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F0000 SS=	INITIAL COMMENTS SKLD Beltline was surveyed for the purpose of an abbreviated survey from 5/13/21 to 5/18/21. Intake #'s: MI00119665, MI00120011, MI00120045, and MI00119758 Census: 158	F0000		
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	F0656	Resident 101 has been reviewed to ensure no negative outcomes form the HOB not being elevated and heels not being offloaded with no negative findings. The plan of care has been reviewed and updated as needed. Resident 109 has been reviewed for negative implications to the HOB not being elevated with no negative findings. The residents plan of care has been reviewed and updated as needed. The facility has determined that residents residing in the facility that have feeding tubes or require the use of heel positioning devices have the potential to be affected. The IDT has reviewed these residents and updated the plan of care as needed. Current staff members that are responsible for following a residents plan of care have been educated on the care plan process with emphasis on following care plan interventions. Staff who have not received the education by June 10, 2021, will be removed from the schedule until the education is completed. DON/designee will conduct random audits on 5 random residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that current residents	6/10/2021

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

Electronically Signed | 06/03/2021

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	outcomes. (B) The resident's preference and potential for future discharge. Facilities must 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 #: MI00119758 Based on observation, interview, and record review, the facility failed to implement interventions from a comprehensive care plan in 2 of 9 residents (Resident #101 and #109) reviewed for comprehensive care plans, resulting in the potential for residents to not meet their highest practicable level of physical and psychosocial wellbeing. Findings include: Review of "Fundamentals of Nursing" revealed, "A well-planned, comprehensive nursing care plan reduces the risk for incomplete, incorrect, or inaccurate care. As a patient's problems and status change, so does the plan. A nursing care plan is a guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used later in evaluation (see Chapter 20). The plan of care communicates nursing care priorities to nurses and other health care providers. It also identifies and coordinates resources for delivering nursing care." Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 16878-16883).		plan of care is being followed appropriately. Any deficiencies will be addressed in the moment and the results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 06/10/2021 and for sustained compliance thereafter.	

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Elsevier Health Sciences. Kindle Edition.

Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual", v1.16, "Chapter 1: Resident Assessment Instrument (RAI)", revealed "...Clinical competence, observational, interviewing and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans. The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practical level of well-being ..."

Resident #101

Review of a "Face Sheet" revealed Resident #101 was originally admitted to the facility on 3/30/21, with pertinent diagnoses which included: stroke and paralysis of one side of the body.

Review of a "Minimum Data Set" (MDS) assessment for Resident #101, with a reference date of 4/2/21 revealed a "Brief Interview for Mental Status" (BIMS) score of 0, out of a total possible score of 15, which indicated Resident #101 was severely cognitively impaired. Review of the "Functional Status" revealed that Resident #101 required extensive two person assist for bed mobility, transfer, dressing, toileting, and personal hygiene.

Review of Resident #101's "Care Plan" revealed, "Resident requires tube feeding r/t (related to)

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	Dysphagia (difficulty swallowing) Date Initiated: 03/30/2021 ... Keep HOB elevated 45 degrees during and thirty minutes after tube feed. Date Initiated: 03/30/2021 ..." Review of Resident #101's "Care Plan" revealed, "Resident has potential impairment to skin integrity r/t incontinence Date Initiated: 03/30/2021 ... Elevate heels off bed surface while at rest in bed. Date Initiated: 03/30/2021 ..." During an observation on 05/13/2021 at 10:34 A.M., Resident #101's tube feeding was running, and the head of her bed was at 21 degrees. During an observation on 05/17/2021 at 9:04 A.M., Resident #101's tube feeding was running, and the head of her bed was at 19 degrees. Resident #101's heels were on the bed with no offloading devices in place. During an observation on 05/17/2021 at 11:06 A.M., Resident #101's tube feeding was running, and the head of her bed was at 19 degrees. Resident #101's heels were on the bed with no offloading devices in place. During an observation on 05/17/2021 at 11:36 A.M., Resident #101's tube feeding was running, and the head of her bed was at 17 degrees. Resident #101's heels were on the bed with no offloading devices in place. During an observation on 05/17/2021 at 12:41 P.M., Resident #101's tube feeding was running, and the head of her bed was at 23 degrees. Resident #101's heels were on the bed with no offloading devices in place. During an observation on 05/17/2021 at 1:21 P.M., Resident #101's tube feeding was running, and the head of her bed was at 22 degrees.			

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Resident #101's heels were on the bed with no offloading devices in place.

During an observation on 05/17/2021 at 1:40 P.M., Resident #101's heels were on the bed with no offloading devices in place.

During an observation on 05/17/2021 at 3:56 P.M., Resident #101's tube feeding was running, and the head of her bed was at 25 degrees. Resident #101's heels were on the bed with no offloading devices in place.

During an observation on 05/18/2021 at 8:51 A.M., Resident #101's tube feeding was running, and the head of her bed was at 25 degrees. Resident #101 had a pressure relieving boot on her right foot and her left heel was on the bed with no offloading device in place.

During an observation on 05/18/2021 at 10:31 A.M., Resident #101's tube feeding was running, and the head of her bed was at 25 degrees. Resident #101 had a pressure relieving boot on her right foot and her left heel was on the bed with no offloading device in place. Resident #101 was loudly moaning, moving her extremities, and grimacing in pain.

Resident #109

Review of a "Face Sheet" revealed Resident #109 was originally admitted to the facility on 2/12/21, with pertinent diagnoses which included: stroke.

