take [his/her] property away from [him/her.] [Lead D] would take [his/her] phone because [s/he] had too many behaviors the supervisor grabbed [his/her] foot and pulled [him/her] away/slide [him/her] from equipment. (I did a report on this) ... [s/he] should not take [his/her] phone home with [him/her] ... when [sic] the phone and seeing [him/her] being pulled by [his/her] foot across the floor, after I reported it I asked to no longer go out there."

Caregiver Y, "[Lead D] was the one that gave [him/her] special attention [s/he] would buy [him/her] fast food that [s/he] would not buy for others sometimes [Resident 1] would get snacks at night that the other residents couldn't have [s/he] had lots of behaviors it took time away from the other residents but if [s/he] didn't get attention [s/he] would raise holy [explicative.]"

On 12/19/2024 at 11:05 AM, Surveyor interviewed Director B and Administrator A at 3:30 PM. Surveyor reviewed the internal investigation documentation including the statements made by caregivers that denoted additional investigations

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would be needed to look into the statements and new allegations. After review of both the November and December investigation interviews both administrators acknowledged the interviews contained new allegations that would need to be investigated individually. Neither administrator could state why follow up questions had not been asked by HR H when the interviewees discussed their concerns during both the November and December investigations. Neither Administrator could state why when the content of the interviews for both investigations were internally reviewed, the additional reports of caregiver misconduct and breeches in resident right were not identified by the provider and addressed prior to the state review of the documentation and review with the administrators.

Observation Notes
Surveyor requested to review the resident observation notes during the survey on 12/05/2024 to Regional Manager C. On 12/06/2024 Director B stated s/he had reviewed Resident 1's observation notes and would send them to Surveyor. Surveyor reviewed the observation notes that spanned 11/07/2023 upon Resident 1's arrival, through 05/02/2024 when Resident 1 was discharged. Surveyor noted occurrences in the notes related to potential violations of Resident 1's rights. The notes were available for all staff to read and none of the concerns and allegations had been investigated or reported to the Department or OCQ.

On 12/19/2024 at 11:05 AM Surveyor interviewed Director D. Director D stated all employees and managers had access to Resident 1's observation notes and that is was the entire care team's responsibility to review the resident notes starting with the house lead to review staff

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charting, then to the Regional Manager and Director to ensure the House Leads and management are reviewing their staff's entries. Director D stated there had been changes in staffing throughout the time Resident 1 resided at the facility and that there had only recently been a Regional Manager hired to oversee the House Lead. Director B stated in the interim time s/he was responsible for the oversight of many program House Leads. Director B stated s/he had briefly reviewed the observation noted on 12/06/2024 prior to sending them and had noted a few entries that were of concern but had not taken a closer look or determined an investigation was needed at that time.

On 12/19/2024 Surveyor interviewed Administrator A at 3:30 PM. Along with reviewing the new allegations and concerns brought forward during the November and December investigation interviews, Surveyor reviewed the multiple entries in the resident observation notes that were incongruent with resident rights. Administrator A acknowledged the documentation of caregiver misconduct, breaches in the resident's rights, and that all of the individual instances would need to be investigated. Administrator A stated it is all of the care team's responsibility to be reviewing the observation notes and ensuring each person under them is completing their job responsibilities, including oversight of day-to-day care to ensure residents safety and rights are maintained. Administrator A immediately began planning with Director B to address and correct the deficient practices.

Cross Reference
Y3234 DHS 50.09(1)(e) Treatment

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Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received treatment that was appropriate to his/ her needs and respected his/her rights. The observation notes and internal investigation interviews contained allegations and documented instances of mistreatment that were not addressed by the provider. The provider had access to the record which exemplified the ongoing mistreatment and did not act to investigate or retrain staff to prevent future occurrences. Findings include: On 06/24/2024 the Department received a complaint alleging caregiver misconduct occurred at the facility.	Y3234		

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Y3234	Continued From page 11 On 12/05/2024 at approximately 12:00 PM, Surveyor interviewed Lead D. Lead D described Resident 1 as having health and functioning that were within normal limits until recent years. Lead D stated Resident 1 had Wilson's disease that caused rapid progressive physical disability which affected the resident's ability to ambulate and speak. Lead D stated Resident 1 was fully cognitive but was unable to effectively express him/herself at times which lead to various behaviors due to the resident's frustration. Lead D stated s/he was the program Lead who trained and oversaw the other staff at the facility. Lead D stated there had been staff members who did not respect Resident 1's right of self-direction despite Resident 1 being his/her own person and a competent adult. On 12/05/2024, Surveyor reviewed former Resident 1's medical record and noted Resident 1 resided at the facility from 11/07/2023 through 05/02/2024. Resident 1 had diagnoses including multiple contractures and Wilson's Disease. Resident 1 required a Hoyer lift for transfers and a wheelchair that staff would assist the resident to move through the home. Resident 1 was able to place him/herself on the floor and at times would do so to crawl as s/he was able. Resident 1 was able to communicate by using a tablet to spell out words. Observation Notes Surveyor requested to review the resident observation notes during the survey on 12/05/2024 to Regional Manager C. On 12/06/2024 Director B stated s/he had reviewed Resident 1's observation notes and would send them to Surveyor. On 12/06/2024 Surveyor received and reviewed the observation notes that	Y3234		

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spanned 11/07/2023 upon Resident 1's arrival, through 05/02/2024 when Resident 1 was discharged. Surveyor noted occurrences in the notes related to potential violations of Resident 1's rights including care, treatment, self-direction, dignity, communication, access to property, seclusion, abuse, and neglect. The notes were available for all staff to read and, per interview with Administrator A on 12/19/20204 at 3:30 PM and record review, none of the concerns and allegations had been investigated or reported to the Department or the Office of Caregiver Quality (OCQ.)

