STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015092	A. BUILDING: _____ B. WING _____	C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ELM GROVE	800 WALL ST ELM GROVE, WI 53122

(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 10/04/2023, Surveyor conducted a complaint investigation and standard survey at Heritage Elm Grove. Seven deficiencies were identified. Two of 7 deficiencies were repeat violations. See statement of deficiencies (SOD) #E9IS11, dated 06/16/2021, SOD #2LIH11, dated 09/25/2019, SOD #RG5F12, dated 05/30/2019, and SOD #RG5F11, dated 01/18/2019. The complaint was substantiated. Census: 69	N 000		
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 at the time of hire a	N 219		

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

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N 219	Continued From page 1	N 219		

complete background check was conducted for 1 of 3 staff reviewed.

Former Culinary Assistant K's full background check was not completed at time of hire.

The complete background check is to include the background information disclosure form (BID), the criminal history search from the department of justice (DOJ), and the information maintained by the department of safety and professional services regarding a person's credentials (IBIS).

Findings include:

The facility is licensed as a Class CNA (non-ambulatory) CBRF licensed to serve up to 89 residents within the client groups of irreversible dementia/Alzheimer's and advanced age.

On 10/04/2023 at approximately 8:30 AM, Surveyor requested the staff roster from Director of Nursing B who stated the staff roster would be the same for the CBRF and connected RCAC and all staff were cross-trained to work in both.

On 10/04/2023 at approximately 10:30 AM, Surveyor reviewed the current staff roster. Former Culinary Assistant K was listed with a hire date of 11/21/2022.

On 10/04/2023, Surveyor reviewed Former Culinary Assistant K's employee file. His/her record contained 2 BIDs dated 11/19/2022 and 06/06/2023, a DOJ dated 06/06/2023 and an IBIS dated 06/06/2023. The record did not contain a DOJ or IBIS done at time of hire.

On 10/03/2023 at 4:25 PM, Surveyor discussed

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N 219	Continued From page 2 concern of Former Culinary Assistant K's full background check not conducted at time of hire with Regional Director A, Director of Nursing B, Regional Director of Clinical Operations C, Wellness Coordinator D, Support Services E, and Executive Director F. Regional Director A stated they did not find Former Culinary Assistant K's DOJ or IBIS done at time of hire and s/he had left employment in August 2023. Support Services E stated it looked like the complete background check was ran but not uploaded in the termed files and they would send completed full background check to Surveyor on 10/05/2023 AM. As of 4:05 PM on 10/05/2023, the Department had not received Former Culinary Assistant K's full background check conducted at time of hire. Cross Reference: N0220 DHS 83.17(2)(a) Employees Screened for Communicable Disease	N 219		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification	N 220		

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N 220	Continued From page 3 purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all employees were screened for clinically apparent communicable disease including tuberculosis (TB) within 90 days before the start of employment for 2 of 4 employees reviewed. Former Culinary Assistant K's TB test was completed 154 days after hire date and communicable disease screen was completed 171 days after hire date. Housekeeper L's communicable disease screen was completed 38 days after hire date. Findings include: On 10/04/2023 at approximately 8:30 AM, Surveyor requested the staff roster from Director of Nursing B who stated the staff roster would be the same for the CBRF and connected RCAC and all staff were cross-trained to work in both. On 10/04/2023 at approximately 10:30 AM, Surveyor reviewed the current staff roster. Former Culinary Assistant K was listed with a hire date of 11/21/2022. On 10/04/2023, Surveyor reviewed Former Culinary Assistant K's and Housekeeper L's employee records. Example 1- Former Culinary Assistant K Former Culinary Assistant K was hired 11/21/2022. His/her record contained	N 220		

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N 220	Continued From page 4 documentation of 2 TB tests, dated 04/24/2023 and 05/09/2023, and a communicable disease screen signed and dated by an RN on 05/11/2023. Example 2- Housekeeper L Housekeeper L was hired 02/27/2023. His/her record contained a communicable disease screen signed and dated by an RN on 03/01/2023 and 04/06/2023. The 03/01/2023 date was crossed out. On 10/03/2023 at 4:25 PM, Surveyor discussed concern of late communicable disease screen including TB with Regional Director A, Director of Nursing B, Regional Director of Clinical Operations C, Wellness Coordinator D, Support Services E, and Executive Director F. Regional Director A stated Former Culinary Assistant K had left employment in August 2023. Support Services E stated Former Culinary Assistant K should not have been included on the current staff roster. Cross Reference: N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation	N 220		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically	N 302		

