STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 E BROADWAY WAUKESHA, WI 53186

(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 01/25/2024, with information gathered through 02/07/2024, Surveyor conducted a verification visit and complaint investigation at New Perspective Waukesha. Five deficiencies were identified. One of the 5 deficiencies were repeat violations. (See Statement of Deficiency (SOD) IIF411). Complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 24	{N 000}		
N 156	83.12(1)(b) Death reporting related to accident or injury Resident death related to an accident or injury. When a resident dies as a result of an incident or accident not related to the use of a physical restraint, psychotropic medication, or suicide, the CBRF shall send a report to the department within 3 working days of the resident ' s death. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report 1 of 1 resident's (Resident 15) death to the Department within 3 days when s/he passed away due to a choking episode which resulted in aspiration and death. Findings include: The provider is licensed to care for 60 residents in the client groups physically disabled, terminally ill, and advanced aged. On 01/06/2024, the Department received a concern alleging a resident had a choking	N 156		

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

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episode which resulted in death.

On 01/25/2024, Surveyor reviewed Resident 15's record.

Resident 15's progress notes documented:
"08/23/2023 5:14 PM - Resident had choking incident earlier today at lunchtime. 911 notified per protocol. Resident admitted to [hospital] with diagnosis of acute resp. (respiratory) failure with hypoxia (low levels of oxygen)."
"08/28/2023 7:54 AM - Updated that resident passed away at [hospital] morning of 08/27."

On 01/25/2024, at approximately 10:00 AM, Surveyor interviewed Administrator T. Administrator T stated s/he had been informed the previous administrator, Administrator A, did not believe Resident 15's choking episode was an incident and did not follow the provider's protocol. Administrator T stated the Department should have been informed when Resident 15 experienced a choking incident that resulted in hospitalization where s/he passed.

On 02/02/2024, Surveyor reviewed Resident 15's hospital records which documented:
"08/23/2023 12:33 PM - Patient on hospice care was choking on lunch, a sausage when [s/he] became acutely hypoxic and short of breath. 911 was called. They found [him/her] to be profoundly hypoxic and in distress. [S/he] was brought into the emergency department where [s/he] was tachycardic [sic: tachycardia] (increased heart rate), hypoxic, tachypneic [sic: tachypnea] (rapid, shallow breathing), ill-appearing. ... [s/he] is in significant amount of respiratory distress here in the emergency room, requiring a high flow amount of oxygen, tachycardic, diaphoretic (sweating heavily). ..."

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N 172	83.12(6) Documentation requirements for written report All written reports required under this section shall include, at a minimum, the time, date, place, individuals involved, details of the occurrence, and the action taken by the provider to ensure residents ' health, safety and well-being. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have a written report for 1 of 1 (Resident 15) resident reviewed that suffered a choking episode, which resulted in hospitalization, that included at minimum, the time, date, place, individuals involved, details of the occurrence, and the action taken by the provider to ensure the residents' health, safety, and well-being. Findings include: On 01/06/2024, the Department received a concern alleging a resident had a choking episode which resulted in death. On 01/25/2024, Surveyor reviewed Resident 15's record. Resident 15's progress notes documented: "08/23/2023 5:14 PM - Resident had choking incident earlier today at lunchtime. 911 notified per protocol. Resident admitted to [hospital] with diagnosis of acute resp. (respiratory) failure with hypoxia (low levels of oxygen)." "08/28/2023 7:54 AM - Updated that resident passed away at [hospital] morning of 08/27." Surveyor noted Resident 15's record did not contain an incident report or an internal investigation regarding the 08/23/2023 choking	N 172		

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N 172	Continued From page 3 episode. On 01/25/2024, at approximately 10:00 AM, Surveyor interviewed Administrator T. Administrator T stated s/he had been informed the previous administrator, Administrator A, did not believe Resident 15's choking episode was an incident and did not follow the provider's protocol. Administrator T stated Resident 15's choking episode was an incident that should have been reviewed internally.	N 172		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assess 1 of 1 resident's (Resident 15) needs, abilities, and condition when s/he continued to be a risk for choking. This is a repeat deficiency. See Statement of Deficiency (SOD) IIF411, dated 04/20/2023. Findings include:	N 381		

