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 04/02/2024

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AMEIRA ORCHIDS ASSISTED LIVING	10401 WEST BRADLEY ROAD MILWAUKEE, WI 53224

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N 000	Initial Comments On 03/29/2024, with information gathered through 04/02/2024, Surveyors conducted a standard survey and 7 complaint investigations at Ameira Orchids Assisted Living. Thirteen deficiencies were identified. One of 7 complaints was substantiated. Six of 7 complaints were unsubstantiated.	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on interviews and record review, the provider did not ensure a written report was sent to the department within 3 working days after law enforcement personnel were called to the facility because of an incident that jeopardized the health, safety, or welfare of residents or employees for 1 of 1 incident. Findings include: On 02/25/2024, the Department received a complaint alleging visitors stood outside ringing the bell to gain entry, but no staff came. The	N 164		

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

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N 164	Continued From page 1 visitors then tried to contact Licensee A who allegedly did not answer their phone. The visitors then called the police who arrived to do a welfare check. On 02/26/2024, at 3:25 PM, Surveyor conducted a phone interview with Hospice Nurse G who confirmed they had contacted and met with police at the facility due to staff not answering the door when they arrived to provide cares to residents. On 03/25/2024, Surveyor reviewed Department records, including documentation of incidents self-reported by the provider. Surveyor did not locate evidence the provider self-reported the incident. On 03/29/2024, at 4:10 PM, Surveyors interviewed Administrator B and Quality Care Coordinator H. Administrator B confirmed they were aware of the reporting requirement but was unsure if a self-report had been submitted.	N 164		
N 185	83.13(2)(b) Resident records retained for 7 years. Resident records shall be retained for 7 years following the date of a resident ' s final discharge. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain all records for 7 years following the resident's date of discharge for 1 of 1 resident. Resident 1 was discharged on 10/20/2023. The provider was unable to provide the closed record. Findings include: On 03/29/2024, at approximately 11:15 AM,	N 185		

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N 185	Continued From page 2 Surveyor requested Resident 1's closed file. Administrator B provided a file folder with Resident 1's name on it, but a different resident's paperwork was inside the folder. On 03/29/2024, at approximately 4:10 PM, Surveyor interviewed Administrator B and Quality Care Coordinator (QCC) H. Administrator B reported they were unable to locate any of the hard copy documents of Resident 1's record. Administrator B reported they had some electronic records they would try to obtain and send to Surveyor. On 04/02/2024, Surveyor received some of Resident 1's documents. Surveyor received Resident 1's face sheet, observation notes (07/01/2023 through 10/30/2023), assessment dated 01/20/2023, assessment dated 02/19/2023, assessment dated 06/16/2023, and 30-Day/Emergency Placement form. Resident 1's record identified Resident 1 was admitted on 01/16/2023 and discharged on either 10/13/2023 (face sheet) or 10/30/2023 (observation notes). Surveyor did not observe Resident 1's tuberculosis screening result, statement showing Resident 1 was free of communicable disease, admission agreement, documentation of significant illnesses, pre-admission assessment, individualized care plan, results of Resident 1's evacuation evaluation, physician orders, documentation of administration of all medications, or nursing care procedures. On 04/02/2024, at 2:30 PM, Surveyor interviewed Administrator B. Administrator B confirmed they were unable to find Resident 1's record.	N 185		

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N 200	Continued From page 3	N 200		
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). Findings include: On 03/29/2024, at approximately 10:00 AM, Surveyors entered the facility and requested to speak with the administrator to begin the survey entrance conference. Administrator B met with Surveyors. On 03/29/2024, at approximately 10:10 AM, Surveyors interviewed Administrator B. Administrator B reported s/he had been the provider's administrator since 01/2024. 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 03/29/2024, Surveyor reviewed the Department's facility electronic file and did not locate any notification of administrator change. On 04/02/2024, at 2:30 PM, Surveyor called Licensee A at the phone number s/he provided to the Department at the time of licensing. Administrator B answered the phone. Surveyor asked Administrator B why s/he answered the phone when Licensee A was called. Administrator B reported Licensee A had all calls automatically	N 200		

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N 200	Continued From page 4 forwarded to Administrator B and Surveyor would need to contact Licensee A via email to contact him/her.	N 200		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a caregiver background check (CBC) was completed for 1 of 3 employees reviewed. Caregiver F did not have a CBC on file. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete CBC, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID).	N 219		