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N 302	Continued From page 5 apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure within 90 days before admission or 7 days after admission, each person admitted to the CBRF was screened for clinically apparent communicable disease, including tuberculosis (TB). Two of 2 residents reviewed were not screened for TB within 90 days prior to admission or 7 days after admission. Findings include: Example 1 Resident 1 On 10/04/2023, Surveyor reviewed the current resident roster received from Director of Nursing B. The roster identified Resident 1 as a current resident admitted 04/04/2022. On 10/04/2023, Surveyor reviewed Resident 1's record. The record contained a chest x-ray dated 12/05/2021 (120 days prior to admission), ruling out TB. Example 2-Resident 2 On 10/04/2023, Surveyor reviewed the current	N 302		

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N 302	Continued From page 6 resident roster received from Director of Nursing B. The roster identified Resident 2 as a current resident admitted 09/01/2022. On 10/04/2023, Surveyor reviewed Resident 2's record. The record contained a chest x-ray dated 05-22-2021 (1 year and 3 months prior to admission), ruling out TB. The record contained a communicable disease screen dated 11/21/2022 (over 2 months after admission). On 10/03/2023 at 4:25 PM, Surveyors discussed concern of resident TB tests and communicable disease not being completed time with Regional Director A, Director of Nursing B, Regional Director of Clinical Operations C, Wellness Coordinator D, Support Services E, and Executive Director F. Regional Director A stated they would into it and did not comment further. Cross Reference: N0220 DHS 83.17(2)(a) Employees Screened for Communicable Disease	N 302		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written	N 310		

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N 310	Continued From page 7 statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure admission agreements were signed by resident or resident's legal representative for 2 of 3 residents reviewed. Resident 1 had not signed his/her admission agreement when his/her Power of Attorney for Health Care was not activated at time of admission. Resident 2 had not signed his/her admission agreement. Findings include:	N 310		

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N 310	Continued From page 8 Example 1- Resident 1 On 10/04/2023, Surveyor reviewed the current resident roster received from Director of Nursing B. The roster identified Resident 1 as a current resident admitted 04/04/2022. On 10/04/2022, Surveyor reviewed Resident 1's record. Resident 1's record contained an admission agreement signed 04/04/2022 by Family Member M and a Statement of Incapacity (activating his/her Power of Attorney for Health Care) dated 03/29/2023. Example 2-Resident 2 On 10/04/2023, Surveyor reviewed the current resident roster received from Director of Nursing B. The roster identified Resident 2 as a current resident admitted 09/01/2022. On 10/04/2023, Surveyor reviewed Resident 2's record. Resident 2 is their own legal decision maker. Resident 2's record contained an admission agreement signed 09/01/2022 by Family Member P. On 10/04/2023 at 4:16 PM, Surveyor interviewed Executive Director F who stated residents without an activated Power of Attorney for Health Care should sign their own admission agreements because by signing it they are consenting to admission to facility. On 10/03/2023 at 4:25 PM, Surveyor discussed concern of residents not signing their own admission agreements with Regional Director A, Director of Nursing B, Regional Director of Clinical Operations C, Wellness Coordinator D, Support Services E, and Executive Director F.	N 310		

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N 310	Continued From page 9 Regional Director A stated Family Member M wanted to sign the admission paperwork to avoid Resident 1 going through the long admission process. Regional Director A stated Family Member P was assisting Resident 2 due to his/her vision impairment.	N 310		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure the resident right to prompt treatment appropriate to resident needs when Resident 2's call pendant and/or emergency pull cords were not answered timely. Between 03/01/2023-03/31/2023 and 08/01/2023-10/03/2023, Resident 2 experienced 57 episodes of call pendant and/or emergency pull cord wait times exceeding 20 minutes. This is a repeat violation. See statement of deficiency (SOD) RG5F11, dated 09/25/2019. Findings include: On 09/18/2023, the Department received a complaint alleging concerns with resident mobility status and long call light times. On 10/04/2023 at 9:00 AM, Surveyor toured the	N 353		

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facility, interviewed residents, and reviewed Resident 2's record. The following was found:

Pull cords are located in resident bathrooms and call pendants are worn by residents.

