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 _____	4/23/2021

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
F0000 SS=	INITIAL COMMENTS SKLD Bloomfield Hills was surveyed for an Annual Survey on 4/23/21. MI00117665, MI00118231, MI00118238, MI00118245, MI00118264, MI00119044, MI00119065, MI00119118, MI00119418. Census = 145	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 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	F0550	Resident #31 no longer resides at the facility. Resident #33 is not interviewable, Kardex has been updated to offer being dressed daily. All residents in the facility have the potential to be affected. The facility policy regarding Dignity and Respect will be followed. By 5/24/21, nursing staff will be educated on Resident Rights Dignity & Respect (7/2018)- which will include but is not limited to caring for and treating all residents in a dignified manner. The Administrator/designee will conduct random dignity and respect audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure residents are cared for and treated in a dignified manner. 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 on 5/24/21 and for sustained compliance thereafter.	5/24/2021

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

Electronically Signed | 05/13/2021

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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	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 #: MI00118238. Based on observation, interview, and record review the facility failed to ensure two residents (R31 and R33) were treated in a dignified manner, resulting in the potential for embarrassment and diminished feelings of self-worth, and self-image. Findings include: According to the facility's policy "Dignity and Respect" dated 7/11/18, "...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...Residents will be appropriately dressed in clean clothes arranged comfortably on their persons..." Resident #33: On 4/20/21 at 11:06 AM, 12:36 PM, 2:26 PM, 4/21/21 at 8:41 AM and 2:53 PM, R33 was observed lying in bed wearing a hospital gown. The closet was observed to have several shirts, pants, and t-shirts.			

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	Review of the clinical record revealed R33 was admitted into the facility on 1/13/21 and readmitted on 3/26/21 with diagnoses which included: metabolic encephalopathy, hyperosmolality and hypernatremia, hypokalemia, unspecified severe protein-calorie malnutrition, history of COVID-19, stiffness of right and left knee, dementia in other diseases classified elsewhere without behavioral disturbance, anorexia, adult failure to thrive, delirium, vascular dementia without behavioral disturbance, and osteoarthritis. According to the significant change MDS assessment dated 2/12/21, R33 had severely impaired cognitive skills for daily decision making and required extensive assistance of one person physical assist for dressing. On 4/23/21 at 1:33 PM, the Director of Nursing (DON) was queried about whether residents should be dressed instead of wearing hospital gowns and reported, they should but wanted to check with the aide who was assigned to R33. On 4/23/21 at 1:45 PM, the Certified Nursing Assistant (CNA) assigned to R33 was in another resident's room and not able to be interviewed. At that time, Nurse Manager 'H' was asked about R33 not being dressed in regular clothes that were in their closet and instead left in a hospital gown. Nurse Manager 'H' reported they were made aware of the concern from the DON a short while ago and further reported that R33 had plenty			

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of clothes available to wear and should be dressed and up in chair.

Resident #31:

On 4/20/21 at approximately 11:00AM, R#31 was observed in their room. The resident was heard to be crying out. Staff were queried as to the name of the resident and went to get another staff member. R#31 was observed to be in a geri-chair, and a sign which discussed positioning needs was observed resting on the front/lap area of the resident. The resident was later identified as R#31.

The clinical record for R#31 was reviewed and revealed the resident was admitted to the facility 2/6/21 and was readmitted 4/6/21 with diagnoses which included, in part, sepsis, peripheral vascular disease, transient cerebral ischemic attack, functional quadriplegia, cerebral palsy and schizoaffective disorder. Review of the resident's minimum data set (MDS) assessment dated 2/10/21 revealed the resident scored 00 out of 15 on a brief interview for mental status, which indicated the resident was severely cognitively impaired.

On 4/2/21 at approximately DON 4/2/21, the facility's Director of Nursing (DON) was queried in regard to the observation of R#31, explained they had spoken with the certified nursing assistant (CNA) and had asked where the sign had come from. The DON acknowledged the sign should not have been

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	there.			
F0554 SS= D	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure one resident (R#134) was assessed for the self-administration of a nasal spray medication. Findings include: On 4/20/21 at approximately 2:21 p.m., R#134 was observed in their room lying in their bed. R#134 was observed to have a bottle of Azelastine Hydrochloride Nasal Solution 0.1% (nasal spray) on their bedside table. R#134 was queried if they had used it and they reported they had and that it "helped clear it all out." On 4/21/21 at approximately 11:04 a.m., R#134 was observed in their room, lying in their R#134 was still observed to have their nasal spray on their bedside table. R#134 was observed to be lethargic. On 4/21/21 at approximately 2:04 p.m., R#134 was observed in their room lying in their bed. R#134 was still observed with their nasal spray on their bedside table. R#134 was	F0554	Resident #134 nasal spray was removed from bedside. Resident #134 has chosen to allow the facility to administer her nasal spray as prescribed. All residents in the facility have the potential to be affected. Facility sweep revealed that no other residents had medications left at the bedside. By 5/24/21, Licensed Nurses will be educated on Care and Treatment Self Administration of Medications (7/2018) to ensure that medications are not at bedside unless self-administration assessment has been completed and determined to be clinically appropriate. The DON/designee will conduct random audits for medications at bedside on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure medications are not left at the bedside unless the resident has been assessed and deemed safe to self-administer their medication. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	5/24/2021

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	queried if they had recently used the nasal spray and they reported they had but did not remember when. On 4/22/21 at approximately 8:48 a.m., R#134 was observed in their room lying in their bed. R#134 was still observed to have their nasal spray on their bedside table. On 4/23/21 the medical record for R#134 was reviewed and revealed the following: R#134 was initially admitted to the facility on 3/29/21 and had diagnoses including stage 4 pancreatic cancer , shortness of breath and anxiety. A review of R#134's MDS (Minimum Data Set) with an ARD (assessment reference date) of 4/1/21 revealed R#134 needed extensive assistance with most of their activities of daily living. R#134's BIMS score (brief interview of mental status) was 11 indicating moderately impaired cognition. A review of R#134's Physician orders reveled no order for administration or the self-administration of Azelastine Hydrochloride Nasal Solution 0.1%. A review of R#134's careplans revealed no careplan for the self administration of nasal spray. On 4/22/21 at approximately 9:20 a.m., during a conversation with Unit Manager "C" (UM "C"), UM "C" was queried regarding the Azelastine Hydrochloride Nasal Solution 0.1% on R#134's bedside table. UM "C" indicated			

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no residents should have medications at their bedside. UM "C" was queried if they were aware of R#134's nasal spray on their bedside table and they reported they were not and that residents needed to be assessed for safety of self-administration of medications. UM "C" was queried if they believed R#134 would be safe to self-administer their nasal spray and they indicated they would not. UM "C" reported that the nasal spray needed to be ordered by the doctor and the nurses will have to be educated.

On 4/22/21 at approximately 3:00 p.m., UM "C" was queried regarding the disposition/follow up of the Azelastine nasal spray that was observed on R#134's bedside table. UM "C" reported the Nurse for R#134 had gone into R#134's room to retrieve it and put it in the nursing cart for safe keeping.

A facility document titled "Policy/Procedure-Nursing Administration-Self Administration of Medications" was reviewed and revealed the following: "POLICY: It is the policy of this facility to respect the wishes of alert, competent residents to self-administer prescribed medication choosing to and capable of self-administration...PURPOSE: To determine the ability of alert residents to participate in self-administration of medications. To maintain the safety and accuracy of medication administration...PROCEDURE: 1. Upon admission, alert residents will be informed of their right to self-administer medications. 2. If

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	a resident, desires to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate the resident based on change in the resident's status. 3. The residents cognitive, communication, visual, and physical ability to carry out this responsibility will be evaluated. If the interdisciplinary team determines that this resident is unable to carry out this responsibility (this would be dangerous to resident or others), the interdisciplinary team may withdrawal this right. 4. If the resident is a candidate for self-administration of medications, this will be indicated in the chart. 5. Resident will be instructed regarding proper administration of medication by the nurse. 6. Nursing will be responsible for recording self-administered doses in the resident's medication administration record (MAR). 7. Storage and location of drug administration (e.g., resident's room, nurses' station, or activities room) will comply with state and federal requirements for medication storage. 8. Interdisciplinary team may include Medical Director or Primary Care Physician, the Director of Nursing Services and other Nursing Representative, and Social Services. 9. Appropriate notation of these determinations will be placed in the resident's care plan."			
F0583 SS= D	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records § 483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F0583	Resident #13 was interviewed and reported having no issues with privacy. Resident #21 was interviewed and reported having no issues with privacy. Resident #53 was interviewed and reported	5/24/2021

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	§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review yhe facility failed to ensure residents' right to personal privacy during treatments (eye examinations and COVID-19 testing) for five (R21, R13, R53, R71, R140) residents reviewed for privacy, resulting in the increased potential for embarrassment, and/or intrusion of privacy. Findings include:		having no issues with privacy. Resident #71 is not interviewable and is being maintained. Resident #140 was interviewed and reported having no issues with privacy. All residents in the facility have the potential to be affected. The facility policy regarding Dignity and Respect will be followed, which will include but not limited to ensuring that privacy is provided during treatments and cares. The facility policy on privacy has been reviewed and deemed appropriate, by 5/24/21, nursing staff will be educated on the Resident Rights □ Dignity & Respect (7/2018) policy which will include but not limited to ensuring that privacy is provided during treatments and care to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on privacy are being followed as presented. The DON/designee will conduct random privacy audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure residents are provided privacy during treatments and cares. 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 on 5/24/21 and for sustained compliance thereafter.	

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	According to the facility's policy "Dignity and Respect" dated 7/11/18, "...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...Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the Resident from passers-by. People not involved in the care of the Resident shall not be present without the resident's consent while they are being examined or treated..." On 4/22/21 at 11:42 AM, observation of the facility's second floor east common lounge area revealed Optometrist 'F' and R140 were at a table in full view during an eye examination and discussion of personal health information. There were several other residents (R53 and R71) seated nearby in full view R140's examination with Optometrist 'F'. There were no privacy screens in place to ensure personal privacy during examination. Optometrist 'F' was then observed to go around to several other residents in the room and when R13 was brought closer into the area by staff, Optometrist 'F' was observed to ask the staff if R13 was there for the exam and the staff indicated they were not and proceeded to place R13 into the common lounge area. On 4/22/21 at 11:50 AM, Nurse Manager 'H' was queried about the observation of residents in the common area without privacy			

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and reported there was no other room to set up. When asked if there were any consideration of alternate places to conduct the eye examinations, Nurse Manager 'H' reported they would find a privacy screen and that this was not the normal process.

Resident #21:

On 4/23/21 at approximately 8:40AM, R#21 was observed seated in a wheelchair in the hallway by the nurses station. The resident was observed to have their breakfast tray in front of them. A person (later identified as subcontractor 'GG' was observed to attempt to obtain a nasal swab from R#21, and was heard to tell the resident, "It doesn't feel super good we need to do it to keep you safe."

Review of the clinical record for R#21 was reviewed and revealed the resident was admitted to the facility on 6/17/19 and was readmitted on 12/6/19 with diagnoses which included, in part, Alzheimer's disease with late onset and dementia with behavioral disturbance. Review of a minimum data set (MDS) assessment dated 1/26/21 revealed the resident scored 3 out of 15 on a brief interview for mental status exam, which indicated the resident was severely cognitively impaired.