Treatment Related to Medical Intervention and Medication Management:
Per interviews on 12/05/2024 with Lead D and Regional Manager C and 12/10/ 2024 with Director B and Administrator A, it was verified that the caregivers did not hold credentials that qualified them to assess residents or make medical decisions. On 12/06/2024 Surveyor reviewed Resident 1's Observation Notes included:

12/13/2023 6:45 PM, Caregiver R, "[Resident 1] had a very very [sic] bloody BM today ..."

There was no documentation of notification to the physician or seeking medical attention.

01/05/2024 9:45 AM, Caregiver M, "[Resident 1] has been up all night [sic] I gave morning meds with a sleep PRN in hopes [s/he] would finally rest the exact opposite has happened ... crawled from [his/her] bed ... to the bathroom ... [s/he] has crawled out of the bathroom with the curtain rod and [his/her] pants and pull up are completely down and [his/her] genital area is completely exposed [sic] I tried to pull up [his/her] briefing

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pants but [s/he] would not budge and would not help at all, [sic] non-emergency was called they advised that they could not help but if fire was to be paged out a $500 fine/ fee would be assessed and I said I would call back if needed [sic] that was the route needed to be taken."

There is no documentation indicating the provider reached out to a medical provider to advise on if a PRN medication for sleep should be given in the morning. There is no documentation indicating the resident requested this medication. After the administration of the PRN sleeping medication in the morning the resident was found in a state where [s/he] was unable to assist with tasks [s/he] typically could perform independently, resulting in [him/her] being found on the bathroom floor with [his/her] pants and depends down, possibly needing non-emergency services to assist as there was not a second caregiver present to assist with cares. There was no follow-up documentation on the incident.

Dignity and Medical Intervention
01/07/2024 9:00 PM, Caregiver M, "... NOC shift had come in to help with cares due to [Resident 1] throwing temper tantrums and would not eat or drink [sic] denied pillow and blanket and kept putting [him/herself] on the floor [sic] when rolled over within the last five minutes [Resident 1] presented with a bloody nose. NOC shift is cleaning [Resident 1] up now and both staff will be assisting [Resident 1] up and into bed ..."

The resident "put [him/herself] on the floor" which resulted in a bloody nose indicating the resident may have fallen to the floor causing the head injury. No medical assessment was sought.

01/11/2024 4:30 AM, Lead D, "[Resident 1] has

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large cuts on [his/her] knuckles from [him/herself] getting mad and punching the wall or the door. The right hand is pretty purple right now so just keep an eye on it. [S/he] also has cuts on knees from crawling and hitting the floor."

There was no documentation of notification to the physician, seeking medical attention, or pain management.

03/07/2024 9:45 PM, Lead D, "... [s/he] is wanting to eat constantly and I feel as if it is due to being bored so please limit [him/her] on the things and snacks we are giving [him/her] [sic] the [sic] more we say no the more [s/he's] going to want it but we need to stick to our plan for health concerns."

There was no order for dietary restrictions and Lead D was not qualified to diagnose health concerns, speculate as to why the resident had an increase in appetite, or impose dietary restrictions.

03/28/2024 5:15 AM, Lead D, "ALL STAFF [sic]- Please be sure you are following ECP and checking off medications as you are giving [Resident 1] has medication [s/he] needs for [his/her] disease this medication is VERY VERY [sic] important and CAN NOT [sic] be missed again! Please keep in mind this medication is in the fridge!!"

04/04/2024 3:30 PM Caregiver F, "... [s/he] put [him/herself] on the floor and went into the kitchen trying to get into the refrig [sic] [s/he] [sic] always wanting to eat [sic] we as [his/her] staff have to try to redirect this. I [sic] am sure it has to be [his/her] medication that makes [him/her] feeling [sic] [s/he] is always hungry. we [sic] cannot keep feeding [him/her] like this it is not healthy for

