STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016798	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUDAHY PLACE	3460 E BARNARD AVE CUDAHY, WI 53110

(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 01/21/2025, Surveyor completed a complaint investigation at Cudahy Place. As a result, 2 deficiencies were identified. The complaint was substantiated. Census: 18	N 000		
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 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 each resident's individual service plan (ISP) was updated when there was a change in resident's needs, abilities or physical or mental condition for 1 of 2 residents (Resident 1). Resident 1 had an elopement and required 1:1 supervision, and her/his ISP did not identify her/his elopement risk or the need for 1:1 service. Findings include: On 12/20/2024, at 12:30 PM, Surveyor reviewed	N 389		

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

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N 389	Continued From page 1 resident records and identified the following: Resident 1 was admitted on 08/17/2023 with diagnoses including Alzheimer's disease, Type 2 diabetes with stage 3 chronic kidney disease, and hypercholesterolemia. Resident 1's ISP, dated 11/29/2023, under section "Orientation/Behaviors", indicated Resident 1 does not exhibit behavioral issues and does not wander. Resident 1's elopement risk assessment tool, dated 07/21/2023, indicated Resident 1 was a high risk for elopement. A request for behavioral health services, dated 05/01/2024, indicated Resident 1 was experiencing the following symptoms: losses, withdrawn, not eating, not sleeping, striking out, wandering, refusing care, confusion, disorientation, memory loss, nervousness, sleep problems, bizarre behavior, paranoia, and suspiciousness. Surveyor reviewed behavior monitoring logs, which identified Resident 1's behaviors as yelling, swearing, wandering, opening the door to get out, arguing, and hitting staff. On 01/21/2025, at 2:00 PM, Surveyor interviewed Administrator A. Administrator A reported s/he completes the resident ISPs. Administrator A reported ISPs were updated every 6 months, and at times changes would be handwritten on the ISP. Surveyor relayed concerns about Resident 1's ISP not identifying behaviors Resident 1 was experiencing, Administrator A acknowledged Resident 1's behaviors should be in Resident 1's ISP.	N 389		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents	N 426		

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N 426	Continued From page 2 the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure appropriate supervision for 2 of 2 residents (Resident 1 and Resident 2). Resident 1 and Resident 2 eloped from the facility, and a family member brought them back in. This is a repeat deficiency. See Statement of Deficiency (SOD) 974N11, dated 05/26/2023. Findings include: On 08/29/2024, the Department received a complaint alleging concerns about resident supervision. On 12/20/2024, at 12:30 PM, Surveyor reviewed a self-report, dated 08/26/2024. The report indicated Resident 1, and Resident 2 eloped from the community on 08/25/2024, at 4:32 PM. Family Member (FM) B found the residents outside and attempted to convince them to come back inside. Resident 1 and Resident 2 were reluctant to go back inside the community, until FM B offered them a ride after dinner. Resident 1 and Resident 2 agreed and came back inside the community at 4:36 PM. "At approximately 4:38 PM, a care staff	N 426		

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member was seen on camera responding to and resetting the alarm after hearing someone yelling from the east hallway. The [FM B] informed the care staff that [Resident 1] and [Resident 2] had gone outside. The [FM B] reported calling the community twice with no response or assistance from the care staff. The [FM B] also called administrator about the incident but received no response ... Care staff on duty reported seeing both [Resident 1] and [Resident 2] sitting in the common living room area watching TV around 4:15 p.m. They did not hear the alarm going off until they heard the yelling form the east hallway. The pager also reportedly didn't go off at the time of the incident ...".

Surveyor reviewed statements from the facility's investigation from Caregiver C and Caregiver D.