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N 219	Continued From page 5 2) A response from the Department of Justice (DOJ). 3) A "Response to Caregiver Background Check" letter from the Department of Health Service, also referred to as the Integrated Background Information System (IBIS). On 03/29/2024, Surveyor reviewed employee records and identified the following: Caregiver F was hired on 12/12/2023. Their record did not include a response from the DOJ or IBIS. On 03/29/2024 at approximately 4:10 PM, Surveyors interviewed Administrator B and Quality Care Coordinator H. Administrator B stated they would look for the missing documentation and send it if found. As of 04/02/2024, no further documentation was received.	N 219		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after	N 243		

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N 243	Continued From page 6 starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 1 of 3 employees reviewed, obtained all training as required within 90 days after starting employment. Cook D did not have training in resident rights, client group training, and recognizing, preventing, managing, and responding to challenging behaviors within 90 days after starting employment.	N 243		

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N 243	Continued From page 7 Findings include: The facility was licensed to provide care and services to residents within the client groups of advanced aged, irreversible dementia/Alzheimer's, physically disabled and terminally ill. On 03/29/2024, Surveyor reviewed employee records and identified the following: The record for Cook D, hired 11/24/2023, did not contain evidence of training or meeting an exemption for resident rights training, client group training and recognizing, preventing, managing, and responding to challenging behaviors training. On 03/29/2024 at approximately 4:10 PM, Surveyors interviewed Administrator B and Quality Care Coordinator H. Administrator B stated they would look for the missing documentation and send it if found. As of 04/02/2024, no further documentation was received.	N 243		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment.	N 247		

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N 247	Continued From page 8 Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 employees obtained dietary training. Cook D, who had responsibilities for performing dietary duties, did not have dietary training prior to assuming these duties. Findings include:	N 247		

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N 247	Continued From page 9 On 03/29/2024, at approximately 11:45 AM, Surveyors observed Cook D preparing and serving the noon meal. On 03/29/2024, at approximately 10:30 AM, Surveyor interviewed Cook D who confirmed s/he had not received dietary training since their hire date. Cook D reported they had received training in their previous position. Surveyor reviewed employee records and identified the following: The record for Cook D, hired 11/24/2023, did not contain evidence of training or meeting an exemption for dietary training. On 03/29/2024 at approximately 4:10 PM, Surveyors interviewed Administrator B and Quality Care Coordinator H. Administrator B stated they would look for the missing documentation and send it if found. As of 04/02/2024, no further documentation was received.	N 247		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid.	N 277		

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N 277	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees reviewed received the annual training in standard precautions, medications, and fire safety and emergency procedures, including first aid, in 2023. Resident Assistant E did not have training in all required topics in 2023. Findings include: On 01/26/2024, Surveyor reviewed Resident Assistant E's employee record. Resident Assistant E was hired 06/29/2022. Resident Assistant E's record identified his/her continuing education for 2023 totaled 17 hours but did not include standard precautions, medications, or fire safety and emergency procedures, including first aid. On 03/29/2024 at approximately 4:10 PM, Surveyors interviewed Administrator B and Quality Care Coordinator H. Administrator B stated they would look for the missing documentation and send it if found. As of 04/02/2024, no further documentation was received.	N 277		
N 301	83.28(3) Provide admission agreement as required. Admission agreement. Before or at the time of admission, the CBRF shall provide the admission agreement as required under s. DHS 83.29(2).	N 301		

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N 301	Continued From page 11 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an admission agreement was provided before, or at the time of admission, for 1 of 3 residents. Resident 6 did not have signed admission agreement with the provider. Findings include: On 03/29/2024, Surveyor reviewed Resident 6's record. Resident 6 was admitted on 06/15/2023. Resident 6 had a court appointed guardian. Resident 6's record included an admission agreement which was not signed. On 03/29/2024, at approximately 4:10 PM, Surveyor interviewed Administrator B. Administrator B reported s/he was new with the company and began employment in January 2024. Administrator B reported s/he had audited Resident 6's file and identified the unsigned admission agreement. Administrator B reported Resident 6's guardian did not visit the facility and s/he had mailed the agreement to the guardian but did not receive it back. Administrator B reported s/he would work on getting the agreement back from the guardian, document all attempts, and create a plan if they have difficulty obtaining signatures in the future.	N 301		
N 328	83.31(4)(c) Involuntary discharge notice requirements. Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or resident ' s legal representative and shall include	N 328		

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N 328	Continued From page 12 all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each involuntary discharge notice included justification for discharge listed under par. (b), a statement regarding the department review of the discharge, the name, address, and phone number of the regional office director, and the name, address, and phone number of the regional office of the board on aging and long-term care's ombudsman program for 1 of 1 resident. Resident 1 was issued an immediate discharge notice on 10/03/2023 which did not include required information. Findings include:	N 328		