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Y3234	Continued From page 15 [him/her] ..." Caregiver F was not qualified to assess the resident's nutritional needs or advise on what is causing an increase in appetite. When the resident tries to express hunger and self-direct, the staff are redirecting him/her and limiting what little independence of choice s/he has. 04/04/2024 3:30 PM, Caregiver F, "... As for [his/her] medication you must be more aware of [his/her] medication. The [sic] one in the refrigerator has been forgotten too much, [sic] these are med [sic] errors. we [sic] cannot ignore this. pay [sic] attention to the mars [sic] and make sure you are making [sic] off what is giving [sic]." 04/04/2024 7:30 AM, Lead D, "[Resident 1's] WILSONS MEDICATION WAS NOT GIVEN 4/3/24 AFTERNOON!!!!! ..." 04/05/2024 10:30 AM, Caregiver F, "[Resident 1] has sores on [his/her] feet they are growing and looking infected. PM staff please remove the bandage on right foot at bedtime. AM staff please put a new bandage on [his/her] foot the bandage on the left foot with [sic] be changed when it [sic] we come in Monday." Caregiver F was not qualified to assess the resident's wounds. The caregiver believed the wounds appeared to be infected and did not promptly seek medical care for the resident but instead directed wound dressing changes without a physician's order. 04/15/2024 1:30 PM, Lead D, "[Resident 1] has blisters on both of [his/her] hands due to holding warm coffee in [his/her] cup and at burning [his/her] hands [sic] [s/he] did not say anything to	Y3234		

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staff at all staff notice hours later [sic] just watch them and make sure [his/her] hands are being cleaned after [s/he] eats and drinks."

Resident 1 has limited ability to communicate and was given a burning hot cup resulting in blisters on his/her hands. Lead D was not qualified to assess the resident's burn injuries and did not seek medical attention for the injuries or possible pain management for the burns.

04/17/2024 Caregiver G, "Resident refused to take meds and stated [s/he] was waiting for a night shift to come in and give them [sic] writer explained to resident that [s/he] should take [his/her] meds by 9:00 PM or they're going to be late ..."

04/26/2024 6:15 AM, Caregiver E, "Upon writers arrival [Resident 1] was lying on the floor ... writer assisted other staff with setting [him/her] up noticed [his/her] right hand knuckled by [his/her] pinky finger was bloody ... writer administered [his/her] PRN melatonin [Resident 1] asked writer to give [him/her] more meds writer said it was 10:30 PM and I am not allowed to pass medication at that point writer explained to [Resident 1] the importance of taking all of [his/her] medication especially at the time it is prescribed by the doctor. Writer told [Resident 1] [s/he] does have the right to refuse medication however we have time limits that have to be followed ..."

The resident had to wait until a 2nd person was present to assist [him/her] off of the floor.

The resident had the right to self-direct his/her own care and medications were not ordered by the physician to be given at a specific time (per

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interview with Lead D on 12/05/2024) as this is a home environment. The caregiver may have been following the provider's policy for medication administration time window, however the resident still has a right to receive their medication even if it is outside of the provider's preference for a medication administration time frame.

04/29/2024 8:18 PM, Caregiver K noted, "Medication was found still in [sic] bubble pack for 8:00 pm medications [sic] this medication was signed off as given. [sic] but was not given."

Treatment Related to Self -Direction, Independence, and Dignity:

11/09/2023 5:45 PM, Lead D, "[Resident 1] told me [s/he] could not have pork chops tonight because [s/he] is allergic but [s/he] is not [s/he] just does not like pork chops [s/he] is not allergic to anything per [Family Member] ... [Family Member] said that [s/he] basically treated [his/her] [Family Member] like a slave so to watch out for that ..."

11/11/2023 5:15 PM, " ... [s/he's] been requesting ice cream all day and I told [him/her] I'll give [him/her] ice cream after meds."

11/12/2023 8:15 PM, Caregiver R, "[Resident 1] asked me to bring [him/her] to [his/her] room so [s/he] could have a BM I did not give [him/her] [his/her] phone this time due to me catching [him/her] on porn last time. This time [s/he] clearly still played with [him/herself] and got [his/her] bodily fluids all over [him/herself] and the floor and did not have a BM. I told [him/her] if [s/he] asks me to go have a BM and doesn't go the next time [s/he] will not be going to [his/her] room and [s/he] will have to go in [his/her] pants

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Y3234	Continued From page 18 and be changed." Along with not being treated or written about with dignity, the caregiver imposes a threat of punitive neglect which is a form of mental abuse. 11/13/2023 3:15 PM, Lead D, "[Resident 1] had to go to the bathroom [sic] when I went in there and gave [him/her] the urinal and [s/he] was not even trying to hold it [sic] I tried to help [him/her] a few times but it did not work so I said well I don't know you're not helping in any way so we will try later ... I go to get lunch together and [s/he] peed all over the living floor ... after that [s/he] calls 911 so the cops came [s/he] said [s/he] did it on accident but I don't think [s/he] did [s/he] knew what [s/he] was doing [s/he] just did not want to lay down in [his/her] bed and wait for [his/her] sling to get washed because [s/he] peed on it." Despite the resident having increasing physical disability due to his/her progressing disease process, Lead D presumed the resident was purposely not being helpful, chose to urinate on the floor, and presumed the resident's reasons as intentional. 11/14/2023 1:30 PM Caregiver P, "Resident doesn't like the cup [s/he] was given (purple with butterflies) and has thrown it on the floor has also refused to eat lunch because [s/he] wanted a different cup." The resident is an adult who recently lost his/her physical independence and ability to freely communicate. The caregiver did not consider the resident's preferences or dignity and did not try to understand the possible lack of dignity the child-like cup may have represented to the resident.	Y3234		