Resident 2 was admitted 09/01/2022 with diagnoses including type 2 diabetes, autonomic neuropathy, spondylosis, and legally blind. Resident 2 is their own legal decision maker.

Resident 2's individual service plan (ISP) dated 10/04/2022 documented Resident 2 required assistance with bathing, dressing, housekeeping, and ongoing health monitoring. Resident 2's ISP documented:
"Pendant utilization: I independently utilize my pendant to call for staff assistance as needed."

On 10/04/2023 at 9:35 AM, Surveyor interviewed Resident 2. Resident 2 reported s/he required assistance with bathing, dressing, and staff walking him/her to meals. Resident 2 reported concerns with long call light times. Resident 2 stated in early March 2023, s/he fell, and it took staff over 1 hour and 30 minutes to assist. Resident 2 stated on 09/01/2023, s/he fell, and it took staff over 20 minutes to respond after call light was pushed. Resident 2 stated on 09/19/2023, s/he pushed their call light for lunch and no one ever came. During interview, Surveyor observed programmed alarms going off on Resident 2's cellphone to remind him/her of the time and activities. Resident 2 reported the most frustrating example of long call lights times is when 1 staff member comes into the room to "clear" out the page and will say "your caregiver will be in shortly", and no one comes."

Surveyor reviewed Resident 2's records and call

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N 353	Continued From page 11 pendant/emergency pull cord logs. Call pendant/emergency pull cord log dated 03/01/2023-03/31/2023 and 08/01/2023-10/03/2023-call pendant response times greater than 20 minutes: 03/02/2023 4:50 PM- 63 minutes (Auto Closed) 03/03/2023 9:30 PM-25 minutes 03/05/2023 9:19 AM-21 minutes 03/05/2023 12:44 PM-24 minutes 03/09/2023 3:43 PM-23 minutes 03/13/2023 10:22 PM-28 minutes 03/17/2023 10:52 AM- 21 minutes 03/21/2023 1:04 PM-23 minutes 03/22/2023 12:53 PM-23 minutes 03/24/2023 11:26 AM-37 minutes 03/27/2023 4:59 AM-45 minutes 03/27/2023 8:26 AM-33 minutes 03/28/2023 9:10 AM-34 minutes 03/29/2023 7:53 AM-28 minutes 08/02/2023 10:07 AM-25 minutes 08/06/2023 7:39 AM-25 minutes 08/06/2023 10:04 AM-33 minutes 08/07/2023 7:37 AM-47 minutes 08/09/2023 9:41 AM-61 minutes 08/10/2023 8:22 AM-28 minutes 08/13/2023 7:36 AM-23 minutes 08/13/2023 8:57 AM-29 minutes 08/14/2023 7:37 AM-29 minutes 08/15/2023 9:03 AM-28 minutes 08/17/2023 8:00 AM-32 minutes 08/18/2023 10:21 AM-93 minutes 08/22/2023 8:09 AM-22 minutes 08/22/2023 12:28 PM-37 minutes 08/23/2023 3:42 PM-24 minutes 08/25/2023 8:10 AM-38 minutes 08/25/2023 7:58 PM-47 minutes 08/26/2023 9:10 AM-79 minutes 08/27/2023 9:13 AM-28 minutes 08/28/2023 7:37 AM-30 minutes	N 353		

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09/02/2023 5:55 AM-22 minutes
09/05/2023 12:45 AM-23 minutes
09/05/2023 3:40 AM-22 minutes
09/06/2023 9:45 AM-54 minutes
09/06/2023 2:50 PM-29 minutes
09/07/2023 8:06 AM-25 minutes
09/08/2023 12:46 PM-47 minutes
09/08/2023 3:17 PM-50 minutes
09/09/2023 7:48 AM-47 minutes
09/11/2023 9:10 AM-23 minutes
09/15/2023 5:34 AM-65 minutes
09/15/2023 3:55 PM-62 minutes
09/16/2023 7:57 AM-25 minutes
09/16/2023 9:10 AM-28 minutes
09/17/2023 7:51 AM-25 minutes
09/18/2023 11:10 AM-24 minutes
09/18/2023 3:52 PM-64 minutes
09/19/2023 1:14 PM-23 minutes
09/21/2023 9:09 AM-25 minutes
09/22/2023 7:31 AM-22 minutes
09/24/2023 7:40 AM-43 minutes
09/25/2023 7:47 AM-38 minutes
09/29/2023 9:28 AM-36 minutes

On 10/04/2023 at 10:30 AM, Surveyor interviewed Caregiver N. Caregiver N stated resident call lights are supposed to be cleared within 10 minutes of the request. Caregiver N stated each staff member carries a cell-phone that alerts the staff when a resident requests help and it will also alert if another staff member assists with that request.