On 04/23/21 at 10:04 AM, the facility's Director of Nursing (DON) was queried in regard to the above observation, and

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	acknowledged residents were supposed to be swabbed in their rooms.			
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 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: Resident 14:	F0584	Resident #33 enteral tube feeding pole and floor was cleaned, wire for TV secured, repair of the wood molding to ensure no sharp edges and a clean privacy curtain was hung in room. Resident #101 floor was cleaned, and repairs completed. Resident # 110 enteral tube feeding pole, floor mats and floor was cleaned. Resident #14 sink vanity in bathroom was repaired to fix the peeling laminate and tightened to ensure vanity was secured to wall. Resident #79 enteral tube feeding pole and bed frame was cleaned. Resident #32 enteral tube feeding was replaced with a new pole that was cleaned and free of rust. The heat/air register was cleaned and free of debris. Resident #31 overbed table was cleaned. All residents in the facility have the potential to be affected. The facility completed an audit which consisted of observing resident rooms to ensure residents reside in a clean and safe environment. The facility policy on Safe/Clean/Comfortable /Homelike Environment has been reviewed and deemed appropriate. By 5/24/21, the Housekeepers, Maintenance and nursing staff will be educated policy for Safe/Clean/Comfortable /Homelike Environment and on the process for notifying environmental services/maintenance to ensure timely repairs and cleaning to ensure that the policy is being followed for continued compliance. Clinical, Housekeeping and Maintenance managers will be providing focused oversight and rounding to follow the	5/24/2021

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	On 4/20/20 at 2:00 PM, an observation of R14's room was conducted. The sink vanity located inside R14's bathroom was observed with loose, peeling laminate covering. The wood underneath the laminate had expanded from water seeping into it and was damp and spongy to the touch. When queried, R14 stated that she was afraid to use the sink, because she thought the wood damage was due to termites. On 4/23/20 at 10:00 AM, an interview was conducted with Maintenance Director (Staff "LL"). Staff LL stated that he was unaware of the issues with R 14's sink, and that he would replace the countertop right away. Residents #32 and #79 On 4/20/21 at 3:07 PM and 4/21/21 at 7:45 AM and 4:25 PM, an observation of R#79's room was conducted. A pole used to hang tube feeding formula was observed with a tube feeding pump that was dirty and covered with a film. The floor underneath the pole was observed with a medium sized dried puddle of tan substance that appeared to be tube feeding formula. The head of R#79's mattress was lifted from the bed frame. The metal bed frame had multiple areas of dried, tan tube feeding formula splattered on it. R#79 was observed to be non-verbal, had a tracheotomy, and received nutrition via a feeding tube. On 4/20/21 at 3:11 PM and 4/21/21 at 7:50 AM and 4:20 PM, an observation of R#32's room was conducted. A pole used to hang tube feeding formula was observed to be		facility□s policy and ensure that the in-services on Safe/Clean/Comfortable /Homelike Environment are being followed as presented. The Administrator/designee will conduct random environmental audits on 5 resident rooms weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained by ensuring the facility maintains a clean and sanitary environment specifically to enteral tube feed poles, privacy curtains, floors and repairs are completed 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 on 5/24/21 and for sustained compliance thereafter.	

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	dirty and rusty and the tube feeding pump covered with a dirty film. The heat/air register was observed to be dirty with debris and dust in the vent area, and on the control panel door. R#32 was observed to be non-verbal, had a tracheostomy, and received nutrition via a feeding tube. On 4/21/21 at 4:31 PM, an interview was conducted with Registered Nurse (RN) "S" and an observation of R#79's room was conducted. When queried about who was responsible to ensure the floor was cleaned if there was spillage of tube feeding formula, RN "S" stated, "Housekeeping is responsible, but I can clean it." On 4/21/21 at 4:42 PM, Environmental Services Director (ESD) "K" was interviewed. When queried about who was responsible to ensure residents' tube feeding poles and machines were clean, and who was responsible to clean up spillage from tube feeding formula, ESD "K" stated, "Housekeeping is responsible, but aides and nurses need to let us know so we don't affect anything with the tube feeding. Once it is dried on the floor, we have to strip the floor". Observations of R#79 and R#32's rooms was conducted with ESD "K". Upon observation of the dirty tube feeding poles and machine in R#79 and R#32's room, tube feeding spillage on the floor and on the bed frame in R#79's room, and the dirty heat/air register in R#32's room, ESD "K" reported it should have been cleaned up by nursing or housekeeping.			

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On 4/22/21 at approximately 8:00 AM, observations of R#79 and R#32's rooms were made. The tube feeding poles, machines, bed frame, floors, and heat register were observed to be in the same condition as the previous observations.

R#79's clinical record was reviewed and revealed R#79 was admitted into the facility on 8/28/19 and readmitted on 3/9/21. A MDS assessment dated 3/12/21 documented R#79 had severely impaired cognition and was totally dependent on staff for all care.

R#32's clinical record was reviewed and revealed R#32 was admitted into the facility on 8/1/19 and readmitted on 2/4/21. A MDS assessment dated 2/7/21 documented R#32 had severely impaired cognition and was totally dependent on staff for all care.

Resident #31:

On 4/21/21 at 8:30 AM the overbed table for R#31 was observed to have multiple stains present which were beige in color.

On 4/21/21 at 3:07 PM the resident's overbed table in the resident was room was observed to have circular stains present which were light in color.

On 4/22/21 at 8:51 AM R#31's overbed table was observed to be soiled with stains which were beige in color.

On 4/22/21 at approximately 8:15AM,

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Housekeeping Staff Member 'HH' explained that when food carts were up, they were not able to do room cleaning. The staff member explained that with lunch and breaks, that gave them three hours to clean. Housekeeping Staff Member 'HH' was queried about getting everything done, and responded it was "impossible".

On 4/22/21 at 8:24 AM. Housekeeping Staff Member 'HH' further explained the food carts were up for two hours for breakfast and lunch, explained there were four housekeeping staff and one person in laundry, and when the carts were up Housekeeping Staff Member 'HH' was supposed to go to laundry. Housekeeping Staff Member 'HH' acknowledged this impacted the cleaning of resident rooms, and resident rooms not being addressed.

Based on observation, interview, and record review, the facility failed to ensure resident rooms were maintained in a clean and sanitary condition for seven (R#s 14, 31, 32, 33, 79, 101, and 110) of 14 residents reviewed for the environment, resulting in the potential for dissatisfaction with their living environment and the spread of infection. Findings include:

According to the facility's undated "Daily Cleaning Procedures (DCP)" policy provided for review, " ...Disinfect. Work your way clockwise around the room (starting at the door and finishing at the door) and disinfect flat surfaces and high-touch items. This includes, but is not limited to ...bed siderails, bed frame, footboard and headboard ...any flat surfaces ...Inspect Privacy Curtains ..."

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	Resident #33: On 4/20/21 at 11:06 AM, 12:36 PM, 2:26 PM, and 4/21 at 8:41 AM, an observation of R33's room was conducted. A pole which had tube feeding formula hung and a pump to run tube feeding was observed in use. At each of these observations, the base of the pole, surrounding floor, side of bed and floor mats were observed to be soiled with a tan colored substance that appeared to be tube feeding formula (same color as in the tube feeding that was in use). The resident's left side of the bed was positioned against the wall and approximately one foot above the resident's feet was a wire sticking out from the television attached to the wall and a decorative wood molding was broken with sharp edges of wood exposed. The resident's privacy curtain was also observed soiled with several dark stains. R33 was observed to be non-verbal and received nutrition via a feeding tube. On 4/21/21 at 8:48 AM, Nurse Manager 'C' entered the room and began to check on the resident's tube feeding. When asked about the facility's process for maintaining a clean and safe environment in the room, Nurse Manager 'C' acknowledged the soiled floor, tube feeding pole and broken wood on the wall and reported, "Anyone can report that, and any staff should let housekeeping know it needs to be cleaned. Also, if anything is broken, there is a binder at each nursing desk that any staff can write in about any concerns			

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that need to be addressed."

Resident #101 and Resident #33:

On 4/22/21 at 8:05 AM, upon entry into the room occupied by R33 and R101, there was no bed in the room on the side that R33 resided and R33 was not in the room at this time. The flooring from just inside the room, over towards R101's side of the bed was observed with multiple splatters of brown colored substance of what appeared to be fecal matter. The room across from R33's room was observed to have an isolation cart placed just outside the door with no name on the door and a sign that indicated the resident was on isolation precautions. At that time, Licensed Practical Nurse (LPN 'J') who had been assigned to R33 on 4/21) was observed in the hallway nearby and when asked about why R33 was not in the room, they reported "I'm not sure, but I believe he was moved last night for c-diff." (Clostridium difficile is a bacteria that can be transmitted from person to person by spores which can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon.)

On 4/22/21 at 8:07 AM, a lab technician was observed to enter into the room with the brown substance while pulling a rolling cart full of lab supplies over the soiled flooring and over to R101 and stated they were there to obtain a blood draw.

On 4/22/21 at 8:09 AM, the Assistant

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	Administrator (Staff 'O') was next door and upon entry into the center hallway was asked to observe the room and confirmed the soiled flooring. On 4/22/21 at 8:20 AM, an interview was conducted with the Administrator and Director of Nursing (DON) in regard to the above observations. The DON reported they would like to review their 24 hour log and upon review, reported R33 had been moved last night at approximately 8:30/9:00 PM due to suspected c-diff and further reported that staff should have cleaned up the room last night. On 4/23/21 at approximately 4:30 PM, the DON was queried if R33's stool specimen results had been received and provided a copy of R33's lab report which documented, "Toxin producing C. difficile DETECTED..." R33's clinical record was reviewed and revealed the resident was admitted into the facility on 1/13/21 and readmitted on 3/26/21. A Minimum Data Set (MDS) assessment dated 2/12/21 documented R33 had severely impaired cognitive skills for daily decision making and was dependent on staff for all aspects of care. R101's clinical record was reviewed and revealed the resident was admitted into the facility on 2/25/21 and readmitted on 3/22/21. A MDS assessment dated 3/25/21 documented R101 had moderately impaired			

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	cognition and required extensive assistance with most aspects of care. On 4/21/21 at 9:04 AM, an interview was conducted with the Maintenance Director (Staff 'LL'). When asked about the facility's process for notification of items that needed repair, Staff 'LL' reported there was a logbook on the units and a "TELS" system but reported "No one really uses that (TELS) much. I review the log several times a day." When asked to review the logbook or TELS system to see if there had been any reports of concern with R33 and R101's room, Staff 'LL' reviewed the logbook and reported due to inability to contract out with vendors, the were only able to do essential repairs. At that time, Staff 'LL' was asked to observe R33 and R101's room. Staff 'LL' confirmed the wires sticking out of the wall and the broken wood molding and reported they would get that fixed. Staff 'LL' reported they had not been notified of those concerns prior to today. On 4/21/21 at 9:15 AM, an interview was conducted with the Environmental Services Director (Staff 'K') who reported they had only been contracted with the facility for about a month. At that time, upon observation of the R33 and R101's rooms, Staff 'K' confirmed the concerns with the soiled tube feeding pole, floor, and fall mats. When asked how often the housekeepers cleaned the resident's equipment such as the tube feeding poles, Staff 'K' reported "The housekeepers come in to check and change			

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trash, disinfect after the resident is hospitalized or moved rooms." When asked what about residents that remained long term and were not discharged, how their equipment such as tube feeding poles were maintained, Staff 'K' reported, "We don't touch (tube feeding poles), when in use don't touch pole in case anything gets disconnected." When asked about the soiled privacy curtains, Staff 'K' reported this week was supposed to be a focus on getting to the resident's privacy curtains.

Resident #110:

On 4/20/21 at 10:47 AM, and 4/21/21 at 8:36 AM, an observation of R110's room was conducted. A pole which had tube feeding formula hung and a pump to run tube feeding formula was observed in use. At each of these observations, the base of the pole, surrounding floor, and floor mats were observed to be soiled with a tan colored substance that appeared to be tube feeding formula (same color as in the tube feeding that was in use). The privacy curtains were also observed to be soiled with multiple dark stains. R110 was observed to be asleep and did not respond to verbal communication upon approach and received nutrition via a feeding tube.