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N 328	Continued From page 13 On 03/29/2024, at approximately 12:00 PM, Surveyors requested Resident 1's closed record from Administrator B. Administrator B reported they had purged records and would try to find the closed record. Administrator B reported s/he would send what s/he found to Surveyors. On 04/02/2024, Surveyor reviewed Resident 1's file documents provided via email and identified the following: -Resident 1 was admitted on 01/16/2023 and discharged 10/13/2023. -Resident 1's assessment, dated 08/16/2023, identified Resident 1 had early memory loss and hoarding behaviors. S/He had stolen others' items and would forget about it. Resident 1 had aggressive/combative behaviors and required staff assistance to manage and redirect aggressive and combative behaviors. Resident 1 was assessed to hoard food and uncooked items in his/her room causing bugs. S/He needed assistance with decluttering daily. -Resident 1's Observation Note, dated 10/11/2023, stated, "on [sic] 10/10/2023 [sic] Resident was smoking in bedroom, [sic] This is an ongoing occurrence [sic] and our policy is against this [sic] therefore [sic] we will discharge resident with a 30 day [sic] notice to terminate contract." -Resident 1's "Emergency Placement Notice Form," dated 10/03/2023, stated, "Emergency Placement...For the following reasons: Resident noncompliance with policies/procedures...Resident safety/health violation issues...Other: Family disrespectful to staff...Further explanation: Resident smoking in room, burning toilet seat, resident's going in other resident's room taking valuable items. Residents continue unclean room daily [sic] fire hazard...hoarder [sic] food in room...30 Day	N 328		

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N 328	Continued From page 14 Notice End Date: Immediately. Emergency Placement Effective Date: 10/03/2023. Your immediate attention in finding suitable placement for the above Resident is very much appreciated." The form was signed by Licensee A and dated 10/03/2023. The notice did not include the following: a statement stating the justification for discharge listed under par. (b); a statement they may ask the department to review the involuntary discharge notice and instructions how to request a review; the name, address and phone number of the department's regional office director; and, the name, address, and phone number of the regional office of the board on aging and long-term care's ombudsman program. On 04/02/2024, at 2:30 PM, Surveyor interviewed Administrator B. Administrator B reported s/he was new to the facility and began employment in 01/2024. Administrator B reported the template the provider utilized included reasons for discharge that were not consistent with code requirements and did not include justification consistent with code requirements, department review information or information regarding contact details for the department regional director and the long-term care ombudsman program. Administrator B reported in the future, the provider would ensure they were compliant with the codes pertaining to discharge and ensure they reviewed all information when they make the decision to involuntarily discharge a resident. Administrator B reported s/he would amend the 30-day discharge notice template to ensure codes were followed.	N 328		
N 389	83.35(3)(d) Service plans updated annually or on changes	N 389		

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	0018396	A. BUILDING: _____ B. WING _____	C 04/02/2024

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N 389	Continued From page 15	N 389		

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 Individualized Service Plan (ISP) was updated annually for 1 of 3 residents. Resident 3's ISP was due to be updated in March 2023 and March 2024 and was not.

Findings include:

On 03/29/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 12/09/2021 with diagnoses including dementia, type 2 diabetes with ophthalmic complications, and chronic kidney disease. Resident 3's ISP was dated 12/10/2021, with a handwritten note on the bottom stating, "Updated 3/3/22." Resident 3's activated power of attorney for healthcare signed the ISP on 12/10/2021. There were no signatures which correlated with the updated note of 03/03/2022. Resident 3's ISP was due for a review by 03/2023 and 03/2024.

On 03/29/2024, at approximately 4:10 PM,

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N 389	Continued From page 16 Surveyor interviewed Administrator B and Quality Care Coordinator (QCC) H. Administrator B reported s/he thought they had completed Resident 3's ISP recently but would have to locate it. Administrator B reported s/he would send the updated ISP to Surveyors by 04/01/2024 at 8:00 AM. As of 04/02/2024, Surveyors did not receive an updated ISP for Resident 3.	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident's Individual	N 408		

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Service Plan (ISP) included the rationale for use of an as needed (PRN) psychotropic medication or complete monthly reviews of the medication usage for 1 of 1 resident who had a PRN psychotropic medication order. Resident 3 had a PRN order for buspirone hydrochloride 7.5 milligrams (up to 2 times per day) and received the medication on 15 occasions from October 2023 to March 29, 2024, and there was no documentation regarding the behaviors requiring the PRN, the effectiveness of the medication, or side effects. Resident 3's ISP did not include the rationale for use of the medication or a detailed description of behaviors which would indicate the need to administer the PRN medication.