On 10/04/2023 at 11:25 AM, Surveyor interviewed Resident 3. Resident 3 stated the call light response times for staff can be long from 10-20 minutes. Resident 3 stated a couple times 1 staff member had entered his/her room, responded to the call light "clearing it" and will tell him/her that "their caregiver will be in shortly and no one

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N 353	Continued From page 13 comes." On 10/04/2023 at 2:30 PM, Surveyor interviewed Regional Director A regarding Resident 2's call light reports. Regional Director A stated staff expectation is for them to respond within 10 minutes of call light request. Regional Director A explained the provider's call light system and how it records response times. On 10/03/2023 at 4:25 PM, Surveyors discussed concerns of Resident 2's call light response times with Regional Director A, Director of Nursing B, Regional Director of Clinical Operations C, Wellness Coordinator D, Support Services E, and Executive Director F. Regional Director A confirmed prior to providing records to the Surveyor, s/he reviewed Resident 2's call light report and confirmed some of the times were longer than provider's expectation for staff. Regional Director A stated Resident 2 pushes his/her call light many times a day, so we are looking at creating a plan to better anticipate Resident 2's needs. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 353		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case	N 389		

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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 observation, interview, and record review, the individual service plan (ISP) was not updated for 1 of 1 resident reviewed when there was a change in resident needs and abilities.

Resident 2's ISP was not updated when s/he had a change in mobility status.

This deficiency is being cited for the 4th time. See statement of deficiencies (SOD) #E9IS11, dated 06/16/2021, SOD #2LIH11, dated 09/25/2019, and SOD #RG5F12, dated 05/30/2019.

Findings include:

On 09/18/2023, the Department received a complaint alleging concerns with resident mobility status and long call light times.

On 10/04/2023, Surveyor reviewed Resident 2's record and identified the following:

Resident 2 was admitted 09/01/2022 with diagnoses including type 2 diabetes and legally blind. Resident 2 is their own legal decision maker.

On 10/04/2023 at 9:35 AM, Surveyor interviewed Resident 2. Resident 2 stated staff assist him/her to each meal, 3x/day, due to his/her diagnosis.

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Resident 2 stated s/he can see colors that are in close, but otherwise Resident 2 required assistance with his/her mobility. Resident 2 noted s/he will press call button before meals and staff assist with mobility with a modified stand-by assistance to each meal. Resident 2 stated staff will take the front of my walker and guide Resident 2 to the dining room. Resident 2 stated staff had been helping with mobility for many months.

On 10/04/2023 at 10:30 AM, Surveyor interviewed Caregiver N. Caregiver N confirmed Resident 2 required staff assistance to meals 3x/day. Caregiver N reported the intervention of assisting Resident 2 with his/her 4 wheeled walker (WW) and guiding him/her to meals. Caregiver N could not recall how long staff have been assisting Resident 2 to meals.

On 10/04/2023 at 11:57 AM, Surveyor observed Supervisor O assist Resident 2 to the dining room. Supervisor O grabbed the front of Resident 2's 4WW and walked in front of Resident 2, while guiding and walking the same pace towards the dining room for lunch. Resident 2 was observed walking with his/her 4 WW and utilizing staff assistance on where to go.

Resident 2's evacuation assessment dated 09/10/20223 documented "Resident has poor vision but is self-starting and ambulated independently with 4 WW. Resident will stay at designated safe area without supervision."

Resident 2's ISP dated 10/04/2022 documented: "Eating: I Am independent with meals and eating and drinking. Dietary aids prepare all meals. Staff provide reminders to attend meals."
"Transferring: I am able to transfer independently.

