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	0014653	A. BUILDING: _____ B. WING _____	C 02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCKINLEY PLACE	W56 N225 MCKINLEY BLVD CEDARBURG, WI 53012

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N 000	Initial Comments On 02/14/2024, Surveyor conducted three (3) complaint investigations at McKinley Place. Additional information was gathered through 02/20/2024. As a result of the survey 3 complaints were substantiated and two (2) deficiencies were identified. Census: 30	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on interviews and record review, the provider did not send a report to the department within three (3) working days after an incident resulting in serious injury requiring hospital admission or emergency room treatment for 1 out of 1 (Resident 1) resident reviewed. Findings include: On 02/14/2024, Surveyor reviewed the department's facility folder for McKinley Place, including documentation of any self-reported incidents. Surveyor did not locate a facility self-report related to Resident 1's incident around 01/31/2024. On 02/14/2024, Surveyors entered the facility to conduct a complaint investigation. Surveyor	N 165		

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

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N 165	Continued From page 1 reviewed Resident 1's individual service plan (ISP). Surveyors were unable to find documentation the ISP was updated when Resident 1 fractured his/her ankle. On 02/14/2024, Surveyor interviewed Caregiver (CG) E. CG E stated Resident 1 fell and now had something (wrong) with his/her ankle, wears a boot and needs help with toileting, dressing and transferring. Surveyor requested resident notes and CG E acknowledged Resident 1 did not have observation notes and staff only chart on a 24 hour board. On 02/14/2024 at 11:00 AM, Surveyor interviewed Resident 1. Resident 1 stated s/he had 3 fractures in his/her ankle from a fall in his/her room around 01/31/2024. Resident 1 acknowledged the pain was so intense, s/he was sent to the hospital. On 02/14/2024 at 1:40 PM, Surveyor interviewed Divisional Director (DD) B. DD B stated s/he did not have an update on Resident 1. DD B stated they give about 2 weeks for a resident to "bounce back" before the ISP is updated. DD B acknowledged the ISP for Resident 1 should have been updated. On 02/20/2024, Surveyor exited with DD B. DD B stated s/he did not find out about Resident 1's fall with injury until well after the fact. DD B will be working with new staff to ensure reports are submitted timely. The provider did not report an incident to the department within three (3) working days after an incident that resulted in emergency room treatment for Resident 1.	N 165		

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Y3244	Continued From page 2	Y3244		
Y3244	50.09(1)(L) Care (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 (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1, Resident 2, and Resident 3 received adequate and appropriate care to meet their needs. Findings include: The provider is a class CNA non-ambulatory CBRF licensed to provide services for up to 65 residents who may be physically disabled, of advanced age and/or have Alzheimer's/dementia. On 11/06/2023, 11/13/2023 and 12/18/2023, the department received complaint information alleging residents' needs were not being met, and long call wait times. On 02/14/2024 at 9:50 AM, Surveyor had entered	Y3244		

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Y3244	Continued From page 3	Y3244		

the facility and was unable to locate any staff. Surveyor observed Resident 3 sitting in the hallway handing out Valentine's candy. Resident 3 stated staff were "around here somewhere." Resident 3 stated some staff were very nice and some shouldn't be working at the facility, and they do not respect older people. At 9:57 AM Surveyor asked Resident 3 to push their pendant to test call wait times. Resident 3 stated s/he had not received a shower since s/he admitted, and thought s/he had been living at the facility for about 9 months. Resident 3 stated s/he had a shower chair, however the chair broke the 1st week at the facility. Resident 3 confirmed s/he had not received a new shower chair and showed Surveyor his/her bathroom. Resident 3 stated s/he would like to take a shower but was only given bed bathes. Resident 3 stated s/he rings for help and calls [family] crying for help. Resident 3 stated some staff will come and say they will be right back, but then they never come back to help. Resident 3 stated s/he is paralyzed and needs help to transfer on/off the toilet, in/out of wheelchair and in/out of bed, and when s/he is crying for help, some staff call him/her a "cry baby." After about 10 minutes with no staff response to Resident 3's call light, Surveyor called the phone # for the facility and informed Manager D, Surveyor was in the facility and was looking for staff.

On 02/14/2024 at 10:07 AM, Surveyor entered with Manager D. Surveyor toured the facility and Caregiver C provided Surveyor with a binder of individual service plans (ISP's) for residents.

RESIDENT 1:

On 02/14/2024, Surveyor reviewed Resident 1's ISP with print date 07/11/2023 and noted

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Resident 1 admitted with diagnoses of COPD, osteoporosis, deep vein thrombosis, diabetes, hypertension, depression, MS, bi-polar, GERD, hyperlipidemia, incontinence and weakness with falls. Resident 1's date of admission was 02/15/2015.
Surveyor noted:
Mobility, Transfer, Escort - "Have you fallen in the last week? Notes: 7/4 fall, 7/3 fall, intervention to use reacher, 7/2 fall intervention to call for assist. Have you fallen in the last month? Note: 6/22 fall intervention to transfer to w/c at van d/t incline, 6/19 fall, 6/15 fall intervention frequent reminders to use walker"
Dressing And Grooming - blank, no help identified.
Medication Assistance - "Staff will order, organize, administer, and monitor medications according to MD orders."

