STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634560	A. BUILDING _____ B. WING _____	11/10/2020

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SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

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F0000 SS=	INITIAL COMMENTS SKLD-Bloomfield Hills was surveyed for an abbreviated survey on 11-10-2020. Intakes: MI00115308, MI00115141, MI00115261, MI00115150, MI00114975, MI00114764, MI00114706, MI00114536, MI00114307, MI00113684, MI00113630, MI00113533, MI00113509, MI00113019, MI00112981, MI00112900, MI00112864, MI00112689, MI00112535, MI00112532, MI00112485, MI00112422, MI00112295, MI00112097, MI00112035, MI00111861, MI0011860, MI00111435, MI00111382-, MI00111404, MI00111082, MI00111147, MI00110995, MI00110981, MI00110898, MI00110907, MI00110412, MI00110164, MI00109445, MI00109253, MI00109188, MI00109348, MI00109051. Census =124	F0000		
F0550 SS= D	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish	F0550	Residents #921, #944, #945 and #946 have had no further occurrences and has had no residual effect resulting from the incident. Residents residing in the facility are at risk for a similar occurrence. Rounding by management staff will be done to ensure that this type of occurrence does not affect like residents. A 1:1 in-service was done with the CNA using the term feeder, CNAs whose behaviors were noted at the nursing station are no longer employed at the facility. In-services have been done for staff regarding dignity, cell phone use on the floors and conversations at the nursing stations to ensure compliance.	12/21/2020

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

Electronically Signed | 12/11/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00109051 and MI00112485. Based on observation, interview, and record review, the facility failed to ensure residents were treated in a dignified manner for four (R#921, R#944, R945, and R#946) of 10 residents reviewed for dignity and multiple residents at the nursing station on the 2 East Unit when staff referred to a resident as a "feeder" and complained about their job in front of residents, resulting in the potential for feelings of embarrassment and diminished self-worth. Findings include: On 11/4/20 at 3:00 PM, an observation of the 2 East Unit was conducted. Certified Nursing Assistant (CNA) "I" was observed standing in the hallway at a computer screen kiosk. CNA "J" was seated, slouched in a chair next to CNA "I". CNA		Observation audits of employee interactions with residents will be done three times a week for one month and randomly thereafter to ensure compliance. Audits will be reviewed at weekly Ad Hoc QAPI meetings to monitor continued performance and compliance and will be submitted to monthly QAPI for further review to ensure compliance. The DON and Administrator will be responsible for continued compliance.	

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"J" was using their personal cell phone. CNA "I" and CNA "J" were engaged in personal conversation and complaining about their job. R#946 was observed seated in the hallway in a reclined geriatric chair within ear shot of CNA "I" and CNA "J"'s conversation. At that time, R#944 was observed forcefully removing R#945 from their room and stated, "Get out of here!" CNA "I" stated, "I'm going somewhere else to chart. There's too much going on here" and stood up and walked down the hallway. When asked their names, CNA "I" and CNA "J" began complaining in ear shot of multiple residents who were seated near the nursing station. CNA "I" stated loudly, "I'm just charting to try to finish up my shift. What am I supposed to do? The afternoon shift is here. I'm trying to finish and go home." CNA "J" stated, "I'm just waiting for her. I'm off my shift already." Unit Manager, Nurse "D" attempted to ask CNA "I" to go to their office to talk away from the residents. CNA "I" continued to complain about their job in front of the residents and returned to the computer kiosk down the resident hallway.

At 3:15 PM CNA "I" was observed complaining about her work to another staff member in the hallway. At that time, Nurse "K" entered the unit and began putting masks on the residents seated in the hallway without an explanation of what was being done. One resident stated, "Is this on right? I feel like I am choking. What is on my face?" The mask was observed over the resident's nose and mouth, but not comfortably pulled down under the chin.

On 11/4/20 at 3:30 PM, Nurse "D" was interviewed. Nurse "D" reported CNA "J" should not have been present on the unit if she was clocked out and staff were not permitted to use their personal cell phones in resident areas. Nurse "D" further reported CNA "I" was still on the clock and therefore was still responsible to the

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residents on the unit and should not participate in personal conversation in front of residents.

On 11/4/20 at 3:45PM the Director of Nursing (DON) was interviewed. The DON reported if staff are on the clock, they are responsible for residents while being paid. The DON further reported use of personal cell phones was prohibited in resident areas and when staff were done with their shift, they should not stay on the unit. The DON reported Nurse "D" spoke with her about the above observations. The DON reported CNA "I" and CNA "J" had a history of similar behavior.

A review of CNA "J"s personnel file revealed the following:

A "Disciplinary Action Record" for CNA "J" dated 7/31/20 documented, "...Employee engage <sic> with another employee verbal confrontation on unit around other staff and residents..."

R#944's clinical record was reviewed and revealed R#944 was admitted into the facility on 8/11/19 with diagnoses that included: dementia with behavioral disturbances and schizophrenia.

R#945's clinical record was reviewed and revealed R#945 was admitted into the facility on 9/17/20 with diagnoses that included: vascular dementia.

R#946's clinical record was reviewed and revealed R#946 was admitted into the facility on 7/23/20 with diagnoses that included: Alzheimer's Disease. A Minimum Data Set (MDS) assessment dated 10/26/20 documented R#946 had moderately impaired cognition.

A facility policy titled, "Policy/Procedure - Nursing Administration...Resident

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	Rights...Dignity and Respect" dated 7/11/2018 was reviewed and it documented, "...It is the policy of this facility that all residents be treated with kindness, dignity, and respect...The staff shall display respect for Resident's when speaking with, caring or <sic>, or talking about them, as constant affirmation of their individuality and dignity as human beings..." R#921 A complaint was submitted to the State Agency regarding the resident not being treated with dignity and respect. R#921 was admitted into the facility on 2/25/13, with a readmission date of 8/19/20 and diagnoses that included: multiple sclerosis, quadriplegia, lack of coordination, contractures, colostomy status, and artificial openings of urinary tract. A Minimum Data set (MDS) dated 8/24/20 documented a Brief Interview for Mental Status (BIMS) score of 15 (indicating intact cognition). Impairment to both the upper and lower extremities are documented, which indicates R#921's total dependence for staff assistance with all ADL's. On 10/28/20 at 1:22 pm, an interview was conducted with R#921. The resident was observed lying on their back in bed with the sheets pulled up to their chest area. When asked about being treated with dignity and respect, the resident stated "No, not all of the time". When queried why their lunch tray was sitting beside their bed uneaten, the resident replied that the staff haven't come into the room to feed them yet. At 1:35 pm, Certified Nursing Assistant (CNA) "CC" entered the room. When asked what time they were going to feed the resident, CNA "CC" replied in part, " ... I have three feeders, this is my second feeder ..." CNA "CC" was observed			

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	stating this at the resident's bedside, in front of the resident. On 10/28/20 at 2:25 pm, the Director of Nursing (DON) was queried on if staff should be referring to residents as "feeder" and acknowledged that they shouldn't and informed the surveyor that they will reeducate their staff. A facility policy titled "Dignity and Respect" (dated 7/11/18) documented in part, " ... It is the policy of this facility that all residents be treated with kindness, dignity and respect ... The staff shall display respect for Resident's when speaking with, caring or, or talking about them, as constant affirmation of their individuality and dignity as human beings ..."			
F0551 SS= D	483.10(b)(3)-(7)(i)-(iii) Rights Exercised by Representative §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or	F0551	Resident #901 has had no further occurrences and no residual effects as a result of the incident. Residents residing in the facility are at risk for a similar occurrence. In-services have been done for staff regarding appropriate authorization prior to providing haircuts to ensure that the responsible party consents to the haircut. DON/Designee will conduct random observations of 5 residents three times a week for 4 weeks, then monthly thereafter for 3 months or until sustained compliance has been achieved to ensure a residents have not received a haircut without permission from responsible party and only by a licensed beautician or barber. Audits will be reviewed at weekly Ad Hoc QAPI meetings to monitor continued performance and compliance and will be	12/21/2020

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	delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00115308 Based on interview and record review the		submitted to monthly QAPI for further review to ensure compliance. The DON and Administrator will be responsible for continued compliance.	

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facility failed to ensure consent was obtained by a resident's legal representative for one resident (R#901) prior to a haircut being given by staff in the facility, resulting in R#901's hair being cut without the knowledge of R#901's legal representative. Findings include:

On 10/28/20 a concern that was submitted to the State Agency was reviewed that indicated that R#901's legal guardian was not informed prior to the completion of a haircut for R#901.

On 10/28/20 at approximately 11:36 a.m., during a phone call with R#901's legal guardian (LG "EE"), LE "EE" was queried regarding R#901's haircut. LG "EE" indicated that they have received a call from the facility indicating that R#901 had been given a haircut but that the facility did not know who had given it and that they were conducting an investigation to see what happened. LG "EE" reported they were not informed that R#901 was going to get a haircut and that the haircut that was done did not look good.

On 10/28/20 the medical record for R#901 was reviewed and revealed the following: R#901 was initially admitted to the facility on 8/1/19 and had diagnoses including Anoxic brain damage. A review of R#901's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/7/20 revealed R#901 was dependent on staff for most of their activities of daily living. R#901's

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was documented as severely impaired. Further review of R#901's demographic facesheet indicated they had a court appointed legal guardian.

A progress note dated 10/13/2020 at 15:59 (3:59 p.m.) revealed the following: "Writer spoke to resident sister r/t (related to) hair cut and hair being washed. Writer informed Sister that hair would be washed tonight. SS (social services) to get resident a satin bonnet for use to decrease tangling and hair matting. No further issues or concerns expressed. Will continue to monitor."

On 10/29/20 at approximately 8:15 a.m., during a conversation with Unit Manager "FF" (UM "FF"), UM "FF" was queried regarding incident of R#901 having their haircut. UM "FF" indicated that they had conducted an investigation into who cut R#901's hair during the evening/midnight shifts on 10/12/20 and that nobody would confess who had done it. UM "FF" indicated that the legal guardian for R#901 was not informed about R#901 having their hair cut prior. UM "FF" indicated they had to discipline the nurse who was in charge of R#901 during the time the incident occurred. UM "FF" was queried how they knew that R#901 had their hair cut and they indicated that they had come in later and seen that it was cut. UM "FF" indicated that their investigation did not reveal who had cut R#901's hair but that it had been cut.

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	On 11/4/20 at approximately 3:13 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding R#901's hair being cut without the legal guardian being informed of the haircutting. The DON indicated that they issued a "write-up" to the nurse on the unit that day for not rounding appropriately. DON indicated they felt that R#901's hair had been cut on the midnight shift on 10/12-10/13, but nobody had admitted to cutting the hair. DON indicated R#901's hair was not but by the facility beautician. A policy for haircuts was requested at this time. None was received before the end of the survey. A statement from activity aide "GG" (AA "GG") dated 10/14/20 pertaining to R#901's haircut was reviewed and revealed the following: "Writer went in patient's room to play gospel music for the patient per families request. Writer observed patient had stray hair clippings on pillowcase and around the bed, writer then went to drop patients head so she could view the music videos and noticed her hair had been cut. Writer then asked the aide (CNA) and the CNA said he noticed in 1st thing this morning. Writer then told nurse..." A facility document titled "Disciplinary Action Record Work Rules" dated 10/14/20 for Nurse "HH" was reviewed and revealed the following: "Date of Infraction-10/12/20...Employee failed to perform job duties by not supervising staff and or			

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	completing frequent rounds during shift...Specific plan for improvement...Employee will monitor/supervise staff and complete frequent rounds..."			
F0558 SS= D	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00112485. Based on observation, interview and record review the facility failed to ensure a resident's call light adapter was in reach for one (R#921) of three residents reviewed for accommodation of needs, resulting in a verbal complaint from the resident, regarding the call light adapter consistently not being within reach and the potential for delayed and/or unmet care needs. Findings include: Review of the medical record revealed R#921 was admitted into the facility on 2/25/13, with a readmission date of 8/19/20 and diagnoses that included: multiple sclerosis, quadriplegia, lack of coordination, contractures, colostomy status, and artificial openings of urinary tract. A Minimum Data set (MDS) dated 8/24/20 documented a Brief Interview for Mental Status (BIMS) score of 15 (indicating intact cognition). Impairment to both the upper and lower extremities are documented, which indicates R#921's total	F0558	Resident #921 had the call light repositioned to be within reach for use. Residents residing in the facility are at risk for a similar occurrence. In-services have been done for staff regarding call light placement within the reach of residents for use when needed. Call light placement audits will be done three times a week for one month and randomly thereafter to ensure compliance. Audits will be submitted to QAPI for review to ensure compliance. The DON and Administrator will be responsible for continued compliance.	12/21/2020

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	dependence for staff assistance with all ADL's. On 10/28/20 at 1:22 pm, an interview was conducted with R#921. The resident was observed lying on their back in bed with the sheets pulled up to their chest area. When queried if the facility staff answered the call light in a timely manner the resident responded in part " ... No, look where it's at ..." The call adapter was located on lower part of the resident's chest. The resident attempted to reach it with their chin but was unable to. The resident stated their call bell is consistently not put in their reach. On 10/29/20 at 7:44 am, the DON was queried regarding the surveyor observation and acknowledged that the resident's call light should have been in reach, for the resident to obtain staff's help. A policy titled, "Rounds, Staff" (dated 7/11/18) documented in part, " ... It is the policy of this facility to ensure the safety and comfort of the resident and to assist in continuity of care and to identify potential change in condition ... Residents will be checked by the nursing staff a minimum of every two (2) hours, Observe resident for privacy, dignity and safety, Note positioning ... & call lights are within resident's reach ..."			
F0580 SS= D	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F0580	Residents #918, #930 and #931 no longer reside in the facility. Residents residing in the facility are at risk for a similar occurrence. Nurses have been in-serviced regarding notification upon change in condition and hospital transfers to responsible party□s/Guardians to ensure compliance. Transfers and changes in condition will be	12/21/2020

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	mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00112864, MI00111404 & MI00111082. Based on interview and record review, the facility		reviewed daily to ensure that the appropriate notification is made. DON/Designee will conduct random chart reviews of 5 residents with a noted transfer to the hospital and/or change in condition to ensure appropriate notifications have been made, these audits will be conducted three times a week for 4 weeks, then monthly thereafter for 1 month or until sustained compliance has been achieved. Audits will be reviewed at weekly Ad Hoc QAPI meetings to monitor continued performance and compliance and will be submitted to monthly QAPI for further review to ensure compliance. The DON and Administrator will be responsible for continued compliance.	

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	failed to notify (three) R#918's legal guardian and the families of R#'s 930 and 931, of three residents reviewed for notification of changes, resulting in R#918's legal guardian not being notified of a stage 3 pressure ulcer timely and R#'s 930 and 931 families to not be notified of the residents being transferred to the hospital for a higher level of care. Findings include: R#918 R#918 was admitted into the facility on 12/3/15 with a readmission date of 6/2/20 and diagnoses that included: paraplegia, convulsions, hydrocephalus, hypertension, and dementia. A MDS dated 3/14/20 documented long- and short-term memory problem and required staff assistance for all ADL's. A review of the clinical record revealed the following: A "late entry" documented on 6/6/20 at 8:10 am with the "effective date" of 5/24/20 at 8:09 am documented in part, " ... CNA reported open area of resident coccyx area to writer, assess area noted open pink base with discoloration area noted, (doctor name redacted) notified and orders rec'd (received) for medihoney gel daily and prn (as needed) ..." Another late entry with a "created date: 5/29/20 13:21 (1:21 pm)" with an "Effective Date: 5/23/20 at 16:12 (4:12 pm)" completed eight days prior to the 6/6/20 note, documented the same findings as the 6/6/20 note. The Treatment Administration Record (TAR) documented Medihoney wound treatment start date as May 24th at 7 pm.			

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	The clinical record was reviewed and there was no documentation found regarding the facility notifying the resident's legal guardian of the resident's coccyx wound until 5/28/20. A Nursing note dated 5/28/20 at 2:57 pm, documented in part " ... Call placed to NP (Nurse Practitioner) order to send to the ER (Emergency Room). Spoke with sister and made aware of change of mental status. Sister states she will be into facility. Sister made aware of coccyx wound while visiting. Sister request brother be sent to (hospital name redacted) ..." This was four days after the facility identified the wound. A hospital discharge summary dated 6/2/20 at 2:41 pm, documented in part " ... Date of admission 5/28/20, Date of Discharge 6/2/20. Discharge Final Diagnosis: Infected necrotic sacral decubitus ulcer status post debridement, Multiple decubitus ulcers involving the left hip left ankle and right fifth metatarsal present on admission ... Patient had debridement of the sacral decubitus ulcer by general surgery ... infectious disease who recommended Vanco (antibiotic) and cefepime (antibiotic) for minimum of 3 to 4 weeks ..." A review of the resident's face sheet revealed (sister name redacted) documented as the legal guardian and emergency first contact. On 11/10/20 at 10:42 am, Licensed Practical Nurse (LPN) "P" was queried on why they didn't notify the resident's legal guardian of the residents wound when identifying it on 5/24/20 and LPN "P" replied that they didn't recall why the legal guardian was not notified. R#930 A complaint was submitted to the State Agency			

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	regarding the facility failing to inform family of a change in condition and transfer to the hospital for a resident. R#930 was admitted into the facility on 10/24/14 with a readmission date of 5/3/18 and diagnoses that included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type 2 diabetes mellitus, chronic kidney disease stage 4, chronic systolic congestive heart failure and hypertension. A review of the clinical record revealed the following: A "Nursing" note dated 3/27/20 at 8:30 pm, documented in part " ... Resident transferred to (hospital name redacted), resident was lethargic, BS (blood sugar) was 50 glucagon given. Oxygen saturation was 83 on 5L (liters). Resident oxygen saturation was 94 on non-breather mask at 25L. Resident continuously to <sic> desat. Notified doctor and daughter of resident condition." A review of the facility's "Nursing Home to Hospital Transfer Form" dated 3/27/20 at 8:12 pm, documented in part " ... Contact Person: (R#930's name documented), Relationship: Agent, Tel (telephone) (R#930's phone number documented), Notified of transfer? Yes, Aware of clinical situation? Yes ..." This indicated the nurse that completed the transfer form called resident #930 to inform them of their own clinical situation and transfer to the hospital, not the resident's daughter. A review of the "Clinical Patient Profile" documented the resident's daughter with her number (which is different from the number documented on the resident's transfer form) as the "Emergency 1st Contact", however the facility failed to notify the resident's family of the			

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resident's change of condition and transfer to the hospital.