R110's clinical record was reviewed and revealed the resident was admitted into the facility on 9/13/18 and readmitted on 12/26/20. A MDS assessment dated 3/22/21

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	documented R110's cognition was severely impaired and was dependent on staff for all aspects of care.			
F0610 SS= D	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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: Based on observation, interview, and record review, the facility failed to thoroughly investigate an allegation of abuse for one (R#81) of four residents reviewed for abuse, resulting in the potential for unidentified and continued abuse. Findings include: On 4/20/21 at 11:05 AM, R#81 was observed sitting up in bed. An interview was conducted with R#81 at that time and the resident was asked about the care they received in the facility. R#81 reported that back in February 2021, Certified Nursing Assistant (CNA) "Y"	F0610	Facility reviewed and completed an investigation for resident #81 All residents in the facility have the potential to be affected. The facility will complete an audit of all FRIs to ensure they have a thorough investigation. The facility policy has been reviewed and deemed appropriate. By 5/24/21, the Administrator and DON were educated on the Facility Abuse and Neglect Policy specifically on ensuring alleged events are investigated appropriately to ensure that the policy is being followed for continued compliance. The company Regional Director of Operations/designee will conduct random audits on any abuse/grievance allegation investigations weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained by ensuring all allegations of abuse/neglect are being thoroughly investigated. The results will be presented to the QAA committee for review and consideration of further corrective actions. The company Regional Director of Operations/designee will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	5/24/2021

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	was rude, rough, and felt the manner in which care was provided was "abusive". R#81 further reported that CNA "Y" responded to R#81's call light, entered the room, and rudely said, "What do you want?" R#81 stated, "She (CNA "Y") was real nasty and said she would come back, smacked her lips, and sighed as she left the room." R#81 further reported CNA "Y" returned to the bathroom and started to prepare things to clean up the resident. R#81 stated, "She stood on the side of the bed and I asked her to wipe my front first because I had a bowel movement. She said, 'I'm not going to do that. Just roll over.' So, I turned over. She took the bed pan into the bathroom and I said, 'You did not wipe me!' Then she had me turn over again and wiped my front, but it was weird because she was like jabbing me when she was doing it, like she was mad at something. Then she had me turn back to my back and was jabbing and twisting. She has always had an attitude but was never physical like that. I did not know what she was so upset about . Then she told me to roll over again to wipe my front again. Then she just cleaned up and left." R#81 reported she did not report the incident to anyone on that day and decided to wait to see what happened the next day. R#81 stated, "But then the next day came and I didn't even want to press my light because I was so uncomfortable with how she cared for me the day before." R#81 reported she pushed her call light around 3:00 AM and a nurse put the resident on the bed pan and CNA "Y" took her off. R#81 reported there			

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was another CNA in the room and CNA "Y" made a comment to the other CNA in front of me. R#81 stated, "I decided I just didn't want to deal with her anymore because I felt abused and on Monday morning, I told the nurse on duty and she had me fill out a grievance form and (the Administrator) came to talk to me."

On 4/22/21 at 2:16 PM, an investigation conducted by the facility was reviewed. A form titled, "Verification of Investigation" for R#81 documented "alleged abuse" and the "Date of Finding" as 2/26/21. A "Summary of Factual Investigative Findings" documented the following: "...On Monday February 22, 2021 at approximately 11:30 am (R#81) completed a concern form which was provided to the administrator immediately. The concern stated that on '2-20-2020 <sic> (CNA "Y") was my caregiver. She was rude and mean when talking to me and physically handling me. I absolutely do not want her for my <sic> anymore.' The administrator immediately queried the resident regarding her concerns and suspended the CNA pending investigation. (R#81) stated to the administrator that the CNA responded to her call light after being placed on a bed pan. She stated that when she completed using the bed pan, she asked the CNA to wipe her front to back first. The resident was not happy that the CNA had her turn to her side before wiping her front, she also felt that the tone of her voice was rude and that she was unhappy that she had a BM (bowel

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	movement)...The resident felt that the CNA could have done it in a more gentle manner without giving any further clarification. Resident did not inform anyone of this concern for two days... ...The CNA was queried by the administrator and stated that she answered the call light as the resident was on the bed pan, the resident asked to be cleaned from the front first and the CNA asked her to roll to the side to remove the bed pan first so it did not spill out. The resident was laying on a brief and wiped cleaned with front first and then had resident roll to the back. The CNA stated no concerns were raised at that time... ...MSW (Masters Social Worker) met with resident in her room where she was laying in bed...discussed recent issue with staff which has been resolved, per her report after talking with facility administrator. (R#81) reported that she has difficulty confronting others. MSW encouraged her to verbalize feelings and advocate for herself... ...A review of the CNA file was completed with no concerns. The CNA was reinstated on 2-26-2021 and will not be assigned to the set...Upon completion of the investigation, the allegation of abuse could not be substantiated..." The "Verification of Investigation" form was signed by the Director of Nursing (DON) on 2/26/21. It was not signed by the Administrator (Abuse Coordinator).			

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A "Grievance and Satisfaction Form" dated 2/22/21 at 11:30 AM did not document the name of the person who received the grievance. A description of the grievance documented, "2/20/21 (CNA "Y") was my caregiver. She was rude mean when talking to me and physical handling of me was abusive. Sunday night was the same energy. I absolutely do not want her to care for me anymore" The "Investigation" section was left blank and the "Resolution" documented, "CNA not to work on her set". The form was not signed by the resident or the Administrator.

A typed document included undated and unsigned statements from the resident (R#81) and CNA (CNA "Y").

A typed document dated 2/22/21 documented R#81's name and "11:30 AM". It was not signed by anyone and documented, "This patient communicated to this LN (licensed nurse) during treatment that a CENA on night shift named (CNA "Y") was rude and displayed 'abusive' behaviors towards the patient. Patient states 'She was really abusive to me and would not wipe me down in the front when I had a BM on Saturday night. She was mean with her tone of voice and rude. She was upset because I told I <sic> had a BM'. LN educated patient on residents rights and the need to disclose this information to management."

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	There was no indication in the investigation file that any other residents were interviewed as part of the investigation or that the person who typed the form on 2/22/21 was identified and interviewed. On 4/22/21 at 2:39 PM, the facility's Administrator, who was identified as the Abuse Coordinator, was interviewed. When queried about how the abuse alleged by R#81 was investigated and how the facility determined it was unsubstantiated, the Administrator reported the DON did the investigation. When queried about whether the investigation was reviewed by the Administrator, the Administrator stated, "I always review the investigations." The Administrator was asked if the investigation conducted was thorough, and they stated, "The investigations are always thorough." When queried about the dates of the interviews, the name of the nurse who R#81 reported the allegation to, who reported the allegation to the Administrator, and if any other residents were interviewed as part of the investigation, the Administrator reported they talked with the resident and the CNA involved and stated, "(R#81) just didn't understand that she had to be rolled off of the bed pan first. We could not substantiate abuse after talking to the resident." When queried about any further details about what exactly R#81 alleged CNA "Y" did physically, the Administrator reported the DON would have more details about the investigation and was unsure if any other residents were			

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interviewed.

At that time, the DON was interviewed about the above investigation. When queried about whether the nurse who R#81 made the allegation to was interviewed, the DON reported she did not talk to the nurse and did not know who the nurse was, but then further reported she called the nurse and left a message, but they did not return the call. The DON reported there were two other nurses who refused to give information, but thought it was another nurse who did not work at the facility any longer. When queried about how it was ruled out if any other residents were affected by CNA "Y", the DON reported she talked to residents, but did not include it in the investigation and did not have the names of the residents she interviewed.

A review of R#81's clinical record revealed R#81 was admitted into the facility 2/27/20 and readmitted on 5/16/20 with diagnoses that included: chronic obstructive pulmonary disease, chronic kidney disease, and diabetes. A Minimum Data Set (MDS) assessment dated 3/6/21 documented R#81 had intact cognition and required extensive assistance with bed mobility, transfers, and toilet use.

A facility policy titled, "Abuse and Neglect" (revised 6/17/2019) documented, "...The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations...The administrator is the abuse

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	coordinator in this facility and is responsible for...conducting the investigation in situations of alleged abuse/neglect..."			
F0658 SS= D	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to administer medications per accepted standards of practice for one (R145) of one resident reviewed for percutaneous endoscopic gastrostomy (PEG - a tube that is passed into the stomach through the abdominal wall) medication administration, resulting in five oral medications crushed together and administered to the resident. Findings include: On 4/22/21 at 8:04 AM, during an observation of a PEG tube medication administration for R145, Registered Nurse (RN) "AA" placed five oral medications: aspirin 81 milligrams (mg), Vitamin D-3 2,000 units, sodium chloride 1 gram (g), Eliquis 5 mg, and Vitamin B-12 100 micrograms (mcg) into a small, rectangular plastic sleeve and crushed all five pills together. RN "AA" poured the five crushed medications into an	F0658	Resident #145 was assessed for any adverse reactions to medication administration via PEG Tube. All like residents in the facility have the potential to be affected. Like residents were assessed to ensure they have not had any adverse reactions to medication administration via PEG Tube. The policy on Enteral Feeding has been reviewed and deemed appropriate. By 5/24/21, Licensed Nurses will be educated on the Enteral Feeding Administration-Medication Administration policy for administering medications through a PEG Tube to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight, observation and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on medication administration via PEG Tube is being followed as presented. The DON/designee will conduct random Enteral Feeding Medication Administration audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure medications are administered via PEG Tube per policy. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	5/24/2021

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approximately six ounce clear water cup, added water and stirred the contents with a plastic spoon. RN "AA" attached an enteral medication syringe to R145's PEG tube, poured the entire contents of the five crushed medications and water into the syringe and began to administer the medications. R145 was observed to begin coughing and RN "AA" stopped the medication administration.

On 4/22/21 at 9:16 AM, RN "AA" was interviewed and asked about crushing R145's five oral medication together. RN "AA" explained she was supposed to crush each medication separately and she did not know which of the medications R145 had received before she stopped the administration.

Review of the clinical record revealed R145 was originally admitted into the facility on 6/28/19 and readmitted 3/30/21 with diagnoses that included: pneumonia, Parkinson's Disease, and seizures. According to the Minimum Data Set (MDS) assessment dated 4/1/21, R145 scored 00 on the Brief Interview for Mental Status (BIMS) exam, indicating severely impaired cognition. The MDS also indicated R145 had a feeding tube.

On 4/22/21 at approximately 11:30 AM, the Director of Nursing (DON) was interviewed and asked about medication administration via PEG tube. The DON explained all medications should be crushed separately and given one at a time.

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	Review of a facility policy titled, "Enteral Feeding Administration - Medication Administration" dated 7/26/18 read in part, "...c. verify that tablet/capsules are approved for crushing...Once verified, dissolve medication in medicine cup using 10 to 30 cc (cubic centimeter) of water. d. Keep medication separate...11. Instill each medication separately..."			
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: This citation pertains to intake #MI00119118. Based on observation, interview and record review, the facility failed to ensure nail care was provided to two (R110 and R29) of 10 residents reviewed for activities of daily living (ADLs), resulting in the presence of long, dirty fingernails. According to the facility's policy for "Nail Care" dated 7/11/18, "It is the policy of this facility to promote cleanliness, safety, and neat appearance of our residents...If nails are too hard or too thick to cut easily, report to charge nurse or physician..."	F0677	Resident #29 received care for fingernails to ensure nails were cleaned and trimmed. Resident #110 no longer resides at the facility. A facility sweep was completed to ensure all residents were assessed to ensure that nails were clean and trim. The facility policy has been reviewed and deemed appropriate. By 5/24/21, direct care staff will be educated on the facility□s Nail Care Policy including the trimming and cleaning of fingernails to ensure that the policy is being followed for continued compliance. Facility managers will be providing focused oversight, observation and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on nail care are being followed as presented. The DON/designee will conduct random nail care 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 Nail Care Policy and residents nails observed to be cleaned/trimmed. The results will be presented to the QAA committee for review and consideration of further corrective actions.	5/24/2021

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	Resident #110: On 4/20/21 at 10:47 AM, and 4/21/21 at 8:36 AM, an observation of R110 revealed the resident was lying in bed with both arms positioned in a manner as if the resident were flexing their arms and both hands were bent down at the wrist with closed fists. The fingernails were observed to be long with dark debris underneath the nail tips at each of these observations. R110 did not respond to verbal communication and kept their eyes closed during these observations. Review of the clinical record revealed R110 was initially admitted into the facility on 9/13/18 and readmitted on 12/26/20 with diagnoses that included: spastic quadriplegic cerebral palsy, abnormal posture, contractures of right and left knees, contractures of right and left hands, cognitive communication deficit, and anoxic brain damage. According to the Minimum Data Set (MDS) assessment dated 3/22/21, R110 had severely impaired cognition, was totally dependent upon staff for all aspects of care and had physical impairment on both sides of the upper and lower extremities. On 4/22/21 at 10:00 AM, an interview was conducted with the Director of Nursing (DON). When queried about the resident's long, dirty nails, the DON reported, "They're (nails/hand contractures) terrible. It's so tight the staff are afraid to get in there. Worried about breaking his fingers." When asked if		The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	

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other interventions such as nail file had been considered if the staff were unable to open the fingers, the DON reported they would have the wound care nurse (Nurse 'L') go to assess. When asked what the facility's process was for ensuring nail care was done, the DON reported the nails were done when showers were completed and was unable to offer any further explanation.