On 02/14/2024 at 10:15 AM, Surveyor interviewed Caregiver (CG) E. CG E acknowledged Resident 1 had fallen and fractured ankle and that staff have to assist him/her with transferring, toileting and dressing, and that Resident 1 wears a boot on foot. CG E stated response time depended on who and how many staff were on the floor, as there are often call ins.

On 02/14/2024 at 11:00 AM, Surveyor interviewed Resident 1. Resident 1 stated, "[It] could be better here," and that some staff were nice and others "mean as hell." Resident 1 stated s/he often rings his/her buzzer and has to wait over an hour for someone to come and help. Resident 1 stated wait times are longer after supper. Resident 1 stated staff leave medications in a cup for him/her to take, but do not observe him/her taking. Surveyor observed laundry piled up in

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Resident 1's room. Resident 1 stated, "Staff are supposed to help put laundry away." Resident 1 stated s/he fell in room trying to transfer self as staff did not respond to his/her call light. As a result of the fall, Resident 1 fractured their right ankle. Resident 1 stated s/he has had to go to meals without appropriate under garments as s/he was unable to put them on without staff assistance. Resident 1's ISP was not updated with change of condition after Resident 1 had a fall.

RESIDENT 2:

Surveyor reviewed Resident 2's most recent ISP with print date 06/28/2023, and noted Resident 2 admitted with diagnoses of hypothyroidism, arthritis, hyperlipidemia, seizure disorder and CVA. Resident 2 was able to make his/her needs known.
Surveyor noted:
Bathroom Assistance - "Notes: [Resident 2] requires full assistance with toileting. Staff to walk with [Resident 2] into the bathroom, help with pulling down pants and depends, stay with [Resident 2] while [s/he] is on the toilet and assist with wiping, pulling back up pants/depends, and walking back to [his/her] desired destination." Resident 2's date of admission was 11/07/2022.

On 02/14/2024 at 10:45 AM, Surveyor interviewed Resident 2. Resident 2 stated, "It is bad here, people do not show up for work." Resident 2 thought if s/he used his/her pendant staff would come to help. Resident 2 stated s/he had often waited hours for someone to come and help him/her. Resident 2 shared an incident where s/he had to go to the bathroom, and s/he rang his/her pendant. After about 20 minutes s/he could not hold it and was incontinent.

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Resident 2 stated then his/her tummy started to rumble, and s/he said s/he had problems with diarrhea. S/he was incontinent of BM and waited about 2 ½ hours in urine and feces before someone came to help him/her. Resident 2 shared in January, there was a day no one came in to make breakfast and at 7:45 AM when residents were in the dining room, no breakfast was available. Resident 2 shared they eventually were given something to eat.

RESIDENT 3

Surveyor reviewed Resident 3's most recent ISP with print date of 06/01/2023, and noted Resident 3 admitted with diagnoses of hypertension, depression GERD, hyperlipidemia, CVA, UTI and arthritis. Resident 3 was able to make his/her needs known.
Surveyor noted:
Bathing - "[Resident 3] requires staff assistance with showering. [Resident 3] uses a shower chair."
Bathroom Assistance - "Staff to assist [Resident 3] with all aspects of toileting. [Resident 3] is aware when [s/he] needs to use the bathroom and will ring for staff assistance." Resident 3's date of admission was 04/30/2023.

On 02/14/2024 at 10:15 AM, Surveyor interviewed Caregiver (CG) E. CG E confirmed Resident 3's shower chair broke and that staff give him/her a bed bath as the shower chair had not been replaced.

On 02/14/2024 at 10:35 AM, Surveyor interviewed CG C. CG C stated things were "bad," but feels things were getting better. CG C acknowledged there seemed to be less call ins. CG C stated s/he thought 1st shift was good but

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thought there were challenges on other shifts. CG C was unable to say how long wait times were, only that s/he tries to respond quickly.

On 02/14/2024 at 11:14 AM, Surveyor interviewed Resident 5. Resident 5 stated s/he didn't need a lot of help, but it is sad when staff will not help residents in wheelchairs. Resident 5 stated s/he was playing Bingo and when it ended, a resident in a wheelchair didn't know where to go so Resident 5 asked staff to help this resident. Staff stated they needed to go to the dining room and walked away without helping.

On 02/14/2024 at 11:35 AM, Surveyor interviewed Resident 4. Resident 4 stated s/he hoped it would get better. Resident 4 stated there had been 8 or 9 executive directors since s/he admitted. Resident 4 stated there was no supervision and staff did not respond to call lights timely. Resident 4 stated there was no one to talk to with concerns.