Review of Resident #109's "Care Plan" revealed, "Resident requires tube feeding R/T Dx (related to diagnosis), Resp failure S/P (status post/after) trach, S/P COVID-19 illness, PCM (protein calorie malnutrition), PTA, NPO (nothing by mouth) status R/T (related to) dysphagia (difficulty swallowing), low BMI (body mass

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	index), UTIs/infections (urinary tract infections), low Albumin levels Date Initiated: 02/13/2021 ... Keep HOB elevated 45 degrees during and thirty minutes after tube feed. Date Initiated: 02/13/2021 ..." During an observation on 05/17/2021 at 12:37 P.M., Resident #109's tube feeding was running, and the head of his bed was at 15 degrees. During an interview on 05/18/2021 at 11:18 A.M., Licensed Practical Nurse (LPN) "E" reported that interventions in resident care plans should be followed to provide comprehensive resident centered care. During an interview on 05/18/2021 at 10:33 A.M., Certified Nursing Assistant (CNA) "H" reported that resident care plans should be followed to provide resident care.			
F0657 SS= D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's	F0657	Resident 101 has been reviewed for appropriateness of the current plan of care and updated as needed. The facility has determined that residents residing in the facility with a new skin alteration have the potential to be affected. A review of current residents has been completed and a care plan review has been completed on residents with new skin alterations to ensure timeliness of interventions. Current clinical managers have been educated on the care planning process and skin identification/intervention process. Clinical managers who have not received the education by June 10, 2021, will be removed from the schedule until the education is completed. The DON/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or	6/10/2021

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	needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #: MI00119758 Based on observation, interview, and record review, the facility failed to review and revise a comprehensive, individualized plan of care for 1 of 9 residents (Resident #101) reviewed for care plans, resulting in the worsening of a pressure ulcer and the potential for impaired physical, mental, and psychosocial well-being. Findings include: Review of the facility policy "Care Planning" last revised 1/15/20 revealed, "It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident...8. The Care Plan will be reviewed and revised by the IDT after each assessment and as the resident's care needs change." Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual", v1.16, "Chapter 1: Resident Assessment Instrument (RAI)", revealed "...Clinical competence, observational, interviewing and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans. The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the		until substantial compliance has been maintained by ensuring the comprehensive care plans are developed, reviewed, and revised as needed. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 06/10/2021 and for sustained compliance thereafter.	

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nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practical level of well-being ..."

Review of a "Face Sheet" revealed Resident #101 was originally admitted to the facility on 3/30/21, with pertinent diagnoses which included: stroke and paralysis of one side of the body.

Review of a "Minimum Data Set" (MDS) assessment for Resident #101, with a reference date of 4/2/21 revealed a "Brief Interview for Mental Status" (BIMS) score of 0, out of a total possible score of 15, which indicated Resident #101 was severely cognitively impaired. Review of the "Functional Status" revealed that Resident #101 required extensive two person assist for bed mobility, transfer, dressing, toileting, and personal hygiene.

Review of Resident #101's "Skin" progress note dated 4/22/21 revealed, "Location:: X2 areas to left buttock. Type of Skin Change/Impairment:: Open areas Measurement(s):: 2x1cm and 1x0.6cm. Both are less than 0.1 cm in depth. Description: include tissue type, drainage erythema, edema, surrounding tissue, etc.: Min serous dng (minimal serous drainage). Wound bed red. Edges not approximated. Skin surrounding wnl (within normal limits). Current Treatment(s):: Topical cream."

Review of Resident #101's "Weekly Skin Assessment" dated 4/22/21 revealed, "Patient has NEW alteration in skin integrity? Yes...Site-Left buttock...Type-Pressure...Length 2cm...Width 1cm...Depth 0.0...Stage-II...Left buttock...Type-Pressure...Length 1cm...Width 0.6...Depth 0.0...Stage-II...Open areas to buttocks not well

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approximated. Wound bed red with very min serous dng (drainage). Cream applied to buttocks. Res (resident) propped on pillow for pressure relief."

Review of Resident #101's "Physician Note" dated 5/5/21 revealed, "Patient is an 81 year old female seen and examined at (facility) along with the wound care team and nurse manager for Stage 2 left buttock ulceration measuring 1.3cm x 0.8cm x 0.1cm, Stage 2 right buttock ulceration measuring 1.9cm x 0.8cm x 0.1cm, Stage 2 sacrum ulceration measuring 4.0cm x 1.8cm x 0.1cm...Plan ...3. PT (patient) should be encouraged to participate in activities outside of room on a daily basis to the best of the patients ability ...5. If patient is in bed, appropriate offloading mattress with frequent turning and positioning every two hours to the best of the patients ability..."

During an interview on 05/18/2021 at 4:25 P.M., Wound Physician (WP) "S" reported that initially Resident #101 had MASD (Moisture Associated Skin Damage) skin breakdown. WP "S" reported that on 5/5/21 he performed an assessment and found Stage II breakdown on Resident #101's left buttock, right buttock, and central sacral area. WP "S" reported that the goal of treatment is to "try to offset and reverse that risk factor as much as possible." WP "S" reported that he instructed facility staff to keep the area clean and dry, perform ordered treatments, and frequent repositioning to offload the sacral area."

Review of Resident #101's "Care Plan" revealed, "Resident has actual impairment to skin integrity r/t (related to) Current break in skin integrity of a stage 2 (pressure ulcer) to her sacrum Date Initiated: 05/10/2021 ... Encourage and assist resident to participate in mobility activities per additional plan of care. Date Initiated:

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	05/10/2021... Follow physician orders for treatment of skin impairments. Refer to eTAR (electronic treatment record) for specifics. Provide pain management with treatments as needed. Date Initiated: 05/10/2021..." During an interview on 05/18/2021 at 11:18 A.M., Licensed Practical Nurse (LPN) "E" reported that interventions should be updated in resident care plans with any new orders or changes in resident condition. During an interview on 05/18/2021 at 1:05 P.M., Wound Nurse (WN) "R" verified that Resident #101's "Care Plan" for her pressure ulcer was not created until 5/10/21.			
F0686 SS= G	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 prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #: MI00119758 Based on observation, interview and record review, the facility failed to implement	F0686	Resident 101 had a full skin review completed with MD and family notification. Appropriate revisions were made to the care plans to reflect all current pressure injury prevention interventions. Residents residing in the facility that are at very high risk have the potential to be affected. These residents have had a skin review completed and their plan of care has been updated as needed. The facility staffing has been reviewed and changed as needed. All nursing staff has been educated on the facility skin process to include care planning, pressure injury prevention and interventions. Staff who have not received the education by June 10, 2021, will be removed from the schedule until the education is completed. The DON/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure adherence to the	6/10/2021

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	interventions that are consistent with resident needs, resident goals, and professional standards of practice and monitor and evaluate the impact of the interventions for 1 of 9 residents (Resident #101) reviewed for the risk for the development of pressure injuries, resulting in the development of a pressure ulcer, and the potential for infection and overall deterioration in health status. Findings include: Review of the facility policy "Pressure Injury Management" dated 2/1/21 revealed, "Policy: This facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries. Definitions: "Pressure Ulcer/Injury" refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. "Avoidable" means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate ...3. Assessment of Pressure Injury Risk ... c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and as needed ...4. Interventions for Prevention and to Promote Healing a. The interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. B. Interventions will be based on factors identified in the Braden scale assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). Evidence-based interventions for		facilities skin process and prevention of facility acquired pressure injuries. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 06/10/2021 and for sustained compliance thereafter.	