On 4/22/21 at 11:32 AM, Nurse 'L' reported they had taken care of R110's fingernails. Nurse 'L' reported they were unaware that this surveyor wanted to observe prior to cutting the resident's nails. Nurse 'L' was asked to observe R110 and upon observation of the resident, there were bandages to several fingers, with blood stained sheets under the left hand. At that time, Nurse 'L' reported the resident's nails had been very long and the R110 had pulled back and "clipped a little close".

Resident #29:

On 4/20/21 at approximately 10:18 a.m., R#29 was observed in their room, up in their wheelchair. R#29 was observed to have long fingernails protruding past the fingers, curling down over their fingers with a dark substance underneath them. R#29 was queried when the last time they were showered, and they indicated that they thought it had been a few days ago.

On 4/20/21 the Medical record for R#29 was

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reviewed and revealed the following: R#29 was initially admitted to the facility on 10/31/20 and had diagnoses including Tobacco use and Lack of coordination. A review of R#29's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/5/21 revealed R#29 needed supervision for most of their activities of daily living. R#29's BIMS score (Brief interview of mental status) was 11 indicating moderately impaired cognition.

A review of R#29's careplan reviewed the following: "Focus-[R#29] has an ADL (activity of daily living) self-care performance deficit. Contributing medical conditions include: extensive psych history, seizure disorder, hyponatremia...Intervention-BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse..."

A review of R#29's shower/bathing documentation revealed R#29 was last provided a shower on 4/6/21 and 4/13/21. No documentation of refusing to have nails cut/scrubbed were observed for the days they were showered on.

On 4/22/21 at approximately 1:04 p.m., LPN "D" (Licensed practical nurse) was queried regarding nail care in the facility. LPN "D" indicated that it should be performed during showers and as needed during regular care. LPN "D" was queried regarding R#29's nails and they indicated that it should have been

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	done during the showers and that if R#29 had refused a shower, then nail care could still be performed outside of the shower in the room. On 4/22/21 at approximately 3:00 p.m., during a conversation with Unit Manger "C" (UM "C"), Shower documentation was reviewed for R#29. UM "C" indicated that R#29's scheduled shower days were on Tuesdays and Fridays. R#29 was documented as having a shower on 4/6 and 4/13. UM "C" indicated that R#29 was supposed to be showered twice a week and did not have any shower sheet documentation for R#29's Friday showers on 4/9 and 4/16. None was received by the end of the survey. A facility document titled "Nail Care" was reviewed and revealed the following: "POLICY: It is the policy of this facility to promote cleanliness, safety, and neat appearance of our residents..."			
F0684 SS= G	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F0684	DPS #1 Resident #145 no longer has a PICC or midline to address the deficient practice. All like residents in the facility have the potential to be affected. An Audit was conducted by the DON/Designee to ensure residents with intravenous lines have a care plan, orders for monitoring the specific line and orders by the MD. The facility policy has been reviewed and deemed appropriate. By 5/24/21, Licensed Nurses will be educated on documenting what specific intravenous line the resident will be	5/24/2021

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	This citation pertains to MI00119065 and MI00118238 and has three deficient practice statements (DPS). DPS #1 Based on observation, interview, and record review, the facility failed to ensure physician orders and a plan of care was in place to care for a PICC line (Peripherally Inserted Central Catheter - a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart) and promptly address a delay in replacement of a malfunctioning PICC for one (R#145) of three residents reviewed for change of condition, resulting in multiple missed doses of IV (intravenous) antibiotics, deep vein thrombosis, pulmonary embolism, and hospital admission. Findings include: On 4/20/21 at 9:15 AM, R#145 was observed lying in bed. R#145 made eye contact but did not verbally respond when spoken to. Oxygen was infusing via nasal cannula and tube feeding formula was hung at R#145's bedside but was not infusing at that time. A review of R#145's clinical record revealed the following: R#145 was admitted into the facility on 6/28/19 and most recently readmitted on 3/14/21 with diagnoses that included: pneumonia, bronchitis, Parkinson's Disease, and history of malignant neoplasm of the		ordered, ensure a MD order is in place to include the care and monitoring of the intravenous line and medications are administered per MD order to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on PICC/Midlines are being followed as presented. The DON/Designee will conduct random midline audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure residents with an intravenous line have a care plan, orders for monitoring the specific line, medications administered timely per order and physician order. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter. DPS#2 Resident #116 will be administered IV antibiotics timely per the physician orders and documented by the Licensed Nurses. Resident #29 will have Nicotine Patches administered and documented per the MD order by the nurses. Resident #449 no longer resides in the facility. All like residents in the facility have the potential to be affected. An Audit was conducted by the DON/Designee to ensure residents medications are available and administered by the Licensed Nurses.	

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	brain (cancerous brain tumor). R#145's resident census revealed the resident was transferred to the hospital on 10/9/20, 10/31/20, 11/13/20, 2/26/21, and 3/14/21. A Minimum Data Set (MDS) assessment dated 4/1/21 documented R#145 had severely impaired cognition, no behaviors, and was totally dependent on staff for bed mobility, transfers, and all activities of daily living. The MDS indicated R#145 received intravenous (IV) medications during the assessment period, required oxygen therapy, and received all nutrition via a Percutaneous Endoscopic Gastrostomy (PEG) tube (feeding tube). A "General Progress Note" dated 10/16/20 at 5:24 PM documented, "Resident arrived to facility via ambulance from [hospital name redacted]. Resident admitted to facility with a diagnosis of sepsis. Resident currently being treated with IV ABT (antibiotics) . Midline (catheter tip is 3-8 inches long and inserted into the Antecubital - inner arm in front of the elbow - area and advanced into the peripheral veins - veins in the arms, legs, hands, or feet) noted to right upper arm. Dressing Clean dry and intact...NP (Nurse Practitioner) and Physician has been notified of resident arrival to facility..." A "Medical Practitioner Note" dated 10/19/20 documented, "...Pt returned from [hospital name redacted]. Pt sent out for unresponsiveness. Was found to have sepsis (blood infection) and started on IV		An audit was conducted by the DON/Designee to ensure blood pressure medications and inhalers are available and given as ordered. The facility policy has been reviewed and deemed appropriate. By 5/24/21, Licensed Nurses will be educated on the documenting notification to the MD for medications not available and/or administered timely to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on physician notifications regarding missed or unavailable medications are being followed as presented. 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 documenting vital signs and notification to the MD for medications not available and/or administered timely and to ensure medications are available and administered per MD order by the Licensed Nurses. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter. DPS#3 Resident#134 collaboration of care will be documented with Hospice Services and the facility to coincide with the plan of care. All like residents in the facility have the potential to be affected. An audit was completed by the DON/Designee to ensure collaboration between Hospice Services and the facility and	

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	antibiotics. Pt was evaluated by ID (infectious disease) and was determined to have enterococcus and coagulase negative staphylococcus aureus bacteremia (bacteria present in the blood). Started on vancomycin and cefepime (antibiotic medications) until 10/26. PICC was placed and patient deemed stable to return to SNF (skilled nursing facility) for LTC (long term care). A "Medical Practitioner Note" dated 10/22/20 documented, "...Follow up...Nursing reports low grade fever this morning of 99.8 (degrees Fahrenheit - F). Pt on ABT for sepsis...Vitals appear stable at this time. Continue to monitor..." A "General Progress Note" dated 10/22/20 at 10:43 AM documented, "...Resident had temp. 99.8 (degrees F) @ 9am, PRN (as needed) Tylenol 650 mg administered, NP (Nurse Practitioner) made aware...New orders to get CBC (complete blood count), CMP (comprehensive metabolic panel) (laboratory tests) once a week x 3 weeks and vanco trough levels twice a week received and in place." A "General Progress Note" dated 10/23/20 at 6:49 AM documented, "Resident in bed. IV ABT in progress...picc line intact." A "General Progress Note" dated 10/24/20 at 5:59 PM documented, "Resident has right upper are <sic> is red, swollen and warm to touch around midline (PICC line) site. His arm		to ensure Hospice Providers document care provided in the medical record. The facility policy has been reviewed and deemed appropriate. By 5/24/21, Hospice Services will document and collaborate the care of the resident receiving services per the plan of care in the medical record. The resident/responsible person will be informed of Hospice Services and care provided. The Hospice Provider and Licensed Nurses will be educated on the policy for Hospice Palliative Care to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on Hospice collaboration and documentation are being followed as presented; additionally, hospice services will be contacted regarding documentation after visits. 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 the Hospice has documented care provided in the medical record and demonstrates collaboration with the facility. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	

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	is warm from the midline site down to his elbow. Np notified. Order given to send out a cbc and Also need venous Doppler (an ultrasound to check for circulation in the veins to detect any blockage). order placed stat (with no delay)." A "General Progress Note" dated 10/24/20 at 6:09 PM documented, "Order for venous Doppler to right upper arm called into [radiology company name redacted]...However Writer was informed that X-ray tech are gone for the day and wont be back in until 8am tomorrow morning. Np Notified awaiting response." A "General Progress Note" dated 10/24/20 at 7:49 PM documented, "Writer informed RN (Registered Nurse) that stat cbc need to be done on resident, however. Writer got RN [RN name redacted] to come and attempt to draw blood. However after several attempts she was unable to draw blood due to edema noted I <sic> upper and lower extremities. Upon assessment of resident arm writer noted that residents midline is still in his arm but out of place. NP has been notified awaiting response. Endorsed to night nurse to follow up." A "General Progress Note" dated 10/24/20 at 8:03 PM documented, "Received response from to have RN draw blood fro <sic> midline. However the RN that was assisting me she think it needs to come out and be replaced because its out of place. Awaiting			

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	response from NP." A "General Progress Note" dated 10/24/20 at 8:29 PM documented, "NP gave order to have call access team to assess and repair/replace. Order endorsed to night nurse." A "General Progress Note" dated 10/25/20 at 12:03 PM documented, "Venous ultrasound complete showing positive for DVT and 2 clots. MD and NP has been notified Order given to start Eliquis (an anticoagulant medication) 5mg twice a day. Also a follow up call was given to [radiology company] for ETA (estimated time of arrival)...going to reach out to the nurse for ETA. she will give a call back to the facility with ETA." A "General Progress Note" dated 10/25/20 at 12:26 PM documented, "ETA for midline Nurse is 4pm. NP notified of ETA. order given to add all missed doses of ABT to the end." A "General Progress Note" dated 10/26/20 at 9:55 AM documented, "[Physician and Nurse Practitioner names redacted] of pt's venous Doppler...Results: Conclusion: Acute RIGHT UPPER extremity DEEP venous thrombosis involving the RIGHT mid Brachial vein. Acute RIGHT upper extremity SUPERFICIAL venous thrombosis (SVT) involving the RIGHT cephalic vein..." The "Radiology Report" dated 10/25/21 documented R#145 had a "PICC line in right basilic vein" (indicating that it had not yet been replaced).			

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A "Medical Practitioner Note" dated 10/26/20 at 10:10 AM documented, "Late Entry:...Received phone call from nursing. Pt had new onset calor (warmth), erythema (reddening), and swelling to RUE with associated midline catheter. Venous Doppler ordered and patient has new RUE (right upper extremity) DVT and SVT. Started on Eliquis. Midline ordered to be changed out. Pt missed several doses of ABT due to midline malfunction. Will add doses on to the end. Edema better on exam. RUE appears better since midline came out. New midline present in left arm. Will continue Eliquis for 3-6 months. Vitals stable. Wound care following. Continue to monitor... ASSESSMENT 1. RUE DVT..." (Note: R#145 first presented with swelling, redness, and warmth to the right upper extremity on 10/24/20).