On 02/14/2024 at 11:43 AM, Executive Director (ED) A talked with Surveyor. ED A stated s/he was helping out as a new ED was just hired and was currently in training. ED A acknowledged there had been staffing issues and that s/he was utilizing agency caregivers to fill openings in schedule. ED A stated s/he uses agency nurses when there was not a certified med person scheduled. ED A stated s/he was aware of longer response times and they replaced some resident pendants and staff pagers. ED A confirmed 2nd shift was a challenge. Surveyor reviewed call light history from 11/01/2023 through 02/14/2024 with ED A and observed:

Resident 1's calls greater than 30 minutes: (wait time hour:minutes:seconds)

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11/08/2023 at 5:07 PM wait time 1:15:51
11/09/2023 at 1:07 PM wait time 46:31
12/21/2023 at 9:08 AM wait time 2:45:41
12/23/2024 at 7:45 PM wait time 34:39
12/24/2024 at 3:34 PM wait time 1:16:13
12/27/223 at 10:57 AM wait time 1:26:04
12/27/2023 at 2:24 PM wait time 37:08
01/05/2024 at 6:25 PM wait time 1:05:35
01/06/2024 at 4:10 PM wait time 2:42:42
01/06/2024 at 7:45 PM wait time 30:42
01/08/2024 at 10:02 AM wait time 1:20:45
01/08/2024 at 2:03 PM wait time 1:10:26
01/08/2024 at 6:57 PM wait time 35:16
01/09/2024 at 9:28 AM wait time 1:39:03
01/09/2024 at 2:44 PM wait time 1:13:12
01/15/2024 at 10:13 AM wait time 3:56:00
01/20/2024 at 7:40 PM wait time 1:13:27
01/21/2024 at 5:34 PM wait time 30:36
01/22/2024 at 9:21 AM wait time 45:49
01/23/2024 at 9:03 AM wait time 53:35
01/29/2024 at 7:57 AM wait time 2:51:08
01/29/2024 at 5:36 PM wait time 47:11
01/29/2024 at 9:17 PM wait time 33:07
02/13/2024 at 10:50 AM wait time 49:30

Resident 2's calls greater than 30 minutes:
11/05/2023 at 6:31 PM wait time 38:37
11/10/2023 at 3:34 PM wait time 41:12
12/18/2023 at 6:34 PM wait time 1:08:54
12/22/2023 at 5:24 PM wait time 2:04:18
12/28/2023 at 6:05 PM wait time 1:20:41
01/20/2024 at 6:04 PM wait time 1:23:52
01/22/2024 at 9:16 AM wait time 49:41
01/31/2024 at 5:46 PM wait time 53:51
02/02/2024 at 5:20 PM wait time 35:43
02/11/2024 at 5:52 PM wait time 1:10:00
02/12/2024 at 3:27 PM wait time 33:49
02/12/2024 at 6:13 PM wait time 1:19:07

ED A stated s/he will show the new ED this report

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Y3244	Continued From page 9 and ensure call lights were being monitored. On 02/14/2024 at 1:40 PM, Surveyor interviewed Divisional Director (DD) B. DD B confirmed there were only 3 medication passers on staff and that they were utilizing nurses from an agency for open shifts. Surveyor shared complaint concerns regarding Resident 1 and an incident when Resident 1 was sent out on pass with his/her medications and 2 other resident medications. DD B stated s/he had spoken with Resident 1's family and was unsure how Resident 1 was sent with his/her medications and 2 other resident medications. DD B stated the staff person that sent the medications out was retrained. DD B stated the wrong med's were not administered to Resident 1 and that the other residents did not miss any doses of the medications. DD B stated they do not have a leave of absence policy, they use a medication release/receipt that states med's, RX number, medication order and time, total # of pills or amount released and total # of pills or amount returned. There is a section for special instructions, telephone # for healthcare facility, pharmacy and physician. DD B was unsure if this form had been completed for Resident 1's leave of absence. Surveyor asked about leaving medications with resident and not observing resident take. DD B stated staff should be administering the medications and ensuring the resident is taking. Medications should not be left in room. DD B provided Surveyor with the Medication Pass Competency which stated "Gives medication directly to resident (does not leave out on tables, chairs, or in other public areas). Observe resident take medications (does not leave med with resident)." Surveyor asked DD B about Resident 1's medications being left for him/her to take and that staff do not observe him/her taking the medications. DD B stated they	Y3244		

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recently hired a new nurse and within the next 2 weeks s/he would conduct an annual medication training with all med passers and redelegate to the med passers.

On 02/20/2024, Surveyor exited with DD B. DD B confirmed staff should utilize the 24 hour board, but also should be doing 72 hour monitoring and charting. The 72 hour charting would go in residents chart after the 72 hours. DD B stated, "My guess, no one was there to enforce, so it didn't happen."

In conclusion, Resident 1's identified care needs in the ISP were not updated after a fall resulting in Resident 1's ankle being fractured and requiring staff assistance with dressing and grooming. Resident 2's identified care needs in the ISP were not provided in a timely manner as evidenced by call light response times. Resident 3's ISP was not updated reflecting Resident 3's shower chair had broken approximately 9 months prior and that Resident 3 was now receiving bed bathes. Caregiver C and Caregiver E confirmed they use resident ISP's to ensure they know what needs the residents have. ED A acknowledged the facility is utilizing different agency staff.

The provider did not ensure residents received adequate and appropriate care timely to meet their needs.