On 11/2/20 at 2:58 pm, the DON was queried on why the transferring nurse documented that the resident's daughter was informed of the resident's change of condition and transfer to the hospital, yet documented that the contact person they notified of the situation was R#930. The DON stated that they would follow up. Shortly after the DON returned acknowledging that they have identified an error regarding the facility staff notifying family/emergency contacts of transfer and have started reeducating their staff.

R#931

On 11/2/20 at 9:46 am, a phone interview was conducted with the complainant, who stated in part " ... She was in the hospital over a day in a half before I knew that she was in the hospital. They (the facility) did not call me, the hospital called me ..."

Review of the clinical record revealed the following:

R#931 was admitted into the facility on 2/24/20 with diagnoses that included: Malignant neoplasm of bronchus or lung, acute respiratory failure, type 2 diabetes mellitus, paraplegia, hypertension, aphasia, and lack of coordination. A MDS dated 3/2/20 documented a BIMS of 11 (indicating moderately impaired cognition) and was dependent on facility staff assistance for ADL's.

A "Nursing" note dated 3/15/20 at 9:48 pm, documented in part " ... Resident is lethargic with chills and BP (blood pressure) 104/55, Temp (temperature) 101.4 temporal, HR (heart rate) 102, SPO2 (oxygen saturation level) 83% on

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room air, R (respirations) 26, new order to transfer to (hospital name redacted), family notified."

A "Nursing Home to Hospital Transfer Form" dated 3/15/20 at 9:31 pm, documented in part " ... Contact Person- (R#931's name documented), Relationship- Agent, Tel (R#931's telephone number documented), Notified of transfer? Yes, Aware of clinical situation? Yes ..." This indicated the nurse that completed the transfer form called resident #931 to inform them of their own clinical situation and transfer to the hospital, not the next of kin and/or emergency contacts.

A review of the "Clinical Patient Profile" documented two emergency contacts, which neither was notified of the resident's change of condition or transfer to the hospital.

On 11/2/20 at 2:58 pm, the DON was queried on why the transferring nurse documented that the resident's family was informed of the resident's change of condition and transfer to the hospital, yet documented the contact person the facility notified of the situation was R#931. The DON stated that they would follow up. Shortly after the DON returned acknowledging that they have identified an error regarding the facility staff notifying family/emergency contacts of transfer and have started reeducating their staff.

A facility policy titled "Discharge or Transfer" (updated 1/28/20) documented in part, " ... It is the policy of this facility to provide the resident with a safe organized structured transfer and or discharge from the facility to include but not limited to hospital ... keep Resident/Family involved with all discharge planning, Complete transfer/discharge form ... Document entire process in Nursing Progress Note ..."

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	A facility policy titled "Change in Condition-Reporting" (dated 7/11/18) documented in part, " ... Any sudden or serious change in a resident's condition manifested by a marked change in physical ... will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge will notify the physician. If unable to contact attending physician or alternate physician timely, notify Medical Director for follow-up to change in resident's condition. Licensed nurse will notify, consistent with the resident's authority, the resident's representative of the change of condition and what steps have been taken. All nursing actions will be documented in the licensed progress notes as soon as possible after resident needs have been met ... Resident plan of care will be updated ..."			
F0584 SS= E	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private	F0584	Residents #942 and #947 have had their rooms cleaned to ensure an appropriate safe/clean environment. Center Unit, 2 West Unit, 2 East unit rooms and hallways have been cleaned to provide a safe/clean environment. Hallway stains have been addressed and removed. Residents residing in the facility are at risk for a similar occurrence. Housekeeping Director and Housekeeping staff have been in-serviced on providing a clean environment. Housekeeping/Floor staff will focus on timely mopping of resident room floors and spotting the hallway carpet as needed for it to remain free of soiled areas. Environmental audits will be done three times a week for one month and randomly thereafter to ensure compliance. Audits will be submitted to QAPI for review to ensure compliance. The Administrator will be responsible for continued	12/21/2020

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	closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake(s): MI00109051, MI00111082, and MI00110915. Based on observation, interview, and record review, the facility failed to maintain adequate housekeeping services to maintain a clean, sanitary, homelike environment for two (R#945 and R#947) of six residents reviewed for the environment, resulting in the potential for feeling uncomfortable and dissatisfied with the living space. This has the potential to affect all residents who reside on the 2nd floor of the facility. Findings include: On 11/9/20 at 8:40 AM, the following observations were made of the 2 West Unit: The carpet on the hallway leading to the 2 West unit was heavily stained in multiple areas. The carpet outside of the lounge where multiple residents were seated in wheelchairs was covered with food crumbs, straws, and various paper food wrappers. The carpet had multiple areas with a dried brown substance. Outside of the door to the "Eagle Room" and in front of the nurses' station a very large, dark stain was observed on the carpet that extended from the door to halfway toward the wall on the other side. The hallway that housed rooms 255 through 267 had carpet that was heavily stained in multiple areas.		compliance.	

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At that time, R#947's room was observed from the hallway. A large area of dried brown liquid that resembled coffee was observed near the bathroom door and was visible from the hallway. The floor was dirty and dull and had a visible layer of dirt. Upon entry to the room, the floor was sticky when walked on and various wrappers and papers littered the floor throughout the room. A floor transition strip was observed to separate the hard flooring in the room from the carpet in the hallway. The floor along the strip was caked with dried black debris.

On 11/9/20 at 9:40 AM, the following observations were made on the 2 East unit: Tan dried liquid was observed on the wallpaper below the telephone hung on the wall in the hallway located to the right when first entering the unit. The dried tan substance was also on the molding along the floor. A brown dried substance was observed around the electrical outlet between rooms 220 and 219. The hallway on the left side of the unit was observed. A brown dried substance was observed near the door when first entering the hallway. R#945's room was observed to have black debris caked along the floor transition strip. Multiple rooms on the 2 East unit that had floor transition strips were observed to have black debris caked along the strip. Wallpaper was observed in the hallway to be strained with brown and tan dried substances. There was a large stain on the carpet in front of the double doors that separated the unit from the connecting hallway. One of the doors was splattered with a dried brown substance.

On 11/9/20 at 9:55 AM, R#947's room was observed to be in the same condition as the observation made over an hour earlier with dried coffee stains, a dirty floor, and black debris along the floor transition strip. At that time, R#947 was interviewed. When queried about the last time

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	their room was cleaned, R#947 reported they had no idea when their room was cleaned. On 11/9/20 at 10:00 AM, an interview with Housekeeping Manager "H" was conducted and observations were made on the 2nd floor. When queried about daily cleaning of the resident areas, Housekeeping Manager "H" reported the housekeeping staff began their day with "morning work" that consisted of cleaning all of the common areas, sanitizing surfaces and door handles, wiping down the nutrition carts, removing garbage, and cleaning the hallways before the food carts were brought to the units. Next, housekeeping staff would start cleaning resident rooms and bathrooms for their assigned unit. Housekeeping Manager "H" reported the department has one housekeeper for each wing per day for a total of five for the building. It was further reported that required cleaning in the resident rooms consisted of cleaning and tidying dressers, wiping off heat registers, and cleaning the floors, toilets, surfaces, call lights, and light switches. When queried about any issues the housekeeping department has identified, Housekeeping Manager "H" stated, "I found that they mop coming out of the room which is causing buildup." When queried about the process if something was spilled in a resident's room or splashed on a door or wall, Housekeeping Manager "H" stated, "Coffee splatters should be wiped up." Housekeeping Manager "H" reported the last housekeeper leaves at 4:30 PM on Sunday and then next shift comes in at 8:00 AM the following morning. There are no designated housekeeping staff in the building during that time. When queried about the stains on the carpet, Housekeeping Manager "H" reported the carpet was shampooed but there has not been approval to remove the carpet yet. The housekeeping staff schedule and any cleaning logs were requested for the past week.			

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	On 11/9/20 at 10:15 AM an interview with the Administrator was conducted. The Administrator reported they do rounds to ensure the facility is kept clean. When queried about any identified issues with cleanliness, the Administrator reported the carpet and floors needed renovation, but it is on hold due to the Coronavirus. When queried about things such as spills that appear dried and not fresh, the Administrator reported they were looking into changing the schedule to have housekeeping in the building later to clean. It was reported that any staff member can clean up spills as they occur, not just housekeeping staff. The Administrator reported they had a professional carpet cleaner address the carpet and that it was worse before. At that time, the invoice for professional carpet cleaning was requested. The invoice provided revealed the carpet had last been professionally cleaned in June 2020. At approximately 11:00 AM, Housekeeping Manager "H" provided a "Housekeeping/Laundry Master Schedule" for November 2020. The schedule revealed three housekeeping staff were scheduled on Saturday (11/7/20) and Sunday (11/8/20) for the whole building. Two of the housekeepers left at 3:00 PM on Sunday and one was scheduled until 4:00 PM. The schedule documented that the building typically had five housekeeping staff on the weekdays and there were never more than four housekeeping staff scheduled on the weekends. "Housekeeping Rounds Audit Tools" were provided for the dates of 11/2/20 through 11/6/20. At approximately 1:00PM, Housekeeping Manager "H" was interviewed, and the schedule and audit tools were reviewed. It was reported by Housekeeping Manager "H" that there are not enough staff to schedule the same on weekends as weekdays. After reviewing the schedule,			

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	Housekeeping Manager "H" reported there were only three housekeeping staff who worked on Saturday or Sunday which was probably why R#947's room remained dirty. Housekeeping Manager "H" explained that the Audit Tools were completed by each housekeeping staff on every shift they work to note what they completed and is there were any issues. Housekeeping Manager "H" reported they did not receive the audit tools from the weekend yet. The following was documented on the audit tools: On 11/2/20, Center Unit, "Floors are always sticking <sic>." On 11/2/20, 2 West Unit, "When returning to my shift, the floors look as if they've not been cleaned due to the residents dropping, throwing etc. etc. ..." On 11/2/20, 2 East Unit, in the section for floors, "Every day needs clean." On 11/3/20, 2 East Unit, in the section for floors, "spills every day". On 11/4/20, 2 East Unit, in the section for work orders for heavy floor care, "Rooms are very (sticky)." On 11/5/20, 2 East Unit, "Floors are stickey <sic>." On 11/6/20, Unit 2, "Roomes <sic> are staceky <sic> daily." A facility policy titled, "Physical Environment - Floors" dated 7/11/2018 was reviewed and documented, "Floors shall be maintained in a clean, safe, and sanitary manner...All floors shall be mopped/cleaned/vacuumed daily..." A policy			

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	regarding general housekeeping was requested, but not received prior to the end of the survey.			
F0609 SS= D	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00114307, MI00111435 and MI00111382. Based on observation, interview, and record review, the facility failed to report allegations of abuse and misappropriation of property to the	F0609	The incident involving resident #910 was not reported within the two-hour limit due to not being reported timely by staff to the Administrator, incident was ultimately reported to the state. Resident #929 no longer resides in the facility. Residents residing in the facility are at risk for a similar occurrence, any new allegations will be reported for similar residents according to reporting requirements. Facility staff have been in-serviced regarding reporting time requirements for allegations requiring reporting to state agencies or law enforcement to ensure compliance. Administrator/Designee will conduct random audits of 5 allegations of abuse/neglect/misappropriation within the building ensuring timely reporting to the abuse coordinator, these audits will be conducted three times a week for 4 weeks, then monthly thereafter for 3 months or until sustained compliance has been achieved; additionally, five staff members will be interviewed weekly for one month and randomly thereafter until compliance is achieved regarding timely reporting of allegations. Audits on timely allegation reporting will be done for timeliness for one month and randomly thereafter for 3 months to ensure compliance. Audits will be reviewed at weekly Ad Hoc QAPI meetings to monitor continued performance and compliance and will be submitted to monthly QAPI for further review to ensure compliance. The DON and Administrator will be responsible for continued	12/21/2020

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	Administrator and/or the State Agency as required for two (R#910 and R#929) of 19 residents reviewed for abuse, resulting in the potential for unidentified abuse and misappropriation of property. Findings include: R#910 A Facility Reported Incident (FRI) submitted to the State Agency documented R#910 alleged a staff member put a pillow on her face. On 10/29/20 at 2:30 PM, an investigation file provided by the facility was reviewed and revealed the following: An investigation summary signed by the Administrator and Director of Nursing (DON) documented on 8/16/20, R#910 reported someone put a pillow on her face, did not know who it was, and did not exhibit any signs of physical or emotional harm, felt safe and was not fearful. The summary documented the allegation was reported to the State Agency on 8/17/20 at 3:47 PM (the day after the allegation was made by the resident). The incident summary documented, "On Sunday, August 16, 2020 at approximately 5pm Nurse (Nurse "X") who was assigned to the unit both Saturday and Sunday was called to the resident's room with daughter present. (R#910) stated someone had put a pillow over her head the previous day (August 15, 2020) approximately 9pm. At that time, CNA (Certified Nursing Assistant "R") entered the room to provide her meal tray. When she was leaving (R#910) pointed at (CNA "R") and stated to the nurse and her daughter 'that's her'. The nurse immediately notified the supervisor, DON, Administrator, and physician. A skin assessment was completed with no concerns. (R#910) assessed by supervisor (Nurse "T")...upon entering room patient was crying saying 'I don't know why my daughter put		compliance.	

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	me in here...why do I have to be the one sick...I don't want to get anyone in trouble."...CNA ("R") suspended and sent home upon investigation...Other residents queried...No concerns expressed...CNA (CNA "BB") said when she walked in the room to talk to the nurse she overheard the resident tell her daughter that an aide put a pillow over her head. (CNA "BB") and (CNA "R") were the assigned CNAs Saturday and Sunday afternoon shift. Monday 8/17 DON and Admin (Administrator) interviewed resident who said to call the daughter and said she felt safe. (R#910) spoke with NP (Nurse Practitioner) from psych and said someone placed a pillow over her face...(CNA "R") on Saturday 8/15 heard (R#910) crying...said someone put a pillow over her head ...stated it was a male...no male was scheduled...allegation of abuse against (CNA "R") unsubstantiated due to conflicting information...Signed by Admin and DON on 8/20/20. On 10/29/20 at 2:45 PM, R#910 was observed lying in bed. R#910 was interviewed at that time. When queried about any concerns she had in the past with staff, R#910 reported a "woman put a pillow on my face". R#910 reported feeling safe and that the staff member did not provide care for her any longer. On 11/2/20 at 9:15 AM, Nurse "X" was interviewed via the telephone. When queried about the allegation made by R#910, Nurse "X" reported R#910 told her and her daughter that CNA "R" put a pillow on her face. Nurse "X" stated, "I don't' think it was intentional and I was shocked when she pointed (CNA "R") out." Nurse "X" reported they notified the DON and the nurse manager of the allegation. On 11/2/20 at 2:00 PM, the DON was interviewed. When queried about the facility's			

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protocol when a resident alleged abuse by a staff member, the DON reported that staff were to notify the Administrator immediately and staff would be suspended pending the investigation. The DON reported the Administrator was the person responsible for reporting abuse to the State Agency. When queried about the allegation made by R#910 on 8/16/20, the DON reported it was reported to both the DON and the Administrator via telephone by Nurse "X" on 8/16/20. The DON reported the alleged incident occurred the day before on 8/15/20 but was not discovered until 8/16/20. The DON further reported CNA "R" was the first staff member that R#910 reported the allegation to on 8/15/20 and they should have reported it to the Administrator at that time.

On 11/2/20 at 3:15 PM, the Administrator (who was identified as the facility's Abuse Coordinator) was interviewed. The Administrator reported all allegations of abuse were reported to the State Agency within two hours and staff were required to report all allegations to him immediately. When queried about when CNA "R" should have contacted the Administrator regarding the allegation made by R#910, the Administrator reported they should have notified him immediately on 8/15/20. When queried about why the Administrator did not report the allegation of abuse made by R#910 until 8/17/20, they acknowledged that it should have been reported within two hours.