A "General Progress Note" dated 10/31/20 at 11:34 AM documented, "Previous RN notified writer that pt had respiratory distress earlier today and was put on 3L (liters) O2 (oxygen) NC (nasal cannula). RN was making her rounds and found pt in respiratory distress. Pt appeared diaphoretic (heavily perspiring), labored breathing using accessory muscles, skin was purple and red in color. VS (vital signs) BP (blood pressure) 169/100 (high), HR 101 (elevated), RR (respiratory rate) 32 (normal rate is between 15 and 20 breaths per minute), Pulse Ox 89% 3LO2NC, left arm midline & Glucose 311 (elevated). Breathing txt (treatment) was administered & pt's Pulse

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	Ox went up to 91%. Nonrebreather (a mask used to deliver oxygen in an emergency situation) placed. Notified [physician name redacted] (and) ordered RN to send pt to the Emergency Department. Notified Manager, DON..." Hospital documents for R#145 from their 10/31/20 to 11/4/20 admission documented R#145's diagnoses included: pulmonary embolism (blockage in one of the pulmonary arteries in the lungs) and bacteremia. A "Medical Practitioner Note" dated 11/9/20 documented, "...PLAN...AC (anticoagulant) stopped in hospital as DVT was PICC line related. Continue SQ (subcutaneous) heparin for now..." Further review of R#145's clinical record was conducted and revealed the following: There were no physicians orders for R#145's IV (Note: the progress notes written by nurses and the NP use the terms midline catheter and PICC line interchangeably despite being different types of IV catheters) between the time the resident was readmitted into the facility from the hospital on 10/16/20 and discharged to the hospital on 10/31/20. There were no care plans in place for care of R#145's IV between 10/16/20 and 10/31/20. An "After Visit Summary" from the hospital dated 10/31/21 documented, "...Discharge			

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Orders:...IV/PICC Care..."

On 4/23/21 at 12:05 PM, and interview was conducted with the DON. When queried about what should be in place for residents who were admitted into the facility with IV catheters, the DON reported there would be a physician's order for the IV, flushes, and dressing changes every shift, and a care plan would be in place. At that time, the DON was asked to verify if there were any orders for R#145's IV, the care of R#145's IV, and if there was a care plan in place. The DON reported there were no orders for R#145's IV upon readmission into the facility on 10/16/20. No additional information was provided prior to the end of the survey.

A facility policy regarding midline catheters was requested. A document with instructions on how to perform a dressing change was received, but it did not include information about what was required for a resident with an IV.

DPS #2:

Based on observation, interview, and record review the facility failed to administer an intravenous (IV) antibiotic and/or nicotine patch per physician order and failed to assess and monitor vital signs prior to administration of blood pressure medications for three (R#29, R#116, R#449) of three residents reviewed for medications, resulting in medications being unavailable,

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administered late, and the potential for improper medication administration. Findings include:

Resident #116:

A complaint was received by the State Agency which alleged R#116 had not been receiving an IV antibiotic medication as ordered.

On 4/20/21 at approximately 3:20PM R#116 was observed seated upright to the side of the bed in the resident's room. The resident was queried in regard to their stay at the facility and explained that they had not been receiving their medication at a time prior.

Review of the clinical record for R#116 revealed the resident was admitted to the facility 3/23/21 with diagnoses which included, in part, chronic multifocal osteomyelitis and osteoporosis. Review of a minimum data set (MDS) assessment for the resident dated 3/26/21 revealed the resident scored 15 out of 15 on a brief interview for mental status (BIMS) exam, which indicated the resident was cognitively intact.

Review of a physician order for the resident dated 3/24/21 documented, "Nafcillin Sodium in Dextrose Solution 2 GM/100ML Use 2 gram intravenously every 4 hours for infection..."

Review of grievance form for R#116 dated

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	4/5/21 at 4:10PM documented, "I'm fed up with the traumatizing care I receive in this facility. I have missed 3 doses of treatment since last night. Each time I've complaint <sic>, the administration has repeatedly assured me that things will be better. By the way, my orthopedist did not mistakenly write a prescription medication every 4 hours..." On 4/22/21 at 12:22PM, the facility's Director of Nursing (DON) was queried in regard to R#116, and explained, in part, that she had write-ups for two different nurses. The DON explained this was related to one nurse who admitted being late with doses, and at the end of the shift was signing out multiple doses at once. The DON explained another nurse was written up related to late administration. Disciplinary action forms were then requested from the DON. Review of disciplinary education referenced above documented the following: Review of a "DISCIPLINARY ACTION RECORD WORK RULES" sheet dated 4/6/21 for Nurse 'OO' documented the following dates of infraction: 3-25, 3-26, 3-27, 3-28, 4-1, 4-4. The reason for disciplinary action was documented as follows: "Falsifying or misrepresenting Records or making statements Known to be False to influence decisions made by company. -Signing meds out at end of Shift. Residents Stating the <sic> received meds late. Unable to verify times meds where <sic> passed based on			

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documentation." The plan for improvement section documented, "Touch patient then document." Employee comments documented, " I know I need to get better."

Review of R#116's Medication Administration Record (MAR) for March 2021 and April 2021 documented Nurse 'OO' had administered the resident's Nafcillin Sodium medication at the following times in comparison to scheduled administration time:

-Due 3/24/21 at 9:00PM, documented as administered 3/25/21 at 12:44AM

-Due 3/25/21 at 1:00AM, documented as administered 3/25/21 at 3:24AM

-Due 3/26/21 at 1:00AM, documented as administered 3/26/21 at 5:04AM

-Due 3/26/21 at 5:00AM, documented as administered 3/26/21 at 5:07AM

-Due 3/27/21 at 1:00AM, documented as administered 3/27/21 at 5:26AM

-Due 3/27/21 at 5:00AM, documented as administered 3/27/21 at 5:38AM

-Due 3/28/21 at 9:00PM, documented as administered 3/28/21 at 11:49PM

-Due 3/29/21 at 1:00AM, documented as administered 3/29/21 at 3:30AM

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	-Due 3/31/21 at 9:00PM, documented as administered 4/1/21 at 1:56AM -Due 4/1/21 at 1:00AM, documented as administered 4/1/21 at 5:03AM -Due 4/1/21 at 9:00PM, documented as administered 4/1/21 at 10:57PM -Due 4/4/21 at 9:00PM, documented as administered 4/4/21 at 11:10PM Review of a "DISCIPLINARY ACTION RECORD WORK RULES" sheet signed on 4/2021 for Registered Nurse (RN) 'PP' documented the following reason for disciplinary action: "FAILURE TO ADMINISTER IV ABX (antibiotics) WITHIN TIME FRAME ALLOWED". Review of the plan for improvement documented, "TIME MANAGEMENT TO ASSURE IV ABX ARE ADMINISTERED WITH 1 HR (hour) BEFORE AND 1 HR AFTER TIME FRAME". Resident #29: On 4/20/21 the Medical record for R#29 was reviewed and revealed the following: R#29 was initially admitted to the facility on 10/31/20 and had diagnoses including Tobacco use and Lack of coordination. A review of R#29's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/5/21 revealed R#29 needed supervision for most of their activities of daily living. R#29's BIMS score (Brief interview of mental status) was 11 indicating moderately impaired			

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cognition.

A Physician's order dated 12/2720 revealed the following: Nicotine Patch 24 Hour 14 MG/24HR Apply 1 patch transdermally one time a day for Smoking Cessation and remove per schedule."

A review of R#29's March and April 2021 MAR (medication administration record) revealed R#29's Nicotine Patch was not available for administration on 3/25, 3/27, 3/28, 3/29, 3/30, 4/1 and 4/6.

On 4/22/21 at approximately 9:20 a.m., R#29's medical record was reviewed with Unit Manager "C" (UM "C") pertaining to R#29's nicotine patches not being available for administration for consecutive days in a row. UM "C" indicated if a resident does not have their medication the pharmacy needs to be called for a drop ship of the medication which it can be delivered in two hours. UM "C" indicated that the nurses should have notified the pharmacy for the need of delivery of R#29's nicotine patches and that the missed administrations could have been avoided had the nursing staff followed facility protocol.

Resident #449:

On 4/21/21 at 12:21 PM, a phone interview was conducted with the complainant that alleged R449 was not receiving medication as ordered and was concerned the facility were

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not properly monitoring the resident.

Review of R449's hospital records at the time of admission into the facility included:

"...4/9/2020...Covid Positive Stepdown from intensive care unit status post-acute vent dependent respiratory failure..."

Review of the clinical record revealed R449 admitted into the facility on 4/11/21 at 6:36 PM and discharged on 4/19/20 to the hospital per resident request and had not returned to the facility. Diagnoses included: COVID-19, other asthma, acute respiratory failure with hypoxia, other viral pneumonia, and essential hypertension. The discharge return anticipated MDS assessment dated 4-19-20 documented R449 had intact short term memory with independent cognitive skills for daily decision making, had no behavior concerns, and was occasionally incontinent of bowel and bladder.

Review of the physician orders included:

Ordered on 4/12/20: "Metoprolol Tartrate (a blood pressure medication) Tablet 25 MG (milligrams) give 1 tablet by mouth two times a day for HTN (hypertension)".

Ordered on 4/12/20: "Lisinopril (a blood pressure medication) Tablet 5 MG give 1 time a day for HTN".

There were no blood pressure parameters

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	included for either of these medications to indicate when to hold this medication, or when to call the physician. This was not completed until the orders for both medications were revised on 4/17/20 which read, "...hold for SBP (systolic blood pressure)<110; HR<60." Ordered 4/12/210 - 4/20/20: "Budesonide Aerosol Powder Breath Activated 180 MCG (micrograms)/ACT (actuation) 1 puff inhale orally every 12 hours for wheezing". Review of R449's documentation for blood pressure and respirations including the vitals tab, progress notes and Medication Administration Records from 4/11/20 to 4/19/20 revealed multiple missed opportunities and blank entries. There were only five blood pressure results between 4/11-4/19/20 which documented: on 4/12/20 at 5:27 PM = 118/58; on 4/18/20 at 8:59 AM = 156/74; on 4/18/20 at 5:06 PM = 136/67; on 4/19/20 at 8:51 AM = 141/66; and on 4/19/20 at 4:17 PM = 123/64. There was no documentation as to whether the physician had been notified of the elevated result on 4/18. There was only one respiration result documented on 4/12/20 at 5:27 PM. There was only one respiration assessment completed on 4/16/20 at 3:26 PM.			