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N 381	Continued From page 4 On 01/25/2024, Surveyor reviewed Resident 15's record. Resident 15 was admitted to the facility, 07/19/2021, with diagnoses including Parkinson's disease, anxiety disorder, chronic obstructive pulmonary disease (COPD) and cerebral infarction. Resident 15's most recent "Comprehensive Assessment," dated 04/18/2023, documented: "Reason for assessment: Change of condition" "Dining Services: Eating Assistance: Resident requires eating assistance in whole or in part; Diet type and change(s): The resident's diet type, texture and consistency must be entered in the Diet area on the Medical Info tab of the resident chart. Is there a change in the resident's diet type, texture or consistency?" This question did not have a documented response. "Is resident at risk for choking? Yes - Instructions to minimize the risk of choking are included in the resident's service plan." Resident 15's "Progress Notes" documented: "05/18/2023 11:56 AM - Called to dining room as resident was 'choking.' Upon RN (registered nurse) arrival noted resident not breathing, with cyanosis (turning blue due to a lack of oxygen). Abd (abdominal) thrusts and back blows were not successful. Resident placed on floor and continued abd and chest compressions to clear airway while EMS (emergency medical services) was enroute. When on side some particles were dislodged and removed." "05/22/2023 2:57 PM - Resident returned from hospital evl (evaluation) on 05/18/2023 with no residual issues or concerns. [S/he] is eating as per usual and being assisted with [his/her]	N 381		

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meals."
"06/09/2023 2:26 PM - Resident had a large emesis (vomit) of undigested food after lunch approx. (approximately) 2 PM. Denies nausea."
"06/14/2023 3:08 PM - Resident having some pocketing of food with meal, when asked if [s/he] is having trouble swallowing replied "yeah." Discussed possible pureed diet with [him/her] and asked if [s/he] knew what was meant by that. ... Hospice updated and order received for diet change as well as pill crushing for safety and comfort."
"07/14/2023 5:12 PM - d/c (discontinue) puree diet. Start minced moist diet ... Feed pt small bites in upright position ... provide oral cares post meals to assess for pocketing."
"08/23/2023 5:14 PM - Resident had choking incident earlier today at lunchtime. 911 notified per protocol. Resident admitted to [hospital] with diagnosis of acute resp. (respiratory) failure with hypoxia (low levels of oxygen)."
"08/28/2023 7:54 AM - Updated that resident passed away at [hospital] morning of 08/27."

Resident 15's "Resident Incident Report," dated 05/18/2023, documented:
"Found resident with an obstructed airway. Cleared airway with protocols and EMS assist sent to ED (emergency department)."
"Found resident not breathing and turning blue. Airway obstructed. Cleared with assist from EMS."

On 01/25/2024, at approximately 12:30 PM, Surveyor interviewed Administrator T. Surveyor asked if Resident 15 had been re-assessed after 04/18/2023. Administrator T confirmed that Resident 15 had not been reassessed when s/he experienced his/her choking incident on 05/18/2023 that resulted in a hospital stay and

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N 381	Continued From page 6 when his/her diet was changed to puree on 06/14/2023.	N 381		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident's (Resident 15) Individual Service Plan (ISP) was followed as written. Resident 15's ISP documented s/he was prescribed a minced moist diet which was not followed resulting in choking episodes and eventually death. Findings include: On 01/06/2024, the Department received a concern alleging a resident had a choking episode which resulted in death. On 01/25/2024, Surveyor reviewed Resident 15's record. Resident 15 was admitted to the facility, 07/19/2021, with diagnoses including Parkinson's disease, anxiety disorder, chronic obstructive pulmonary disease (COPD) and cerebral infarction. Resident 15's "Resident Service Agreement," dated 01/01/2023 and 08/19/2023, documented: "Diet: Mechanical Soft/Minced and Moist (IDDSI #5) [International Dysphagia Diet Standardisation	N 388		

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Initiative], Thin Liquids"
"Dining: Extensive Asst Eating - Effective Date: 04/06/2023 - Start minced moist diet. Continue with thin liquids. Feed pt. (patient) small bites in upright position and keep upright for 20-30 min (minutes) post meals. Provide oral cares post meals to assess for pocketing."
"Dining: Risk for choking - Effective Date: 07/19/2021 - Assist with resident to get to meals and help with eating. You must sit with resident and feed [him/her]."