R#929

On 11/4/20 the medical record for R#929 was reviewed and revealed the following: R#929 was initially admitted to the facility on 10/25/2019 and had diagnoses including Paraplegia and Lack of Coordination. R#9292's MDS (Minimum Data Set) with an

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	ARD (Assessment Reference Date) of 5/3/2020 revealed R#929 needed extensive assistance from facility staff with most of their activities of daily living. R#929's BIMS score (brief interview on mental status) was 15 indicating intact cognition. On 11/4/20 at approximately 1:46 p.m., R#929 was contacted by phone regarding allegation of money being stolen. R#929 indicated that they had their money in a pillow and that they woke up one day and it was gone. R#929 indicated that they "know someone who worked there [at the facility] took the rest of it and their wallet. A "Grievance and Satisfaction Form" dated 5/27/20 was reviewed and revealed the following: "Name-[R#929]...Describe grievance or satisfaction-[R#292], reports to staff and writer that he is missing $1600.00 including his wallet with bank cards and credit cards inside. [R#929] states that the money and wallet was tied in a plastic bag and placed under his pillow. Money and wallet was tied in a plastic bag and placed under his pillow. Money and wallet last seen on memorial day 5-25-20. While taking this statement patient change the dollar amount and states 'I'm missing 1580.00. with my wallet, credit card and bank card.''...Administrator Notification...Date Administrator Received 5/27/20...Administrator Assigned to: NHA (Nursing Home Administrator)/ DON (Director of Nursing)/ Hskp (housekeeping)-			

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	Laundry...Investigation-[R#929] was offered a lock box or the option of putting his belongings (valuables) in a safe which he declined. On 5/26/2020 NHA was brought $250.00 (2-100, 1-50) which was found in the laundry (no missing money was reported) and was secured in office. On 5/27/20 a 100 dollar bill was brought to the NHA which was found in the laundry. On 5/27/20 it was reported that [R#929] reported 1600 in cash and a Gucci wallet missing, no other money was reported missing in the bldg (building). [R#929] reported that the money was being kept in his pillowcase for safe keeping. Review of the circumstances revealed a very high probability that the money and wallet went to the laundry with a bed change and went through washer and dryer. At this time only 350.00 has been recovered. Laundry employees continue to search for additional bills and the wallet and linen is sorted and folded. Lint traps and drains were searched without success..." On 11/4/20 at approximately 1:54 p.m., during a conversation with the facility Administrator, when queried regarding R#929's money, the Administrator indicated that R#929 said someone stole their money and that R#929 indicated the amount was $1580. The Administrator reported only $350.00 was found in the laundry, not including R#929's wallet. The Administrator further indicated that they called the police on behalf of R#929 but that they did not report to the allegation to the state agency.			

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	The Administrator was queried why they didn't report the allegation to the State Agency, and they indicated that they had found some of the money in the laundry, so they didn't report it. A facility policy titled, "Abuse and Neglect", revised on 6/17/19 was reviewed and it documented the following: " ...All allegations and/or suspicions of abuse/neglect must be immediately reported to the facility Administrator or designee in the absence of the administrator. Failure of an employee to report an allegation and/or suspicion of abuse will result in disciplinary action ...The abuse coordinator must submit a preliminary investigation report to the appropriate State Agencies immediately once assurances for the resident's or other resident's safety have been established. However, if the event that caused the allegation involved abuse or resulted in serious bodily injury, the allegation of abuse must be reported to appropriate state agencies immediately and not later than 2 hours after receiving the allegation of abuse ..."			
F0645 SS= D	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined	F0645	Resident #907 no longer resides in the facility. Residents residing in the facility are at risk for a similar occurrence. Status of PASSARRs has been determined for current residents and updates are being completed as needed.	12/21/2020

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	in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k) (2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to		Facility Social Workers have been in-serviced on timely PASSARR referrals so as not to delay transfers to other facilities in addition to preadmission screening for individuals with mental disorders and intellectual disability to ensure compliance. New residents admitting will have their PASSARRs reviewed for completeness and to determine if any follow-up is required. Social Services Director/Designee will conduct random chart reviews of 5 residents to ensure timely evaluations are completed on residents as not to delay transfer, these audits will be conducted three times a week for 4 weeks, then monthly thereafter for 1 month or until sustained compliance has been achieved. Audits of PASSARRs will be done on admission for one month and randomly thereafter to ensure compliance. Audits will be reviewed at weekly Ad Hoc QAPI meetings to monitor continued performance and compliance and will be submitted to monthly QAPI for further review to ensure compliance. The DON and Administrator will be responsible for continued compliance.	

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	require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00114764. Based on interview and record review the facility failed to ensure a referral was made for a level II evaluation (a comprehensive evaluation completed by the local community mental health agency) in a timely manner for one resident (R#907) of three residents reviewed for PASARR (Preadmission Screening/Annual Resident Review) screenings, resulting in the delay of transfer to another facility and the potential for R#907 to not receive specialized mental health services. Findings include: On 10/27/20, review of an allegation submitted to the state agency indicated there was a delay in having a level II evaluation completed for R#907 which resulted in R#907 having to wait to be transferred to another nursing facility until the receiving facility was provided a copy of the level II evaluation.			

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	On 10/28/20 the medical record for R#907 was reviewed and revealed the following: R#907 was initially admitted to the facility on 4/29/19 and had diagnoses which included: generalized anxiety disorder and major depressive disorder. A review of R#907's Minimum Data Set (MDS assessment with an Assessment Reference Date (ARD) of 8/6/19 revealed R#907 needed extensive assistance from facility staff with most of their activities of daily living. R#907's BIMS score (brief interview of mental status) was 15 which indicated intact cognition. A Social Services note dated 9/19/2019 documented, "Res.'s (resident) son contacted writer regarding Level II screening from [local Community Mental Health Services Program] (CMHSP), and the delay for the screening. Writer informed son, [CMHSP]was contacted on 9/18 on status of screening and was told that res. is on the list and after screening, there will be a 7-10 day delay on documentation. Son became very irate and requested the phone number to [CMHSP]; writer provided this to son." A review of R#907's admission Level I PASARR screening (unsigned and undated) revealed R#907 had depression, was taking Zoloft (antidepressant medication) prior to hospitalization and was taking Ativan (antianxiety medication) at the hospital. In addition, R#907 had multiple boxes on their level 1 screening checked "yes" indicating that R#907 required a referral to the CMHSP.			

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	A review of the accompanying 3878 (exemption criteria form) for R#907 dated 4/26/19 indicated that R#907 was marked as a hospital exempted discharge without any further exemption criteria marked. Further review of R#907's medical record only revealed one level II evaluation that had a referral date of 9/23/19 and a completion date of 9/27/19. On 10/28/20 at approximately 1:48 p.m., during a phone conversation with the CMHSP-PASARR Administrator "Z" (CMHSPA "Z"), CMHSPA "Z" was queried if a referral for a level II evaluation had been received prior to the referral made in September 2019 and they indicated that no prior referral for a level II evaluation was received for R#907. At that time, R#907's admission level 1 screening along with their 3878 was reviewed with the CMHSPA and they indicated that a referral for a level II evaluation should have been made by the facility within 30 days of admission and confirmed this was not done. On 10/28/20 at approximately 2:16 p.m., during a conversation with social worker "A" (SW "A"), SW "A" was queried regarding R#907's level II evaluation. SW "A" indicated that R#907 did not have a referral made or a level II completed until September 2019. SW "A" was queried if they had any evidence a referral was made for a level II evaluation prior to September 2019 and they indicated they had not. R#907's level I screening and form 3878 was reviewed with SW "A" and			

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	they indicated that R#907 should have been referred for a level II evaluation in May 2019 prior to 30 days after their admission. A facility document titled "Pre-admission screening Annual resident review (PASRR) (undated) was reviewed and revealed the following: "Policy-The intent of this policy is to ensure that residents receive necessary mental health rehabilitative services for mental illness and mental retardation as determined by the Preadmission Screening, Annual Resident Review (PASRR), comprehensive assessment and care plan, to prevent avoidable physical and mental deterioration and to assist them in obtaining or maintaining their highest practicable level of functional and psychosocial well-being...The facility shall be responsible for...4. The facility must coordinate assessments with the Preadmission Screening and Resident Review Program to avoid duplicative testing and effort..." A review of the PASARR level 1 screening (form 3877) revealed the following: "The person screened shall be determined to require a comprehensive Level II OBRA (Omnibus Budget Reconciliation Act) evaluation if any of the above items are "Yes" UNLESS a physician, nurse practitioner or physician's assistant certifies on form DCH-3878 that the person meets at least one of the exemption criteria...DISTRIBUTION: If any answer to items 1 - 6 in SECTION II is "Yes", send ONE copy to the local Community			

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	Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative..."			
F0656 SS= D	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must	F0656	Residents #903 and #916 no longer reside in the facility. Residents residing in the facility are at risk for a similar occurrence. Residents on antibiotics have had their care plans reviewed and updated to reflect current needs. Residents who show signs of aggression will be care planned to meet their needs and referred to psych services to be followed. Nurses and MDS staff will be in-serviced on the development and update to current care plans to accurately reflect the resident□s current needs upon admission. Audits of admission care plans will be done for timeliness for one month and randomly thereafter to ensure compliance. Audits will be reviewed at weekly Ad Hoc QAPI meetings to monitor continued performance and compliance and will be submitted to monthly QAPI for further review to ensure compliance. The DON and Administrator will be responsible for continued compliance.	12/21/2020

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document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:

This citation pertains to intake(s): MI0014706, MI00114975, MI00115261.

Based on interview and record review, the facility failed to develop and/or implement timely individualized care plans for two R#903 (aggressive/combative behaviors) and R#916 (Urinary Tract Infection - UTI) of two residents reviewed for care plans, resulting in a resident with a known history of combative behaviors (R#903) to have three resident to resident physical altercations with R#'s 904, 906 and 908 and the potential to have a physical altercation with all of the residents that resided in the facility at that time and failing to develop and implement interventions to identify risks/problems associated with a UTI (R#916). Findings Include:

R#903

R#903 was admitted into the facility on 9/1/20 with diagnoses that included: Fracture of upper and lower end of right fibula, cognitive communication deficit, bipolar disorder, autistic disorder, and down syndrome. A Minimum Data Set (MDS) dated 9/7/20 documented a Brief Interview for Mental Status (BIMS) as not completed (Interview not conducted) "resident is rarely/never understood" and was dependent on staff assistance for all Activities of Daily Living

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(ADL's).

Review of the clinical record revealed the following:

A "Nursing" note dated 9/11/20 at 5:34 am documented in part, " ... Resident slept at short intervals during the night. Resident was running through the hallways, going into other residents' rooms, throwing a wastebasket in the hallway and made several attempts to open alarmed door on unit ... This writer was unable to obtain residents VS (vital signs) due to resident attempting to hit this writer ..."

A "Nursing" note dated 9/13/20 at 7:09 am documented in part, " ... Resident slept at short intervals during the night. Resident was running through the hallway, into other residents' rooms, and throwing the furniture around in his room."

On 9/13/20 a facility investigation report documented the following in part, " ... at approximately 12 am (nurse initial redacted) went to go answer the call light in (R#908's name redacted) room when she observed (R#903 initials redacted) leaving R#908's room ... R908 stated "he hit me" ... queried where she had been hit and R#908 pointed to her left upper chest ..."

R#908 was admitted into the facility on 5/19/20 with a readmission date of 6/25/20 and diagnoses that included: Infection of amputation stump (right lower extremity), chronic kidney disease stage 3 and dementia. A MDS dated 8/24/20 documented a BIMS of 04 (indicating severely impaired cognition) and required assistance from staff for all ADL care.

On 9/26/20 a facility investigation report documented in part, " ... R#903 quickly jumped out of the wheelchair and slapped (R#906 initials

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redacted) with <sic> open hand on left side of face ..." On 11/4/20 at 8:14 am, Licensed Practical Nurse (LPN) "II" was queried regarding the above incident and stated in part, " ... She (R#906) said he hit me. I wasn't prepared but next time, I'll be ready ..."

R#906 was admitted into the facility on 2/14/19 and readmitted on 4/1/20 with diagnoses that included: Dementia and Parkinson's disease. A MDS assessment documented a BIMS of 00 (indicating severely impaired cognition) and required staff assistance for all ADL's.

On 10/6/20 a facility investigation report documented the following in part, " ... at approximately 4:30 pm ... (Nurse initials redacted) stated (R#903) ran past him and into (R#904's initials redacted) room ... stated (R#903) quickly struck R#904 in the back and neck ..."

R#904 was admitted into the facility on 9/24/20 with a readmission date of 10/2/20 and diagnoses that included: hypotension, dementia, lack of coordination and tremor.

A review of R#903's preadmission packet that the facility received documented the following in part, " ... Date 8/31 ... Patient has down syndrome and is non-verbal. He has episodes of combative behaviors ... Assessment & Plan- Bipolar disorder, current episode depressed, severe, with psychotic features ..." This indicates that the facility was well aware of the resident's episodes of combative behaviors when they reviewed the referral packet before the resident's admission into the facility.

A care plan titled "Resident is/has potential to be aggressive r/t (related to) Poor impulse control likely to present as side effect of communication and/ or coping barrier. Resident had actual

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	resident/resident altercations and continues to be at risk ..." (created on 9/18/20) this care plan was implemented 17 days after the resident's admission into the facility. The facility failed to plan, educate and implement safety interventions to protect R#'s 904, 906 and 908 and the potential to affect other residents residing at the facility. The delay in implementing a care plan for R#903's aggressive/combative behaviors failed to inform, prepare, and implement effective interventions for the front-line staff (nurses and aides) to manage the resident's behaviors. On 11/2/20 the Director of Nursing (DON) was queried on why the facility accepted R#903 if the facility was unable to ensure adequate supervision for R#903 and ensure the safety of other residents at the facility. The DON replied in part, " ... Central Intake accepted the admission..." the DON then stated that the facility was unable to review the referral packet until the resident was already in the building. On 11/4/20 at 11:16 am, the DON and Administrator was queried on R#903's care plan and why the care plan wasn't implemented upon admission and/or after the facility staff identified behaviors with the resident on 9/11/20, which failed to educate their staff on the resident's behaviors, implement interventions to manage the behaviors and failed to implement interventions to ensure the safety of the other resident's residing in the facility at that time. The DON stated they would look into it. The DON was also queried on why the care plan was not modified after R#'s 906 and 903 was hit and replied in part, "... We did all that we could do..." At 12:14 pm, the DON returned and stated in part, " ... The Social Worker should have implemented a baseline behavior care plan." At that time, the request was made to the DON for the facility's Social Worker. The facility social worker failed to interview with the surveyor by the end of survey.			

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R#916

R#916 was admitted into the facility on 5/13/20 with diagnoses that included: type 2 diabetes mellitus, hemiplegia and hemiparesis affecting the left non-dominant side, dysphagia, difficulty walking, hypertension, and legal blindness. A MDS assessment dated 5/20/20 documented a BIMS score of 12, indicating moderately impaired cognition and required staff assistance for all ADL's.

A review of the clinical record revealed the following:

A physician note dated 6/10/20 at 5:30 pm, documented in part " ... UTI (Urinary Tract Infection) ... WBC (white blood Cell) elevated to 28.0. + uti, culture + sensitivity pending ... running 0.9% NS at 75ml/hr. Has received first 2 doses of Cefeprime and Vanco (both antibiotics) ..."

A "Nursing" note dated 6/15/20 at 6:29 pm, documented in part " ... Resident observed on the floor on her left side. Nurse writer performed skin assessment and ROM (range of motion) was completed without any pain ... NP (Nurse Practitioner) ordered neurochecks ..."

A "Nursing" note dated 6/24/20 at 12:16 pm, documented in part " ... Writer was called into pt. (patient) room by housekeeper. Pt was observed laying on left <sic> next to bed and tray table. Pt. states "I was trying to reach for the phone and I rolled out of bed". Neuro checks started; Blood pressure was low at 79/50 ... PRN (as needed) Norco given for generalized pain ..."

R#916 care plans were reviewed and revealed no care plan implemented for a Urinary Tract

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	Infection. The facility failed to implement individualized interventions for staff to monitor for the risks and/or complications associated with a UTI. Review of the medical record revealed, "ED (emergency department) to Hosp (hospital)-Admission consultation dated 6/24/20 at 11:28 pm, documented in part " ... Disposition: Admission, Final Impression: Severe Sepsis 2/2 (secondary to) urinary tract infection ..." On 11/9/20 at 1:30 pm, the Director of Nursing (DON) was queried on the absence of a UTI care plan for the resident and stated they would look into it. At 2:20 pm, the DON confirmed that they could not find a UTI care plan for the resident. A facility policy titled "Care Planning- Baseline" (dated 7/11/18) was reviewed and documented in part, " ... It is the policy of this facility that a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission ... To assure that the resident's immediate care needs are met and maintained ... The Interdisciplinary Team will review the healthcare practitioner's orders ... and implement a baseline care plan to meet the resident's immediate care needs ..."			
F0677 SS= D	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F0677	Resident #914□s toenails were clipped on 11/9/2020 by the treatment nurse. Residents residing in the facility are at risk for a similar occurrence. A full house sweep of resident toenails will be done to identify residents in need of toenail care. The facility is contracting with a podiatry group that has the resources to provide services to the facility. Nurses have been in-serviced to	12/21/2020

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	This citation pertains to intake #MI00113509 Based on observation, interview and record review the facility failed to ensure activities of daily living (ADL's) were consistently provided for one resident (R#914) resulting in curling/elongated toenails. Findings include: On 11/9/20 at approximately 9:38 a.m., R#914 was observed in their room lying in their bed. R#914 was queried if they have had their toenails clipped recently and they indicated they had not. R#914 reported the staff do not cut them because they (the staff) wanted a Podiatrist to do the work but no Podiatrist had been in to see them. R#914 indicated they did not have diabetes so they were unsure why the Nurse or the CNA (certified nursing assistant) could not cut them. R#914's toenails were then observed to be elongated and curling on both of R#914's feet. On 11/9/20 the medical record of R#914 was reviewed and revealed the following: R#914 was last admitted to the facility on 2/19/20 and had diagnoses which included: chronic kidney disease and osteoarthritis. R#914's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 9/30/20 revealed R#914 needed extensive assistance with most of their activities of daily living. R#914's BIMS score (brief interview on mental status) was 15, which indicated intact cognition.		notify Social Work of residents in need of podiatry care and to notify nursing administration of residents with difficult to cut toenails to ensure timely ADL care when requested, outside appointments will be made if the facility is unable to provide the service within the facility. Audits of toenail care will be done for timeliness for one month and randomly for 3 months thereafter to ensure compliance. Audits will be reviewed at weekly Ad Hoc QAPI meetings to monitor continued performance and compliance and will be submitted to monthly QAPI for further review to ensure compliance. The DON and Administrator will be responsible for continued compliance.	

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A Physician's order dated 3/3/20 read, "consult social work for podiatry visit for toenail clipping."