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	prevention will be implemented for all residents who are assessed at high risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination; iii. Provide appropriate, pressure-redistributing, support surfaces ...d. Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present. i. Treatment decisions will be based on the characteristics of the wound, including the stage, size, amount of exudate, and presence of pain, infection, or non-viable tissue ...f. Interventions will be documented in the care plan and communicated to all relevant staff ..." According to Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 71227-71234). Elsevier Health Sciences. Kindle Edition. "Pressure ulcer, pressure sore, decubitus ulcer, and bedsore are terms used to describe impaired skin integrity related to unrelieved, prolonged pressure. The most current terminology is pressure ulcer which is consistent with the recommendations of the pressure ulcer guidelines written by the Wound, Ostomy and Continence Nurses Society (WOCN, 2010). A pressure ulcer is localized injury to the skin and other underlying tissue, usually over a bony prominence (e.g., sacrum, greater trochanter), as a result of pressure or pressure in combination with shear and/or friction. A number of contributing factors are also associated with pressure ulcers; the significance of these factors is not yet clear (NPUAP, EPUAP, PPPIA, 2014). Any patient experiencing decreased mobility, decreased sensory perception, fecal or urinary incontinence, and/ or poor nutrition is at risk for pressure ulcer development."			

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Review of a "Face Sheet" revealed Resident #101 was originally admitted to the facility on 3/30/21, with pertinent diagnoses which included: stroke and paralysis of one side of the body.

Review of a "Minimum Data Set" (MDS) assessment for Resident #101, with a reference date of 4/2/21 revealed a "Brief Interview for Mental Status" (BIMS) score of 0, out of a total possible score of 15, which indicated Resident #101 was severely cognitively impaired. Review of the "Functional Status" revealed that Resident #101 required extensive two person assist for bed mobility, transfer, dressing, toileting, and personal hygiene.

Review of Resident #101's "Braden Skin Assessment for Predicting Pressure Ulcers" dated 4/21/21 revealed a score of 8 indicating Resident #101 was "very high risk" for the development of a pressure ulcer.

Review of Resident #101's "Care Plan" revealed, "Resident has potential impairment to skin integrity r/t incontinence Date Initiated: 03/30/2021 ... Elevate heels off bed surface while at rest in bed. Date Initiated: 03/30/2021 ..." There was no documentation in the care plan to indicate a turning/repositioning schedule or type of support surface for Resident #101 to reduce the likelihood of pressure injury.

According to the National Pressure Injury Advisory Panel (NPIAP), "Pressure Injury Prevention Points...Risk Assessment: Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface...Repositioning and Mobilization: Turn and reposition all individuals at risk for pressure

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injury, unless contraindicated due to medical condition or medical treatments. Choose a frequency for turning based on the support surface in use, the tolerance of skin for pressure and the individual ' s preferences. Consider lengthening the turning schedule during the night to allow for uninterrupted sleep. Turn the individual into a 30-degree side lying position and use your hand to determine if the sacrum is off the bed. Avoid positioning the individual on body areas with pressure injury. Ensure that the heels are free from the bed..."

Review of Resident #101's "Weekly Skin Assessment" dated 4/20/21 revealed, "Patient has NEW alteration in skin integrity? NO.

Review of Resident #101's "Skin" progress note dated 4/22/21 revealed, "Location:: X2 areas to left buttock. Type of Skin Change/Impairment:: Open areas Measurement(s):: 2x1cm and 1x0.6cm. Both are less than 0.1 cm in depth. Description: include tissue type, drainage erythema, edema, surrounding tissue, etc.: Min serous dng (minimal serous drainage). Wound bed red. Edges not approximated. Skin surrounding wnl (within normal limits). Current Treatment(s):: Topical cream."

Review of Resident #101's "Weekly Skin Assessment" dated 4/22/21 revealed, "Patient has NEW alteration in skin integrity? Yes...Site-Left buttock...Type-Pressure...Length 2cm...Width 1cm...Depth 0.0...Stage-II...Left buttock...Type-Pressure...Length 1cm...Width 0.6...Depth 0.0...Stage-II...Open areas to buttocks not well approximated. Wound bed red with very min serous dng (drainage). Cream applied to buttocks. Res (resident) propped on pillow for pressure relief."

Review of Resident #101's "Weekly Skin

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	Assessment" dated 5/4/21 revealed, "Patient has NEW alteration in skin integrity? Yes...Site-Sacrum...Type-Pressure...Length 4.3(cm)...Width 3.3(cm)...Depth (blank)...Stage (blank)..." Review of Resident #101's "Skin & Wound" Evaluation" dated 5/5/21 (lock date 5/17/21) revealed, "Type: Pressure ...Stage: Stage 2 ...Location Right Buttock ...In House Acquired ...How long has the wound been present? New ...Area 1.1cm2-Length 1.9cm-Wideth 0.8cm-Depth 0.1cm ... Goal of Care: 2. Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration ...Additional Care ...Turning/repositioning program ..." Review of Resident #101's "Skin & Wound" Evaluation" dated 5/5/21 (lock date 5/17/21) revealed, "Type: Pressure ...Stage: Stage 2 ...Location-Left Buttock ...In House Acquired ...How long has the wound been present?...New ...Area 0.8cm2-Length 1.3 cm-Width 0.8cm-Depth 0.1cm ... Goal of Care: 2. Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration ...Additional Care ...Turning/repositioning program ..." Review of Resident #101's "Skin & Wound" Evaluation" dated 5/5/21 (lock date 5/17/21) revealed, "Type: Pressure ... Stage: Stage 2 ...Location-Sacrum ... In House Acquired ...How long has the wound been present?...new ...Wound Measurements Area 5.8cm2-Length 4.0cm-Width 1.8cm-Depth 0.1cm ... Goal of Care: 2. Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration ...Additional Care ...Turning/repositioning program ..." Review of Resident #101's "Incident Report" dated 5/5/21 revealed, "Resident assessed by this nurse and wound physician due to change in skin alteration. Area now non-blanchable with depth			