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	On 4/22/21 at 2:45 PM, an interview and record review was completed with the Director of Nursing (DON). When asked about the frequency of obtaining blood pressure and monitoring for the resident's respirations, the DON reported respirations should be obtained every shift and blood pressure should have parameters in place and depending on those, medication would be held, or the physician would be contacted. The DON was queried about why this had not been done, given the resident's status at the hospital just prior to admission and in accordance with acceptable standards of practice, the DON reported they were unable to offer any further explanation. The DON reviewed the available documentation and confirmed there was no further documentation available for review. Review of a facility policy with a subject "Administration of Drugs" dated 7/11/18 and revised 12/19/19 documented, in part, "It is the policy of this facility that medications shall be administered as prescribed by the attending physician..." DPS #3 Based on observation, interview and record review the facility failed to ensure consistent documentation of collaboration for hospice services for one resident (R#134) of two residents reviewed for hospice services, resulting in the potential for facility staff, the resident and/or family to be unaware of			

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	hospice visits and care they provided. Findings include: On 4/20/21 the medical record for R#134 was reviewed and revealed the following: R#134 was initially admitted to the facility on 3/29/21 and had diagnoses including stage 4 pancreatic cancer , shortness of breath and anxiety. A review of R#134's MDS (Minimum Data Set) with an ARD (assessment reference date) of 4/1/21 revealed R#134 needed extensive assistance with most of their activities of daily living. R#134's BIMS score (brief interview of mental status) was 11 indicating moderately impaired cognition. A Physician's order dated 3/30/21 revealed the following: "Admit to [Name of R#134's Hospice provider] D/T (due to) Pancreatic Cancer..." A review of R#134's careplan revealed the following: "Resident has a terminal prognosis r/t (related to) her diagnosis. Resident will be assisted to feel comfortable with her dignity maintained...Intervention-Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met..." On 4/21/21 at approximately 2:38 p.m., A Hospice "collaboration log" (a log for R#134's hospice provider to document what services were performed for R#134) was reviewed at the Nursing station with Social Worker "NN" (SW "NN"). The collaboration log revealed			

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	only one entry from the Hospice admission Nurse on 3/31/21. The rest of the collaboration log was blank with no further visits or provision of care being documented. SW "NN" indicated that the log should have been filled out for every visit and it was not being completed. SW "NN" reported there was "no excuse" for the lack of documentation and that they will have to call R#134's hospice provider to inform them that they needed to document the services that were being provided in the collaboration log. SW "NN" was queried if they could tell from the log what services had been provided from the hospice provider since 3/31/21 and they indicated they could not. On 04/21/21 at approximately 2:46 p.m., during a conversation with Unit Manager "C" (UM "C"), UM "C" was queried regarding the lack of documentation of hospice visits in R#134's hospice collaboration log. UM "C" indicated the hospice provider should have been documenting in the hospice collaboration log what they did for R#134 when they visited them. A facility document titled "Hospice/Palliative Care" was reviewed and revealed the following: "It is the policy of this facility to administer hospice or palliative care, also known as comfort care, when medically appropriate for residents who wish to participate to such principle of care as ordered by the physician. Hospice/Palliative care is primarily directed at providing relief to			

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	a terminally ill patient through symptom management."			
F0688 SS= D	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to apply range of motion and protective devices per plan of care for two (R110 and R111) of four residents reviewed for limited range of motion, resulting in the potential for development and/or worsening of contractures, skin breakdown, and increased physical limitations. Findings include: Resident #110:	F0688	Resident #110 no longer resides at the facility. Resident #111 will have his knee brace provided as ordered and care planned. All residents in the facility not receiving therapy have the potential to be affected. An audit was completed for residents to ensure they are receiving splint application and protective devices as ordered and care planned. The facility policy has been reviewed and deemed appropriate. By 5/24/21, nursing staff will be educated on the Adaptive Equipment policy to prevent a decline in ROM to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight, rounding and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on adaptive equipment are being followed as presented. The DON/designee will conduct random splint application and protective devices on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure they are applied as ordered and care planned. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	5/24/2021

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	On 4/20/21 at 10:47 AM, and 4/21/21 at 8:36 AM, and 4/22/21 at 8:03 AM, observations of R110 revealed the resident was lying in bed with both arms positioned in a manner as if the resident were flexing their arms and both hands were bent down at the wrist with closed fists. The fingernails were observed to be long with dark debris underneath the nail tips at each of these observations. There were no palm protectors or splinting devices in place at each of these observations, nor where there any observed in the room. R110 did not respond to verbal communication and kept their eyes closed during these observations. Review of the clinical record revealed R110 was initially admitted into the facility on 9/13/18 and readmitted on 12/26/20 with diagnoses that included: spastic quadriplegic cerebral palsy, abnormal posture, contractures of right and left knees, contractures of right and left hands, cognitive communication deficit, and anoxic brain damage. According to the Minimum Data Set (MDS) assessment dated 3/22/21, R110 had severely impaired cognition, was totally dependent upon staff for all aspects of care and had physical impairment on both sides of the upper and lower extremities. Review of the Kardex revealed the section for "SPECIAL NEEDS" read, "Encourage resident to wear B (bilateral) palm protectors daily as tolerated."			

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	On 4/21/21 a 2:44 PM, an interview was conducted with the Certified Nursing Assistant (CNA 'M') who was assigned to R110. When queried about whether they were aware of whether R110 used any palm protectors, CNA 'M' stated, "I've never seen those for him. No, I don't know anything like that for him. I want to be honest." When asked if they were familiar with R110, CNA 'M' reported they had been working at the facility for a while and was frequently assigned to R110. When asked if there were any palm protectors available for use located in the resident's room, CNA 'M' went to the closet and reported "No". On 4/21/21 at 2:55 PM, an interview was conducted with Licensed Practical Nurse (LPN 'J') who was currently assigned to R110. When asked if they were aware of R110 using palm protectors, LPN 'J' reported they were "not aware of the resident using anything like those". On 4/21/21 at 3:10 PM, an interview was conducted with the Therapy Manager (Staff 'N'). Staff 'N' reported they were familiar with R110 as they had recently evaluated the resident during a quarterly evaluation. When asked about the resident's use of palm protectors, Staff 'N' reported they had been working with the resident to use palm protectors. When informed of the multiple observations of the lack of palm protectors and lack of staff's awareness the resident was to use them, Staff 'N' reported if they were			

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missing, staff would normally let therapy know and would provide, but they had not been made aware of this until now. Staff 'N' was requested to provide the most recent discharge summary with recommendations.

On 4/22/21 at 9:00 AM, Staff 'N' provided copy of R110's discharge summary signed by Staff 'N' on 1/15/21 which documented, "...Precautions...multiple contractures, quadriplegic. Discharge Plans & Instructions Pt. (patient) will remain long term care per family request. Staff will continue to follow splint wearing schedule daily as tolerated as well as complete skin checks to assure skin integrity is intact."

On 4/22/21 at 10:00 AM, an interview was conducted with the Director of Nursing (DON). When asked about the resident's contractures, long nails and lack of palm protectors, the DON reported the contractures and nails were terrible, "It's so tight the staff are afraid to get in there (to cut nails) worried about breaking his fingers." The DON was informed that the staff interviewed did not know about any sort of range of motion exercises including passive during care or that the resident's plan of care included use of palm protectors. The DON reported the current staff needed a lot of education and had planned to do this week but did not due to the survey.

Resident #111

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	On 4/20/21 at approximately 10:40 a.m., R#111 was observed in their room, up in their wheelchair. R#111 was observed to have a knee brace on their chair across from their bed. R#111 was queried if they had any issues with range of motion of their knee and they reported the knee brace was supposed to put on every day, but sometimes the staff do not do it. On 4/21/21 at approximately 2:30 p.m., R#111 was observed in their room, up in their chair. No knee brace was observed applied. R#111's Knee brace still observed in the same place on the chair in room. R#111 was queried if anyone had attempted or offered to put the knee brace on and they indicated nobody had. On 4/22/21 at approximately 11:13 a.m., R#111 was observed in their room, up in their wheelchair. R#111 was observed without their knee brace on. R#111 was queried if anyone had offered to help put on their brace and they indicated that nobody had. The knee brace was still observed on their chair in the same place as the previous observations. On 4/23/21 at approximately 10:09 a.m., Observed R#111 in their room up in their wheelchair. R#111 was observed without their knee brace on. R#111 was queried regarding their knee brace and if anyone had put it on them the day before or had offered to put it on them that day and they stated			

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"no". R#111 was queried regarding the consistency of their knee brace. They indicated that sometimes staff will put it on, but it depends on who is working.

On 4/20/21 the medical record for R#111 was reviewed and revealed the following: R#111 was admitted to the facility on 9/8/2014 and had diagnoses including Stiffness of right knee and contracture of muscle-multiple sites. R#111's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/23/21 revealed R#111 needed supervision with most of their activities of daily living and had impairment on one side with both lower and upper extremities.

A review of R#111's Physician order for their knee brace dated 9/8/2020 revealed the following: "Encourage use of knee brace to R knee daily as resident tolerates."

A review of R#111's careplan revealed the following: "The resident has an ADL self-care performance deficit r/t (related to) CVA (stroke) with right Hemiplegia, Limited Mobility, Limited ROM (range of motion) to RUE...Intervention-Please assist pt in donning and doffing R knee splint daily; to be worn 2-4 hours, or to tolerance..."

On 4/23/21 at approximately 1:10 p.m., Unit Manager "C" (UM "C") was queried regarding R#111's knee brace. UM "C" indicated they were made aware of the issue with the application of R#111's knee brace that they

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	had reviewed the CNA documentation pertaining to R#111's knee brace and was aware that the CNA's were not documenting the application of it. UM "C" indicated that they were going to talk to the NP (Nurse Practitioner) and see if they would order the brace to be PRN (as needed).			
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 pertains to intake #MI00119418. Based on observation, interview and record review, the facility failed to provide consistent supervision, and ensure fall assessments were completed, and adequate interventions were implemented for three (R98, R101, and R451) of eight residents reviewed for accidents, resulting in residents sustaining multiple falls, some with injuries requiring medical treatment and the increased potential for serious harm and injury. Findings include: According to the facility's policy "Fall" dated 7/11/18, "...Resident will not be moved until a nurse evaluates the resident's condition...Initiate neurological checks for any	F0689	Residents #98, #101 and #451 plan of care and interventions were reviewed by the DON/Designee to ensure staff provide consistent supervision and adequate interventions to assist in prevention of falls are implemented per the plan of care. All like residents in the facility have the potential to be affected. An audit was completed by the DON/Designee to ensure residents at risk for falls have a care plan with adequate interventions. The facility policy has been reviewed and deemed appropriate. By 5/24/21, the staff will be educated on the facility fall management program to include ensuring residents receive consistent supervision, adequate interventions are implemented per the plan of care, neuro checks and fall assessments as necessary per policy to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight, observation, and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on falls is being followed as presented The DON/designee will conduct random audits on 5 residents who have fallen weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure staff follow	5/24/2021

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	fall where a resident hit his/her head or for any unwitnessed fall...Notify the physician for further orders and follow instructions. (All falls must be reported to the physician)...Document all appropriate information in the medical record...If condition from fall is life threatening, the nurse shall initiate EMS (Emergency Medical Services) stat and then place a call to physician...A fall without injury is still a fall...Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred." Resident #101: On 4/20/21 at 3:33 PM, R101 was observed seated in a gerichair recliner in a reclined position across from the second floor east nursing desk. R101 was observed to have two bandages to the forehead and the left knee was observed to have an open abrasion without any bandage. R101 was unable to participate in an interview due to significant cognitive limitations. Review of the clinical record revealed R101 was admitted into the facility on 2/25/21 and readmitted on 3/22/21 with diagnoses that included: multi-system degeneration of the autonomic nervous system, pain in left ankle and joints of left foot, insomnia, dementia in other diseases classified elsewhere with behavioral disturbance, and Parkinson's disease. According to the Minimum Data Set (MDS) assessment dated 3/25/21, R101 had		procedures for residents with falls to ensure fall assessment, neuro checks, interventions implemented per plan of care. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	

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moderately impaired cognition with trouble concentrating, had no behavior concerns including no hallucinations or delusions, required extensive assist of one person for bed mobility, dressing, eating, toilet use, personal hygiene, required extensive assist of two plus persons for transfers, walking in room and corridor, used a walker and wheelchair, and had one fall since admission without injury.

Review of the physician orders revealed R101 was prescribed "Apixaban Tablet 5 MG (milligrams) by mouth two times a day for anticoagulant (a blood thinning medication)". Additionally, R101 had been prescribed a onetime order for "Quetiapine Fumarate (Seroquel - an antipsychotic medication) 12.5 MG by mouth one time only for Combative behavior for 1 day" (received on 4/7/21 at 3:56 PM).

Review of the progress notes revealed R101 had 12 fall occurrences between 3/3/21 and 4/22/21. Documentation for these falls included:

On 3/3/21 at 7:35 AM, "...found on floor next to bed - no injury - bilateral bed mats ordered, and scoot bed ordered , bed low to floor..." On 3/5/21 at 7:39 AM, the Interdisciplinary Team (IDT) recommended scoop mattress, floor mats and for R101 to be up in the chair during waking hours for closer supervision.