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N 389	Continued From page 16 Staff encourage me to call for assistance if feeling weak or unsteady. Staff will report to the nurse if I have a change in my ability to transfer." "Mobility: Ambulation-I ambulate independently with 4ww. If I have a change in my ability to ambulate staff will inform the nurse." "Vision: I have vision loss to both eyes." Resident 2's record did not contain an updated ISP when s/he had a change in mobility status. On 10/03/2023 at 4:25 PM, Surveyor discussed concern of Resident 2's ISP not being updated when s/he had a change in mobility status with Regional Director A, Director of Nursing B, Regional Director of Clinical Operations C, Wellness Coordinator D, Support Services E, and Executive Director F. Wellness Coordinator D confirmed Resident 2's ISP did not include new interventions for staff to assist with walking Resident 2 to each meal. Wellness Coordinator D stated when Resident 2 admitted family did not want the provider to assist to meals. Wellness Coordinator D could not recall how long staff had been assisting Resident 2 to meals. There was no other comments regarding Resident 2's ISP not being updated when s/he had a change in needs/abilities. Cross Reference: N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment	N 389		
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	N 452		

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N 452	Continued From page 17 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 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 record review and interview, the provider did not ensure food was stored and distributed under sanitary conditions. Food was stored uncovered in the walk-in cooler under dusty fans, transported uncovered in a public elevator to the living area, and left uncovered prior to serving next to a sink where staff washed their hands. Findings include: The facility is licensed as a Class CNA (non-ambulatory) CBRF licensed to serve up to 89 residents within the client groups of irreversible dementia/Alzheimer's and advanced age. Example 1- Cooler On 10/04/2023 at approximately 11:20 AM, Surveyor toured the kitchen with Executive Chef G and observed a tall sheet pan rack in the cooler directly under 2 ceiling height built-in fans. The	N 452		

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fans were dusty and blowing air. The rack and individualized servings of macaroni salad were uncovered. Executive Chef G stated the food should have been covered.

On 10/04/2023 at 11:36 AM, Executive Chef G stated to Surveyor s/he requested maintenance clean the fans asap.

Example 2- Transported
10/04/2023 at 11:43 AM, while waiting for elevator on 2nd floor with Maintenance Director H, Surveyor observed the elevator door open. A uncovered tall sheet pan rack was in the elevator. Uncovered plates containing salads and dinner rolls were on the rack. The elevator was empty except for the rack. Surveyor rode the elevator down to the 1st floor with the rack and Maintenance Director H. Maintenance Director H stated the elevator was a public elevator. The rear door of the elevator opened to the kitchen. Executive Sous Chef I was waiting in the kitchen at the elevator when the door opened. Executive Sous Chef I stated s/he had put the cart in the elevator then went to get ice cream and by the time s/he returned with the ice cream the elevator had left. Executive Sous Chef I entered the elevator. Surveyor accompanied Executive Sous Chef I to the 2nd floor dining room where s/he left delivered the cart to the dining room.

At 11:45 AM, Surveyor interviewed Sous Chef I who stated on 10/4/2023 at breakfast, they had run out of cart bags used to cover the sheet pan rack. Sous Chef I stated s/he had no other way to cover the rack or plates. Sous Chef I stated there were 37 plates of food on the rack.

Example 3- Next to Sink
On 10/03/2023 at 11:51 AM, Surveyor observed 2

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N 452	Continued From page 19 uncovered trays each containing 3 uncovered plates of salad and dinner roll set on the cupboard next to the sink in the mini server on the memory care unit. At 11:53 AM, Surveyor observed CNA Supervisor J wash his/her hands at the sink memory care mini server sink next to the uncovered plates of salad. On 10/03/2023 at 12:01 AM, Surveyor showed Executive Chef G the uncovered plates containing salad and roll set next to the sink. Executive Chef G stated the plates should have been covered. Executive Chef G moved the trays from the sink area to the top of a tray rack. On 10/03/2023 at approximately 3:00 PM, Executive Chef G showed Surveyor a picture depicting the cooler fans had been cleaned. On 10/03/2023 at 4:25 PM, Surveyor discussed concern of uncovered food stored and transported to the dining room with Regional Director A, Director of Nursing B, Regional Director of Clinical Operations C, Wellness Coordinator D, Support Services E, and Executive Director F. Executive Director F stated they would monitor food transportation more closely and review the equipment food was transported in.	N 452		