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	of 0.1 (cm) ...Treatment updated by wound physician, AMP (alternating pressure mattress) ordered ...Injury Type-Pressure ...Injury Location-Sacrum ..." Review of Resident #101's "Skin & Wound" Evaluation" dated 5/11/21 revealed, "Type: Pressure ...Location-Left Buttock ...In House Acquired ...How long has the wound been present?...1 week ...Wound Measurements 1. Area 0.8 cm2-Length 1.3 cm-Width 0.9cm-Depth 0.1cm ...Goal of Care: 2. Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration ..." Review of Resident #101's "Skin & Wound" Evaluation" dated 5/11/21 revealed, "Type: Pressure ... Stage: Stage 2 ...Location-Sacrum ... In House Acquired ...How long has the wound been present?...1 week ...Wound Measurements Area 12.8cm2-Length 7.0cm-Width 3.2cm-Depth 0.1cm ... Goal of Care: 2. Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration ...Additional Care ...Turning/repositioning program ..." Review of Resident #101's "Skin/Wound Evaluation" dated 5/11/21 revealed, "Wound evaluation completed. Resident wound type is Pressure. Wound location is Left Buttock. Wound measurements are: Area - 0.8 cm2, Length - 1.3 cm, Width - 0.9 cm, Depth - 0.1 cm ..." Review of Resident #101's "Skin" progress note dated 5/13/21 revealed, "Location: Sacrum Left Buttock Right Buttock - resolved/healed Type of Skin Change/Impairment: Pressure Injury - Stage 2 ..." (No other progress note related to sacral or other wounds documented on 5/13/2021) During an interview on 05/18/2021 at 1:05 P.M., Wound Nurse (WN) "R" reported that there was a			

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	wound identified on 4/22/21 for Resident #101 and the wound was no longer moisture associated. Resident #101 originally had 3 separate wounds and on 5/11/21 the right buttock wound had merged with the sacral wound and turned into 1 wound. WN "R" reported that the care plan for impaired skin integrity was not initiated until 5/10/21 but nurses and Certified Nursing Assistants (CNA's) should still be following professional standards of practice for repositioning immobile residents. WN "R" reported that the standard of practice for immobile residents is to reposition every 2 hours as well as providing incontinence care at least every 2 hours if required. WN "R" reported that just because a resident has hemiparesis it does not mean the resident will get a wound. It just puts her at high risk." WN "R" stated that "sometimes with interventions in place they (pressure ulcers) are unavoidable." During an interview on 05/18/2021 at 4:25 P.M., Wound Physician (WP) "S" reported that initially Resident #101 had MASD (Moisture Associated Skin Damage) skin breakdown. WP "S" reported that on 5/5/21 he performed an assessment and found Stage II breakdown on Resident #101's left buttock, right buttock, and central sacral area. WP "S" reported that at that time he ordered collagen wound dressings to the affected area to be changed Monday, Wednesday, and Friday. WP "S" reported that Resident #101 was examined on 5/12/21 and the right buttock wound had coalesced (merged) with the sacral wound. WP "S" reported that Resident #101 had many unavoidable factors such as hemiplegia and hemiparesis, incontinence, cognitive impairment, low hemoglobin and albumin, diabetes, and protein calorie malnutrition. WP "S" reported that the goal of treatment is to "try to offset and reverse that risk factor as much as possible." WP "S" reported that he instructed facility staff to keep the area clean and dry, perform ordered			

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treatments, and frequent repositioning to offload the sacral area."

Review of Resident #101's "Care Plan" revealed, "Resident has actual impairment to skin integrity r/t (related to) Current break in skin integrity of a stage 2 (pressure ulcer) to her sacrum Date Initiated: 05/10/2021 ... Encourage and assist resident to participate in mobility activities per additional plan of care. Date Initiated: 05/10/2021... Follow physician orders for treatment of skin impairments. Refer to eTAR (electronic treatment record) for specifics. Provide pain management with treatments as needed. Date Initiated: 05/10/2021..." Note no intervention for resident repositioning. Resident #101's pressure injury was identified on 4/22/21 and the care plan for "Actual Skin Impairment" was not created until 5/10/21 (18 days).

During an observation on 05/17/2021 at 9:04 A.M., Resident #101 was in bed on her back. Resident #101's head of bed was at 19 degrees. Resident #101's heels were on the bed with no offloading devices in place.

During an observation on 05/17/2021 at 11:06 A.M., Resident #101 was in bed on her back. Resident #101's head of bed was at 19 degrees. Resident #101's heels were on the bed with no offloading devices in place.

During an observation on 05/17/2021 at 11:36 A.M., Resident #101 was in bed on her back. Resident #101's head of bed was at 17 degrees. Resident #101's heels were on the bed with no offloading devices in place.

During an observation on 05/17/2021 at 12:41 P.M., Resident #101 was in bed on her back. Resident #101's head of bed was at 23 degrees. Resident #101's heels were on the bed with no

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	offloading devices in place. During an observation on 05/17/2021 at 1:21 P.M., Resident #101 was in bed with a pillow behind her right side. Resident #101's head of bed was at 22 degrees. Resident #101's heels were on the bed with no offloading devices in place. During an observation on 05/17/2021 at 1:40 P.M., Resident #101 was in bed with a pillow behind her left side. Resident #101's heels were on the bed with no offloading devices in place. During an observation on 05/17/2021 at 3:56 P.M., Resident #101 was in bed with a pillow behind her left side. Resident #101's head of bed was at 25 degrees. Resident #101's heels were on the bed with no offloading devices in place. During an observation on 05/18/2021 at 8:51 A.M., Resident #101 was in bed with a pillow under her left side. Resident #101's head of bed was at 25 degrees. Resident #101 had a pressure relieving boot on her right foot and her left heel was on the bed with no offloading device in place. During an observation on 05/18/2021 at 10:31 A.M., Resident #101 was in bed with a pillow under her left side. Resident #101's head of bed was at 25 degrees. Resident #101 had a pressure relieving boot on her right foot and her left heel was on the bed with no offloading device in place. Resident #101 was loudly moaning, moving her extremities, and grimacing in pain. During an observation and interview on 05/18/2021 at 11:15 A.M., in Resident #101's room, Certified Nursing Assistant (CNA) "H" reported that Resident #101 was loudly moaning. Resident #101 did not have barrier cream or the ordered treatment dressing covering the wound.			