Caregiver C's statement stated, "I [sic] [Caregiver C] was scheduled to work 8/25/24 from 3pm-11pm. I did not hear the alarm go off. At the time [sic] I did not have a pager because there was only one when I came in and it was on the med cart so I did not take it as I assumed when you counted with [Caregiver D], you would give it to [her/him]. The other one has been missing since Friday because we were looking for it and could not find it when I worked last. At around 4:10 pm me and [Caregiver D] started toileting and bringing residents down to the dining room for water and drinks and start an activity. I last seen both [Resident 2] and [Resident 1] sitting together on the couch reading magazines together and watching Tv. I am not sure want to say right before this happened (Elopement), I let [Caregiver D] know I was going down to kitchen to get dinner ready. [Caregiver D] stated being good on the floor and starting med pass on west hall I went down about 4:20ish. I came back up

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towards the dining room with the cups to set tables around 4:35 maybe when I heard yelling and seen it was [FM B] yelling at [Caregiver D] about [Resident 2] and [Resident 1] getting out and why did not s/he come if s/he was an idiot. [Caregiver D] did not know what happened and neither did I [sic] but once [FM B] said they got out I made sure I checked that all the residents were in the building and no one else was outside on sheet. [FM B] was yelling about short staff no one here but [Caregiver D] when [Caregiver D] asked her/him to calm down that s/he did not hear alarm and was passing meds. That was when [FM B] seen me ..."

Caregiver D's statement stated, "On Sunday August 25th, 2024 [sic] I, [Caregiver D] was scheduled to work a 16 [sic] hour shift. My shift started @ [sic] 3pm. At 4pm I was admindisting [sic] pills while in the common area. And [FM B] notified me that 2 residents [Resident 2 and Resident 1] had left the building. I asked [her/him] where could they have exited? [sic] [S/He] said by [Resident 3's] door. The alarm didn't go off. The 'stop' emergency sign was completely off. [S/He] also indicated [s/he] let them back in the building. I advised [FM B] I was passing medications and at the moment the only person on the floor. [S/He] started to get very belligerent and aggressive (verbally) towards staff."

Surveyor reviewed resident records and identified the following:

Resident 1 was admitted on 08/17/2023 with diagnoses including Alzheimer's disease, Type 2 diabetes with stage 3 chronic kidney disease, and hypercholesterolemia. Resident 1's ISP, dated 11/29/2023, under section "Orientation/Behaviors", indicated Resident 1

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does not exhibit behavioral issues and does not wander. Resident 1's elopement risk assessment tool, dated 08/26/2024, indicated Resident 1 was a high risk for elopement. Resident 1's record contained a 30-day notice of discharge which indicated the care Resident 1 required was inconsistent with the community's program statement and goes beyond what the community was to provide under the terms of the admission agreement. The 30-day notice indicated Resident 1 wanted to leave the facility daily and required 1:1 supervision at all times from the care staff.

Resident 2 was admitted on 12/14/2022, with diagnoses including Alzheimer's dementia without behavioral disturbance, seizure disorder, pan lobular emphysema, and scoliosis of lumbar spine. Resident 2's ISP, dated 05/30/2024, under section "Orientation/Behaviors", indicated Resident 2 experiences agitation, anxiety, fluctuates emotionally, and wanders with exit-seeking behaviors. Resident 2's ISP indicated Resident 2's family hired a 3rd party to help assist with 1:1, which was identified as an intervention to Resident 2's behaviors. Resident 2's record contained a 30-day notice of discharge, dated 08/30/2024, which indicated the care Resident 2 required was inconsistent with the community's program statement and goes beyond what the community was to provide under the terms of the admission agreement. The 30-day notice indicated Resident 2 wanted to leave the facility daily and required 1:1 supervision at all times from the care staff.

Surveyor reviewed door alarm report. On 08/25/2024, the memory care exit 104 alarm was activated at 4:32 PM. The alarm was reset at 4:39 PM.

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N 426	Continued From page 6 On 12/20/2024, at 1:45 PM, Surveyor and Administrator A toured the facility. Administrator A showed Surveyor the door on the west side of the building where Resident 1 and Resident 2 eloped from. The door contained delayed egress, and a sign across on the door which stated, "STOP". There was an additional alarm mounted at the top of the door. Administrator A turned off the additional alarm, so Surveyor could hear what the alarm sounded like on the day of the elopement. Surveyor went to stand in the east hallway of the building where Caregiver D had reported during the investigation s/he was during the time of the elopement. Surveyor was unable to hear the auditory alarm on the door. Surveyor observed staff members wearing pagers, respond immediately to the alert which came across the pagers. On 12/21/2024, at 1:45 PM, Surveyor interviewed Administrator A. Administrator A reported s/he added the additional alarm after the elopement to ensure staff could hear the alarm if the door was opened.	N 426		