Resident 15's "Progress Notes" documented:
"05/18/2023 11:56 AM - Called to dining room as resident was 'choking.' Upon RN (registered nurse) arrival noted resident not breathing, with cyanosis (turning blue due to a lack of oxygen). Abd (abdominal) thrusts and back blows were not successful. Resident placed on floor and continued abd and chest compressions to clear airway while EMS (emergency medical services) was enroute. When on side some particles were dislodged and removed. Resident began to breathe but airway remained partially obstructed. Once EMS arrived, they cleared a piece of bratwurst. (Resident had been sitting with [his/her] [mother/father] who is on a general diet, resident's meal was cut into small pieces and [s/he] had finished [his/her] meal, but [his/her] [mother/father] still had food at table.)"
"08/23/2023 5:14 PM - Resident had choking incident earlier today at lunchtime. 911 notified per protocol. Resident admitted to [hospital] with diagnosis of acute resp. (respiratory) failure with hypoxia (low levels of oxygen)."
"08/28/2023 7:54 AM - Updated that resident passed away at [hospital] morning of 08/27."

Resident 15's "Resident Incident Report," dated 05/18/2023, documented:

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"Found resident with an obstructed airway. Cleared airway with protocols and EMS assist sent to ED (emergency department)."
"Found resident not breathing and turning blue. Airway obstructed. Cleared with assist from EMS."
"Comments: [mother/father] may have shared food with [Resident 15]."
There was no incident report for the 08/23/2023 choking incident.

On 01/25/2024, Administrator T provided Surveyor with the menu that was served for lunch on 08/23/2023 which documented, "Baked chicken wings, French fries, celery sticks/ranch dressing, fresh fruit, and ice cream."

On 01/25/2024, at approximately 11:45 AM, Surveyor interviewed Caregiver W. Caregiver W stated, "I was working the CB section (unsecured area of the memory care unit) when I heard people yelling from the secured area. I ran to assist. [Resident 15] was choking. I told staff to call 911 and 911 assisted walking us through how to assist [Resident 15]. I heard the ambulance arrive and I pushed [Resident 15] in [his/her] wheelchair quickly to the front of the building and met the EMT's (emergency medical technicians)." Caregiver W stated s/he asked the caregiver who had been feeding Resident 15 if s/he ensured his/her food was cut up; the caregiver said [s/he] had been cutting it up. Surveyor stated that s/he had been informed that chicken and French fries had been served for lunch. Caregiver W stated, "That would not be considered a mechanical soft food unless it was chopped up very fine, like in a blender."

On 01/25/2024, at approximately 11:55 AM, Surveyor interviewed Caregiver X. Caregiver X

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stated s/he had been working the CB section with Caregiver W. Caregiver X stated s/he and Caregiver W ran to assist the memory care unit; Caregiver W took the lead, "[S/he] is very good." Caregiver X stated Resident 15 was actively choking. Caregiver X stated, "[Resident 15] was on a pureed diet. [S/he] hated it. [S/he] would cry when I would feed [him/her]." Surveyor stated that s/he had been informed that chicken and French fries had been served for lunch. Caregiver X stated, "I would not consider chicken to be a mechanical soft food."

On 01/25/2024, at approximately 12:05 PM, Surveyor interviewed Caregiver Y. Caregiver Y explained that the kitchen was aware of each resident's dietary restriction. Caregiver Y stated, "If a resident needs a pureed diet or food minced, the kitchen takes care of that, and staff then serve the food that the kitchen sends out."

On 02/01/2024 at 12:04 PM, Resident 15's Power of Attorney V emailed Surveyor a copy of Resident 15's coroner's report, dated 09/06/2023, that documented:
"Date Pronounced Dead: 08/27/2023"
"Immediate Cause of Death: Aspiration Pneumonia"

On 02/02/2024, Surveyor reviewed Resident 15's hospital records which documented:
"05/18/2023 12:26 PM - The patient comes to the ED (emergency department) for evaluation after choking on food at [his/her] nursing home. The patient was hypoxic and was given oxygen prior to arrival. [S/he] was not hypoxic upon arrival. ... The patient comes to the ED for evaluation after having a choking episode. [S/he] was eating a brought [sic: brat] on a bun. [S/he] coughed it out. Paramedics stated that [s/he] was "cyanotic

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in the fingers" (blue/purple in color) ..."
"08/23/2023 12:33 PM - Patient on hospice care was choking on lunch, a sausage when [s/he] became acutely hypoxic and short of breath. 911 was called. They found [him/her] to be profoundly hypoxic and in distress. [S/he] was brought into the emergency department where [s/he] was tachycardic [sic: tachycardia] (increased heart rate), hypoxic, tachypneic [sic: tachypnea] (rapid, shallow breathing), ill-appearing. ... [s/he] is in significant amount of respiratory distress here in the emergency room, requiring a high flow amount of oxygen, tachycardic, diaphoretic (sweating heavily). ..."