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	Resident #101 had a large irregular shaped wound on her left buttock/sacrum. Observed half of the wound on the left buttock with an area of connection to the sacral area of the wound. The wound was open, and the wound bed had red tissue noted. Approximately ¼ of the wound contained slough and in the center of the slough there was dark green tissue noted. The wound was irregular in shape but was approximately 4cm in diameter. There was a moderate amount of serosanguinous (watery fluid that is blood tinged) fluid noted on Resident #101's brief. Under the left buttock wound there was a pencil eraser sized open area with a bright red wound bed. During an observation and interview on 05/18/2021 at 11:18 A.M., Licensed Practical Nurse (LPN) "E" reported that Resident #101's wound had worsened since the last time she observed it. During an observation and interview on 05/18/2021 at 11:23 A.M., Unit Manager (UM) "J" reported that Resident #101's wound was ongoing. UM "J" reported that nurses perform weekly skin assessments on all residents and the wound care team rounds on Wednesdays with the wound physician for measurements. UM "J" measured Resident #101's wound and reported the length of the wound was 4cm, width was 3.75, and the depth was 0.2cm. UM "J" reported that it is measured as 1 wound and the wound is measured by diameter. The additional wound (size of a pencil eraser) was not measured at that time. Review of Resident #101's "Evaluation of Pressure Sore Unavoidability" dated 5/5/21 revealed, "CONDITIONS THAT MAKE PRESSURE ULCER(S) UNAVOIDABLE: (check all that apply...Coma, Semi-coma or Supor (sic)...Quadriplegia, paraplegia,			

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	hemiparesis...Urinary Incontinence, continuous...AGGRAVATING FACTORS: (check all that apply)...Memory/Cognitive Deficits...Albumin less than 3.5...Bowel incontinence...Hemoglobin (less than) 10 (female)...Treatment, HOB (Head of Bed) elevation (greater than) 30 degrees required...Total protein 6.1, Type 2 DM (Diabetes Mellitus) (with) Diabetic nephropathy." Review of Resident #101's "Physician Note" dated 5/5/21 revealed, "Patient is an 81 year old female seen and examined at (facility) along with the wound care team and nurse manager for Stage 2 left buttock ulceration measuring 1.3cm x 0.8cm x 0.1cm, Stage 2 right buttock ulceration measuring 1.9cm x 0.8cm x 0.1cm, Stage 2 sacrum ulceration measuring 4.0cm x 1.8cm x 0.1cm. Hemiparesis makes wounds unavoidable ...Plan ...3. PT (patient) should be encouraged to participate in activities outside of room on a daily basis to the best of the patients ability ...5. If patient is in bed, appropriate offloading mattress with frequent turning and positioning every two hours to the best of the patients ability ...7. Apply collagen dressing to wounds, cover with sacral foam dressing, change MWF/PRN (Monday, Wednesday, Friday, and as needed)." Review of Resident #101's "Physician Note" dated 5/12/21 revealed, "Patient is an 81 year old female seen and examined at (facility) along with the wound care team and nurse manager for Stage 2 left buttock ulceration measuring 1.3cm x 0.9cm x 0.1cm, Stage 2 right buttock ulceration now healed/resolved, Stage 2 sacrum ulceration measuring 7.0cm x 3.2cm x 0.1cm. Hemiparesis makes wounds unavoidable ... Plan ...3. PT (patient) should be encouraged to participate in activities outside of room on a daily basis to the best of the patients ability ...5. If patient is in bed, appropriate offloading mattress with frequent turning and positioning every two hours to the			

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best of the patients ability ...7. Apply collagen dressing to wounds, cover with sacral foam dressing, change MWF/PRN (Monday, Wednesday, Friday, and as needed)."

According to the "State Operations Manual" the definition of "unavoidable" revealed, "Unavoidable means that the resident developed a pressure ulcer/injury even though the facility had evaluated the resident's clinical condition and risk factors; defined and implemented interventions that are consistent with resident needs, goals, and professional standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate." Note Resident #101's head of bed was not greater than 30 degrees during observations, resident was not repositioned every 2 hours, there was no bandage on Resident #101's sacrum during the observation, Resident #101's heels were not offloaded, and there were no care planned interventions for repositioning. Indicating Resident #101 did not meet the definition of unavoidable pressure ulcer/injury.

According to "Nursing Times" (VOL: 98, ISSUE: 11, PAGE NO: 41. Gebhardt, S.K PhD). "Part 1. Causes of pressure ulcers...Pressure ulcers occur when soft tissues (most commonly the skin) are distorted in a fixed manner over a long period. This distortion occurs either because the soft tissues are compressed and/or sheared between the skeleton and a support, such as a bed or chair when the person is sitting or lying...Immobility is rarely the primary cause of pressure ulcers.

During an interview on 05/18/2021 at 10:33 A.M., CNA "H" reported that at that time there were only 3 CNA's working on the entire 600 unit. CNA "H" reported that it is "impossible" to get to the immobile residents and reposition them every 2 hours with the number of staff working

