STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018396	A. BUILDING: _____ B. WING _____	C 05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMEIRA ORCHIDS ASSISTED LIVING	10401 WEST BRADLEY ROAD MILWAUKEE, WI 53224

(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 04/17/2025 with information gathered through 05/05/2025, Surveyors conducted 5 complaint investigations at Ameira Orchids Assisted Living. Four complaints were substantiated One complaint was unsubstantiated. Four deficiencies were identified. One of 4 was a repeat deficiency (see Statement of Deficiency PBY611 dated 04/02/2024). Census: 47	N 000		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify the Department within 7 days of administrator change for 1 of 1 administrator (Administrator B). This is a repeat deficiency. See Statement of Deficiency PBY611 dated 04/02/2024. Findings include: On 04/17/2025, at approximately 9:00 AM, Surveyors entered the facility and requested to speak with the administrator to begin the survey entrance conference. Administrator B met with Surveyors. On 04/17/2025, at approximately 10:10 AM, Surveyors interviewed Administrator B. Administrator B stated s/he had been the provider's administrator "for about a month".	N 200		

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

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N 200	Continued From page 1 Administrator B reported s/he did not report the administrator change to the Department. Administrator B reported s/he was not sure if Licensee A sent notification to the department. On 04/21/2025, Surveyor reviewed the Department's facility electronic file and did not locate notification of administrator change.	N 200		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident received medication in accordance with physician's orders for 3 of 3 residents. Resident 1 missed medication to address and infection. Resident 2 missed medication to manage his/her multiple sclerosis symptoms. Resident 4 missed medications to manage his/her diabetes symptoms. Findings include: On 03/28/2025, 04/02/2025, and 04/08/2025, the department received complaints alleging residents did not always receive their prescribed medications. Example 1 -Resident 1	N 352		

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N 352	Continued From page 2 On 04/17/2025, Surveyors reviewed Resident 1's record. Resident 1 was admitted to the facility on 01/29/2025, with diagnoses including adrenocortical insufficiency, malnutrition, hyperlipidemia, dementia, anxiety, depression, and mood disorder. Progress note dated 03/05/2025 at 5:15 PM, recorded, "The resident was given Bactrim at 12:20 PM and a paper prescription was sent with the resident for Bactrim that should be taken 2 times daily for one week. This writer [Registered Nurse C] has confirmed receipt of the prescription and that it was faxed to the pharmacy." Progress noted dated 03/07/2025 at 2:30 PM, recorded, " [Resident 1] was asking about antibiotics pill that I didn't see in the chart to give, so [they] was hollering how [they] was going to call 911 and the ambulance if [they] didn't get it. And they did just that." [Med Passer F]. Progress note dated 03/08/2025 at 1:15 PM, recorded "[Resident 1] behavior has been very aggressively. Keeps calling 911, punching on caregiver. Screaming and shouting all over antibiotics we have not received yet ." [Med Passer F]. Review of Resident 1's medication administration records for March 2025 showed no change in Medication Administration Record to include Bactrim antibiotics. The provider failed to obtain and administer the prescription resulting in the following 13 missed doses: 03/05/2025 - PM dose.	N 352		

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N 352	Continued From page 3 03/06/2025 - AM dose. 03/06/2025 - PM dose. 03/07/2025 - AM dose. 03/07/2025 - PM dose. 03/08/2025 - AM dose. 03/08/2025 - PM dose. 03/09/2025 - AM dose. 03/09/2025 - PM dose. 03/10/2025 - AM dose. 03/10/2025 - PM dose. 03/11/2025 - AM dose. 03/11/2025 - PM dose. Example 2-Resident 2 On 04/17/2025, Surveyors reviewed Resident 2's record. Resident 2 was admitted to the facility on 02/29/2024, with diagnoses including multiple sclerosis, epilepsy, hypertension, major depressive disorder, and anxiety disorder. Resident 2's Individual Service Plan (ISP), dated 03/04/2024, and ISP, dated 03/12/2025 identified Resident 2's medications were administered by staff. Resident 2's Incident Report, dated 04/02/2025, reported, "Resident has been discharged from our facility providers due to non-compliance. Resident has medication in [his/her] room and is not given [sic] them to administration so that we can check them over and add medication to our system. Administration and staff have asked resident multiple times." There was no additional documentation found in Resident 2's record indicating interventions attempted to assist Resident 2 with medication management. Resident 2's medication administration records from November 2024 through February 2025 identified the following medications the resident did not receive: Copaxone (medication to slow advancement of	N 352		