Findings include:

On 03/29/2024, Surveyor reviewed Resident 3's record and identified the following:

-Resident 3 was admitted on 12/09/2021 with diagnoses including dementia.

-Resident 3's admission orders, not dated, identified Resident 3 required staff assistance with medication administration.

-Resident 3's physician order, dated 06/30/2022, identified Resident 3 was prescribed buspirone hydrochloride 7.5 milligrams twice a day as needed for depression and anxiety.

-Resident 3's ISP, dated 12/10/2021 and updated 03/03/2022, identified, "Aggressive/Combative...Resident's Needs: Resident requires staff assistance to manager/redirect aggressive/combative behaviors. Frequency: As Needed Every Day...Resident's Desired Outcomes: To have

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interventions in place that help alleviate behaviors." There was no mention Resident 3's PRN buspirone or behaviors staff would observe to prompt them to give Resident 3 the medication.

-Resident 3 was given a dose of the PRN 15 times from October 2023 through the date of the on-site survey. Resident 3's progress notes did not have any documentation identifying the description of behaviors requiring the PRN, the effectiveness of the medication after it was given, or side effects.

-Resident 3's record did not have documentation of monthly reviews from October 2023 through February 2024 to ensure staff were using the medication as intended.

-Resident 3's MARs identified the following administration:
--October 2023-Administered on 10/05/2023, 10/26/2023, and 10/30/2023. The MAR did not identify the rationale for use, description of behaviors requiring the PRN, the effectiveness of the medication, or side effects.
--December 2023-Administered one dose on 12/02/2023, 12/13/2023, 12/16/2023, 12/21/2023, 12/27/2023, and 12/30/2023. Administered two doses on 12/17/2023 and 12/25/2023. The MAR did not identify the rationale for use, description of behaviors requiring the PRN, the effectiveness of the medication, or side effects. The MAR did not identify the rationale for use, description of behaviors requiring the PRN, the effectiveness of the medication, or side effects.
--January 2024-Administered on 01/01/2024 and 01/06/2024. The MAR did not identify the rationale for use, description of behaviors requiring the PRN, the effectiveness of the

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N 408	Continued From page 19 medication, or side effects. The MAR did not identify the rationale for use, description of behaviors requiring the PRN, the effectiveness of the medication, or side effects. On 03/29/2024, at approximately 4:10 PM, Surveyor interviewed Administrator B and Quality Care Coordinator (QCC) H. Administrator B reported s/he and QCC H had just began working in his/her role with the provider in January 2024. Administrator B reported s/he did not know what behaviors Resident 3 exhibited which would require the use of PRN buspirone. QCC H reported s/he did not know why Resident 3 required the medication but reported Resident 3 was anxious and packed his/her room daily thinking his/her family member was coming to get him/her and take him/her home. Administrator B reported s/he knew the requirement for including details regarding the use of the PRN psychotropic in each resident's ISP and s/he would ensure Resident 3's ISP was updated. Administrator B and QCC H reported they did not know why staff did not document the effectiveness of the medication or behaviors observed which required the use of the PRN. Administrator B reported s/he would work on fixing the compliance issues identified immediately.	N 408		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored	N 452		

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N 452	Continued From page 20 in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all food was covered and stored under sanitary conditions for the prevention of food borne illnesses prior to serving 48 of 48 residents residing in the facility. Foods in the kitchen, freezer, and cooler were not covered and dated. Additionally, the provider did not ensure hot food was held at 140° Fahrenheit (F) or above prior to serving to residents. This had the potential to affect all residents in the facility. Findings include: Example 1 On 03/29/2024 at approximately 10:30 AM, Surveyor toured facility kitchen accompanied by Cook D. Surveyor observed the following: Kitchen -One approximately 10-gallon unmarked bin with a scoop laying inside the bin on top of what appeared to be flour. -One unsealed 10-pound bag of noodles. Freezer	N 452		

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-One approximately 10-pound bag of what appeared to be sausage patties opened, unsealed, and unmarked.
-One partially used 5-pound bag of what appeared to be uncooked buns, unsealed and unmarked.
-One partially used approximately 10-pound bag of bone in chicken, unmarked and not dated.