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	On 3/8/21 at 6:45 (no am/pm noted), "...resident lying on right side of bed...offered toileting after meals..." On 3/9/21 at 12:49 PM, the IDT recommended R101 be placed in lounge for closer supervision and activities. On 3/10/21 at 12:02 PM, "...res (resident) observed on floor mat at bedside around 11:30 am...morning care provided res placed in w/c (wheelchair), closed <sic> monitoring is in place - will provide a low bed and require resident to be up for meals each day..." There was no IDT follow up documentation provided for review following this fall. R101 was sent to the hospital on 3/15/21 due to difficulty breathing/change in condition and returned to the facility on 3/18/21 at 4:00 PM. On 3/19/21 4:58 AM, "...assigned aide called nurse to room at 12:19 AM - res observed on floor on top of the floor mat lying on right site <sic> - no injury - resident has a baseline confusion and can't state reasons for fall...." On 3/19/21 at 2:57 PM, "(Name of Assistant Administrator/AA 'O') upon walking into the 2W dining lounge he saw resident stand up from his w/c and asked res to sit back down for safety - res then sat back in chair - (Name of AA 'O') started speaking to another res in the same room and saw R101 in corner of his eye tipping forward out of his chair - res was on his hand and knees and did not hit his			

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	head...Per residents daughter resident at home rocks back and forth so he can stand up from w/c..." The IDT follow up documentation to these two falls on 3/19/21 at 6:24 noted a recent dose reduction to an antidepressant medication on 3/16/21 and also that R101 had increased impulsivity and was awaiting psych evaluation and therapy to evaluate for proper wheelchair as the resident may need a high-backed wheelchair. R101 was sent to the hospital on 3/19/21 due to unresponsiveness with short periods of apnea and returned to the facility on 3/22/21. On 3/22/21 at 6:48 PM, "...The patient also became anxious and began to get out of the bed...the patient was required to sit at nursing station for one on one monitoring for the rest of the shift." On 3/24/21 at 7:48 PM, Nurse Practitioner (NP 'Q') documented, "...Pt c/o (complained of) severe constant left ankle pain since last night after hitting his ankle on the wheelchair...ordered left ankle XR (x-ray) to r/o (rule out) fx (fracture)..." There was no documentation of any investigation into the resident hitting their ankle on the wheelchair provided by the end of the survey. On 3/25/21 at 4:37 PM, "...pt was observed in the dining room on the floor crawling on the floor...pt was assisted to a standing position and put back into the wheelchair..." On 3/25/21 at 6:23 PM, the IDT review of this fall			

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	included staff to remain in the dining room when R101 was present and to have therapy evaluate the wheelchair (already an identified intervention on 3/19/21). Review of the post fall documentation provided by the facility also identified, "Falls in past 90 days and/or since admission: 4...Root Cause (s) and Contributing Factors as determined by IDT: impulsive, in dining room without staff present...Was this fall preventable? Yes...how could fall have been prevented? staff to not leave unattended in dining room...What changes do we need to make when caring for resident to prevent him/her from experiencing the same type of fall? staff to not leave unattended in dining room...What action(s) does leadership need to take to decrease reoccurrence at system level, i.e., was there a task, judgement, communication, and/or system error that requires further review? staff to not leave unattended in dining room..." On 4/4/21 at 6:39 PM, "...res was observed on floor by activity worker in dining room..." Review of the post fall documentation on 4/6/21 at 9:44 AM for the fall on 4/4/21 documented, "Falls in past 90 days and/or since admission: 6...Root Cause (s) and Contributing Factors as determined by IDT: Impulsive due to disease process attempts to self-transfer/ambulate without cognitive and/or strength to do so safely...What changes do we need to make when caring for resident to prevent him/her from experiencing the same type of fall? Staff to			

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	reach out to family for phone conversation when resident becomes anxious/impulsive...What action(s) does leadership need to take to decrease reoccurrence at system level, i.e., was there a task, judgement, communication, and/or system error that requires further review? Additional monitoring when possible..." On 4/7/21 at 3:32 PM, Registered Nurse (RN 'S') noted they had contacted NP 'Q' regarding R101's "combative behavior and anxiety", but there was no details of what these behaviors were, or any circumstances. According to the Medication Administration Record (MAR), R101 received this medication on 4/7/21 at 3:56 PM. On 4/7/21 at 9:40 PM, an entry from Licensed Practical Nurse (LPN 'T') documented, "Resident was observed on the floor lying on the left side of his face in a pool of blood. upper lip broken and tooth appear chipped...Doctor and DON contacted without response. 911 called and resident will be taken to the hospital in suspicion of trauma to the head..." On 4/7/21 at 11:37 PM, an entry from LPN 'T' documented, "...Writer was called to room (number redacted) at around (9:00 PM) and resident was observed on the floor lying on the left side of his face in a pool of blood. Upper lip broken and tooth appear chipped...Resident was a little lethargic, Doctor and DON contacted without			

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	response. 911 called and resident will be taken to the hospital on suspicion of trauma to the head and internal bleeding because patient is on blood thinner...EMS (Emergency Medical Services) with disapproval, that writer shouldn't have sent the resident out to the hospital and that she could make the writer's life miserable if this happens next time, "this is not an emergency' - she said. "I called both you and the DON without response and had to do what is best for the resident and not business. No supervisor on the floor, I was concerned about head trauma and internal bleeding because resident is on blood thinner..." R101 returned to the facility on 4/8/21 around 2:00 AM. Review of the post fall documentation on 4/8/21 at 9:00 AM for the fall on 4/7/21 at 9:00 PM documented, "Falls in past 90 days and/or since admission: 7...Root Cause (s) and Contributing Factors as determined by IDT: attempted to self transfer from bed, impulsive with poor cognition...What changes do we need to make when caring for resident to prevent him/her from experiencing the same type of fall? 15 minute monitoring until psych evaluates medication with concern for recent GDR..." On 4/8/21 at 2:12 PM, NP 'Q' documented, "...Nursing staff called yesterday afternoon reporting that pt was being defiant and combative. Nursing staff reported that she was concerned that resident was going to fall. Verbal order given for psych consult and Seroquel 12.5 mg PO x 1 for chronic			

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	dementia w/ behaviors. Per nursing documentation, it was noted that pt had a fall on last night and was sent to the ED. Pt returned last night w/ no new orders. Pt seen and examined today. Pt reports wellbeing and is w/o (without)complaint...Diagnosis/Status/Plan...Acute lip laceration s/p fall...Lip laceration noted. No other injury noted during full body exam..." There was no identification of the onetime antipsychotic medication as a potential contribution to the fall in the post fall documentation on 4/8/21. On 4/13/21 at 7:24 PM, "...while passing medication at around 1150 am the activity aide told the writer that the patient was on the floor. writer went into the room to find pt sitting on his bottom on the floor on the side his of bed. writer left pt in the same spot on the floor, writer went to get help from another cena to help get pt in bed. and when I walked in room the pt was already put back in the bed by his aide writer notified ADON and the daughter of pt fall..." There was no documented IDT follow up to review interventions to prevent future occurrences for this fall. On 4/15/21 at 5:33 PM, "...Writer was called into patient room and observed patient on floor on knees in front of room door. Geri chair at end of pt bed...Skin tear observed to left knee...Care plan updated..." On 4/22/21 at 9:59 AM, an entry indicated			

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R101 was to move to another room on the second floor.

On 4/22/21 at 8:44 PM, an entry (not identified as a late entry) by Registered Nurse (RN 'I') documented, "Writer entered lounge and saw pt. laying face down next to Geri-chair. Pt. was assessed...Writer noticed two abrasions noted to forehead. Unit manager notified." There was no documentation provided that this fall incident had been documented when it occurred (4/21/21 before dinner), been investigated, whether the physician had been notified, or that neurochecks had been initiated to monitor for changes or risks due to R101 being on blood thinning medication.

On 4/21/2021 at 5:58 PM, an entry from NP 'Q' documented, "...Staff and other residents reports a fall on last night...Diagnosis/Status/Plan...Acute forehead abrasion s/p (status post) fall- labile - no injury noted on full body exam. Bacitracin to forehead BID (twice a day) x 7 days...." Review of the treatment administration records revealed the first documented wound care had not been provided until 4/22/21 at 12:03 PM.

On 4/23/21 at 10:29 AM, an interview was conducted with the Director of Nursing (DON) to review R101's falls. When asked what the facility's process was to review falls, the DON reported the IDT usually meet the next morning and also completed a QAPI

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	(Quality Assurance Performance Improvement) form to discuss what to do for interventions and update the care plan. The DON indicated the post fall assessments would be located under the assessments tab and the QAPI form was not available but would look into whether that could be provided for review. When asked about the therapy documentation, the DON reviewed the surveyors access and reported those were not available and could print what was needed. The DON was asked about the lack of supervision as identified during the post fall documentation, acknowledged similar concerns, and reported that the facility was working on hiring more staff, but was limited at times. When asked about the fall noted on 4/22/21 by RN 'I', the DON reported that they had found out about R101's fall from 4/21/21 only last night from another resident. The DON further reported that when RN 'I' was asked about it, they had reported they had seen the resident following the fall and picked up R101 themselves and had only implemented a behavior care plan that the DON reported had since been discontinued. The DON reported RN 'I' had not completed an incident report, notify the physician, or initiated any neurocheck monitoring. The DON also indicated the entry read as if there was a fall on 4/22, but RN 'I' should have indicated it had been a late entry. On 4/23/21 at 10:45 AM, an interview was conducted with RN 'I' who was currently assigned to the facility's first floor. When			

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	asked about R101's fall incident on 4/21/21 and what had been done following the fall, RN 'I' reported, "It was on afternoon before dinner. I was his nurse. I walked in the lounge. (R101) was face down and had two abrasions on forehead." When asked if the gerichair was in a reclined position, or if the leg rest had been positioned down, RN 'I' reported they were not able to recall the positioning but did state, "He was lying next to it on the side." When asked what was done following that, RN 'I' reported, "I notified Unit Manager (UM 'C') and saw there was a care plan for behavior where he lays on floor." When asked if there were any neurochecks initiated given R101 received blood thinning medication, and whether the physician had been contacted, RN 'I' reported they had not and offered no further explanation. On 4/23/21 at 11:16 AM, the DON provided additional "IDT-INTERDISCIPLINARY POST FALL FOLLOW UP V2" and reported the days the resident had multiple falls, they were not able to print both follow ups. The DON reported these documents were done when IDT reviewed the falls which usually occurred the next day unless it was over a weekend. The DON reported they had tried 15 minute monitoring for R101 but due to staffing challenges that was difficult and there were not many other interventions left to try. The DON reported the neurocheck forms were maintained in the miscellaneous tab and were scanned in by medical records. The DON confirmed there were only 2			

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	neurocheck documents on 3/10 and 3/19. There were no other neurochecks documented following any of the other fall occurrences. The DON was queried as to whether the one time antipsychotic medication that had been ordered on 4/7/21 may have contributed to the fall on 4/7/21 and the DON reported that had been a consideration as well but confirmed documentation did not reflect that. When asked about how and/or when R101 was provided with a gerichair recliner, instead of high backed wheelchair as suggested in one of the post fall recommendations, the DON reported therapy was responsible for evaluating resident's chair needs. The DON was unable to offer any further explanation into R101's falls. There was no additional documentation provided by the end of the survey. On 4/23/21 at 1:08 PM, an interview was conducted with the Director of Therapy (Staff 'N'). Staff 'N' was asked about R101's therapy needs and reported R101 was last discharged from therapy on 4/16/21 and at that time was assessed as safe to use a high-backed wheelchair with elevating leg rests and was able to self-propel around the unit. When asked about the gerichair recliner, Staff 'N' reported they were not notified of the resident's fall from 4/20 until yesterday (4/22) and had "put their eyes on him and would be doing another evaluation today for appropriateness of the gerichair." When asked how the resident who was last			

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assessed as being able to self-propel from a high-backed wheelchair was able to maneuver a gerichair recliner, Staff 'N' offered no response. Staff 'N' was unable to verify when R101 had been provided with the gerichair recliner but reported sometimes nurses would provide them and would be going to assess R101 to see if in correct chair today.

Resident #98:

On 4/20/21 at 3:02 PM, R#98 was observed in bed awake. R#98 appeared anxious and restless, was mumbling softly, was holding onto pillows, and trying to throw her legs over the side of the bed attempting to climb out. An over the bed table was observed on the other side of the room, not within reach of the resident. R#98 pointed to the cup placed on the table and softly spoke about not wanting to be alone. R#98's call light was not within reach of the resident. At that time, Certified Nursing Assistant (CNA) "BB" brought a fresh cup of water and placed it on the overbed table across the room from the resident. The straw was inserted into the cup and the straw wrapper was intact covering the top portion of the straw.