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N 352	Continued From page 4 symptoms of multiple sclerosis) 40 milligrams (mg)/milliliter (mL) syringe-inject subcutaneously every evening on Monday, Wednesday, and Friday was not given on the following dates: 12/09/2024, 12/11/2024, 12/13/2024, 12/18/2024, 12/25/2024, 01/31/2025, and 02/07/2025. MAR identified on 01/31/2025 and 02/07/2025 Resident 2 needed a new medication prescription. Baclofen (used to help relax tightness of muscles caused by multiple sclerosis) 20 mg tablet-take 1 tablet my mouth 4 times a day (7:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM) was not given on the following dates: 02/21/2025 (2 doses), 02/22/2025 (3 doses), 02/23/2025 (3 doses), 02/24/2025 (1 dose), 02/25/2025 (3 doses), 02/26/2025 (2 doses), 02/27/2025 (1 dose), and 02/28/2025 (2 doses). On 02/19/2025 a note on the MAR indicated this medication needed to be ordered. There was no MAR available for review for medication administration from 03/01/2025 through date of survey, 04/17/2025. There was no evidence the provider staff administered any medications during this timeframe. On 04/17/2025, at 9:40 AM, Surveyor interviewed Resident 2. Resident 2 confirmed the pharmacy the provider used to get medications was often out of his/her medications and s/he has missed some in the past. Resident 2 reported it was important for him/her to receive his/her multiple sclerosis injection to reduce the advancement of symptoms. Resident 2 reported the provider had not worked to obtain his/her prescriptions timely from the pharmacy. Resident 2 decided to obtain his/her medications from a different pharmacy and gave them to staff at the facility, so s/he had the medications s/he was out of.	N 352		

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N 352	Continued From page 5 On 04/17/2025, at approximately 3:00 PM, Surveyor interviewed Administrator B. Administrator B reported Resident 2 did not tell the facility where s/he was obtaining his/her medications from, so they did not provide medications from March 2024 through present. Administrator B reported Resident 2 was his/her own person and had been difficult to work with regarding medications and following the rules of the facility, so they did not have a record of any medications given after February 2025. Administrator B reported they tried to talk with Resident 2 so they could get the medications fixed, but it was unsuccessful. Surveyor requested all documentation of how the provider worked with Resident 2 so they could provide him/her medications as his/her physicians ordered. Administrator B reported they provided Resident 2 with a 30-day notice because of his/her lack of following policies and procedures and health violation concerns. Example 3-Resident 4 On 04/17/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 08/03/2021 with diagnoses including insulin dependent diabetes. Resident 4's ISP, dated 02/19/2024, and ISP, dated 03/12/2025, identified Resident 4 required staff to provide medication management and administration. Resident 4's medication administration records from November 2024 through March 2025 identified the following medications the resident did not receive: Humulin 70-30 units (u)/mL injection-inject subcutaneously in the morning per sliding scale: 71-90, 13 units; 91-150, 27 units; 151-200, 29 units; 201-250, 31 units; 251-300, 33 units;	N 352		

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301-350, 35 units; 351-400, 37 units; 401-450, 39 units; 451 or above, 41 units, maximum daily dose 75 units. Resident 4 did not receive this medication on 11/06/2024 (note indicated they were out of blood glucose test strips), 01/13/2025, 01/14/2025 (note stated, "no one order [his/her] refilled [sic] in four days"), 01/24/2025, and 02/05/2025.

Humulin 70-30 units (u)/mL injection-inject subcutaneously in evening per sliding scale: 71-90, 10 units; 91-150, 20 units; 151-200, 22 units; 201-250, 24 units; 251-300, 26 units; 301-350, 28 units; 351-400, 30 units; 401-450, 32 units;, 451 or above, 34 units, maximum daily dose 75 units. Resident 4 did not receive this medication on 11/06/2024 (note indicated they were out of blood glucose test strips), 12/19/2024, 01/10/2025, 01/13/2025, and 03/20/2025 (note stated "no blood strips").

On 04/17/2025, at 1:45 PM, Surveyor interviewed Resident 4. Resident 4 reported s/he needed assistance with administering his/her medications. Resident 4 reported they have run out of blood glucose test strips and his/her insulin in the past. When asked if Resident 4 felt it might happen again, Resident 4 stated, "It's going to happen again." Resident 4 reported when s/he did not have the insulin, s/he reported s/he did not feel any effects of not having the medication.