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	each shift. CNA "H" reported that Resident #101's "bottom has been getting worse and worse because we can't reposition like we need to." CNA "H" reported it started as 1 wound, then 4 wounds, and now "it's all big and open." CNA "H" stated, "I know (Resident #101) got the pressure ulcer because she's not repositioned, but we did everything we could ...it's impossible with staffing." During an interview on 05/18/2021 at 12:29 P.M., LPN "E" reported that because of the short staffing the facility aides "cannot get to repositioning" the immobile residents on the unit. During an interview on 05/13/2021 at 11:21 A.M., CNA "N" reported that there were not enough staff to meet the needs of the residents. CNA "N" reported that most residents on the 600 Unit were extensive 2 person assist and needed frequent repositioning and incontinence care. CNA "N" reported that the staff could not "keep up" and meet the needs of the residents. During an interview on 05/13/2021 at 3:06 P.M., CNA "U" reported that there were only 3 CNA's for the entire 600 unit for 2nd shift. CNA "U" reported that 3 CNA's and 2 nurses was not enough to meet the needs of the residents. CNA "U" reported that at times they have to put residents to bed before dinner in order to get all residents to bed before the end of shift. CNA "U" reported that the staff attempt to get to the immobile residents to check and change and reposition but reported it was difficult without enough staff. CNA "U" reported that the 600 Unit had many 2 person assist residents.			
F0693 SS= D	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous	F0693	Resident 101 has been reviewed to ensure no negative outcomes form the HOB not being elevated with no negative findings. The plan of care has been reviewed and updated as	6/10/2021

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	endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #: MI00119758 Based on observation, interview and record review, the facility failed to provide appropriate treatment and services for residents with enteral feeding in 2 of 9 residents (Resident #101 and #109) reviewed for enteral feeding, resulting in the potential for aspiration of enteral feeding due to poor positioning. Findings include: According to Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 65243-65250). Elsevier Health Sciences. Kindle Edition. "A serious complication associated with enteral feedings is aspiration of formula into the tracheobronchial tree. Aspiration		needed. Resident 109 has been reviewed for negative implications to the HOB not being elevated with no negative findings. The residents plan of care has been reviewed and updated as needed. Residents residing in the facility that require enteral feeding have the potential to be affected. A review of these residents has been completed to ensure the head of bed is care planned and will remain at a minimum of 30 degrees while the enteral feeding is running. All staff have been educated, on enteral feeding residents head of bed being 30 degrees or higher. Residents that have an enteral feeding tube with a BIMS 13 or higher will also be educated on head of bed being 30 degrees or higher. Staff who have not received the education by June 10, 2021, will be removed from the schedule until the education is completed. The DON/designee will conduct random audit on 5 residents who receive enteral nutrition and/or hydration weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the head of the bed is at 30 degrees or higher. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 06/10/2021 and for sustained compliance thereafter.	

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	of enteral formula into the lungs irritates the bronchial mucosa, resulting in decreased blood supply to affected pulmonary tissue (McCance et al., 2014). This leads to necrotizing infection, pneumonia, and potential abscess formation ...Keep the head of the bed elevated a minimum of 30 degrees, preferably 45 degrees..." Resident #101 Review of a "Face Sheet" revealed Resident #101 was originally admitted to the facility on 3/30/21, with pertinent diagnoses which included: stroke. Review of Resident #101's May 2021 "Medication Administration Record" revealed, "Elevate HOB (Head of Bed) 30-45 degrees during all feeding and flushes every shift for minimizing risks." Review of Resident #101's "Care Plan" revealed, "Resident requires tube feeding r/t (related to) Dysphagia (difficulty swallowing) Date Initiated: 03/30/2021 ... Keep HOB elevated 45 degrees during and thirty minutes after tube feed. Date Initiated: 03/30/2021 ..." During an observation on 05/13/2021 at 10:34 A.M., Resident #101's tube feeding was running, and the head of her bed was at 21 degrees. During an observation on 05/17/2021 at 9:04 A.M., Resident #101's tube feeding was running, and the head of her bed was at 19 degrees. During an observation on 05/17/2021 at 11:06 A.M., Resident #101 was in bed on her back. Resident #101's tube feeding was running, and the head of her bed was at 19 degrees. During an observation on 05/17/2021 at 11:36 A.M., Resident #101's tube feeding was running,			

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and the head of her bed was at 17 degrees.

During an observation on 05/17/2021 at 11:37 A.M., Licensed Practical Nurse (LPN) "M" observed Resident #101's HOB at 17 degrees and adjusted the HOB to approximately 30 degrees.

During an observation on 05/17/2021 at 12:41 P.M., Resident #101's tube feeding was running, and the head of her bed was at 23 degrees.

During an observation on 05/17/2021 at 1:21 P.M., Resident #101's tube feeding was running, and the head of her bed was at 22 degrees.

During an observation on 05/17/2021 at 3:56 P.M., Resident #101's tube feeding was running, and the head of her bed was at 25 degrees.

During an observation on 05/18/2021 at 8:51 A.M., Resident #101's tube feeding was running, and the head of her bed was at 25 degrees.

During an observation on 05/18/2021 at 10:31 A.M., Resident #101's tube feeding was running, and the head of her bed was at 25 degrees.

Resident #109

Review of a "Face Sheet" revealed Resident #109 was originally admitted to the facility on 2/12/21, with pertinent diagnoses which included: stroke.

Review of Resident #109's "Physician Orders" dated 5/7/21 revealed, "Elevate HOB 30-45 degrees during all feeding and flushes. every shift for minimizing risks."

Review of Resident #109's "Care Plan" revealed, "Resident requires tube feeding R/T Dx (related to diagnosis), Resp failure S/P (status post/after) trach, S/P COVID-19 illness, PCM (protein

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	calorie malnutrition), PTA, NPO (nothing by mouth) status R/T (related to) dysphagia (difficulty swallowing), low BMI (body mass index), UTIs/infections (urinary tract infections), low Albumin levels Date Initiated: 02/13/2021 ... Keep HOB elevated 45 degrees during and thirty minutes after tube feed. Date Initiated: 02/13/2021 ..." During an observation on 05/17/2021 at 12:37 P.M., Resident #109's tube feeding was running, and the head of his bed was at 15 degrees. During an interview on 05/18/2021 at 1:05 P.M., Wound Nurse (WN) "R" reported that if a tube feeding is running the head of the bed should be at 30-45 degrees. During an interview on 05/18/2021 at 11:02 A.M., LPN "D" reported that if a tube feeding is running the head of the bed should be at 45 degrees.			
F0725 SS= G	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of	F0725	Social services visited Resident 101, 102, and 103 for a psychosocial wellness visit. No adverse outcomes were noted, and care plans were reviewed and updated by the IDT as needed. Residents residing in the facility requiring assistance have a potential to be affected. Residents with a BIMS of 13 and above have been interviewed regarding if their needs are being met and if they feel safe in their current environment. Grievance forms have been generated and resolved to resident□s satisfaction. Residents with a BIMS of less than 13, a skin assessment has been completed to ensure no adverse effects from deficient practice. An initial review of the facility staffing has been completed and adjusted based on the needs of the residents and current staff input.	6/10/2021