Cooler
-Two pounds of summer sausage in an unsealed, undated plastic sleeve.
-One stainless steel chafing dish holding approximately 15 pancakes and 15 French toast, uncovered and unmarked.
-One 2-quart stainless steel chafing dish, partially covered with aluminum foil, containing what appeared to be green beans not properly sealed.
-One 4-quart stainless steel chafing dish holding approximately 1 quart of what appeared to be cooked rice partially covered with saran wrap.

On 03/29/2024 at approximately 10:40 AM, Surveyor interviewed Cook D who stated, "we do not have seal tight containers for the leftovers."

On 03/09/2024 at approximately 4:30 PM, Surveyor asked Administrator B if they had a food storage policy in place to ensure the kitchen was following DHS 83 regulations. Administrator B gave Surveyor a copy of DHS 83.41 and confirmed this was what the kitchen was instructed to follow. Quality Care Coordinator H confirmed the staff would be re-trained.

Example 2

On 03/29/2024, at approximately 12:27 PM, Surveyor observed food being prepared in the kitchen. There were approximately 14 plates of

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food on a 2-tiered cart with wheels. Surveyor took the temperature of the hamburger of one of the plates. The hamburger was 105° Fahrenheit (F). The French fries were 99° F. Dietary Aide (DA) I took the plates to the dining room and served the residents. The food was not reheated to 140° F prior to serving the residents.

On 03/29/2024, at approximately 12:27 PM, Surveyor interviewed Cook D. Cook D reported s/he took the temperature of the food before they took it off the stove to ensure it was done. Cook D reported it was their process to plate all the food and then take it to the dining rooms and pass them out. Cook D reported they would microwave the food if it was not warm enough for the residents. Cook D confirmed the hot food was not maintained at 140° or above prior to serving to residents. Cook D reported they began plating the food approximately 30 minutes prior to serving to residents.

On 03/29/2024, at approximately 12:35, Surveyor interviewed DA I. DA I reported s/he did not know what temperature the food should have been prior to serving residents. DA I reported s/he warmed the food in the microwave if the residents complained about it being too cold. DA I reported s/he frequently had to warm the food in the microwave.

On 03/29/2024, at approximately 12:45 PM, Surveyor interviewed Resident 6 about his/her lunch. Resident 6 reported his/her hamburger and fries were cold when s/he received it at his/her table. Resident 6 stated s/he gave his/her plate to another resident to help with heating it in the microwave. The food was warm enough after the other resident warmed it for him/her. The other resident also warmed his/her own food at the

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N 452	Continued From page 23 same time. Resident 6 reported the food served was often too cold for his/her liking. On 03/29/2024, at approximately 12:48 PM, Surveyor interviewed Resident 7 about his/her lunch. Resident 7 stated, "The food is never warm." Resident 7 explained s/he had diabetes and needed to eat and many times the food served was not appetizing because it was cold. "Leaving food out too long at room temperature can cause bacteria to grow to dangerous levels that can cause illness. Bacteria grow most rapidly in the range of temperatures between 40° F and 140° F, doubling in number in as little as 20 minutes. This range of temperatures is often called the 'Danger Zone.' Keep Food Out of the 'Danger Zone'...Keep hot food hot-at or above 140°F. Place cooked food in chafing dishes, preheated steam tables, warming trays, and/or slow cookers." (Source: United States Department of Agriculture Website, "Danger Zone" (40° F - 140° F), June 28, 2017, https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/danger-zone-40f-140f (retrieval date - April 02, 2024).)	N 452		
N 531	83.47(4)(a) Fire extinguishers: type and inspection. At least one portable dry chemical fire extinguisher with a minimum 2A, 10-B-C rating shall be provided on each floor of the CBRF. All fire extinguishers shall be maintained in readily usable condition. Inspections of the fire extinguisher shall be done by a qualified professional one year after initial purchase and annually thereafter. Each fire extinguisher shall be provided with a tag documenting the date of	N 531		

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N 531	Continued From page 24 inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 13 of 13 fire extinguishers were maintained in readily usable condition and inspected by a qualified professional annually in 2022 and 2023. Findings include: On 03/29/2024, at approximately 1:30 PM, Surveyors toured the facility accompanied by Administrator B and Quality Care Coordinator H. Surveyors observed 13 fire extinguishers located throughout the facility. All fire extinguishers had original inspection tags with monthly staff initials beginning in 01/2021. There was not an inspection conducted by a qualified professional in 2022 or 2023. On 03/29/2024 at approximately 4:10 PM, Surveyors interviewed Administrator B and Quality Care Coordinator H. Asking if they were aware the fire extinguishers were out of compliance. Administrator B stated they were not aware but would get them inspected as soon as possible.	N 531		