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Y3234	Continued From page 19 11/14/2023 5:15 PM Lead D, "[Resident 1] got pretty upset today about [his/her] family member ... and through [his/her] pencil and notebook off the table along with [his/her] cup [s/he] then wanted another cup but I staff told [him/her] no there was no reason for a different cup and because we do not have an extra one [sic] I also spoke with [his/her] [Family Member] about calling 911 [s/he] said that we can take [his/her] phone away from [him/ her] ..." Lead D, who is the day-to-day lead caregiver and in charge of directing other caregivers did not recognize the resident's right to not have his/her property taken away as a punitive measure. On 12/19/2024 at 3:30 PM, Surveyor interviewed Administrator A who stated the provider had re-educated Lead D about the resident's right to his/her own property and believed this education was done shortly after the note was written. Surveyor discussed with Administrator A, despite the re-education, the observation notes detail the resident continued to have personal items taken away as a means of punishment after the time of the re-education and brought the additional entries to Administrator A's attention. 11/21/2023 6:30 PM, Caregiver R, "[Resident 1] had a BM on my shift and went in [his/her] pants I think [s/he] is seeking attention and did it on purpose ..." 12/02/2023 10:15 AM, Caregiver P, "Resident has been very very [sic] sassy since getting up. Has thrown [his/her] phone [his/her] urinal that's full of urine and said "[explicative] you" when I told [him/her] to stop being sassy ..." 12/02/2023 5:45 PM Caregiver P, "Resident 1 ...	Y3234		

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has purposely peed all over [his/her] clothing three different times today."

12/03/2023 6;30 PM, Caregiver P, "Resident has thrown [his/her] cup and peed [his/her] pants three times and needed to be changed."

In the following note Lead D confirmed the caregiver's subjective opinions had not been fair treatment of the resident:

12/04/2023 6:45 AM, Lead D, "[Resident 1] is not peeing all over [him/herself] like others say [sic] what's happening is when you take [him/her] to the bathroom you have to make sure [his/her] pants are far enough down so it won't push up on [his/her] urinal causing [him/her] to SPILL [sic] [his/her] urine all over [him/her] [s/he] does not have much muscle so we need to make sure we are helping [him/her] even if you have to stay in there and hold the urinal for [him/her] it beats changing [him/her] all the time but [s/he] is not peeing all over [him/herself] on PURPOSE [sic] !! [sic] "

12/06/2023 8:45 PM, Caregiver R, "[Resident 1] was disrespecting residents by banging on [his/her] wheelchair and hitting [his/her] box in the kitchen table [s/he] was also blocking the walkway for [Resident 2] to get through so I moved [him/her] out of the way and I told [him/her] if [s/he] did it one more time [s/he'd] be going to bed [sic] seconds later [s/he] pushed [his/her] chair back and got in [Resident 2's] way so when I moved [him/her] into [his/her] room [s/he] punched me in the face while I was trying to get [him/her] in [his/her] Hoyer lift [sic] once I finally got the Hoyer lift set up [s/he] pushed [him/herself] out of [his/her] wheelchair onto the floor ..."

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Y3234	Continued From page 21 12/13/2023 6:15 PM, Lead D, "[Resident 1] was throwing [his/her] candy ... along with [his/her] cup I took everything away from [him/her] for a while then [s/he] was good but then started doing it again so I told [him/her] [s/he] can have drinks only at the kitchen table if [s/he] continues to throw [his/her] cups and if [s/he] keeps throwing [his/her] candy [s/he] will lose all of that also!" 01/03/2024 9:15 PM, Caregiver U, "... resident [sic] was writing down that [s/he] is going to start breaking items in the household just because [s/he] wouldn't get [his/her] phone back [s/he] got [his/her] phone taken away because [s/he] was throwing items at another resident so until [s/he] behaves and acts right [s/he] will [sic] get [his/her] phone back." 01/05/2024 1:15 PM, Director B, "... looking into getting [Resident 1] an alarm for when [s/he] is in and out of [his/her] bed. In the meantime please do a 2-hour check stating what [s/he] is doing at that time. Offer [him/her] [his/her] TV music anything to keep [him/her] busy TALK TO [HIM/HER] [sic] [s/he] understands everything you are saying. On that note when giving a report about [him/her] do so out of [his/her] earshot [s/he] can hear everything ... if you have questions feel free to reach out during normal business hours ..." The provider does not have the right to put an alarm on the resident without an order or [his/her] consent. The resident has a right to be a part of [his/her] care planning and hear shift reports relative to [him/herself] and [his/her] care. 01/07/2024 4:15 AM, Lead D, "[Resident 1] was up until 1:32 AM [s/he] finally fell asleep ... after...	Y3234		

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getting out of [his/her] bed [s/he] was banging on the wall trying to get staff attention I went in there one time [s/he] wanted [his/her] music on so I put it on and told [him/her] [s/he] needed to go to sleep ..."

01/09/2024 5:45 PM, Lead D, "[Resident 1] had the phone today ... [s/he] kept calling 911 ... so I took the phone." Lead D noted Resident 1 became physically behavioral so s/he then, "called the cops on consumer ..."