"A mechanical soft diet is a texture-modified diet that restricts foods that are difficult to chew or swallow. It's considered Level 2 of the National Dysphagia Diet in the United States. Foods can be pureed, finely chopped, blended, or ground to make them smaller, softer, and easier to chew. It differs from a pureed diet, which includes foods that require no chewing.
Foods to eat: As long as a food makes chewing and swallowing safer and easier, it can be included in the diet. Examples of permitted foods include:
Meat, poultry, fish: tender meats (e.g., canned tuna, ground beef), thinly shaved meat, and other meats that have been mechanically altered (but always remove the fat and gristle from meat cuts, since they may be difficult to chew)
Foods to avoid: Some foods are considered unsafe and unsuitable for a mechanical soft diet. These may include:
Meats, poultry, fish: hard cuts of meat (e.g., steak, jerky, pork chops), meats or poultry with the bone (e.g., chicken wings), hot dogs, sausage, shellfish, fried meat or fish, and others."
(Source: Healthline website, What is a

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mechanical soft diet?, October 7, 2021, https://www.healthline.com/nutrition/mechanical-soft-diet#basics (retrieval date - February 2,2024).)

"Level 5 - Minced & Moist food may be used if you are not able to bite off pieces of food safely but have some basic chewing ability. Some people may be able to bite off a large piece of food, but are not able to chew it down into little pieces that are safe to swallow. Minced & Moist foods only need a small amount of chewing and for the tongue to 'collect' the food into a ball and bring it to the back of the mouth for swallowing. It ' s important that Minced & Moist foods are not too sticky because this can cause the food to stick to the cheeks, teeth, roof of the mouth or in the throat. These foods are eaten using a spoon or fork. ... Meat served finely minced or chopped to 4mm (millimeter) lump size served in a thick, smooth, non-pouring sauce or gravy." (IDDSI (International Dysphagia Diet Standardisation Initiative) Consumer Handout, https://iddsi.org/IDDSI/media/images/ConsumerHandoutsAdult/Consumer_Handouts_for_Adults_All_Levels.pdf, 2019)

On 02/06/2024, Surveyor reviewed Resident 15's EMS reports which documented:
"05/18/2023 - ...female a/ox1 (Healthcare providers score a person's orientation on a scale of 1 to 4. The higher the number, the better oriented a person is considered.) laying in the left lateral recumbent position on ground. ... Staff stated pt (patient) was eating [his/her] lunch when [s/he] began to choke. Staff stated that they did perform the Heimlich maneuver prior to crew arrival with success. PT chief complaint of choking. ... Upon assessment, pt presented with food in mouth. ... Crew encouraged pt to cough and spit out food. Pt spit out food with what

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appeared to be 1" in diameter piece of bratwurst. Staff stated that they believed the mother of PT fed [him/her] the food. Staff stated that pt does not normally consume solid food. ... Pt secured to cot with straps. Pt began to spit out more food with the same presentation. Patient was continually coached in attempt for [him/her] to spit out any other food [s/he] had in [his/her] mouth. ..."
"08/23/2023 - ... pt outside in the front reception area in her wheelchair with healthcare staff present. Pt had consumed what they believed to be a French fry and had choked on the food item. Pt had been able to eject what appeared to be a partial French fry while EMS was completing initial assessment. ..."

On 02/06/2024, Surveyor reviewed Resident 15's hospice notes which documented:
"05/12/2023 - Eating approx. 75% of meals. Needs to be fed."
"05/19/2023 - Patient had loss of airway choking event this week for which EMS were called. Patient airway was able to be re-established and patient was transported to hospital for evaluation. Returned to facility. ... Diet changed to minced moist."
"05/24/2023 - Eating approx. 50% of meals and is very leery about swallowing post choking incident last week. Needs to be fed. RN (registered nurse) discussed minced moist diet with staff nurse and crushing pills with applesauce."
"06/02/2023 - Diet changed to puree with thin liquids post choking episode requiring EMS intervention to clear."
"06/07/2023 - Eating approx. 50% of meals. Tolerating minced moist diet. Needs to be fed."
"06/14/2023 - Reports fear of eating post chocking episode. Staff reporting patient pocketing food. New orders obtained for pureed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018236	A. BUILDING: _____ B. WING _____	R-C 02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 E BROADWAY WAUKESHA, WI 53186