A review of R#914's careplan revealed the following: "Focus-The resident has an ADL self-care performance deficit r/t (related to) lymphedema, morbid obesity...Goal-The resident will receive the necessary staff assistance to ADL tasks are completed thru next review..."

On 11/9/20 at approximately 8:56 a.m., during a conversation with Social Worker "A" (SW"A"), when queried if R#914 had any podiatry consultation since March 2020, SW "A" reviewed R#914's record and indicated that R#914 has not been seen by podiatry. R#914 indicated that Podiatry services have not been into the building since the pandemic started and that if someone needed services, they should have been sent out to receive them.

On 11/9/20 at approximately 10:04 a.m., during a conversation with the Director of Nursing (DON), when queried why R#914's toe nails had not been clipped and if R#914 needed Podiatry services to clip their nails or staff in the facility could perform the task, the DON indicated that staff in the facility could do it and that they would have the wound care nurse cut them that day. The DON was queried why regular clipping of R#914's nails had not occurred and they indicated that the wound care nurse had recently started

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	working there a few months ago and that podiatry services had not been in the facility. A facility document titled "Nursing Administration-Care and Treatment (Rounds, Staff)" adopted 7/11/2018 was reviewed and revealed the following: "Policy:-It is the policy of this facility to ensure that safety and comfort of the resident and to assist in continuity of care and to identify potential change in condition...4. Observe grooming and dressing, hair combed (men and women) oral care and lack of order..." A second facility document titled "Policy and Procedures-Ancillary Services" adopted 7/11/2018 revealed the following: "Policy-The facility will provided any ancillary services it offers through affiliated or related companies in accordance with all statutes, regulations and standards of professional practices applicable to such services..."			
F0686 SS= H	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and	F0686	Residents #918, #913, #919, #916, 935, and #909 no longer reside in the facility. Residents residing in the facility are at risk for a similar occurrence. Skin checks will be done weekly, wound nurse completed wound rounds on 12/15/2020 on residing residents with wounds to ensure intervention were in place to prevent worsening of wounds and timely application of treatments. The facility has developed and implemented a comprehensive wound care program which is overseen by an accredited wound care nurse. Skin care assessments are done upon	12/21/2020

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	prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: This citation pertains to intake(s): MI00114536, MI00112689, MI00110981, MI00113533, MI00112535, MI00112864 & MI00112981. Based on interview and record review, the facility failed to consistently complete weekly skin assessments, identify and report worsening of a wound, implement timely treatments and/or consistently complete treatments, consistently turn and reposition and maintain an effective wound vac for six residents (R#'s 909, 913, 916, 918, 919 & 935) of seven residents reviewed for pressure ulcers, resulting in the worsening of wounds (R#'s 909, 913, 916, 918 & 919) , a defective wound vac (R#935), resident (R#916) that entered the facility with no pressure ulcers, to have developed a stage III (within 42 days of admission) and for R#918 who required hospitalization and surgical debridement for an infected necrotic sacral ulcer (that developed within 4 days from the facility first identifying the wound). Findings include: R#918 On 10/29/20 at 11:55 am, an interview with the complainant revealed the following in part, " ... they didn't notice that he had a sore on his bottom ... the wounds are badly infected ... his wounds is still really bad ... the facility kept saying they were understaffed ..." A review of the clinical record revealed the following: R#918 was admitted into the facility on 12/3/15 with a readmission date of 6/2/20 and diagnoses		admission, appropriate treatments and sleep surfaces are initiated at that time if appropriate by a licensed nurse along with notification to wound care nurse. Residents are followed through resolution of treatment to ensure compliance. Audits of skin assessments and treatment orders will be done for timeliness for one month and randomly for 3 months thereafter to ensure compliance Audits will be reviewed at weekly Ad Hoc QAPI meetings to monitor continued performance and compliance and will be submitted to monthly QAPI for further review to ensure compliance. The DON and Administrator will be responsible for continued compliance.	

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	that included: paraplegia, convulsions, hydrocephalus, hypertension, and dementia. A Minimum Data Set (MDS) dated 3/14/20 documented long- and short-term memory problems and required staff assistance for all Activities of Daily Living (ADL's). A "late entry" documented on 6/6/20 at 8:10 am with the "effective date" of 5/24/20 at 8:09 am documented in part, " ... CNA (Certified Nursing Assistant) reported open area of resident coccyx area to writer, assess area noted open pink base with discoloration area noted, (doctor name redacted) notified and orders rec'd (received) for medihoney gel daily and prn (as needed) ..." Another late entry with a "created date: 5/29/20 at 1:21 pm, with an "Effective Date: 5/23/20 at 4:12 pm" completed eight days prior to the 6/6/20 note, documented the same findings as the 6/6/20 note. The Treatment Administration Record (TAR) documented Medihoney wound treatment start date as May 24th at 7 pm. This entry was crossed out by the writer. Review of the weekly skin assessments revealed the following: 5/2/20 Appearance of skin- normal, temperature of skin- warm, skin turgor- normal, Patient has NEW alteration in skin integrity? Including open areas of any type, bruising, red areas, rashes, etc.- No. Further review revealed no documentation of alterations in skin integrity noted for this assessment. 5/9/20 Appearance of skin- normal, temperature of skin- warm, skin turgor- normal, Patient has NEW alteration in skin integrity? Including open areas of any type, bruising, red areas, rashes, etc.- Yes. "Right 5th toe digit - open area, mushy heels".			

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The facility failed to complete 5/16/20 & 5/23/20 Weekly skin assessments.

A care plan titled "The resident has st (stage) 4 pressure ulcer to sacrum r/t (related to) Immobility" this care plan was Initiated and Created on 6/3/20, 10 days after being identified by the facility staff.

The clinical record was reviewed and revealed no documentation or interventions implemented by the facility's Interdisciplinary Team (IDT).

A wound consultation dated 5/26/20, documented the wound physician assessing the resident's right heel, right 5th toe and left ankle. The coccyx was not assessed at this consultation, indicating staff failed to notify the wound doctor of the resident's coccyx wound. The clinical record was reviewed and there was no documentation found of notification to the wound doctor until the initial consultation on 6/9/20. The facility failed to have the resident's coccyx wound assessed in a timely manner.

A review of the "Bed Mobility" (turning and positioning) documentation sheets revealed the facility failed to complete the tasks on the following shifts:

April 2020: Night shift- 2nd, 3rd, 6th, 9th & 10th, Evening shift- 13th, 17th and 24th, Day shift- 18th and 26th.

May 2020: Night shift- 6th, 10th, Evening shift- 4th, 5th, 14th, 18th, 19th, 21st, 27th, 28th, Day shift- 13th, 22nd, 27th.

On 5/28/20 a transfer form was completed to send the resident to the hospital for "alerted <sic> mental status". The transfer form documentation failed to identify and inform the hospital staff of

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the resident's coccyx wound at the time of the transfer.

A "Debridement of Sacral Decubitus Ulcer - Operative Note" dated 6/2/20 at 9:19 am documented in part, " ... Left sacral decubitus ulcer, stage 4 ... Left sacral wound debridement ... Findings: Left sacral decubitus ulcer, stage 4, 10 cm x 7 cm x 4 cm (L x W x D) ..."

A hospital discharge summary dated 6/2/20 at 2:41 pm, documented in part " ... Date of admission 5/28/20, Date of Discharge 6/2/20. Discharge Final Diagnosis: Infected necrotic sacral decubitus ulcer status post debridement, Multiple decubitus ulcers involving the left hip left ankle and right fifth metatarsal present on admission ... Patient had debridement of the sacral decubitus ulcer by general surgery ... infectious disease who recommended Vanco (antibiotic) and cefepime (antibiotic) for minimum of 3 to 4 weeks ..."

On 10/29/20 at 12:39 pm the Director of Nursing (DON) was queried on the missing skin assessments, shower sheets, delay in identifying pressure ulcer, delay in identifying worsening of wound, delay in wound assessment by the wound physician, delayed implementation of sacral/coccyx care plan and why the IDT (risk management, dietician etc.) failed to implement further interventions for R#918. The DON requested time to look into the questions. At 1:13 pm, the DON stated the facility identified major concerns with wounds and implemented a wound nurse who is now consistently assessing the wounds, showers are back on scheduled board, skin assessments are being completed during showers and the facility completed extensive additional education and training with their staff. The DON stated that the concerns have been discussed at their QAPI (Quality Assurance

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Performance Improvement) meetings and the facility have identified a huge improvement overall. The DON confirmed the facility could not provide any additional information or documentation for R#918 regarding the facility's deficient practices for the resident's wound.

On 10/29/20 at 2:17 pm, the Wound Care Coordinator (WCC) "G" was queried regarding the concerns noted for R#918's wound and stated they were recently hired and was not employed by the facility during the time of the resident's care.

On 11/10/20 at 10:42 am, Licensed Practical Nurse (LPN) "P", the nurse that documented the late entry that first identified the resident's wound was queried on their late entries, why a wound consult was not completed after identifying the wound and LPN "P" replied that they didn't remember why the late entry was documented twice on two different days and why the wound consult was not completed for the wound doctor to assess on 5/26/20. When asked, who they notified of the resident's wound, LPN "P" stated in part, " ... I notified (unit manager "D" name redacted) the unit manager ..."

On 11/10/20 at 11:35 am, Unit Manager (UM) "D" was queried on being notified by LPN "P" regarding the resident's coccyx/sacral wound and UM "D" replied that they were not notified by LPN "P" of the residents wound when it was first identified.

R#913

On 10/29/20 at 8:52 am, a phone call interview with the complainant revealed the following in part, " ... she was septic from an ulcerated wound and had to be put on hospice ..."

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	Review of the medical record revealed the following: R#913 was admitted into the facility on 6/24/20 with diagnoses that included: encounter for surgical aftercare following surgery on the digestive system, colostomy status and dysphagia. A MDS dated 6/27/20 documented a BIMS score of 15 (indicating intact cognition) and was dependent on staff for all ADL's. A "Nursing Admission Screening/History" dated 6/24/20 documented in part, " ... Skin, Sacrum, Pressure ..." the nurse failed to document the length, width, depth, and stage of the pressure ulcer. A review of the preadmission paperwork from the discharging hospital revealed the following (dated 6/24/20), " ... Instructions ... Sacral wound: Allevyn silicone boarded foam dressing. Cleanse wound with normal saline, keep area clean and dry. Reposition patient every 2 hours ..." The admission (June 2020) Treatment Administration Record (TAR) revealed the following order in part, " ... Sacrum wound care every day and night shift, Cleanse with NS (normal saline). Pack wet to dry dressing cover with DD (dry dressing)" This order was not the recommended order documented on the hospital discharge paperwork for the resident's sacrum wound, however this order was documented on the resident's discharge paperwork as the recommended treatment for the resident's wound care of their "midline abdominal incision". A review of the clinical record revealed no weekly skin assessments documented on the resident's sacrum wound. The facility failed to complete two weekly skin assessments for this resident.			

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A "Wound Consultation" dated 6/30/20 documented in part, " ... Initial consult ... coccyx wound, 7.5 x 6.5, neurotic, unstageable ... Santyl to coccyx QD (every day) ..."

A "Wound Consultation" dated 7/7/20 documented in part, " ... Coccyx ulcer, 8.0 x 7.5 ..." A review of the clinical record revealed no identification from the facility staff of worsening of the wound or notification to the physician of the wound worsening.

On 7/9/20 at 10:27 am, a nursing note documented the resident being transferred to the hospital for a blood transfusion.

The clinical record was reviewed and the last vital set (temperature, heart rate, blood pressure, respiration, and oxygen saturation levels) were taken on 7/8/20. There were no documented vital signs for 7/9/20.

A review of the hospital records for 7/9/20 admission revealed the following in part, " ... Pt (patient) brought in by EMS (Emergency Medical Services) ... rapid heart rate. Pt was initially sent in by facility for low hgb (hemoglobin) and need for transfusion. However, on ems arrival pt. found to have hr (heart rate) between 120's to 140's. Pt awake but confused ..."

An "Infectious Diseases" consultation note dated 7/13/20 at 8:06 am documented in part, " ... Labs notable for leukocytosis (increase in the number of white cells in the blood, especially during an infection) of 22.8K (normal 4.5-11.0K) ..."

A hospital discharge summary documented in part, " ... Admitted for a fib (an irregular, often rapid heart rate)/fever. Found to have bacteremia (bacterial infection that has spread to the bloodstream), thought to be from wound. Id

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(Infectious Disease) consulted. No abt (antibiotics) per family request as goal of comfort. Was in A fib, initially Cardizem, d/c (discharge) on oral meds. D/c home with hospice ..."

On 10/28/20 at 12:34 pm, the DON was queried regarding the facility not following the hospital discharge instructions for the Sacral/Coccyx wound, the lack of weekly skin assessments, and the failure of the facility to identify and report the worsening of the wound to the wound physician. The DON stated they would look into it. At 4:13 pm, the DON returned and confirmed findings and stated the facility could not provide any additional information or documentation.

R#919

A complaint was submitted to the State Agency regarding the worsening in the resident's coccyx pressure ulcer being "down to the bone".

A review of the resident's record revealed the following:

R#919 was admitted into the facility on 5/5/20 with diagnoses that included: COVID 19, type 2 diabetes mellitus, dementia, and hypertension. A MDS dated 5/8/20 documented a BIMS score of 00 indicating severely impaired cognition and required assist from staff for all ADL's.

A Nursing Admission Screening dated 5/5/20 documented in part, " ... Coccyx, Pressure, 0.5 (Length) 0.5 (Width) 0.0 (Depth), Stage II (Partial thickness loss of dermis) ... Pt. (patient) assessed by manager and orders in place for treatment ..."

An admission "Braden Scale for Predicting Pressure Sore Risk" dated 5/5/20 documented a score of 13.0, indicating a "Moderate Risk".

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A weekly skin assessment dated 5/12/20 documented no new measurements for the resident's Coccyx pressure ulcer. The assessment documented in part, " ... open wound on coccyx ... see wound consult, treatment in place ..."

A "Wound Consultation" dated 5/12/20 documented in part, " ... Initial Consult ... Coccyx Ulcer 7.0 x 8.5 ... Stage III (Full thickness tissue loss. Subcutaneous fat may be visible) ... MediHoney to both QD (everyday) ..." The wound consultation was completed seven days after admission and revealed worsening of the wound from admission. A review of the clinical record revealed no documentation of staff identifying or informing a physician of the wound worsening since admission.

A care plan dated 5/14/20 (three days after being diagnosed with a Stage lll wound) titled "The resident has st (stage) 3 to coccyx r/t immobility ... Administer treatments as ordered and monitor effectiveness ... Assess/record/monitor wound healing ... Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements and declines to the MD (medical doctor) ..."

A weekly skin assessment dated 5/19/20 documented no new measurements for the resident's Coccyx pressure ulcer. The assessment documented in part, " ... open wound to sacrum, see wound consult, treatment in place ..."

A "Wound Consultation" dated 5/19/20 documented in part, " ... Coccyx ulcer ... 8.0 x 8.5, Necrotic, Unstageable ..."

The residents progress notes were reviewed and revealed no documentation of the facility staff identifying or notifying the physician of the

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wound worsening from the 5/12/20 consultation.

The resident was inpatient at this facility for a total of two weeks and 2 days, admitted with a stage II that progressed into a larger, necrotic, and unstageable pressure ulcer to their Coccyx area.

On 10/28/20 at 11:09 am, the Director of Nursing (DON) was queried on why the facility staff failed to identify the worsening of the wound during daily toileting/brief changes and showers and why there was no documentation of the staff notifying the physician of the worsening of the wound since admission despite the treatment of medihoney. The DON stated that they were not employed by the facility at the time of this resident's stay at the facility. The DON was then asked to provide any additional information and/or documentation regarding the residents wound or physician documentation of the wound and no further documentation was received by the end of survey.

R#916

A review of the clinical record revealed the following:

R#916 was admitted into the facility on 5/13/20 with diagnoses that included: type 2 diabetes mellitus, hemiplegia and hemiparesis affecting the left non-dominant side, dysphagia, difficulty walking, hypertension, and legal blindness. A MDS assessment dated 5/20/20 documented a BIMS score of 12, indicating moderately impaired cognition and required staff assistance for all ADL's.

A "Nursing Admission Screening/History" dated 5/13/20 documented no skin issues or concerns upon admission into the facility.

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	An admission "Braden Scale for Predicting Pressure Sore Risk" dated 5/13/20 documented a score of "16.0" indicating "At Risk". For the weeks of 5/17/20 and 5/24/20 the facility failed to complete the resident's skin assessments. A 6/3/20, 6/10/20 and 6/17/20 weekly skin assessments documented the following in part, " ... Appearance of skin: Normal .... Patient has NEW alteration in skin integrity? Including open areas of any type, tears, bruising, red areas, rashes, etc. No ... Additional comments or information related to skin: no new skin changes noted ..." The assessment revealed no alterations to the resident's skin integrity. A Nursing note dated 6/17/20 at 15:10 (3:10 pm) documented in part, " ... on 6/16/2020 resident was seen by (doctor name redacted) regarding wound care of MASD (Moisture Associated Skin Damage) on bilateral buttocks, orders rec'd (received) for calmoseptine every shift and prn (as needed). No c/o (complaints of) pain and discomfort noted ..." The clinical record was reviewed and revealed no documentation of prior identification of changes with the resident's skin. A "Wound Consultation" dated 6/16/20 documented in part, " ... Initial Consult ... Open wound coccyx ... Coccyx wound 3.0 x 5.5 ..." A Nursing note dated 6/24/20 at 11:28 am documented in part, " ... on 6/23/20 resident was seen by (doctor name redacted) regarding wound care, orders rec'd (received) for medihoney gel to coccyx/bil. (bilateral) buttocks due <sic> stage 3 pressure ulcer ... Continue with treatment plan of care ..." The clinical record was reviewed and revealed no identification by the staff of worsening of the wound (for that past week) or any notification to the physician of any skin			

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changes.