Resident 1 is his/her own person and is allowed to make phone calls and accept the consequences of calling 911 for non-emergency issues. Instead, the staff limited [his/her] right of communication and self-direction by taking away [his/her] phone which caused the resident to become upset and have physical behaviors for which the provider then called the police on the resident.

01/11/2024, 9:00 AM, Caregiver M, "[Resident 1] peed a huge amount on the floor right in front of [his/her] room this morning as part of [his/her] temper tantrum [s/he] was not getting [his/her] way and was being extremely impatient ..."

01/13/2024 9:00 AM, Caregiver M, "Sucker punched staff ... [Resident 1] was upset that [s/he] couldn't go into another [resident's] room and staff placed [him/her] back into [his/her] room. Did not go to bed until ½ [sic] AM this morning ... until [s/he] decided it was time for bed."

01/20/2024 11:45 PM, Caregiver M, "... while trying to finish up dinner ... [Resident 1] decided [s/he] wasn't going to answer staff on whether [s/he] wanted more spaghetti or not ... wouldn't

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take [his/her] meds right away ... during [his/her] little temper tantrum staff went ahead and moved to the last resident that needed to be fed [Resident 1] got mad and started throwing items across the table onto the floor ... the whole tantrum lasted about 30 to 45 minutes ..."

In the following note Lead D noted the emotional effects the resident was experiencing:
01/21/2024 4:30 AM, Lead D noted Resident 1 was having difficulty sleeping and expressed his/her frustration, "... had a pretty long hard crying session saying things like why me, I miss my old life, I just want to go back to the way it was ..."

01/21/2024 12:15 AM, Caregiver M, "... while putting resident to bed with another staff member present [Resident 1] was mad and apparently didn't like the fact that [s/he] was in bed even though it was well past [his/her] bedtime and proceeded to chuck the remote ..."

01/21/2024 1:45 PM, Caregiver M, "WOuld [sic] not let staff feed anyone else until [s/he] was cared for ... peed pants more than once ... normally [s/he] comes out and lets staff know or uses the urinal [him/herself] [sic] [s/he] threw more than one temper tantrum to day [sic] tried to control every TV in the household staff said no, the only TV [s/he] could control is the TV in [his/her] bedroom, [sic] [s/he] got really mad and started punching ..."

01/21/2024 1:45 PM, Caregiver M, "... wants [his/her] phone back staff has explained that [his/her] [Family Member] has taken away the phone and there's nothing staff can do [sic] [s/he's] angry and will not get off the subject continues to pound on objects to make noise ..."

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Y3234	Continued From page 24 02/12/2024 6:45 PM, Lead D noted Resident 1 was having behaviors and "wanted to call 911 on [his/her] [Family Member] about [his/her] [sic] SSI and money and staff said we could just call the [Family Member] instead and [s/he] got mad and wanted to call 911 ... [s/he] began punching the side of the cabinet and busted open [his/her] knuckles on [his/her] left hand had blood all over the place [sic] staff cleaned [him/her] up and put band aids on [his/her] knuckles." Resident 1 was denied communication and assistance with reporting a grievance. It resulted in frustration that led to Resident 1 causing injury to him/herself. The staff did not seek medical assessment for the injuries despite noting the state of his/ her injuries as "busted open knuckles" with "blood all over the place" and knowing Resident 1 relied on his/ her hands to move independently. There was no documentation of pain assessment or notifying the resident's physician. 03/10/2024 12:30 AM, Caregiver E, "... Staff asked if [s/he] wanted to go to bed before [s/he] left. [S/he] said no." Resident 1 began to display behaviors and Caregiver E continued, "... writer used the Hoyer lift to transfer [him/her] into [his/her] bed while assisting [him/her] [s/he] hit and kicked staff. Writer finished [his/her] cares within 30 minutes loud pounding could be heard from [his/her] room [Resident 1] had thrown [him/herself] out of bed. When writer attempted to communicate and assist [him/her] [s/he] swung at writer and kept shaking [his/her] head no [s/he] was on [his/her] knees and writer decided to give [him/her] some space writer asked [Resident 1] a few times if [s/he] was ready for bed [s/he] said no two times until asked at 1:00 AM [s/he]	Y3234		

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cooperated and allowed writer to Hoyer [him/her] into bed."

Caregiver E documented Resident 1 stated s/he did not want to go to bed before proceeding to put him/her in bed, which then transpired into behaviors. Resident 1 was given no other option than to comply with the caregiver's plan of going to bed.

03/11/2024 9:15 PM, Caregiver G, "... resident did go outside with staff to enjoy the weather resident did have behaviors while outside because [s/he] wanted to go for a walk so staff had to redirect resident back inside the facility ..."

03/15/2024 11:30 PM, Caregiver E, "While writer was feeding [Resident 1] ... insisted on waffles instead. Writer informed [him/her] it was 10:45 PM at this time and writer would not be cooking. [S/he] threw [him/herself] to the ground [s/he] then made [his/her] way down the hallway and began opening and slamming peer's bedrooms doors ... Writer and second staff offered to get [Resident 1] in bed but [s/he] refused numerous times ... at 11:30 PM [s/he] cooperated ..."