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	this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #'s: MI00119758, MI00119665, and MI00120011 Based on observation, interview, and record review, the facility failed to provide sufficient staffing to meet resident needs for 2 of 9 residents (Resident #101 and Resident #102) and all residents residing on the 600 Unit reviewed for care needs, resulting in unmet care needs and the potential for impaired physical, mental, and psychosocial well-being. Findings include: Resident #101 Review of a "Face Sheet" revealed Resident #101 was originally admitted to the facility on 3/30/21, with pertinent diagnoses which included: stroke. Review of Resident #101's "Braden Skin Assessment for Predicting Pressure Ulcers" dated 4/21/21 revealed a score of 8 indicating Resident #101 was "very high risk" for the development of a pressure ulcer. Review of Resident #101's "Weekly Skin Assessment" dated 4/22/21 revealed, "Patient has NEW alteration in skin integrity? Yes...Site-Left buttock...Type-Pressure...Length 2cm...Width 1cm...Depth 0.0...Stage-II...Left buttock...Type-		The administrator, scheduler, Director of Nursing, and HR or designee will meet 2 days/week for 4 weeks and randomly as needed to ensure there is adequate staffing to meet resident needs. Ancillary staff will assist with meeting resident needs as needed. The Director of Nursing, or designee will complete random call light audits of 5 residents weekly for 4 weeks, then monthly for 3 months thereafter to ensure residents needs are met timely. or until sustained compliance is achieved to ensure timeliness of care to meet resident needs. The Director of Nursing, or designee will complete 3 random resident interviews weekly for 4 weeks, then monthly for 3 months thereafter to ensure residents needs are met timely. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 06/10/2021 and for sustained compliance thereafter.	

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	Pressure...Length 1cm...Width 0.6...Depth 0.0...Stage-II...Open areas to buttocks not well approximated. Wound bed red with very min serous dng (drainage). Cream applied to buttocks. Res (resident) propped on pillow for pressure relief." Review of Resident #101's "Weekly Skin Assessment" dated 5/4/21 revealed, "Patient has NEW alteration in skin integrity? Yes...Site-Sacrum...Type-Pressure...Length 4.3(cm)...Width 3.3(cm)...Depth (blank)...Stage (blank)..." Review of Resident #101's "Skin & Wound" Evaluation" dated 5/5/21 (lock date 5/17/21) revealed, "Type: Pressure ...Stage: Stage 2 ...Location Right Buttock ...In House Acquired ...How long has the wound been present? New ...Area 1.1cm2-Length 1.9cm-Wideth 0.8cm-Depth 0.1cm ... Goal of Care: 2. Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration ...Additional Care ...Turning/repositioning program ..." Review of Resident #101's "Skin & Wound" Evaluation" dated 5/5/21 (lock date 5/17/21) revealed, "Type: Pressure ...Stage: Stage 2 ...Location-Left Buttock ...In House Acquired ...How long has the wound been present?...New ...Area 0.8cm2-Length 1.3 cm-Width 0.8cm-Depth 0.1cm ... Goal of Care: 2. Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration ...Additional Care ...Turning/repositioning program ..." Review of Resident #101's "Skin & Wound" Evaluation" dated 5/5/21 (lock date 5/17/21) revealed, "Type: Pressure ... Stage: Stage 2 ...Location-Sacrum ... In House Acquired ...How long has the wound been present?...new ...Wound Measurements Area 5.8cm2-Length 4.0cm-Width 1.8cm-Depth 0.1cm ... Goal of Care: 2. Slow to			

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	Heal: wound healing is slow or stalled but stable, little/no deterioration ...Additional Care ...Turning/repositioning program ..." Review of Resident #101's "Skin & Wound" Evaluation" dated 5/11/21 revealed, "Type: Pressure ...Location-Left Buttock ...In House Acquired ...How long has the wound been present?...1 week ...Wound Measurements 1. Area 0.8 cm2-Length 1.3 cm-Width 0.9cm-Depth 0.1cm ...Goal of Care: 2. Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration ..." Review of Resident #101's "Skin & Wound" Evaluation" dated 5/11/21 revealed, "Type: Pressure ... Stage: Stage 2 ...Location-Sacrum ... In House Acquired ...How long has the wound been present?...1 week ...Wound Measurements Area 12.8cm2-Length 7.0cm-Width 3.2cm-Depth 0.1cm ... Goal of Care: 2. Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration ...Additional Care ...Turning/repositioning program ..." Review of Resident #101's "Skin/Wound Evaluation" dated 5/11/21 revealed, "Wound evaluation completed. Resident wound type is Pressure. Wound location is Left Buttock. Wound measurements are: Area - 0.8 cm2, Length - 1.3 cm, Width - 0.9 cm, Depth - 0.1 cm ..." Review of Resident #101's "Skin" progress note dated 5/13/21 revealed, "Location: Sacrum Left Buttock Right Buttock - resolved/healed Type of Skin Change/Impairment: Pressure Injury - Stage 2 ..." (No other progress note related to sacral or other wounds documented on 5/13/2021) During an interview on 05/18/2021 at 1:05 P.M., Wound Nurse (WN) "R" reported that there was a wound identified on 4/22/21 for Resident #101			

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and the wound was no longer moisture associated. Resident #101 originally had 3 separate wounds and on 5/11/21 the right buttock wound had merged with the sacral wound and turned into 1 wound. WN "R" reported that the care plan for impaired skin integrity was not initiated until 5/10/21 but nurses and Certified Nursing Assistants (CNA's) should still be following professional standards of practice for repositioning immobile residents. WN "R" reported that the standard of practice for immobile residents is to reposition every 2 hours as well as providing incontinence care at least every 2 hours if required. WN "R" reported that just because a resident has hemiparesis it does not mean the resident will get a wound. It just puts her at high risk." WN "R" stated that "sometimes with interventions in place they (pressure ulcers) are unavoidable."