A "Wound Consultation" dated 6/23/20 documented in part, " ... Follow Up Evaluation ... Coccyx Ulcer ... Coccyx Ulcer 6.0 x 5.0 ..."

All care plans were reviewed and revealed no care plan for the resident's changes in skin (MASD or stage III).

Further review of the clinical record revealed no dietary intervention for wound healing documented.

On 10/28/20 at 9:37 am, the DON was asked to provide any additional documentation and/or explanation on the resident's weekly skin assessment that weren't completed, the staff failing to identify and notify the physician for the worsening of a wound and failing to implement wound care plans. At 2:32 pm, the DON confirmed that they could not provide any further information and/or documentation of the resident's wounds.

R#935

A complaint submitted to the State Agency, reported the facility not properly caring for a resident's wound vac.

R#935 was admitted into the facility on 2/20/20 with diagnoses that included:

A review of the clinical record revealed the following: Encounter for other orthopedic aftercare, chronic osteomyelitis right ankle/foot, type 2 diabetes mellitus with foot ulcer and chronic kidney disease stage 2. A MDS dated 2/24/20 documented a BIMS score of 15 (indicating intact cognition) and required staff assistance for all ADL's. Further review of the

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	clinical record revealed the resident was admitted with a right heel diabetic ulcer, measurements 7.5 L (length) x 5.4 W (width) x 1 D (depth)- stage III. On 3/7/20 at 8:34 pm, a "Nursing" note documented in part " ... Resident's dressing changed with wet to dry dressing due to wound Vac missing hardware ..." Further review revealed no documentation indicating how long the resident's wound vac was missing the necessary hardware or if it was ever replaced. A review of the resident's March 2020 Treatment Administration Record (TAR) revealed on 3/7/20 despite the wound vac missing hardware and the nurse performing a wet to dry dressing to the resident's wound, the nurse signed the TAR on 3/7/20 as completed for the "Wound Care for Surgical Ulcer to Left leg. Apply wound vac with adaptic over entire ulcer site, placed under foal. Change wound q (every) 3 days. Every 72 hours for wound ..." Further review revealed no order for the wet to dry dressing that was performed as indicated in the Nurse's note. A note documented on 3/10/20 at 1:14 pm, documented the resident being sent to the hospital for an evaluation and blood transfusion. An attempt was made to contact the nurse that wrote the 3/7/20 note regarding the resident's hardware, however, was unsuccessful. On 10/28/20 at 2:40 pm, the Director of Nursing (DON) was queried regarding the missing hardware to resident wound vac, how long the hardware was missing, if the wound vac was ever fixed and functional before the resident transferred to the hospital, the nurse			

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implementing a wet to dry dressing without a physician's order and why the nurse signed for the wound vac when they were unable to complete the order. The DON stated they would look into it; however, they were not employed by the facility at that time. Shortly after, the DON stated they were unable to find any additional information or documentation regarding all concerns.

R#909

On 10/28/20, review of a concern submitted to the State Agency indicated that R#909's wound treatments were not being completed.

On 10/28/20 the medical record for R#909 was reviewed and revealed the following:

R#909 was initially admitted to the facility on 8/7/2020 and had diagnoses which included: congestive heart failure and morbid obesity. A review of R#909's MDS assessment with an Assessment Reference Date (ARD) of 8/13/20 revealed R#909 needed extensive assistance from facility staff with most of their activities of daily living. R#909's BIMS score was 14 indicating intact cognition. Section "M" indicated R#909 had an unhealed pressure ulcer.

A "Nursing Admission Screening/History" form with a lock date of 8/8/20 revealed the following: "A. Admission Details: 1a. Reason for admission from paperwork-Stage 2 Pressure injury of R. (right) buttock and

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hip...L. Skin: Relevant History/DX (diagnosis)- Stage 2 Pressure injury of R. buttock and hip...Site: 21)-Right iliac crest (rear)- Pressure...31)- Right buttock-pressure..."

A review of R#909's progress notes revealed the following:

An entry on 8/7/20 documented, "Pt. (patient) A&Ox4...Skin assessment completed upon arrival. Skin is very dry. Stage 1 pressure ulcer along upper, mid, and lower portion of back. Abrasion and Stage 1 pressure ulcer on coccyx. Yeast under fold of stomach. Feet have dry skin beginning to peel and crack open. NP (Nurse Practitioner) notified of arrival. Orders and assessments endorsed to midnight nurse..."

An entry on 8/10/20 documented "[R#909 demographics] admitted as a full code, allergy to gabapentin on a NAS (no added salt diet) bedside 8/10/20, integumentary system is grossly impaired with assessment to right lateral side of back with excoriation bridge together 20x10cm 100% pink base epithelial tissue with irregular edges scant amount of serous drainage, no infection. Periwound skin abnormal with yeast rash under abdomen folds. Right lateral hip stage III pressure ulcer 5x2.5x0.01cm clean with light serous drainage ulcer 75% pink base epithelial 25% loose soft pale white slough. No infection Periwound skin texture moisture and color is normal. Treatments as order: right lateral back xeroform gauze QDPRN

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(every day as needed) right thigh santyl QDPRN..."

A review of R#909's Physician orders for their wounds included:

"Silver Sulfadiazine Cream 1 % Apply to affected area topically one time a day for wound treatment: Start date-8-8-20, Discontinued 8-14-20". Review of the August TAR (treatment administration record) revealed no documentation of treatment being completed on 8/8, 8/11, and 8/12.

"xeroform sheet to right lateral side as needed: Start date 8-14-2020". Review of August TAR revealed no documentation of treatment being completed in August 2020.

"xeroform sheet to right lateral side every day shift for excoriation to right lateral side: Start date 8/15/20". Review of August TAR revealed no documentation of treatment being completed on 8/15 and 8/16.

"Santyl Ointment 250 UNIT/GM (Collagenase) Apply to right lateral thigh topically every day shift for pressure ulcer for 30 Days: Start date 8-15-20 with an ending date of 9-14-20". Review of August TAR revealed no documentation of treatment being completed on 8/15 or 8/16.

Santyl Ointment 250 UNIT/GM (Collagenase) Apply to right lateral thigh topically every day shift for pressure ulcer for 24 Days Apply

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	santyl with 4x4 gauze and cover with 6x6 border gauze dressing: Start date 8-20-20 with an ending date of 9-13-20...Review of September TAR revealed no documentation of treatment being completed on 9/6... A review of R#909's careplan revealed the following: No careplan was provided for R#909's pressure ulcers. On 11/4/20 at approximately 12:26 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding R#909's wound treatments not being documented as completed on the TAR. The DON acknowledged that some of the treatments were not completed as ordered for R#909 and indicated that they had identified the facility had a problem with wound treatments being completed when they started working and had been working to correct it. The DON was queried why R#909 initially only had a topical cream ordered for their wound and the DON indicated that was not an appropriate order for R#909's wound and that a dressing should have been ordered when they were admitted. The DON was queried regarding the progress note on 8/10/20 that indicated a Xerofoam gauze treatment was in place, but no order for it was observed in R#909's record until a start date of 8/14/20 and they indicated that they were aware and that R#909 was a resident that they had identified as one that had a problem with getting their wound care. At the end of the conversation			

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	the DON was queried for any additional documentation pertaining to R#909's wounds. None was received by the end of survey. A facility policy titled "Skin Monitoring and Management- Pressure Ulcer" dated 07/11/2018 documented in part " ... A resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new, unavoidable sores from developing ... A skin risk assessment should be completed on a weekly basis ... A licensed nurse (which may be the facility Wound Nurse) must assess/evaluate a resident's skin at least weekly. All areas of breakdown, excoriation, or discoloration, or other unusual findings must be documented in the resident's clinical record ... A licensed nurse (which can be the facility wound nurse) must assess/evaluate at least weekly each wound ... This assessment/evaluation should include but not be limited to: Measuring the wound, Staging the wound, Describing the nature of the wound ... Describing the location of the wound, Describing the characteristics of the wound, Describing the progress with healing, and any barriers to healing which may exist, Identifying any possible complications or signs/symptoms consistent with the possibility of infection ... If the clinical assessment/evaluation indicates a change in condition or decline in the wound, the assessing/evaluating nurse will notify the physician and create a narrative nurse's note			

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	documenting that notification ... Licensed Nurse should document skin evaluations in accordance with this policy in the resident's clinical record ... Re-evaluate existing treatment regimen in connection with the resident's clinical presentation ... if any wound is non-healing or not showing signs of improvement after 14 days or any time a wound is worsening ... On shower days, CNA (Certified Nursing Assistants) to observe the resident skin ... Communicate findings to nurse ... Licensed nurse to acknowledge findings, document pertinent information in resident's clinical record, and respond/obtain and implement treatment order as appropriate ... Weekly skin check conducted by a facility licensed nurse ... Any changes in the condition of the residents skin as identified daily, weekly ... or otherwise, must be timely communicated to: The resident's physician, The resident/responsible party, Others as necessary to facilitate healing ..." A facility policy titled "Change in Condition-Reporting" (dated 7/11/18) documented in part, " ... Any sudden or serious change in a resident's condition manifested by a marked change in physical ... will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge will notify the physician. If unable to contact attending physician or alternate physician timely, notify Medical Director for follow-up to change in resident's condition. Licensed nurse will notify, consistent with the resident's			

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	authority, the resident's representative of the change of condition and what steps have been taken. All nursing actions will be documented in the licensed progress notes as soon as possible after resident needs have been met ... Resident plan of care will be updated ..."			
F0689 SS= G	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This citation has three deficient practices. This citation pertains to intake number(s): MI00112422, MI00112900, and MI00113630. Deficient Practice #1 Based on interview and record review, the facility failed to develop and implement interventions to prevent falls, thoroughly assess for injury after a fall, and determine the root cause of the fall for two (R#922 and R#917) of ten residents reviewed for accidents, resulting in R#922 falling from bed, being found in a pool of blood, sustaining multiple lacerations to the head and arm, including one that extended to the skull bone, and requiring an emergency transfer to the hospital where the resident received multiple staples and sutures to their	F0689	Residents #922, #912 and # 917 no longer reside at the facility. Residents #944 and #945 were separated to ensure safety. Residents residing in the facility are at risk for a similar occurrence. Residents who have triggered for a high risk for falls have been audited for current and appropriate interventions. Residents who use mechanical devices for transfer will be audited for appropriate transfer status. Residents for high risk for wandering will be reviewed and update care plans as appropriate. Nursing staff will be in-serviced on proper use of mechanical transfer devices to provide safe transferring, in addition to review of the Fall Program with the nursing staff. Nurses have been in-serviced on assessing for injury and root cause in addition to entering timely interventions for falls. Staff has been educated on monitoring resident interaction to protect high risk wandering resident from potential incidents. Observation audits of 5 staff interactions with wandering residents to prevent potential incidents, observation of staffs use of mechanical lift devices for safe transfers in addition to audits for proper assessments and timely/proper interventions based on root cause will be done three times a week for one	12/21/2020

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	head and R#917 falling repeatedly with the potential for injury. Findings include: R#922 A complaint was submitted to the State Agency that alleged the following: "(R#922) resides in Skilled Nursing. Last night, EMS (Emergency Medical Services) was dispatched to (R#922's) home due to her falling. (R#922) was in her bed when EMS arrived, staff members picked (R#922) up before EMS arrived. Per (R#922), she fell out of her bed due to staff members putting her bed up too high, to the point that if she tried to get out, she would fall. When staff members were asked about the height of the bed, they stated that it was at a normal height. (R#922) had marks/bruises that were bandaged and were bleeding through the bandages. (R#922) also had a laceration on her right eye, right ear, right arm, and left leg. Upon arrival to the ER (emergency room), (R#922) began to vomit. (R#922) is unsteady on her feet, she is obese." An unannounced, onsite investigation was conducted at the facility to investigate the complainant's allegations. A review of R#922's clinical record was conducted and revealed the following: R#922 was admitted into the facility on 4/10/20 with diagnoses that included: COVID-19, urinary tract infection, morbid obesity, chronic obstructive pulmonary disease, chronic kidney disease, aphasia, and history of transient ischemic attack. A Minimum Data Set (MDS) assessment dated 4/17/20 documented R#922 had a Brief Interview of Mental Status (BIMS) score of 4		month and randomly thereafter for 3 months to ensure compliance. Audits will be reviewed at weekly Ad Hoc QAPI meetings to monitor continued performance and compliance and will be submitted to monthly QAPI for further review to ensure compliance. The DON and Administrator will be responsible for continued compliance.	

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out of 15 which indicated the resident had severely impaired cognition. R#922 also required physical assistance of at least two staff members for bed mobility and transfers only occurred once or twice during the assessment period with assistance of one staff member. The MDS documented R#922 did not have any falls during the assessment period.

A progress note dated 5/20/20 at 11:26 PM documented, "Called in by the aid (R#922) was observed on the floor in a right side lying position with head under the chair. Prior to the fall, patient was told not to get out of the bed without held <sic> and to use her call light. There was a pool of blood. Upon assessment, skin laceration was observed on the head and on the right elbow...Bleeding was stopped temporarily by gauze dressing applied...911 called and patient was taken to the hospital..."

A progress note dated 5/21/20 written by the former Director of Nursing (DON) of the facility documented, "Place low bed in room once returned from the hospital."

A "Fall Risk Assessment" completed on 4/11/20 at the time of R#922's admission into the facility documented the resident was at moderate risk for falling, had no history of falls, and "overestimates or forgets limits".

A "Post-Fall Assessment" dated 5/20/20 documented R#922 had a history of falls, had no diagnoses or conditions that would increase risk of falls, and no medications checked in the medication section. It was documented R#922 was not doing usual activities at the time of the fall. Previous interventions were documented as "Use of

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call light". The assessment was signed by Nurse "Q" on 5/21/20.

A "Nursing Home to Hospital Transfer Form" for R#922 documented the resident was transferred to the hospital on 5/20/20 due to a fall. It was documented R#922 had pain on the top of their scalp. The form was signed as completed and sent by Nurse "D" on 5/21/20 at 9:34 AM (the day after the fall occurred).

A falls care plan was created on 4/11/20. An intervention was initiated on 5/21/20 to keep the bed in the lowest position.

On 11/4/20 at 9:30 AM, any incident reports, investigations, and grievance forms for R#922 were requested.

On 11/4/20 at approximately 9:45 AM, the DON reported there were no investigations for R#922 and there was one incident report. When queried about R#922's fall that occurred on 5/20/20, the DON reported they did not work in the facility at that time and the incident report was the only document related to R#922 that she was able to find. At that time, the DON was queried about the CNA who was assigned to R#944 at the time of the incident. The DON reviewed R#922's clinical record and the assignment sheets for 5/20/20. The clinical record revealed R#944 had a room/unit change from the 2 East unit to the 1 East unit on 5/20/20. The DON reported it appeared to occur in the afternoon. According to the DON and the assignment sheets from the night shift on 5/20/20, CNA "V" was assigned to R#922 on the 2 East Unit during the night shift and Nurse "Q" was the nurse assigned to R#922 on the 1 East Unit on the night shift. The

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"Documentation Survey Report" (a report that documented care provided by the CNAs) for May 2020 was reviewed with the DON. The "Evening" shift (3:00 PM - 11:00 PM) did not have any documentation of care provided to R#922 on 5/20/20. CNA "V" documented care was provided to R#922 during the night shift (11:00 PM - 7:00 AM) at 6:34 AM, however, R#922 was no longer in the facility at that time. The DON reported CNA "V" should never document that care was provided if it was not.

An incident report dated 5/20/20 at 11:41 PM completed by Nurse "Q" documented the same description as documented in the progress note. It documented R#922 reported she was "trying to get off the bed". The "Immediate Action Taken" documented, "...Bleeding was stopped temporarily...911 called and patient was transported to the hospital". In the section that asked, "Patient Taken to the Hospital?", "N" (which indicated no) was documented. The incident report documented there were no injuries at the time of the incident and R#922 had a pain level of "7" (out of 10). In the "Injuries Report Post Incident" section, the injury location documented "top of scalp" and "right elbow". The "Injury Type" documented, "No Apparent Injury". It was documented that a predisposing environmental factor was "low bed." No predisposing situation factors were documented. No Witnesses were documented.

On 11/4/20 at 10:50 AM, Nurse "Q" was interviewed via the telephone. When queried about what occurred with R#922 on 5/20/20, Nurse "Q" reported they were called into the resident's room by a certified nursing assistant (CNA) who heard a noise. Nurse

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	"Q" further reported R#922 reported they were trying to go to the bathroom but did not typically use the bathroom and utilized a bed pan. When Nurse "Q" entered the room, R#922 was lying beside the bed in a pool of blood that was coming from the resident's head. Nurse "Q" reported the resident could not explain what happened. Nurse "Q" reported R#922 was sent out to the hospital and the DON (former) and the physician was notified. When queried about why they documented in the progress note that R#922 was told not to get out of bed without using the call light, Nurse "Q" could not remember. On 11/4/20 at 11:51 AM, CNA "V" was contacted via telephone for an interview, in addition to a request for the facility to contact the CNA. CNA "V" was not available for an interview prior to the end of the survey. On 11/4/20 at 12:15 PM, the DON was interviewed. When queried about the protocol when a resident was found on the floor, the DON reported the nurse would be called for assistance, the nurse would complete a full head-to-toe assessment of the resident which would include looking for any redness, range of motion issues, pain, or swelling. The nurse would also observe the body placement and environment, call the physician and family, and send to the hospital if needed. When queried about the facility's protocol when a resident was found on the ground with injuries, the DON reported the incident would be investigated to determine the cause of the incident. When asked what occurred with R#922 and how they ended up on the ground in a pool of blood and what time the incident occurred, the DON reported they did not work at the facility at the time of the incident, but stated,			

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"I cannot tell what happened based on the available information." The DON reported they were unsure when R#922 fell or how it occurred.