03/16/2024 6:15 PM, Caregiver F, "[Resident 1] asked for a root beer float right after dinner [sic] staff told [him/her] that would be a good snack at 7:00 PM for snack. [S/he] didn't like the answer so [s/he] reached over and tipped the chair over writer took [him/her] to [his/her] room sat with [him/her] talking to [him/her] about how [s/he] needs to work with staff and not get so upset ..."

03/16/2024 9:30 PM, Caregiver F writes a 2nd note about the incident, "[Resident 1] want [sic] root beer float at 5 pm and staff told [him/her] [s/he] could have it for snack at 7 pm [sic] [s/he]

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didn't like my answer so [s/he] knocked over the dining room chair, [sic] when staff took [him/her] to [his/her] room we had a talk about [his/her] actions. [sic] told [him/her] that [s/he] can't act that way and get what [s/he] wants ... at about 7pm [Resident 1] put [him/herself] on the floor and soon after fell asleep staff tried to wake [him/her] so the residents could get to their rooms but [s/he] would not allow us to get [him/her] up so we got the Hoyer out and got [him/her] up and laid [him/her] in bed when writer tried to get sling out from under [him/her] [s/he] pulled my hand to [his/her] mouth and tried to bite me ..."

03/19/2024 11:15 PM, Caregiver E described Resident 1 becoming upset when Caregiver G was about to leave and noted Resident 1 "kept asking [Caregiver G] to take [him/her] with [him/her.]" Resident 1 became upset and tried to leave the facility, "[Resident 1] made [his/her] way to the front door and opened it. [Caregiver G] talked to [Resident 1] and closed the door ... Writer then switched place with [Caregiver G] and stood in front of the door ..."

12:45 PM, Caregiver F noted Resident 1's family visited, "[Family Member] found [his/her] vap [sic] they told staff they do not want [him/her] doing that. [sic] they took it away from [him/her.] ... [Family Member] seen [sic] the pad on the wall and asked why? [sic] i [sic] told [family] because [Resident 1] pounds on the wall at night and it helps keep the noise down. They [sic] speak Russian [sic] don't[sic] know what they said. [sic] but [sic] after they left [s/he] was very quiet."

04/03/2024 2:30 AM Lead D, "... when staff got in [Resident 1] was a mess [his/her] clothes were all sticky with food and milk and everything else we need to make sure we are cleaning up all

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Y3234	Continued From page 27 consumers after every meal even if that means changing them ..." 04/03/2024 8:15 PM, Caregiver F, "... after dinner [Resident 1] asked for dessert when staff told [him/her] [s/he] can have it in an hour at snack time [s/he] didn't like that answer and put [him/herself] on the floor and crawled [him/herself] over to the fridge and tried pulling things out ..." 04/06/2024 6:00 PM, Caregiver F noted Resident 1's family , "... came by to see [him/her] brought [him/her] some bigger clothes said [s/he] feels [s/he] needs to back off the milk that [s/he] has put on too much weight ... [s/he] told [him/her] that [s/he] messed this place up that [s/he] not ever going to find a good place like this one said [s/he] knows [Lead D] spoils [him/her] too much lol [sic] but [s/he] will never get just how much [s/he] [explicative] [him/herself] ..." The note detailed the resident's family chastising him/her for his/her behavior noting that it has led to the resident being discharged from the facility. 04/11/2024 9:30 PM, Caregiver K noted Resident 1 "... did not receive [his/her] Blizzard today do [sic] to behaviors." 04/27/2024 12:00 AM, Caregiver E noted, "Upon writer's arrival [Resident 1] was lying on the living room floor ... when asked what was wrong [s/he] spelled out [s/he] wanted to smoke. Staff told [him/her] it was raining and that [s/he] doesn't have cigarettes at the house. Writer told [him/her] I didn't smoke and that [s/he] should not demand or expect staff who do smoke to give [him/her] theirs ... [Resident 1] kept spelling out 'call [Lead D.] [s/he] will smoke. [S/he] will put me to bed.'	Y3234		

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Writer told [Resident 1] that [Lead D] is not to be bothered unless it's an emergency ... [s/he] hit at us and wouldn't allow the Hoyer sling to be put under [him/her] [sic] at 10:30 PM writer informed [Resident 1] that [Caregiver K] needed to go home that I cannot get [him/her] into bed unless [s/he's] safe and cooperative as the Hoyer could tip [sic] I asked [him/her] if [s/he] wanted to sleep on the floor I would get the mat out, a pillow and a blanket [sic] I asked [him/her] if [s/he] was choosing to sleep on the floor? I told [him/her] it was [his/her] right to refuse to go to bed and I would accommodate [him/her] and make [him/her] as comfortable on the floor if that's what [s/he] was choosing for the night [s/he] then changed [his/her] mind and allowed staff to get [him/her] into bed ..."

The facility is required to staff appropriate to the residents needs and if 2 people are required to safely transfer the resident, 2 people need to be present at the facility at all times. Stating the resident could choose to sleep on the floor if they do not go to bed when the staff say so is a threat and not an accommodation.