During an observation and interview on 05/18/2021 at 11:15 A.M., in Resident #101's room, Certified Nursing Assistant (CNA) "H" reported that Resident #101 was loudly moaning. Resident #101 did not have barrier cream or the ordered treatment dressing covering the wound. Resident #101 had a large irregular shaped wound on her left buttock/sacrum. Observed half of the wound on the left buttock with an area of connection to the sacral area of the wound. The wound was open, and the wound bed had red tissue noted. Approximately ¼ of the wound contained slough and in the center of the slough there was dark green tissue noted. The wound was irregular in shape but was approximately 4cm in diameter. There was a moderate amount of serosanguinous (watery fluid that is blood tinged) fluid noted on Resident #101's brief. Under the left buttock wound there was a pencil eraser sized open area with a bright red wound bed.

During an interview on 05/18/2021 at 10:33 A.M., Certified Nursing Assistant (CNA) "H"

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	reported that at that time there were only 3 CNA's working on the entire unit. CNA "H" reported that it is "impossible" to get to the immobile residents and reposition them every 2 hours with the number of staff working each shift. CNA "H" reported that Resident #101's "bottom has been getting worse and worse because we cant reposition like we need to." CNA "H" reported it started as 1 wound, then 4 wounds, and now "it's all big and open." CNA "H" stated, "We cannot do what we need to do with 3 aides. I have to pick the "heavy wetters" and some residents get pressure ulcers because we cant get to them. Then we get in trouble even when we say we need help. We cant do it all." CNA "H" reported that there are many 2 person assist residents on the 600 Unit, CNA "H" reported that on top of the multiple 2 person assist residents they also have to shower all the residents (2 showers per week for residents), set up meal trays, feed multiple residents, perform brief changes and repositioning, and intervene with resident behaviors. CNA "H" reported that with the prior owners of the facility there were 6 aides and at times an additional shower aide. CNA "H" reported "that was perfect and residents received better care." Resident #103 Review of a "Face Sheet" revealed Resident #103 was originally admitted to the facility on 1/29/21. Review of a "Minimum Data Set" (MDS) assessment for Resident #101, with a reference date of 4/2/21 revealed a "Brief Interview for Mental Status" (BIMS) score of 0, out of a total possible score of 15, which indicated Resident #101 was severely cognitively impaired. Review of the "Functional Status" revealed that Resident #101 required extensive two person assist for bed mobility, transfer, dressing, toileting, and			

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personal hygiene.

Review of a "Minimum Data Set" (MDS) assessment for Resident #103, with a reference date of 3/16/21 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #103 was cognitively intact.

During an interview on 05/18/2021 at 8:27 A.M., Resident #103 reported that he had concerns with the facility being short staffed. Resident #103 reported that he was sitting in a wet brief and had asked for assistance all morning. Resident #103 reported that he had had a wet brief since 3:00 A.M. Resident #103 reported that normally there were only 1-2 CNAs on the Unit for each shift. Resident #103 stated, "Because state is here, they have extra staff on during the day."

During an interview on 05/13/2021 at 12:38 P.M., Licensed Practical Nurse (LPN) "M" and LPN "O" reported that they were the nurses covering "split units." LPN "O" reported that because the facility was short staffed on that day they had to "cover" additional Units. LPN "M" reported that it wasn't safe to work with the shortage for the residents. LPN "O" reported nursing staff could not complete tasks timely and residents would often have to wait. LPN "O" reported the 600 Unit had high acuity residents with high needs. LPN "O" reported that when they are fully staffed "it is fine" but when the nurses cover additional units the nursing staff cannot meet resident needs "timely or at all." LPN "O" reported that medications were passed late that day because of being short staffed. LPN "O" reported as needed pain medications are not administered when residents request them at times and "residents shouldn't be punished because of it (short staffing)."

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SKLD BELTLINE	**2320 E BELTLINE SE GRAND RAPIDS, MI 49546**

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	During an interview on 05/13/2021 at 3:06 P.M., Certified Nursing Assistant (CNA) "U" reported that there were only 3 CNA's for the entire 600 unit for 2nd shift. CNA "U" reported that 3 CNA's and 2 nurses was not enough to meet the needs of the residents. CNA "U" reported that at times they have to put residents to bed before dinner in order to get all residents to bed before the end of shift. CNA "U" reported that the staff attempt to get to the immobile residents to check and change and reposition but reported it was difficult without enough staff. CNA "U" reported that the 600 Unit had many 2 assist residents. During an interview on 05/13/2021 at 11:21 A.M., CNA "N" reported that there were not enough staff to meet the needs of the residents. CNA "N" reported that most residents on the 600 Unit were extensive 2 person assist and needed frequent repositioning and incontinence care. CNA "N" reported that the staff could not "keep up" and meet the needs of the residents. CNA "N" reported that 4 CNAs scheduled for 44 residents, with many that required 2 person assist, was too difficult to handle. CNA "N" reported that many days there were only 3 CNAs scheduled for the 600 Unit. During an observation and interview on 05/18/2021 at 11:18 A.M., LPN "E" reported that it is not safe to care for as many residents as they are. LPN "E" reported that medications are consistently administered late because of the number of residents the nurses are responsible for. During an interview on 05/18/2021 at 12:29 P.M., LPN "E" reported that because of the short staffing the facility aides "cannot get to repositioning" the immobile residents on the unit. During an observation and interview on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414290	A. BUILDING _____ B. WING _____	**5/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	05/18/2021 at 3:26 P.M., CNA "L" reported that at that time there were only 2 CNA's schedule for 2nd shift on the 600 Unit for approximately 44 residents. CNA "L" reported that the other CNA scheduled at that time was on her break which left her to be alone on the 600 Unit. CNA "L" reported she was doing the best she could but could not assist 2 person assist residents when she was the only aide and the nurses were also short staffed and busy. Observed 6 call lights on at the time of the interview. Review of the facility schedule dated 5/18/21 revealed that on 5/18/21 there was only 1 CNA scheduled on the 600 Unit for the 2nd shift. CNA "L" extended her shift to assist with coverage. Review of the "Facility Matrix" revealed that on 5/17/21 there were 44 residents on the 600 Unit. Review of a list provided by the facility on 5/17/21 revealed that there were 23 residents on the 600 Unit that required 2 person assist for cares.			