On 04/17/2025, at 2:00 PM, Surveyors interviewed Administrator B. Administrator B reported staff were able to order medications from the pharmacy when residents were running low. Administrator B confirmed they had run out of some medications and residents missed some medications due to not refilling the medications fast enough or the medication passers not calling

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N 352	Continued From page 7 the pharmacy to get more medication. Administrator B reported s/he needed to do more training and education with his/her staff to ensure the residents did not run out of medication and they always received what was prescribed to them.	N 352		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident had a comprehensive individualized service plan which identified the methods for delivering needed cares for 1 of 1 resident. Resident 2's ISP did not provide methods for staff to deliver needed care, which resulted in Resident 2 having verbal aggression. Findings include:	N 386		

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N 386	Continued From page 8 On 04/17/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 02/29/2024, with diagnoses including major depressive disorder, anxiety disorder, multiple sclerosis, muscle weakness, neuromuscular dysfunction of bladder, abnormalities of gait and mobility, other lack of coordination, weakness, and was dependent on a wheelchair for mobility. Resident 2's ISP, dated 03/12/2025, identified the following: -"Bathing...Resident's Needs: Resident requires full assistance form staff to complete bathing tasks. Independent with bathing/showing [sic]. Resident requires monitoring and/or reminders and cues to complete bathing tasks. Resident requires partial assistance from staff to complete bathing tasks...Method for delivering care/who is responsible? Resident." Resident 2's ISP did not identify how staff were to assist Resident 2 with bathing. -"Dressing...Resident's Needs: Resident requires partial assistance from staff to complete dressing tasks...Method for delivering care/who is responsible: [blank]." Resident 2's ISP did not identify how staff were to assist Resident 2 with dressing. -"Mobility and Transferring...Resident's Needs: Independent with ambulation, Independent with positioning, Independent with transfers...Method for delivering care/who is responsible: Resident." -"Toileting...Resident's Needs: Resident requires partial assistance from staff to complete toileting tasks. Member is on a foley bag, needs emptying as needed...Method for delivering care/who is responsible: [blank]." Resident 2's ISP did not identify how often staff were to check Resident 2's bag to empty it. Resident 2's observation notes identified the following:	N 386		

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N 386	Continued From page 9 -01/29/2025 at 10:00 AM-"After breakfast [Resident 2] requested assistance with showering from this writer. While assisting [Resident 2] [s/he] exclaimed that [s/he] wasn't able to properly clean [his/her] bottom half of [his/her] body but was able to do the top half and proceeded with asking that this writer wash [his/her] feet and scrub [his/her] hair. This writer explained to [Resident 2] that [his/her] hair as [sic] part of the body that [s/he] is capable of handling on [his/her] own as it is the top half of [his/her] person. [Resident 2] immediately became aggressive and was throwing and tossing the shower head in an unsettling manner of anger and disorientation. This writer asked [Resident 2] what the problem was, and [s/he] answered [s/he] can't feel [his/her] fingers so [s/he] can't scrub [his/her] own hair. This writer proceeded with scrubbing [Resident 2's] hair, but [Resident 2] was still upset and disoriented..." -03/20/2025 at 12:30 PM-"[Resident 2] stated [s/he] was trying to reach something and accidentally rolled over and fell out of bed. after [sic] this writer found [him/her] on the floor by [his/her] bedroom door. Also stated that [s/he] tried pulling [his/her] call light but the string broke off and was unable to alarm staff for help. But [s/he] was able to scoot to the bedroom door to open it so someone could see [him/her]. [S/He] was assisted in [his/her] chair from the floor and required no assistance getting back into bed-only observation." -03/26/2025 at 3:00 PM-"[Resident 2] used [his/her] call light for assistance with getting dressed. This writer went in to assist and after grabbing [Resident 2's] clothes from the drawer and handing them to [him/her] [s/he] became upset and in an aggressively loud tone stated, 'I'm still paraplegic' this writer excused [himself/herself] to ask another staff if [Resident	N 386		

