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 07/26/2023

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 07/26/2023, Surveyor completed a complaint investigation at Ameira Orchids Assisted Living. One deficiency was identified. One complaint was substantiated. Census: 44	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an allegation of abuse was reported within 7 calendar days to the department and the provider did not take immediate steps to ensure the safety of all residents.	N 158		

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

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N 158	Continued From page 1 On 06/28/2023, at approximately 5:00 AM, Resident 1 needed pain medication and found Caregiver D sleeping on a sofa. Resident 1 woke Caregiver D. Caregiver D became verbally abusive and pushed Resident 1. Person E notified Assistant Administrator B of the incident at approximately 5:00 AM. Administrator B did not go into the facility until 7:00 AM, placing residents at risk. Caregiver D notified Assistant Administrator B of the incident at 7:00 AM. Findings include: On 06/30/2023, the department received a complaint alleging a staff member was asleep on 06/29/2023 between 5:00 AM and 5:30 AM. A resident woke the caregiver, and the caregiver became aggressive and pushed the resident. On 07/14/2023 at approximately 12:15 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 03/18/2023 with diagnoses of cerebrovascular disease, hypertension, anxiety, depression, and short/mid-term memory loss. Resident 1 was under Hospice care with a primary diagnosis of cerebrovascular disease. Resident 1 had physician orders for methadone 10 milligrams (mg) 1 tablet every 8 hours for pain and morphine sulfate 20 mg/5 milliliters (ml) solution to take 0.25 ml (5 mg) by mouth every 2 hours as needed for pain. On 07/14/2023, Surveyor reviewed Caregiver D's record. Caregiver D started to provide services on 06/25/2023. Caregiver D's record revealed all required training was completed. On 07/14/2023 at approximately 2:30 PM,	N 158		

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N 158	Continued From page 2 Surveyor interviewed. Surveyor asked if Resident 1 recalled the incident that occurred 06/28/2023. Resident 1 stated s/he remembered it well. Resident 1 stated s/he always woke up between 3:00-5:00 AM due to pain. Resident 1 came out of their room to look for a caregiver. Resident 1 found Caregiver D laying on a sofa talking on a cell phone. Resident 1 stated s/he could hear the voice of the person Caregiver D was talking to. Resident 1 requested pain medication. Caregiver D told Resident 1 to go back to bed and you would not have any pain. Resident 1 stated s/he needed pain medication. Caregiver D stood up and started to walk away. Resident 1 followed Caregiver D thinking they were going to the medication room. Caregiver D was screaming, cussing, and threatened to knock Resident 1 out. Resident 1 felt disrespected and started hollering back and forth with Caregiver D. Resident 1 stated they never got to the medication room. Caregiver D turned around and told Resident 1 to get out of Caregiver D's face. Resident 1 told Caregiver D s/he just wanted to make sure s/he received the pain medication. Caregiver D then used 3 fingers to push Resident 1 on the left side of chest. Resident 1 stated it hurt. Caregiver D threatened to hit Resident 1. Resident 1 had balance issues but did not fall. Resident 1 did not receive any pain medication and returned to his/her room. At approximately 8:00 AM, Hospice arrived at the facility and administered Resident 1's pain medication. On 07/25/2023, Surveyor reviewed the investigation completed by Assistant Administrator B. The report identified on 06/28/2023 at approximately 5:00 AM, Assistant Administrator B received a phone call from Person E. Person E claimed s/he received a call from Resident 1 stating a caregiver had hit	N 158		

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N 158	Continued From page 3	N 158		

Resident 1. This was the first notification received of the incident. After being notified, Assistant Administrator B attempted to contact Caregiver D multiple times at the facility. Caregiver D was not answering the phone. Assistant Administrator B left multiple voice messages. Caregiver D contacted Assistant Administrator B at approximately 7:00 AM to explain the incident with Resident 1. According to Caregiver D, Resident 1 requested a pain pill and was told Resident 1 had to wait because Resident 1 just received a pain pill. According to the medication report of medications administered in the 12 hours prior to 06/28/2023, the last dose of morphine was administered at 12:36 AM. Resident 1 should have been given a dose of morphine as requested as more than 2 hours had elapsed since the last dose.
Resident 1 followed Caregiver D to the medication room. Caregiver D stated Resident 1 was upset, started yelling, and was in her/his personal space so Caregiver D turned Resident 1 around. Caregiver D admitted to laying hands on Resident 1 to turn around. Assistant Administrator B informed Caregiver D s/he would be in the facility at 7:00 AM to start the investigation.

On 07/25/2023, at approximately 5:25 PM, Surveyor interviewed Assistant Administrator B. Assistant Administrator B verified s/he first learned of the incident at 5:00 AM. Assistant Administrator B went to the facility at 7:00 AM, 2 hours after the incident. Assistant Administrator B added when s/he spoke with Person E, Person E informed Assistant Administrator B Resident 1 was very upset after the incident. The investigation report indicated Assistant Administrator B assured Person E that Assistant Administrator B was coming to the facility in the morning and would check on Resident 1 and

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N 158	Continued From page 4 write a report. Surveyor asked Assistant Administrator B when s/he saw Resident 1. Assistant Administrator B stated s/he saw Resident 1 at approximately 7:15 AM on 06/29/2023. Assistant Administrator B reported s/he was unable to come any sooner due to having an infant at home. Assistant Administrator B reported s/he was not aware of the code requiring the facility to take immediate steps to ensure the safety of all residents after learning of an allegation of abuse. Assistant Administrator B stated the Hospice agency took care of reporting the incident to the State. Surveyor informed Assistant Administrator B it is the provider's responsibility to report allegations of abuse to the State within 7 days and as of 07/24/2023, the Office of Caregiver Quality (OCQ) has not received any report of misconduct. On 07/26/2023 at approximately 4:32 PM, Surveyor interviewed Administrator A. Administrator A was aware of the requirement to report to the state and will report the incident to OCQ.	N 158		