In the following note Lead D confirms the resident's right to self-direct had not been being respected:
04/30/2024 12:15 PM, Lead D noted, "[Resident 1] can not [sic] be forced to go to bed [sic] [s/he] around [sic] 8pm [s/he] does not want to go to bed at that time and [s/he] does not have to ..."

Treatment related to Abuse and Neglect:

Abuse
11/29/2023 7:15 PM, Caregiver R, "at [sic] 7:00 PM [Resident 1] decided to get out of [his/her] wheelchair in the living room and I found [him/her]

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Y3234	Continued From page 29 laying on the floor [sic] told [him/her] [s/he'll] be [sic] going to be laying in bed the rest of the night." Abuse and Neglect 12/15/2023 7:45 PM, Caregiver R, " ... around [sic] 7:15 [Resident 1] was screaming from [his/her] room when I checked on [him/her] [s/he] was face down on the floor told [him/her] [s/he] would stay like that until I was done passing out meds [sic] I also said if [s/he] did it again [s/he'd] be waiting for night shift to come in and help me get [him/her] up." Neglect 02/29/2024 7:45 PM, Lead D, "... staff walked into [Resident 1] sleeping on the floor face first half on [his/her] blue mat and half on floor [sic] [his/her] [sic] face was pushed against the floor and [s/he] was laying there for the night [s/he] was laying in a puddle of [his/her] urine when staff turned resident went over [s/he] had a huge bruise on [his/her] left cheek on no other injuries staff asked other staff why [s/he] was on the floor and staff stated [s/he] threw out [his/her] shoulder while trying to turn [Resident 1] over." Neglect 03/16/2024 9:00 PM, Caregiver F, "[Resident 1] threw [him/herself] on the floor [sic] writer let [him/her] lay on the floor for a while [sic] [s/he] fell asleep [sic] tried to wake [him/her] so we could get [him/her] out of the way for the other residents to their rooms [sic] we hoyered [him/her] into bed ..." Self- direction, Medical Intervention, and Abuse 03/20/2024 9:00 PM, Caregiver F, "... when staff came in at 5:00 PM [Resident 1] was sitting on the floor in front of the door with the team lead.	Y3234		

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Y3234	Continued From page 30 Staff asked what was going on [sic] was told [s/he] was trying to get out [sic] wanted to leave so staff was standing by the door and trying to get [him/her] to come back into the living room ... pushed [him/her] back so [s/he] wouldn't hit me again [s/he] fell backwards [sic] team lead came over to try to get [him/her] away from the door got [him/her] in the living room and team lead needs to leave for the night [sic] staff did an incident report [sic] leg has bruises from this but not [sic] medical attention is needed." The staff was unqualified to assess the resident and did not seek medical assessment. The event was documented in an incident report and no investigation was conducted into the caregiver's conduct. Prompt Medical Intervention and Neglect: 04/19/2024 1:00 PM, Caregiver F, "... [Resident 1] wasn't happy about that and dropped [him/herself] to the floor crawled to the refrigerator and started taking things out and throwing them on the floor [sic] staff just went on with [his/her] business not really letting [him/her] bother me [sic] at one point [s/he] was sitting [s/he] was hitting the door with [his/her] fist [sic] after a bit asked if [s/he] was ready to get in [his/her] chair [s/he] said no so I went on with other things [sic] again a bit later asked again if [s/he] wanted in [his/her] chair [s/he'd] finally said yes [sic] I hoyered [him/her] up into chair ... about 10 minutes later [s/he] started to moan like [s/he] was in pain staff asked if [s/he] hurt [s/he] said yes asked where [s/he] showed me [s/he] showed [his/her] left lower side asked [him/her] if [s/he] needed to with the hospital and [s/he] said yes so [Lead D] called 911 for [him/her] [sic] it ended up being kidney stones."	Y3234		

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Y3234	Continued From page 31 Self-direction, Medical Intervention, and Abuse 04/25/2024 9:45 PM Caregiver K, "... residents started swinging [his/her] fists at writer because [s/he] wanted milk instead of water [sic] previous to administering meds writer and resident had a little talk about how [his/her] medication with water tonight due to the fact [his/her] urine output was very minimal and was dark brown and syrupy and that [s/he] needed water to help with this issue and it was only for [his/her] meds nothing else [sic] [Resident 1] agreed by shaking [his/her] head yes and started taking [his/her] meds ... resident decided [s/he] didn't want the water anymore and started to swing [his/her] fists right at writer ... [s/he] then put [him/herself] on the floor and started pounding on the cabinet with shredder on it ... there are heavy things on top which could fall on [his/her] head, [s/he] continued for another 10 minutes as writer did try and move [him/her] away from the cabinet by dragging [him/her] by [his/her] feet but the residents started to kick with [his/her] legs so writer backed off and let the resident be until NOC shift arrived to assist. Incident report made out." The resident was diagnosed with kidney stones on 4/19/2024. Caregiver K is not qualified to assess the resident. Encouraging fluid intake would include the resident's preference for milk. After not allowing the resident self-direction, behaviors occurred which then led to less fluid intake, the resident being dragged across the floor by the staff, and ultimately having to wait until a second staff member was present to assist. There was an associated incident report completed which should have flagged the event for further investigation.	Y3234		