On 11/10/20 at 3:06 PM, EMS staff "JJ" was interviewed via the telephone. They reported they received a 911 call at 9:58 PM on 5/20/20 and arrived at the facility at 10:05 PM. EMS staff "JJ" reported when they arrived to the facility R#922 was moved to the bed by staff and appeared very nervous. EMS Staff "JJ" reported the resident reported staff put the bed up really high and she fell out and was left on the floor for 30 minutes. EMS Staff "JJ" reported the bed was in a low position when they arrived, however, staff reported R#922 had been lying in a pool of blood which was already cleaned up by the time we arrived. EMS Staff "JJ" further reported that R#922 had a left leg abrasion, was bleeding from above the right eyebrow, had a laceration behind their right ear. EMS Staff "JJ" reported it would be unusual for a resident who was found in a pool of blood with multiple lacerations to be cleaned up, put into bed, bandages applied, and the blood cleaned up within a matter of seven minutes (the time the 911 call was received and the time EMS arrived).

Hospital record for R#922 were reviewed and revealed the following:

"ED Provider Notes" dated 5/20/20 at 10:39 PM documented, "...presenting by EMS from ECF (extended care facility) with fall from approximately 3 feet with head injury. Patient states she fell from as high as her stretcher could go because she tried to get out of bed...Complains of headache...Head: ...Laceration (Multiple) present..." It was

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	documented R#922 had four areas of injury to the head including a one centimeter (cm) laceration to the right eyebrow that required sutures, a large skin tear to the right side of the forehead, an eight to nine cm laceration to the top of the head that extended through the "galea" (tough fibrous sheet of connective tissues that extends over the cranium forming the middle layer of the scalp) to the skull (bone) that required 5 sutures and 14 staples, and a two to three cm laceration to the left side of the top of the head that required 2 staples. R#922 also sustained a skin tear to the right elbow. (Note: the facility documented R#922 had an injury to the top of the scalp and right elbow but did not have any documentation of the appearance of those wounds or of the additional injuries noted in the hospital records or reported by EMS Staff "JJ"). A "Grievance and Satisfaction Form" dated 6/2/20 at 11:00 AM submitted to the former DON was provided. It documented, "Son called the facility to question how (R#922) fell and required 21 cranial stitches". The "Investigation" section documented, "Son asked what were the contributing factors of the fall. It was explained that she had not had a fall since admission. She was in a high low bed positioned lowest to the ground and rolled off the bed. She was immediately assessed and sent to the emergency department for follow up treatment and diagnostics. Diagnostics negative for closed head injury..." The "Resolution" documented, "Resident is not returning to facility. Proper measures and documentation from facility staff implemented." It was documented the grievance was resolved on 6/2/20 and the Administrator signed off on the same date. The investigation into the grievance did not			

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address the extent of R#922's injuries including the laceration to the head that required staples or any evidence of an investigation into how the fall occurred or why it was unclear what time the incident occurred.

R#917

On 10/28/20 a concern that was submitted to the State Agency was reviewed and indicated that R#917 had multiple falls in the facility.

On 10-28-20 the medical record for R#917 was reviewed and revealed the following: R#917 was initially admitted to the facility on 11/23/12, last admitted on 6/17/2020 and had diagnoses including Dementia and Polyneuropathy. A review of R#917's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/24/20 revealed R#917 needed extensive assistance with most of their activities of daily living and limited assistance with eating. R#917's BIMS score (brief interview on mental status) was zero indicating severely impaired cognition.

A review of R#917's documentation of falls while in the facility was reviewed and revealed the following: 1. Date-2-29-20 at 22:09...Incident Description: Nursing Description-Staff heard a loud thud, followed by yelling, Staff immediately went into pts (patient) room. Pt was observed laying on her back on the floor in her bathroom. Pt complains of left thigh pain 5/10 and a headache 5/10. Pt has knot located on the right side of her [cut off]...Patient Description-I was trying to get up and forgot to unlock my wheelchair...Immediate Action Taken:

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	Description-Neuros (neurological checks) initiated, Skin assessment done. Pt assisted to bed. PRN (as needed) pain pill given. Pt education provided on use of call light, and safe transfer techniques. NP (Nurse Practitioner) notified, orders to continue neuros given and to send out if pt has any status changes.... 2. Date-3-10-20 at 17:30...Incident Description: -Nursing Description-Resident was observed sitting on floor in room screaming HELP. Patient Description-Resident stated she was trying to transfer herself from bed to wheelchair...Immediate Action Taken: Description-Assessed for injuries, 0 noted...Safely transferred to wheelchair. The importance of using call light was explained to resident. Notified NP,...Neuro check initiated... 3. Date-4-2-20 at 15:31...Incident Description: -Nursing Description-Writer heard screaming coming from patient room. Writer went into patient room and observed patient in bathroom on knees in front of toilet. Patient Description-Patient stated that she was trying to go to bathroom and lost her balance and fell to the floor...Immediate Action Taken: Description- Vital signs taken. Skin assessment complete. Neuro-check complete and on-going. ROM (range of motion) complete. Patient transferred back into wheelchair via facility protocol. Family and NP notified... 4. Date-4-2-20 at 19:41...Incident Description: -Nursing Description-Pt observed sitting in front of toilet trying to self transfer. Patient Description- I can't do it any more...Immediate Action Taken: Description-ROM, WNL (within normal limits) VSS (vital			

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	signs stable), MD (Medical Doctor) notified, family notified. Intervention for therapy eval... 4. Date-5-3-20 at 20:30...Incident Description: -Nursing Description-Writer was in the hallway and heard resident yelling help, nurse immediately went into resident room and observe resident on bathroom floor. Patient Description-Writer asked resident what happened, and resident stated I fell, I fell while on the toilet...Immediate Action Taken:-Description- obtain vital signs, assess resident skin for injuries none noted, perform ROM, initiated neuro checks, notified doctor and family of the occurrence, assist resident back into wheelchair and placed call light within reach... 5. Date-5-16-20 at 03:40...Incident Description: -Nursing Description-pt observed on the floor after hearing her call for help, pt complained of pain to her left ribs. Patient Description-Patient unable to give description...Immediate Action Taken: Description- head to toe assessment, ROM, WNL, vitals taken...family and MD notified... 6. Date-5-18-20 at 18:24...Incident Description: -Nursing Description- Patient observed on the floor lying on back in-between bed and wheelchair. Patient Description- Patient stated she was trying to go to the bathroom...Immediate Action Taken: Description-Assisted to wheelchair x 2 and toileting offered... 7. Date-5-25-20 at 17:10...Incident Description-Nursing Description- patient observed on floor in the bathroom laying on the left side of her body in between her wheelchair and the toilet. Patient Description-Pt states 'I was trying to get back in my			

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	wheelchair.'...Immediate Action Taken: Description- Pt assisted off floor by staff. Vitals taken, skin assessed, pt has bruise under left breast and bruises to right wrist and right forearm. No c/o (complaints of) pain. Neurochecks started, Writer spoke with daughter and MD about pt condition. Pt in room call light within reach. 8. Date-6-3-20 at 16:35...Incident Description-Nursing Description-Writer was notified by CNA (certified nursing assistant) that patient was on the floor. Writer went into patient room and observed patient on left side, in between her and roommate bed. Patient Description-patient stated she was trying to get up and fell...Immediate Action Taken-Description- Vital sins taken, ROM complete. Skin assessment complete. Neuro-check complete and on-going. Patient transferred back into bed via facility protocol. Care plan updated. Family and NP notified. Invite daughter to visit at window on first floor in private area. 9. Date-6-15-20 at 06:15...Incident Description: -Nursing Description- [R#917] was observed on the bathroom floor, she had a laceration on her head and was bleeding. Pressure was applied after cleaning it up and dressing was put over it to cover it. Vital signs was taken, neuro checks was started, call light was within reach and pt was told to always call for help when needed. Doctor was notified. Family was notified. Patient Description-Patient unable to give description...Immediate Action Taken: Description-MD notified, neuros started, resident assisted back to bedroom change for regular window visits... On 11/2/20 at approximately 12:37 p.m.,			

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	R#917's multiple falls were reviewed with the Director of Nursing (DON) along with the corresponding interventions that were implemented on the care plan to reduce the occurrence of R#917's falls. The DON was queried what the facility's process was when a resident in the facility experiences a fall and the DON indicated that an incident/accident document (I&A) is filled out by the Nurse regarding what happened and what was done. In addition to the I&A, the care plan had to be updated with new interventions in an attempt to reduce future falls for the resident that fell. The DON was queried when the nurse is supposed to perform neuro checks and they indicated that neuro checks should be completed for an unwitnessed fall or when a resident hits their head. R#917's fall on 2/29/20 was reviewed and the DON indicated that neuro checks were started and that the intervention that occurred was that R#917 was educated on use of their call light and safe transfer. The DON was queried if that intervention was appropriate for R#917 who had a Dementia diagnosis and the DON indicated that it was not an appropriate intervention due to R#917's lack of ability to remember the education. The fall on 3/10/20 was reviewed and the DON and the DON reported the intervention put into place was again education on using the call light and that neuro checks were started. The DON indicated that the education was still not appropriate for R#917. The fall on 4/2/20 at 15:31 and the 2nd fall on 4/2/20 at 19:41 was reviewed and the DON indicated that both had occurred in R#917's bathroom and that no immediate intervention was put into place for either of the falls until 4/3/20 in which a new intervention was added to R#917's care plan that was to increase the frequency of			

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	toileting for 72 hours and to assist the resident to the bathroom. The DON was queried if the intervention was implemented after the first fall in the bathroom if the 2nd fall might have been prevented and they indicated that it might have because the resident would have already been toileted. The fall on 5/3/20 was reviewed and the DON indicated that neuro checks were initiated but no new immediate interventions were put into place to prevent another fall. A new intervention was later added to the care plan on 5/7/20 to offer toileting after bedtime. The fall on 5/16/20 was reviewed and the DON indicated that an activities intervention was added on 5/17 but hat the intervention was not appropriate to prevent the fall. The DON indicated that since it was an unwitnessed fall neuro checks should have been initiated but were not indicated on the I&A. The fall that occurred on 5/18 was reviewed and the DON indicated that no immediate interventions were put into place but that another intervention was added to the care plan a day later which was to increase visual communication between the patient and family. The DON indicated that intervention was not appropriate as it wasn't measurable and wasn't sure how it would have been implemented. The fall on 5/26/20 was reviewed and the DON indicated that no immediate interventions were put into place and that a therapy evaluation was added as an intervention but that the therapy evaluation was not resident specific and that a resident specific intervention should have been added to address the fall. The DON further indicated that after every fall it's standard for a therapy evaluation to occur. The fall on 6/15/20 was reviewed and the DON indicated that no new immediate interventions were put into place to address			

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	toileting in the bathroom but that a room change was put into place so family could use the window. The DON indicated that neuro checks were also initiated after the fall on 6/15/20. At that time the DON was queried for documentation for the neuro checks for all of R#917's falls that had neuro checks initiated. On 11/4/20 at approximately 11:22 a.m., during a follow-up conversation with the DON regarding R#917's neuro check documentation for their falls, the DON indicated that they did not have evidence of any neuro checks being completed except for the fall on 6/15/20 in which the neuro checks were not completed. The DON was queried how the nursing staff document that they completed the neuro checks and the DON indicated that they check them off on a neuro check paper document. At that time, any other neuro check documentation was requested for R#917's falls. None were received by the end of the survey except the incomplete neuro check form for the fall on 6/15/20. On 11/9/20 a facility document titled "Nursing Administration-Care and Treatment-Fall Prevention" (adopted 7/11/2018) was reviewed and revealed the following: "It is the policy of this facility that the Fall Prevention Program is designed to ensure a safe environment for all residents. Each resident will be evaluated upon admission, quarterly and as needed by an RN/LPN to assess his/her individual level of risk. The Interdisciplinary Team will review the Fall Risk Assessment completed by the nursing department and if appropriate, a fall prevention protocol will be initiated...4. The Interdisciplinary Team will be responsible for			

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	reviewing the Fall Risk Assessments, if assessed to be a high risk and/or is appropriate they will initiate fall prevention interventions...6. The Director of Nursing/designee will be responsible for ensuring that residents who have been identified at risk or who have experienced a recent fall have all recommended interventions in place as well as current assessments and documentation reflecting notification of applicable disciplines, resident's physician and resident's family/responsible party..." Deficient Practice #2 Based on observation, interview, and record review, the facility failed to ensure two (R#944 and R#945) of 10 residents were properly supervised, resulting in R#945, a resident with known wandering behaviors entering R#944's room and R#944 forcefully removing them from their room. Findings include: On 11/4/20 at 3:00 PM, an observation of the 2 East Unit was conducted. R#945 was observed wandering up and down both hallways of the unit utilizing a specialized walking aid that surrounded the resident and allowed them stability while walking to prevent falls. Certified Nursing Assistant (CNA) "I" was observed standing in the hallway to the right at a computer screen kiosk. CNA "J" was seated, slouched in a chair next to CNA "I". CNA "J" was using their personal cell phone. CNA "I" and CNA "J" were engaged in personal conversation and complaining about their job. R#945 entered the hallway where CNA "I" and CNA "J" were located and entered into R#944's room. R#945 was not redirected from the hallway			

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or from entering the other resident's room. R#944 was observed forcefully removing R#945 from their room by pushing the walking aid out into the hallway and yelling, "Get out of here!" CNA "I" stated, "I'm going somewhere else to chart. There's too much going on here" and stood up and walked down the hallway without addressing the incident between R#944 and R#945.

On 11/4/20 at 3:30 PM, the 2 East Unit Manager, Nurse "D" was interviewed. Nurse "D" reported CNA "J" should not have been present on the unit if she was clocked out and staff were not permitted to use their personal cell phones in resident areas. Nurse "D" further reported CNA "I" was still on the clock and therefore was responsible to the residents on the unit and should not participate in personal conversation in front of residents.

On 11/4/20 at 3: The Director of Nursing (DON) was interviewed. The DON reported if staff are on the clock, they are responsible for residents while being paid. The DON further reported use of personal cell phones was prohibited in resident areas and when staff were done with their shift, they should not stay on the unit. The DON reported that R#945 should have been supervised and CAN "I" should have intervened when R#945 entered R#944's room and after R#944 forcefully removed R#944.

R#945's clinical record was reviewed and revealed the following:

R#945 was admitted into the facility on 12/8/17 with diagnoses that included: vascular dementia with behavioral disturbances. A Minimum Data Set (MDS)

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assessment dated 8/18/20 documented R#945 had severely impaired cognition and no behaviors. Care plans were reviewed and did not include any interventions or goals to address wandering behaviors.

R#944's clinical record was reviewed and revealed the following:

R#944 was admitted into the facility on 4/14/17 with diagnoses that included: dementia with behavioral disturbances and schizophrenia. A MDS assessment dated 8/13/20 documented R#944 had moderately impaired cognition and no behaviors. Care plans were reviewed and documented R#944 had history of yelling and having hallucinations and delusions.

A facility policy titled, "Resident Rights - Abuse and Neglect" last revised on 6/17/19 was reviewed and documented, "...Prevention...Identify, correct and intervene in situation in which abuse...is more likely to occur...This includes analysis of...The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict...Resident who have behaviors such as entering other residents' room..."

Deficient Practice #3

Based on interview and record review the facility failed ensure a safe transfer for one resident (R#912) resulting in an injury during a mechanical lift transfer. Findings include:

On 10/28/20 a concern submitted to the State Agency was reviewed that indicated

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R#912 was transferred inappropriately and sustained an injury.

On 10/29/20 the medical record for R#912 was reviewed and revealed the following: R#912 was initially admitted to the facility on 7/10/20, last admitted on 7/27/20 and had diagnoses including Hemiplegia and hemiparesis and Post traumatic seizures. A review of R#912's MDS with an ARD of 7/16/20 revealed R#912 was dependent on staff for most of their activities of daily living including transfers. R#912's BIMS score was 9 indicating moderately impaired cognition.

A progress note dated 7/24/2020 at 1:23 p.m. revealed the following: "Nurse notified by CNA (certified nursing assistant): CNA X2 assist using hoyer lift (mechanical lift) to transfer to bed. PT was lifted in lift, as CNA began to lower PT to bed, PT leaned forward and hit his head on bar located on the lift. CNA informed PT to lay back until lift is positioned on bed. Nurse initiated neurological assessment and assess for pain and injury...Pain 2/10. Scratch observed at L (left) eyelid, small amount of bleeding observed. Scratch above L eyelid cleaned, bleeding stopped <1 minute, bandage placed on area. Tylenol 500mg given PO (by mouth). PT (Physical therapy) notified for EVAL of transfer status...Will continue to monitor."