(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
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diet."
"07/07/2023 - Continued fear of eating post choking episode. Staff reporting patient pocketing food."
"07/13/2023 - Eating approx. 25% of meals or less. Diet was changed back to minced moist. Continued fear of eating post choking episode. Staff reporting patient pocketing food."
"07/24/2023 - Patient has an increased difficulty swallowing and has been spitting out foods and medications frequently. ... Writer assisted patient with AM meal, pt needed frequent reminders to swallow food and only accepted a couple bites before beginning to spit out foods."
"07/31/2023 - consumed only a couple small bites, with assistance from Writer. Pt needed frequent reminders to swallow food."
"08/07/2023 - Writer fed pt today ate 90% of [his/her] meal but eats less then 25% per [Caregiver W], also informed that pt is pocketing food most of the time. Advised to give small bits and needs to be fed slowly mech (mechanical) soft diet give some liquids to make it easy to swallow ..."
"08/14/2023 - Patient continues to pocket food and need frequent reminders to chew and swallow food."

On 02/07/2024, at approximately 3:50 PM, Surveyor interviewed Administrator T. Surveyor reviewed the hospice notes, hospital notes and EMS notes with Administrator T. Administrator T stated s/he was new to the position and had not been made aware that Resident 15 was to be fed and supervised during his/her dining times. Administrator T stated based on the information, s/he could not state that Resident 15 had received a minced moist diet and s/he would be reviewing diets with staff and the importance of following them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018236	A. BUILDING: _____ B. WING _____	R-C 02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 E BROADWAY WAUKESHA, WI 53186

(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 446	83.41(1)(b) Equipment. Equipment. The CBRF shall store equipment and utensils in a clean manner and shall maintain all utensils and equipment in good repair. This Rule is not met as evidenced by: Based on observation and staff interview, the provider did not ensure all equipment and utensils were store in a clean manner. Findings include: On 01/25/2024 at 10:30 AM and 12:33 PM, Surveyor toured the memory care kitchenette and kitchen of the facility. Surveyor observed the following: On 01/25/2024 at 10:20 AM, Surveyor observed the facility's kitchen and noted water on the floor with a line of water coming from under the steam oven. The puddle of water measured approximately 3 feet by 6 feet and was under the fryer and extended towards the walkways to the coolers. On 01/25/2024 at 10:25 AM, Surveyor interviewed Cook U. Cook U stated the steamer oven had been leaking recently from a hose in the back. Cook U did not provide a timeline but noted s/he had put in a work order with maintenance. Surveyor asked why staff had not squeegeed the water towards one of the many drains in the kitchens floor. Cook U stated the kitchen had been under staffed recently and s/he	N 446		

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	0018236	A. BUILDING: _____ B. WING _____	R-C 02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 E BROADWAY WAUKESHA, WI 53186

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N 446	Continued From page 15 is trying to get meals out on time. - The steamer basin in the kitchenette was very dirty with burned on food in the bottom of the steamer. Surveyors noted the steamer basin had the same appearance during the previous surveys dated 05/04/2023 and 09/13/2023. At 12:00 PM, Surveyors observed staff cleaning the steamer basin. -The flat top grill was discolored and covered in black stains. The range hood next to the flat top grill was covered in black grease stains dripping to the floor. -The conventional oven top was covered in food crumbs and food spills were stuck to the 6 burners. Black and white stains were observed throughout the burners. -The door to the steamer had food crumbs and food stains stuck to the doors. The doors had spilled liquid stained. -The 2 basket fryer had spilled grease marks around the unit and the floor. Grease marks were observed on the range hood next to the fryer dripping to the floor. Food crumbs were observed on the floor and black residue on top of the fryer. On 01/25/2024 at 1:01 PM, Surveyor interviewed Administrator T. Administrator T acknowledged the kitchen needed to be cleaned and was recently cleaned by a service, but we felt s/he did not do a good job so the provider would be calling them back to clean again. Administrator T stated the kitchen had come along way, but noted over the last 2 years a cleaning schedule had been lacking.	N 446		