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Y3234	Continued From page 32 Investigation Interviews On 12/19/2024, Surveyor received and reviewed caregiver interview notes from an internal investigation completed by the provider on 12/11/2024. Surveyor noted the caregiver's documented statements included statements regarding the treatment of Resident 1. The provider's investigation documentation did not contain the names of the employee/s conducting the investigation, a summary of the findings, or any actions taken by the provider. The investigation consisted of 12 documented employee interviews including Caregivers N, V, W, M, X, Q, S, and Y: Caregiver N, "I know there was [Lead D] and [another person with the same name; Caregiver G] at McKinley the other one had a bias against [him/her] because of [his/her] parents' religion. [Caregiver G] told me that God was punishing [Resident 1] and when I told [him/her] that's not OK to say [s/he] said 'Well [his/her] parents say the same thing' ... [Resident 1] was [sic] being treated well at all. 2nd shift gave [him/her] less attention due to behaviors. 3rd and 2nd shift ignored [him/her.] When [s/he] was ignored that's when [s/he] had behaviors ... [S/he] could have done really well at McKinley if [s/he] was treated better by staff ..." Caregiver V, "... remembers [Resident 1] and recalls that some staff were nice to [him/her] and others were not nice." Caregiver W, "[Resident 1] was cocky to all staff if [s/he] didn't want to do something [s/he] wouldn't and would throw [him/herself] on the floor." Caregiver M, "[Resident 1] was a rough one ... it was [his/her] temper ... if [s/he] did not get	Y3234		

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[his/her] way [s/he] would make it [explicative] ... I told [him/her] no [s/he] didn't like being told no so [s/he] took me down ... [s/he] was allowed to have a phone but [his/her] [relative] took it away from [him/her] [sic] [s/he] would have behaviors ... [s/he] took [his/her] temper out on us if you did not have a backbone it would be hard ..."

Caregiver X, "[Resident 1] made it difficult ... it would be difficult to do the behaviors refusing to do things [s/he] couldn't talk much but would throw a tantrum ... we got through it even when [s/he] was a jerk."

Caregiver Q, "[s/he] had behaviors mostly because staff didn't take the time with [him/her] to get to know and understand [him/her] [s/he] had some bully tendencies but other consumers picked on [him/her] some staff put [him/her] on a back burner because [s/he] had behaviors ... some of the staff allowed Gabe to pick on [Resident 1] ... [Resident 1] did target [Caregiver M] only because [s/he] ignored [him/her.] I did have to address [Lead D] once because [s/he] was telling staff to ignore [Resident 1] and that's not OK."

Caregiver S, "I wrote a statement and talked with Administrator A and felt that [his/her] sister was talking about restraints and lead did not stand up for resident 1 and I said I was not going to restrain [him/her] I did not think it was OK to take [his/her] property away from [him/her.] [Lead D] would take [his/her] phone because [s/he] had too many behaviors the supervisor grabbed [his/her] foot and pulled [him/her] away/slide [him/her] from equipment. (I did a report on this) ... [s/he] should not take [his/her] phone home with her ... when [sic] the phone and seeing [him/her] being pulled by [his/her] foot across the floor, after I

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Y3234	Continued From page 34 reported it I asked to no longer go out there." Caregiver Y, "... [s/he] had lots of behaviors it took time away from the other residents but if [s/he] didn't get attention [s/he] would raise holy [explicative.]" Interviews On 12/19/2024 at 11:05 AM, Surveyor interviewed Director D. Director D stated all employees and managers had access to Resident 1's observation notes and that is was the entire care team's responsibility to review the resident notes starting with the house lead to review staff charting, then to the Regional Manager and Director to ensure the House Leads and management are reviewing their staff's entries. Director D stated there had been changes in staffing throughout the time Resident 1 resided at the facility and that there had only recently been a Regional Manager hired to oversee the House Lead. Director B stated in the interim time s/he was responsible for the oversight of many program House Leads. Director B stated s/he had briefly reviewed the observation noted on 12/06/2024 prior to sending them and had noted a few entries that were of concern but had not taken a closer look. On 12/19/2024 Surveyor interviewed Administrator A at 3:30 PM. Surveyor reviewed the multiple entries in the resident observation notes and interviews that were incongruent with resident rights. Administrator A acknowledged the documentation of caregiver misconduct, breaches in the resident's rights, and treatment. Administrator A stated it is all of the care team's responsibility to be reviewing the observation notes and ensuring each person under them is completing their job responsibilities, including	Y3234		

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MCKINLEY HOUSE	75 N PARK ST CLINTONVILLE, WI 54929

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Y3234	Continued From page 35 oversight of day-to-day care to ensure residents safety and rights are maintained. Administrator A stated the observation note entries noted clear mistreatment of Resident 1 that should have been "caught" by staff reading the notes and re-education provided. Administrator A acknowledged the entries that described neglect and abuse and stated s/he would be following up with Human Resources and reporting to OCQ. Administrator A immediately began planning with Director B to address and correct the deficient practices. Cross Reference N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect	Y3234		