A progress note dated 7/24/2020 at 3:30 p.m. revealed the following: "Nurse in room with PT completing neurological assessment, no

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	change in LOC (level of care). pain 0/10. Responsible party arrives to room. Nurse introduces self... [family member] states she is upset and doesn't understand how "it could have happened". Nurse turns to resident and asked him what happened earlier. Resident states "I was up in the air in the thing and hit my head against the bar". [family member] states she wants medical records and to speak to the supervisor because she "don't know why it happened" Nursing supervisor notified." An Incident form dated 7/24/20 revealed the following: "Incident Description: Nursing Description-Nurse notified by CNA (certified nursing assistant): CNA X2 assist using hoyer lift to transfer to bed. PT was lifted in lift, as CNA began to lower PT to bed, PT leaned forward and hit his head on bar located on the lift. CNA informed PT to lay back until lift is positioned on bed. Nurse initiated neurological assessment and assess for pain and injury...Pain 2/10. Scratch observed at L (left) eyelid, small amount of bleeding observed. Scratch above L eyelid cleaned, bleeding stopped <1 minute, bandage placed on area. Tylenol 500mg given PO (by mouth). PT (Physical therapy) notified for EVAL of transfer status...Will continue to monitor...Patient Description-PT states 'I bumped my head on the thing."...Immediate Action Taken: Description-Nurse initiated neurological assessment and assessed for pain and injury. Area cleaned, dried and bandage placed on area. Tylenol give for			

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	pain...CNA demonstrated appropriate use of hoyer." On 10/29/20 at approximately 11:30 a.m., during a conversation with the DON, the DON was queried regarding the incident for R#912 on 7/24/20 and how the resident hit their head on the hoyer lift bar. The DON indicated that the CNA (CNA"DD") who placed R#912 in the sling did not properly center them and when the resident raised their head they were too far to the side and hit the hoyer lift bar. The DON was queried what action if any had taken place and the DON indicated that they had to give a 1:1 in-service to the CNA (CNA"DD") regarding hoyer lift transfer to try and ensure it does not happen again and that they knew how to transfer appropriately On 11/9/20 a facility document titled Policy/Procedure-Nursing Clinical-Mechanical Lifts (adopted 7/11/2018) was reviewed and revealed the following: "Policy- It is the policy of this facility to move a resident by mechanical means as needed...10. Place sling on resident's back. Ensure that it is properly placed for support...14. Position resident to ensure comfort..."			
F0692 SS= G	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids).	F0692	Residents #913, #916, #917, and #919 no longer reside in the facility. Residents residing in the facility are at risk for a similar occurrence. Residents triggering for weight loss within the last 30 have been	12/21/2020

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	Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #'s MI00112900, MI00113533, MI00112981 & MI00112689. Based on interview and record review, the facility failed to ensure consistent monitoring of resident weights and implement dietary interventions to prevent significant weight loss for four residents (R#'s 913, 916, 917, 919,) of six residents reviewed for nutrition, resulting in excessive weight loss and poor nutritional intake. Findings include: R#917 On 10/28/20, review of a concern submitted to the State Agency indicated R#917 had excessive weight loss at the facility. On 10/28/20, the medical record for R#917		reviewed by the RD and plan of care updated if indicated. IDT will meet weekly to discuss weight concerns and interventions. The RD and IDT have been in-serviced regarding the consistent monitoring of resident weights and the implementation of interventions to prevent weight loss. Weights and at-risk residents will be monitored weekly for changes in weight, interventions will be initiated as appropriate. The facility RD will be responsible for ensuring notification of weight needs weekly as well as any supplements as appropriate. Review of clinical alerts will be done 5 times a week for consumption less than 25% for two meals in 48 hours to ensure residents nutritional needs and weights are being monitored. Audits of weekly weights will be done three times a week for one month and randomly thereafter for 3 months to ensure compliance. Audits will be reviewed at weekly Ad Hoc QAPI meetings to monitor continued performance and compliance and will be submitted to monthly QAPI for further review to ensure compliance. The DON and Administrator will be responsible for continued compliance.	

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	was reviewed and revealed the following: R#917 was initially admitted to the facility on 11/23/12, last admitted on 6/17/2020 and had diagnoses which included: dementia and polyneuropathy. A review of R#917's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 6/24/20 revealed R#917 needed extensive assistance with most of their activities of daily living and limited assistance with eating. R#917's BIMS score (brief interview on mental status) was zero which indicated severely impaired cognition. A dietary progress note dated 12/13/2019 documented, "Nutrition/Weight- Nutrition assessment completed: [R#917 demographics] here for LTC (long term care) WT (weight) 143.6# 12/5, down x 2 months from 152# 10/2. Recorded intake 75-100% most meals per FAR (food acceptance record). Diet GI (gastrointestinal) soft for dx IBS (irritable bowel syndrome). Meds/labs reviewed. Physician services following for tooth pain. Wt change discussed with pt (patient), pt reports good tolerance to meals, denies chewing/eating difficulty r/t (related to) tooth pain. Potential for wt changes r/t dx (diagnosis) dementia, depression, anxiety, fluid shift/diuretic tx (treatment). Recommend ensure plus once per day to support intake r/t wt change - pt agreeable." Review of R#917's record revealed there were no new Physician orders for ensure plus until the order with a start date on 2/14/20 which			

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read, "Ensure Plus one time a day."

A dietary progress note dated 5/27/2020 documented, "Nutrition/Weight Note Text: Wt down from 132.6# 4/12 to 115# 5/22. Physician services recently following for pt refusing to eat/take meds - improved following medication adjustment by psyche services. Recorded intake 50% or more most meals per FAR. Diet regular. Magic cups tid (three times a day) in place for support with good acceptance recorded. Meds/labs reviewed. On Remeron for dx depression. Potential for wt changes r/t fluid shift/diuretic tx, dx dementia, dx depression/anxiety. Pt able to self manage for dx IBS. Recommend continue magic cups tid (three times a day); add HPJC (juice supplement) tid for increased support; routine wts for trend."

A dietary progress note dated 7/6/2020 documented, "Nutrition/Weight Note Text: Pt with hospital stay 6/16-6/17 following fall. Pt now under hospice care. WT 115# 6/7, hospital wt 136.7#. Recorded intake 0-25% most meals per FAR. Diet regular, mech (mechanical) soft. Ensure plus tid in place for support. On Remeron for dx depression. Alb (albumin) 2.9L/tp 5.1L 6/18. Skin: impaired. Potential for wt changes r/t hospice status. Diet/supplements per hospice. Staff to continue to assist with meals and encourage intake as appropriate."

Further review of R#917's record revealed there were no new Physician orders for

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ensure plus until the order with a start date on 2/14/20 which read, "Ensure Plus one time a day."

Another Physician's order with a start date of 3/15/20 read, "Weigh weekly every day shift every Sun." Further review of the physician order on 3/15/20 to obtain weekly weights revealed only 5 were documented. There were approximately 8 missed opportunities. The identified weight on 3/6 was 134.6 and on 6/7 was 115.

A review of R#917's documented weights from March 2020 through June 2020 revealed the following: The only weights completed were as follows: 3/6/2020-134.6...4/12/20-132.6...5/22/20-115...5/31/20-116...6/7/2020-115.

A review of R#917's care plan including revised interventions revealed the following: "Focus-Nutritional status: suboptimal intake with potential for wt changes r/t fluid shift, dx depression/dementia, anxiety, pt refusing to eat/take medications, hospice status; recent wt change r/t increased depression/anxiety/refusing to eat/take medications. Under hospice care - overall decline in condition expected/anticipated r/t to end of life care. Date Initiated: 12/02/2015. Revision on 7/8/2020...Interventions-Review weights and notify physician and responsible party of significant weight change. Date Initiated: 12/02/2015...nutrition/supplements as ordered Date Initiated:

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	12/02/2015...Revision on: 03/23/2020..." On 11/2/20 at approximately 4:19 p.m., during a conversation with Registered Dietician "F" (RD "F"), when queried regarding R#917's weight loss and lack of documented weights in R#917's record when the Physician had ordered weekly weights starting in March 2020 and RD "F" indicated that the DON (Director of Nursing) at the time had stopped doing weights in the building due to the pandemic. RD "F" was queried how they were able to monitor residents at risk for weight loss when the facility was not obtaining weights and they indicated they had to rely on staff to let them know how much they were eating. RD "F" was queried why some weights were taken but the weekly weights weren't and they indicated that they were unsure as to why some weights were taken. RD "F" was queried regarding their order for ensure plus to be started per their progress note on 12/13/19 and RD "F" indicated that an order was not put in for the ensure plus until February 2020. RD "F" was queried if an order should have been in place when they added ensure plus to R#917's regimen in December 2019 and they indicated that it should have. R#916 A compliant was submitted to the State Agency on the facility's failure to assist with eating and drinking for a dependent resident, resulting in rapid weight loss.			

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	R#916 was admitted into the facility on 5/13/20 with diagnoses that included: type 2 diabetes mellitus, hemiplegia and hemiparesis affecting the left non-dominant side, dysphagia, difficulty walking, hypertension, and legal blindness. A MDS assessment dated 5/20/20 documented a BIMS score of 12, indicating moderately impaired cognition and required staff assistance for all ADL's. A "Nursing Admission Screening/History" dated 5/13/20 documented in part, " ... Weight: 150.0 (Lbs.), Date: 5/16/2020 08:53 (AM), Scale: Last weight obtained-refusal ..." This is dated three days after admission. A review of the resident's weights completed at the facility, documented one weight of 150.0 lbs. on 5/16/20. A review of the clinical record revealed no other weights documented for this resident. The resident was admitted into the facility on 5/13/20 and discharged to the hospital on 6/24/20, with no documented attempts to obtain the resident's weight throughout the resident's stay at the facility. A Nursing note dated 6/8/20 at 3:59 pm, documented in part " ... Cena reported appetite decreased ..." The documentation for the "Amount of Meal Taken" for the month of June 2020 was reviewed and revealed the following: Refusals of meal: 7th dinner, 13th breakfast, lunch, dinner, 21st breakfast and lunch Eaten 25% of meal: 8th lunch and dinner, 9th breakfast, lunch, dinner, 10th breakfast, lunch, 11th breakfast, lunch, 12th breakfast, lunch, 14th breakfast, dinner, 16th dinner, 18th dinner, 19th breakfast, lunch, dinner, 21st dinner and 22nd			

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	breakfast. There was no documentation of the resident being offered/assisted with their meals on 20th breakfast, lunch and 22nd lunch. The resident was transferred to the hospital on 6/24/20 and the admission weight at the hospital was documented as "113 lb. 5.1 oz". Indicating a 36.5-pound loss during the resident's 42 day stay at the facility. Further review of the hospital medical records revealed the following: Albumin levels 2.7 (normal 3.5-4.9). A laboratory report dated 5/14/20 documented the resident's admitting albumin levels of 2.9, noting a .2 decline within their stay at the facility. The hospital medical record revealed recommendation from the hospital Registered Dietician that documented in part, " ... Severe Protein-Calorie Malnutrition ... as evidenced by 8% weight loss x 1 month and moderate depletion of muscle stores ... If po (by mouth) intake is poor and aggressive medical nutrition therapy desired, then consider Corpak placement for enteral nutrition support ..." A care plan titled "Nutrition status: therapeutic diet; potential for wt. (weight) changes r/t fluid shifts with edema and diuretic use" (dated 5/16/20) documented interventions in part, " ... Review weights and notify physician of significant weight changes ..." A care plan titled "The resident has an ADL self-care performance deficit r/t deconditioning, blindness, IDDM (insulin dependent diabetes mellitus), mobility limitations" (dated 5/14/20) documented interventions in part, " ... eating: provide 1:1 assistance as resident is visually impaired ..."			

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	On 10/28/20 at 9:54 am, Dietician was queried on the resident's admission weight and weight monitoring while inpatient at the facility. The dietician stated the admission weight is usually obtained with the first 24 hours of admission into the facility. When asked if the documented refusal weight should have been reattempted, the dietician stated that it should have. When asked how they were able to effectively identify/monitor trends regarding the resident's weight if the facility failed to obtain the resident weights, the dietician stated the previous Director Of Nursing (DON) made the decision to only obtain the admission weight and to discontinue all other weights during COVID. The dietician then stated that they would monitor the residents per their intake of meals as documented by the staff. When queried on the frequent documentation of the lack of meal consumption for the resident and no further dietary monitoring or evaluation noted in the clinical chart, the Dietician did not offer any further explanation. When asked what kind of scales were utilized at the facility, the dietician stated " ... platform, wheelchair and lift scales ..." On 10/28/20 at 2:32 pm, the Dietician and DON stated they were unable to provide any further information and/or documentation regarding the resident's weight loss. No further information and/or documentation was received by the end of survey. R#919 A compliant submitted to the State Agency, reported a 20-pound weight loss during the resident's two week and two day stay at the facility. The complainant noted the resident's weight to be 145 pounds the day of discharge (5/21/20). R#919 was admitted into the facility on 5/5/20			

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	with diagnoses that included: COVID 19, type 2 diabetes mellitus, dementia, and hypertension. A MDS dated 5/8/20 documented a BIMS score of 00 indicating severely impaired cognition and required assist from staff for all ADL's. A "Nursing Admission Screening" dated 5/5/20 documented in part, " ... Reason for admission from paperwork: COVID 19 recovery ... Weight: 165 lbs. (pounds), Date: 5/5/2020 ... Standup scale ..." A review of the resident's weights revealed one documented weight on 5/5/20 at 165.0 lbs. The clinical record was reviewed and revealed no other documented weights throughout the resident's stay at the facility. A "Dietary Evaluation" dated 5/16/20 (11 days after admission) documented in part " .... weight of 165 lbs. (5/5/20) ... Loss of 5% or more in the last month or loss of 10% or more in last 6 months, No or unknown .... Loss of 7.5% in the last 3 months, No or unknown ... Is there any gradual, unintended, progressive weight loss or gain over the last 3 months, No ... On average, what is the patient's overall intake of meals? 26-75% of meals ..." The dietician failed to address the fact that the resident's weight had not been taken since admission. On 10/28/20 at 11:34 am, the Dietician was queried on why the resident's weight was only taken on admission, not monitored throughout their inpatient stay and why 5/16/20 dietary evaluation was completed using the resident's admission weight instead of a current weight for the resident. The Dietician replied the prior Director of Nursing (DON) stopped all weight monitoring during COVID. When asked how they were able to effectively monitor weight loss trends for the resident at the facility during that			

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time, the Dietician stated by what the CNA's documented for food intake. The Dietician was then asked to provide any additional information and/or documentation regarding the monitoring of the resident's weight and any dietary interventions that were implemented and no further information and/or documentation was received by the end of survey.

On 10/28/20 at 2:32 pm, the DON stated that they were not employed by the facility at the time and they could not find any further information or documentation to provide regarding the monitoring of the resident's weight loss. The Dietician was also asked to provide any further information or documentation regarding the resident's weight loss and monitoring and provided no further information by the end of survey.

R#913

A complaint was received by the State Agency regarding the facility not feeding or giving fluids to the resident resulting in weight loss and dehydration.

R#913 was admitted into the facility on 6/24/20 with diagnoses that included: encounter for surgical aftercare following surgery on the digestive system, colostomy status and dysphagia. A MDS dated 6/27/20 documented a BIMS score of 15 (indicating intact cognition) and was dependent on staff for all ADL's.

A review of the clinical record revealed the following:

A "Nursing Admission Screening/History" dated 6/24/20 documented in part, " ... Weight: 190 (lbs.-pounds), Dated 6/24/20 20:51 (8:51 pm), Scale: Mechanical Lift ..." This is the only

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	documented weight for the resident throughout this inpatient stay (6/24/20 - 7/9/20). On 7/9/20 at 10:27 am, a nursing note documented the resident being transferred to the hospital for a blood transfusion. A review of the resident's hospital medical record documented an admission weight of 78.2 kg (kilogram) (172 lb. 6.4 oz). During the resident's 15 day stay at the facility, the resident lost a total of almost 18 pounds. An admission "Dietary Evaluation" dated 7/3/20 (9 days after admission) documented in part " ... Most Recent Weight: 190.0, Date: 6/24/20 ... Is there any gradual, unintended, progressive weight loss or gain over the last 3 months? No" No or unknown was marked off for the following: Loss of 5% or more in the last month or loss of 10% or more in last 6 months, Loss of 7.5% in the last 3 months. The evaluation failed to be completed timely by the facility and failed to complete the evaluation off of the resident's current weight at the time. The dietician failed to address the fact that the resident's weight had not been taken since admission. Further review of the clinical record revealed no identification of the resident's weight loss by the facility staff or any notification to the dietician. A "Document Amount of Meal Taken" documentation (which is documented by the facility staff) revealed the following: June 2020- 27th breakfast- eaten 25%, lunch- refused, dinner- eaten 25%, 30th lunch- refused, dinner- eaten 25% July 2020- 2nd breakfast and lunch- eaten 25%, 3rd breakfast and lunch- eaten 25%, dinner not			

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documented as offered this night, 4th breakfast and lunch- eaten 25%, 5th lunch- refused and dinner not documented as offered this night, 6th breakfast and lunch- not documented as offered, 7th lunch- eaten 25% and the 8th breakfast and lunch- 0% and dinner not documented as offered this night.

On 10/28/20 at 9:54 am, Dietician was queried on the resident's admission weight and weight monitoring while inpatient at the facility. The dietician stated the admission weight is usually obtained with the first 24 hours of admission into the facility. When asked how they were able to effectively identify/monitor trends regarding the resident's weight if the facility failed to obtain the resident weights and the dietician stated the previous Director Of Nursing (DON) made the decision to only obtain the admission weight and to discontinue all other weights during COVID. The dietician then stated that they would monitor the residents per their intake of meals as documented by the staff. When queried on the frequent documentation of the lack of meal consumption by the resident and no further dietary monitoring or evaluation noted in the clinical chart, the Dietician did not offer any further explanation. When asked if the facility implemented a protocol or guidance for the staff to monitor for weight trends, due to the previous DON making the decision to discontinue obtaining the resident's weights and the Dietician stated "No".