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N 386	Continued From page 10 2] was still able to get [himself/herself] dressed. It was confirmed to this writer that [s/he] can still get [himself/herself] dressed but if [s/he] is asking for assistance to assist [him/her]..." Resident 2's "Care Sheet," not dated, and observed hanging in his/her room, identified Resident 2 did not need help with any transfers, did not need assistance with positioning, had a foley catheter, needed assistance with cares, had a history of falls. Under "Safety," it stated, "I have a history of falls and should be monitored accordingly" and "I am often unsteady with my movements and may need help." There was no additional information describing how to keep Resident 2 safe from falls or what was required to monitor him/her. The care card did not address Resident 2's needs when bathing or how to assist with dressing. It did not address how frequently staff needed to assist with emptying the foley catheter. On 04/17/2025, at 9:45 AM, Surveyor interviewed Resident 2. Resident 2 reported staff had been resistant to assisting him/her when s/he asked for help. Resident 2 reported s/he has fallen, but staff had not assessed him/her or put additional interventions in place to keep him/her safe from falling. Resident 2 pointed to his/her call light fixed to the wall and reported it used to have a string, but it had not been fixed, so s/he was unable to call for help if needed. Resident 2 reported s/he often lays in bed because staff do not assist with transfers and s/he fears if s/he falls, s/he would not be able to get up and staff would not know s/he had fallen for a long time. Resident 2 reported sometimes his/her catheter bag fills up so much s/he thinks it may burst. Resident 2 reported s/he needed it emptied at least once per shift. Resident 2 reported s/he	N 386		

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cannot feel the tips of her fingers and had asked for additional assistance with washing his/her body and staff had been resistant to providing assistance. Resident 2 reported s/he needed assistance with getting dressed because some days s/he feels weaker than others and needs more help, but staff had been resistant to providing assistance. Resident 2 reported s/he is looking for somewhere else to live to get the assistance s/he needs. Resident 2 reported s/he did not feel like the provider was meeting his/her needs.

On 04/17/2025, at approximately 2:00 PM, Surveyors interviewed Administrator B. Administrator B reported staff utilized only the Care Sheets to provide cares to residents. They also used a daily task list located on their electronic record keeping system that listed just the tasks to ensure they were completed. Administrator B reported staff did not view the ISPs to identify how to care for each resident. Administrator B reported staff were trained how to work with the residents by informing them of any changes and hands on training when they were hired.

On 05/05/2025, at approximately 2:00 PM, Surveyors interviewed Licensee A, Administrator B, and Registered Nurse (RN) C. RN C explained in addition to the ISPs, staff also utilized the Care Sheets which were in each resident's room to identify how to care for them. RN C reported they also used the electronic record keeping system which lists daily tasks for staff to complete, but did not include specific instructions on assistance. RN C stated the ISPs should have listed the methods to deliver the needed care. Licensee A reported they would review the ISPs and make changes as needed.

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N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a system for documenting the dose of insulin given to 1 of 1 resident who had a sliding scale. Resident 4 received insulin at different doses based on his/her blood sugar testing and the dose of insulin given was not documented. Findings include: On 04/17/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 08/03/2021 with diagnoses including insulin dependent diabetes. Resident 4's ISP, dated 02/19/2024, and ISP, dated 03/12/2025, identified Resident 4 required staff to provide medication management and administration. Resident 4's medication administration records (MARs) from November 2024 through March 2025 identified the following medications were prescribed and administered to Resident 4:	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018396	A. BUILDING: _____ B. WING _____	C 05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 415	Continued From page 13	N 415		

-Humulin 70-30 units (u)/mL injection-inject subcutaneously in the morning per sliding scale: 71-90, 13 units; 91-150, 27 units; 151-200, 29 units; 201-250, 31 units; 251-300, 33 units; 301-350, 35 units; 351-400, 37 units; 401-450, 39 units;, 451 or above, 41 units, maximum daily dose 75 units.

-Humulin 70-30 units (u)/mL injection-inject subcutaneously in evening per sliding scale: 71-90, 10 units; 91-150, 20 units; 151-200, 22 units; 201-250, 24 units; 251-300, 26 units; 301-350, 28 units; 351-400, 30 units; 401-450, 32 units;, 451 or above, 34 units, maximum daily dose 75 units.

Resident 4's MARs documented the blood glucose readings, but did not document how much insulin was administered to Resident 4 in the mornings and in the evenings. Resident 4 had a maximum daily dose of receiving 75 units and staff would be unable to follow the order of the maximum dose threshold without tracking the units of insulin received at each medication pass.

On 05/05/2025, at approximately 2:00 PM, Surveyors interviewed Licensee A, Administrator B, and Registered Nurse (RN) C. Licensee A confirmed they did not document the specific dosage of insulin provided to a resident who had a sliding scale insulin order. Licensee A reported they took blood glucose levels to find out the specific dosage to give the resident. Licensee A did not know how the staff would track the daily dosage to ensure they did not go over the maximum daily dose if one was prescribed. Licensee A reported s/he would work with their electronic record keeping system staff to find out a way to add that information onto the MARs and

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N 415	Continued From page 14 identify a way to flag staff not to give more than the maximum daily dose.	N 415		