A care plan titled "Nutrition status: mechanically altered diet; potential for wt. (weight) changes r/t (related to) fluid shifts, advanced age" (created on 7/3/20- 9 days after admission) documented in part, " ... Goal: Will experience no significant weight change, Interventions: Nutrition as ordered, Honor food preferences, Observe for s/s (signs/symptoms) of fluid imbalance, Review weights and notify physician of significant weight

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	changes, Encourage and assist as needed to consume foods and/or supplements and fluids offered ..." On 10/28/20 at 2:32 pm, the Dietician and DON was asked if they had any further documentation or information to provide and none was provided by the end of survey. A facility policy titled "Nutrition Monitoring & Management Program" dated 07/11/2018 documented in part, " ... It is the policy of this facility to ensure that all residents maintain acceptable parameters of nutritional status, such as body weight ... Each resident is to be weighed within twenty-four (24) hours of admission, weighed weekly for four (4) weeks ... The weight will be entered into the resident's medical record ... the Registered Dietician, the IDT (interdisciplinary team) will further assess nutritional needs and goals of the resident in the context of his/her overall condition, including the following: The frequency with which the resident will be weighed, Any desired changes in weight ..."			
F0755 SS= D	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation.	F0755	Residents #905, and #943 no longer reside at the facility. Residents residing in the facility are at risk for a similar occurrence. A EMAR audit will be done three times a week for ensuring medication availability. Med pass observations will be conducted randomly to ensure the 6 Rights of Medication pass. The pharmacy has conducted a full cart audit ensuring that all medications are available. Monthly pharmacy visits have resumed to ensure ongoing compliance. The nurse attempting to give the incorrect medication was re-educated on medication	12/21/2020

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SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

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	The facility must employ or obtain the services of a licensed pharmacist who-§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00109051 and MI00115150. Based on observation, interview, and record review, the facility failed to ensure medications were available and administered according to physicians orders for two (R#905 and R#943) of six residents reviewed for medication, resulting in the potential for pain and adverse effects. Findings include: R#943 A complaint submitted to the State Agency alleged R#943 did not receive medications according to physician's orders. On 11/2/20, R#943's clinical record was reviewed and revealed the following: R#943 wad admitted into the facility on 11/13/19 and discharged on 2/11/20 with diagnoses that included: cervical disc disorder, spinal stenosis, arthropathy, depression, anxiety, and liver disease. A		administration. Nurses will be in-serviced on obtaining medications not available in the medication carts from back-up, nurses who have medications whose prescriptions have run out will call the physician for a new prescription and an order to take a dose from back-up until the prescription has been filled. The physician will be called for doses that are unable to be administered. Audits of non-administered meds will be done 5 times a week for one month and randomly thereafter for 3 months to ensure compliance to determine if there have been any medications not available for follow-up and delivery with the pharmacy that day. Audits will be reviewed at weekly Ad Hoc QAPI meetings to monitor continued performance and compliance and will be submitted to monthly QAPI for further review to ensure compliance. The DON and Administrator will be responsible for continued compliance.	

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	Minimum Data Set (MDS) assessment dated 11/20/19 documented R#943 had intact cognition and occasional pain with an intensity level of "5" (out of 10). A review of R#943's Physicians Orders revealed the following: Gabapentin Capsule 300 MG (milligram) Give 1 capsule by mouth every 8 hours (ordered 11/30/20) Gabapentin Capsule 100 MG Give 1 capsule by mouth every 8 hours for neuropathy pain (ordered 1/13/20) A review of R#943's Medication Administration Record (MAR) revealed the 100 MG dose of Gabapentin was not administered until 1/17/20 at 2:00 PM, as indicated by "9" documented on the MAR for each administration time. A documentation of "9" indicated that the medication was not administered and there was an associated progress note to explain why the medication was not given. Progress Notes were reviewed for R#943 for January 2020 and revealed the following: A "Medical Practitioner Note" dated 1/13/2020 documented, "...will increase gabapentin to 400mg Q 8hrs and monitor response-script provided to nurse." A progress note dated 1/13/2020 at 4:44 PM documented, "...Gabapentin Capsule 100 MG Give 1 capsule by mouth every 8 hours for neuropathy pain Pharmacy to deliver..." A progress note dated 1/13/2020 at 11:14			

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	PM documented, "...Gabapentin Capsule 100 MG... on order..." A progress note dated 1/14/2020 at 5:39 AM documented, "...Gabapentin Capsule 100 MG... awaiting delivery..." A progress note dated 1/14/2020 at 3:06 PM documented, "...Gabapentin Capsule 100 MG... per pharmacy cannot dispense due to need of script..." A progress note dated 1/14/2020 at 8:51 PM documented, "...Resident Gabapentin 100 MG ned <sic> sscript <sic> befor <sic> pharmacy will depense <sic> NP (Nurse Practitioner) notified..." A progress note dated 1/14/2020 at 9:05 PM documented, "...Gabapentin Capsule 100 MG... on order not avail (available)..." A progress note dated 1/15/2020 at 5:10 AM documented, "...Gabapentin Capsule 100 MG... on order awaiting delivery..." A progress note dated 1/16/2020 at 6:19 AM documented, "Gabapentin Capsule 100 MG... not avail, on order..." A progress note dated 1/17/2020 at 3:42 AM documented, "...Gabapentin Capsule 100 MG... need signed C2 (Schedule II controlled substance), per pharmacy..." A progress note dated 1/17/2020 at 3:45 AM documented, "...Text MD/NP regarding order needed for (brand name for Gabapentin) 100mg before pharmacy dispenses. resident notified..."			

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	A progress note dated 1/17/2020 at 9:32 PM documented, "...refaxed signed C2 (Gabapentin 100mg) to [pharmacy name redacted], confirmed with [name redacted] faxed received, and received auth (authorization) code...to pull from cubex (back up medication supply)..." There was no documented evidence of physician or NP follow up between 1/14/20 and 1/17/20 or that the Director of Nursing (DON) or Medical Director was contacted for further instruction. On 11/2/20 at 2:10 PM, the facility's DON was interviewed. When queried about the facility's protocol for ensuring medications were available for administration, the DON reported the physician would be notified and the DON. If the medication was available in the back up supply, authorization should be obtained, or the physician would direct the nurse what to do. The DON reported the facility received medication orders every three days. A list of medications available in the back up supply box and a report of any medications removed in January 2020 was requested at that time. The DON was unable to confirm the medications removed from back up in January 2020 and a list of medications in the back up supply were provided. Gabapentin 100 MG was listed as a medication available in the back up supply in the facility. A facility policy titled, "Administration of Drugs" updated on 12/19/19 was provided and reviewed. The policy documented the following: "...It is the policy of this facility that medications shall be administered as prescribed by the attending physician...Medication must be administered			

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in accordance with the written orders of the ordering/prescribing physician...Should a drug be withheld, refused, or given other than the scheduled time, the nurse must enter an explanatory note. NOTE: The Director of Nursing and attending physician must be notified when two (2) doses of a medication are refused or withheld..."

R#905

On 10/28/20 at approximately 10:58 a.m., R#905 was observed in their room, sitting in their bed. R#905 was queried if they had any concerns regarding the administration of their medications and they indicated that they did. R#905 reported Nurse "AA" had given an incorrect medication to them in October 2020. R#905 indicated that Nurse "AA" gave them a medication cup with a crushed medication in it that was the color blue. R#905 reported that they told Nurse "AA" they weren't going to take it because it was the wrong medication. R#905 indicated that after the incident they had informed the management regarding it. R#905 indicated that they had informed the facility management about it because they felt nobody should be getting the wrong medications and that if they had not said anything, they would have taken it.

On 10/28/20 the medical record for R#905 was reviewed and revealed the following: R#905 was last admitted to the facility on 6/19/2020 and had diagnoses which included: chronic obstructive pulmonary

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disease and rheumatoid arthritis. A review of R#905's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 9/25/2020 revealed R#905 needed extensive assistance from facility staff with most of their activities of daily living. R#905's BIMS score (brief interview of mental status) was 15 which indicated intact cognition.

Review of a physician's order with an order date of 6/25/2020 documented, "Gabapentin Capsule 300 MG (milligram) Give 1 capsule by mouth every 8 hours for neuropathy."

A form titled "Grievance and Satisfaction" with a report date of 10-5-20 documented:

"Describe Grievance or Satisfaction-Resident stated nurse attempted to give wrong medication and had to correct it. DON (Director of Nursing) spoke with resident desk phone with resolution...Investigation-Nurse admitted to DON nearly passed wrong medication...Resolution-Nurse received education..."

On 10-28/20 at approximately 11:36 a.m., during a conversation with the DON, the DON was queried regarding R#905's reported incident of a nurse attempting to administer the wrong medication to them. The DON indicated that it was true and that the nurse attempted to administer Neurontin (Gabapentin) 100 mg (milligram) (a controlled substance) to R#905 when they

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were supposed to be administered Neurontin 300 mg. The DON reported that they knew it was Neurontin 100 mg because it has blue writing on it. The DON indicated that Nurse "AA" did not practice the "five rights of medication administration" and that they received disciplinary action for it.

A facility document titled "Disciplinary Action Record" for Nurse "AA" dated 10/6/20 documented:

"Describe the reason(s) for disciplinary action, including date, time and supporting documentation: Failing to perform job duties satisfactorily in accordance with the established job description. Employee fail to the five rights when passing medication and attempted to give the wrong medication to the wrong pt. (patient)...Specific plan for improvement, including timeline (to be completed by supervisor): Employee will perform the five rights with every pt. before administering medication. Employee will ensure pt. takes all of their medication.

A facility document titled "Policy/Procedure-Nursing Clinical...Section: Medication Administration...Subject Six right of Medication Administration" with an adopted date of (7/11/2018) was reviewed and revealed the following: "Policy: It is the policy of this facility to ensure that the six rights of medication administration are followed in order to ensure safety and accuracy of administration...Procedure: The six rights of

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	medication administration are as follows in order to ensure safety and accuracy of administration. 1. Right Resident-Resident is identified prior to medication administration. 2. Right Time-Medications are administered within prescribed time frames. 3. Right Medication-Medication are checked against the order before they are given. 4. Right Dose-Medications are administered according to the dose prescribed. 5. Right Route-Medications are administered according to the route prescribed. 6. Right Documentation-Document administration or refusal of the medication after the administration or attempt and note any concerns."			
F0776 SS= D	483.50(b)(1)(i)(ii) Radiology/Other Diagnostic Services §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00112532	F0776	Resident #920 no longer resides in the facility. Residents residing in the facility are at risk for a similar occurrence. 24 hour report will be reviewed 5 times a week for incidents requiring x-rays to ensure that they were ordered timely. X-ray services was not providing non-emergent services during the period of time at the beginning of the COVID outbreak, the x-ray should have been ordered STAT. Nursing staff has been in-serviced on timely ordering of x-rays and that crucial X-rays should be ordered STAT to ensure appropriate interventions. Audits of the order listing report for x-ray will be done 5 times a week for one month and randomly for 3 months thereafter to ensure compliance. Audits will be reviewed at weekly Ad Hoc QAPI meetings to monitor continued	12/21/2020

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	Based on interview and record review the facility failed to ensure a diagnostic X-Ray was completed in a timely manner for one resident (R#920) resulting in a delay in having the X-ray completed and the potential for a delay in reporting any abnormal results to the ordering provider. Findings include: On 10/27/20, review of an allegation submitted to the State Agency indicated the facility had a delay in obtaining a Physician ordered X-ray for R#920 after R#920 experienced a fall in the facility. On 10/28/20, the medical record for R#920 was reviewed and revealed the following: R#920 was initially admitted to the facility on 4/24/20 and had diagnoses which included: Alzheimer's disease and chronic kidney disease. A review of R#902's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 4/29/20 revealed R#920 needed extensive assistance from facility staff with most of their activities of daily living. R#920's cognition was documented as being severely impaired. Review of a progress note dated 5/24/20 documented, "Resident observed on the floor at about 5:20am 5/24/20, writer was summoned into residents room per aide, and while in room resident was noted laying on her left side on the floor facing her husband, per aide resident was cared for and well positioned after care was performed not long before fall, Husband awake and stated he didn't see his wife falling. Skin assessment performed with ROM (range of motion), no injuries , no bumps or bruises, assisted to bed. Resident has a baseline of confusions and was unable to state reasons of fall..." Review of a Physician note dated 5/24/20 documented, "Date of Service: 05/24/2020...I was		performance and compliance and will be submitted to monthly QAPI for further review to ensure compliance. The DON and Administrator will be responsible for continued compliance.	

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	asked by the floor head nurse...to check on the patient because she had a fall this morning. She was found on the floor. There was no evidence of injury. The family was concerned so I was asked to evaluate the patient...CHIEF COMPLAINT: Post fall....HISTORY OF PRESENT ILLNESS: This is an 89-year-old female with known history of advanced dementia who is staying with her husband in the same room. She was found by her husband where her head and body were on the floor. The patient is not able to give any history...PLAN OF CARE: I will order an x-ray of the skull and the C-spine just to be on the safe side and rule out any fractures, which I doubt clinically. I notified the nurses of my evaluation..." Review of R#920's Physician orders included an order on 5/24/20 which documented, "C spine xray and skull xra=y (sic) one time only for Pain related to OTHER ABNORMALITIES OF GAIT AND MOBILITY (R26.89) for 2 Days." A second Physician order dated 5/29/20 documented, "STST (STAT) XRAY of skull and C spine." Further review of R#920's radiology results revealed there was no X-Ray of the spine taken as ordered on 5/24/20. On 11/9/20 at approximately 10:20 a.m., The Director of Nursing (DON) was queried how long it should take to get an X-ray completed once ordered and they indicated that it should be a few days but if it's ordered STAT it could be the day it was ordered. During that same interview with the Director of Nursing (DON), when queried regarding the delay in obtaining R#920's X-ray that was ordered on 5/24/20 after R#902's fall, the DON			

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	indicated that the Diagnostic provider was taking a long time to do X-rays and that they (the facility) should have ordered it STAT (immediately) to obtain the X-ray in a timely manner. On 11/9/20 a facility document titled "Nursing Clinical-X-Ray Services (adopted 7/11/2018) was reviewed and revealed the following: "Policy-It is the policy of this facility to assure X-ray services are ordered and that the results are reported to the physician. The Physician, Physician assistant; Nurse practitioner or Clinical nurse specialist in accordance with state law, including scope of practice laws will order the X-ray. The nurse in charge will take responsibility for ordering the X-ray, arranging transportation if needed, and notifying the order Physician, Physician assistant; Nurse Practitioner or Clinical nurse specialist of all results that fall outside of a normal clinical reference range...Procedure: 1. Obtain order for X-ray and document order. Clarify whether X-ray is to be done per portable X-ray unit or out-patient services...3. Order X-ray services..."			
F0842 SS= D	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically	F0842	Resident #922 no longer resides at the facility. Residents residing in the facility are at risk for a similar occurrence. POC compliance will be reviewed 5 times a week to ensure compliance. In-services for nursing staff on only documenting on residents during their shifts and ensuring that they are documenting on the appropriate resident they are providing care for at the time of care. All licensed nurses have been educated on verifying CNA charting by end of shift. Point of Care charting audits for accuracy will be done three times a week for one month	12/21/2020

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	organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:		and randomly thereafter to ensure compliance. Audits will be reviewed at weekly Ad Hoc QAPI meetings to monitor continued performance and compliance and will be submitted to monthly QAPI for further review to ensure compliance. The DON and Administrator will be responsible for continued compliance.	

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This citation pertains to Intake Number(s): MI00112422

Based on interview and record review, the facility failed to accurately document care provided for one (R#922) of 47 residents reviewed for medical records, resulting in care that was not provided being documented and the potential for unmet care needs. Findings include:

On 11/4/20, a review of R#922's clinical record was conducted and revealed the following:

R#922 was admitted into the facility on 4/10/20 with diagnoses that included: COVID-19, urinary tract infection, morbid obesity, chronic obstructive pulmonary disease, chronic kidney disease, aphasia, and history of transient ischemic attack. A Minimum Data Set (MDS) assessment dated 4/17/20 documented R#922 had a Brief Interview of Mental Status (BIMS) score of 4 out of 15 which indicated the resident had severely impaired cognition. R#922 also required physical assistance of at least two staff members for bed mobility and transfers only occurred once or twice during the assessment period with assistance of one staff member. The MDS documented R#922 did not have any falls during the assessment period.

A progress note dated 5/20/20 at 11:26 PM documented, "Called in by the aid (R#922) was observed on the floor in a right side lying position with head under the chair. Prior to the fall, patient was told not to get out of the bed without held <sic> and to use her call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634560	A. BUILDING _____ B. WING _____	**11/10/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BLOOMFIELD HILLS	**2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304**

(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) COMPLETION DATE
	light. There was a pool of blood. Upon assessment, skin laceration was observed on the head and on the right elbow...Bleeding was stopped temporarily by gauze dressing applied...911 called and patient was taken to the hospital..." On 11/4/20 at 9:30 AM, any incident reports and investigations for R#922 were requested. On 11/4/20 at approximately 9:45 AM, the DON reported there were no investigations for R#922 and there was one incident report that documented the same information as was noted in the progress note mentioned above. When queried about R#922's fall that occurred on 5/20/20, the DON reported they did not work in the facility at that time and the incident report was the only document related to R#922 that she was able to find. Information about the Certified Nursing Assistant (CNA) who was assigned to R#944 at the time of the incident was requested from the DON at that time. The DON reviewed R#922's clinical record and the assignment sheets for 5/20/20. The clinical record revealed R#944 had a room/unit change from the 2 East unit to the 1 East unit on 5/20/20. The DON reported it appeared to occur in the afternoon. According to the DON and the assignment sheets from the night shift on 5/20/20, CNA "V" was assigned to R#922 on the 2 East Unit during the night shift. The "Documentation Survey Report" (a report that documented care provided by the CNAs) for May 2020 was reviewed with the DON. The "Evening" shift (3:00 PM - 11:00 PM) did not have any documentation of care provided to R#922 on 5/20/20. CNA "V"			

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	documented care was provided to R#922 during the night shift (11:00 PM - 7:00 AM) at 6:34 AM, however, R#922 was no longer in the facility at that time (R#922 was transferred to the hospital at approximately 10:00 PM). The DON reported CNA "V" should never document that care was provided if it was not and confirmed that R#922 was not present in the facility at the time CNA "V" documented care was provided. A policy regarding medical record was requested. A policy was not received prior to the end of the survey.			