On 4/20/21 at 4:00 PM, R#98 was observed in bed, pointed at the water cup, was mumbling softly, and appeared restless.

On 4/20/21 at 4:45 PM, R#98 continued to appear restless and reached toward the water

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and was attempting to shift her body in the bed. At that time, CNA "Z" who was identified as R#98's assigned CNA, was interviewed. When queried about the placement of R#98's water and the resident's restlessness, CNA "Z" nervously answered that he was pulled to work on that hallway and did not know much about the residents. CNA "Z" began moving R#98's bed up and down with the remote and stated, "What do you want me to do?" When queried about whether R#98 was able to reach the water, CNA "Z" said he did not know. When queried about whether R#98 should be left in the room when restless, CNA "Z" reported he did not know. When queried about where the CNAs would look to find out about a resident's care, CNA "Z" reported he did not know. When queried about who the assigned nurse was, CNA "Z" reported he did not know.

At that time, Registered Nurse (RN) "AA" was interviewed. RN "AA" reported she was R#98's assigned nurse. When queried about R#98, RN "AA" reported the resident was a "fall risk" and required one to one assistance with eating and drinking. When queried about R#98's restless behavior, RN "AA" reported she would look into it.

R#98's clinical record was reviewed and revealed the following:

R#98 was admitted into the facility on 11/13/20 and readmitted on 2/10/21 with diagnoses that included: Parkinson's disease,

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chronic obstructive pulmonary disease, Moderate protein calorie malnutrition, osteoporosis, osteoarthritis, psychotic disorder, dysphagia, and dementia. A MDS assessment dated 3/16/21 documented R#98 signed onto hospice services, was severely cognitively impaired, had no behaviors, and required extensive assistance with bed mobility, transfers, and eating. The MDS documented R#98 had two or more falls with no injury.

Incident Reports for R#98 were reviewed since their admission date of 11/13/20. Between the dates of 11/13/20 and 4/1/20, R#98 fell 21 times as follows:

1. On 11/15/20 at 12:11 PM, R#98 was observed on the floor. It was documented R#98 had a low bed and a fall mat on the right side of the bed, there were no witnesses, and the resident was "ambulating without assistance".

2. On 11/15/20 at 5:52 PM (approximately 5 hours after the previous fall), R#98 was observed on the floor with her legs crossed. It was documented the activities department was to provide additional one to one (1:1), R#98 was alert and not oriented to person, place, or time, there were no witnesses, R#98 had a low bed and a fall mat on the left side of the bed (the previous incident report documented a fall mat on the right side of the bed). It was documented R#98 was ambulating without assistance.

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3. On 11/16/20 at 3:12 PM the activities coordinator heard R#98 fall in her room. R#98 was found sitting on the padded floor next to the bed. It was documented R#98 had a low bed and a fall mat to the right side of the bed. The floor mat was removed, and R#98 was placed on 15 minute monitoring for three days. It was documented R#98 was ambulating without assistance.

4. On 11/30/20 at 3:00 PM, a Certified Nursing Assistant (CNA) observed R#98 on the floor on their knees.

5. On 12/1/20 at 2:20PM, R#98 was observed seated on her buttocks with her hands on the side near doorway to room. It was documented there was a fall mat on the right side of the low bed.

6. On 12/2/20 at 2:55 PM R#98 was observed by staff lowering herself to the ground to sit on the floor. It was documented R#98's call light was not on, she was wearing non-skid socks, and was standing at the dresser yelling at staff about wanting to be on the floor.

7. On 12/8/20 at 5:39pm, R#98 was observed on her left knee in her room and sustained a skin tear to left knee noted with blood. R#98 reported she was trying to pick something up from the floor.

8. On 12/15/20 at 4:38 PM, R#98 was found by the doorway to her room seated on her

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	buttocks on the floor. R#98 reported she was trying to go to the bathroom. 9. On 12/16/20 at 2:21 PM, R#98 was observed easing herself from the low bed to the floor and crawling on the floor. 10. On 12/20/20 at 5:42 PM, R#98 was observed "leaning down in wheelchair reaching for something on the ground" and slid out of the wheelchair and landed on her knees. Dycem seat grip was documented as an intervention to be added to R#98's wheelchair when she was up out of bed. 11. On 12/23/20 at 11:46 PM, it was documented R#98 was agitated and combative at the beginning of the shift and was placed in bed at 11:15 PM. The incident report documented, "While dr. was called for possible medications, few minutes later resident slide out of the bed to the floor...resident is confused..." 12. On 12/26/20 at 1:15 PM, R#98 was observed on the floor mat in her room. 13. On 1/3/21 at 2:30 PM, it was documented R#98 was in a wheelchair in the hallway. It was documented, "around 2:30 resident was observed lying on her back on the floor in front of nurse station...redness noted at middle nose..." Interventions documented, "...psych consult and continue current fall risk care plan. Facility to initiate many room changes to open rooms to provide a quieter			

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environment with less stimulation for this resident...resident to move downstairs..." It was documented that R#98 sustained a bruise to the face and "Staff heard a loud noise and observed resident's w/c tilted to the left and resident on the floor on her back on hallway floor."

14. On 1/6/21 at 5:27 PM, R#98 was observed sleeping on the floor mattress during medication pass. It was documented R#98 preferred to sleep on floor mattresses at times.

15. On 1/12/21 at 5:53 PM, R#98 was observed lying on the floor on her back with her head still on bed.

16. On 2/1/21 at 8:20 PM, the following was documented, "writer walked into residents room at 9:10 pm to administer HS (bedtimes) medications. while in room resident was lying across the bed, blood noted on the floor, bump noted on left upper eye with blood noted around swollen left eye...unable to state reasons for falls..."

17. On 2/3/21 at 7:43 PM, R#98 was observed on the floor mattress by her bed by the floor nurse. It was documented R#98's "head was on the frame of the bed side table", that R#98 was seen by the CNA 15 minutes before the fall while passing meal trays, and R#98 was unable to state what happened. It was documented R#98 sustained a laceration above her right eye that was bleeding.

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	Interventions documented were a scoop mattress and R#98 was to be "in view of staff at nursing station during mealtimes". 18. On 2/12/21 at 7:37 PM, R#98 was observed seated on the bathroom floor. It was noted that R#98 was checked on by the CNA 15 to 20 minutes prior to the fall and R#98 was in bed resting. It was documented that R#98 was to be kept "in view of staff during waking hours..." 19. On 2/22/21 at 12:27 PM, R#98 was observed on the side of the bed on the floor mat on her knees and reported she was trying to get out of bed. Interventions documented R#98 was to be taken to the bathroom after lunch and kept in view of staff during waking hours. 20. On 2/24/21 at 6:00 PM, R#98 was observed on the floor by her bed facing the door...It was documented R#98 was to receive one on one supervision when awake "to be done by nurses and CNA by 30 min rotation and Q (every) 10 minute rounds while asleep..." 21. On 4/1/21 at 6:30 PM, R#98 was observed by the CNA with her knees on the floor with her head and arms on the bed. It was documented R#98 sustained a "small laceration above right eyebrow" and was "observed sleeping in bed 15 minutes prior to incident". R#98 was unable to give a description of the incident. It was			

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documented R#98 was currently under "direct observation" and staff should "attempt to wake prior to dinner and in view of staff..."

On 4/21/21 at 3:30 PM, R#98 was observed seated in a geriatric chair at the nurses station with a staff member. At 4:23 PM, R#98 was observed seated at the nurses station with a staff member watching a television show on a tablet.

On 4/22/21 at 9:45 AM, an interview was conducted with the Director of Nursing (DON). When queried about what was in place for R#98 due to the history of 21 falls, the DON stated, "(R#98) should always be at the nursing station in a gerichair when awake and staff is required to check on her constantly to ensure she is not awake and alone in her room." Observations from 4/20/21 were shared with the DON. The DON reported R#98 should not have been left in the room alone, especially if she was awake and the staff who entered her room should have intervened. When queried about where interventions were documented, the DON reported on the care plan and Kardex.

A review of R#98's care plans was conducted, and the following was revealed:

A care plan initiated on 11/14/20 and revised on 2/11/21 documented, "(R#98) is at risk for falls r/t (related to) dementia, psychoactive medication use, poor safety awareness and

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balance impairments. Resident has multiple falls secondary to her impulsive behavior..." An intervention initiated on 12/1/20 documented, "Anticipate and meet resident's needs by checking patient every 15 mins". An intervention initiated on 11/4/20 documented, "Be sure call light is within reach, provide cueing and reminders for use as appropriate due to level of cognition".

A care plan initiated on 4/1/21 documented, "(R#98) has had an actual multiple falls r/t Unsteady gait, Parkinson's and increase anxiety (sundowners episodes)". An intervention initiated on 4/1/21 documented, "Attempt to wake prior to dinner. Place in common area." An intervention initiated on 1/6/21 documented, "In view of staff during waking hours." An intervention initiated 2/24/21 documented, "15 min rounds while asleep". An intervention initiated 2/22/21 documented, "Toilet after lunch and keep in view of staff during waking hours".

Resident #451

On 4/20/21 at 11:20 AM, R451 was observed dressed and sitting on the side of the bed. Fall mats were observed folded and standing up against the wall next to the left side of the bed, on the right side, fall mats were observed folded and pushed to the far side of the room. R451 was asked if the fall mats were ever placed next to the bed. R451 appeared confused and explained the mats were not comfortable to sit on, then began to

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talk about an unrelated topic.

Review of the clinical record revealed R451 was admitted into the facility on 4/13/21 with diagnoses that included: anxiety disorder, vascular dementia, and osteoarthritis. According to the MDS assessment dated 4/16/20, R451 scored 99 on the BIMS exam, indicating severely impaired cognition. The MDS also indicated R451 required the assistance of staff for all ADL's.

Review of R451's fall care plan initiated 4/15/21 revealed an intervention that read, "Neuro-checks for post fall. Place resident in a low bed with bilateral floor mat [sic] while in bed".

Review of an I&A for R451 revealed on 4/14/21 "Resident was seen lying naked and sleeping on the floor." In the action taken it read, "...Place resident in a low bed with bilateral floor mats while in bed. Frequent monitor and follow safety precautions."

On 4/21/21 at 8:16 AM, 4/21/21 at 1:54 PM, 4/22/21 at 8:05 AM, R451 was observed either sitting on the side of the bed or lying in the bed with the fall mats noted to be in the exact same position folded against the wall and folded pushed to the side of the room.

On 4/22/21 at 9:29 AM, the DON was interviewed and asked about R451's fall mats. The DON explained they should be on the

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	floor next to the bed anytime R451 was in bed. The DON was informed of the observation of the fall mats in the same position since 4/20/21. The DON had no explanation.			
F0690 SS= D	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F0690	DPS#1 Resident #449 is no longer in the facility. All residents in the facility that are incontinent have the potential to be affected and will receive incontinent care per their plan of care. The facility policy has been reviewed and deemed appropriate. By 5/24/21, nursing staff will be educated on timely and appropriate incontinent care to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight, rounding and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on incontinent care are being followed as presented. The DON/designee will conduct random incontinent audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure residents are receiving appropriate incontinent care. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter. DPS#2 Resident #31 no longer resides in the facility. All residents in the facility that have foley catheters have the potential to be affected and proper care and positioning of the foley	5/24/2021

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	This citation pertains to intake #s: MI00118238 and MI00119044 and has two deficient practice statements (DPS). DPS#1 Based on interview and record review, the facility failed to ensure timely incontinence care was provided for one (R449) of four residents reviewed for bowel and bladder incontinence, resulting in the resident being left in urine for prolonged periods of time, and the potential for skin breakdown and loss of dignity and embarrassment. Findings include: On 4/21/21 at 12:21 PM, the complainant was interviewed by phone to review their concerns which included the resident, who was dependent upon staff for toileting assistance, to go without incontinence care for long periods of time and having to sit in their wet brief. Review of the clinical record revealed R449 admitted into the facility on 4/11/21 at 6:36 PM and discharged on 4/19/20 to the hospital per resident request. Diagnoses that included: COVID-19, other asthma, acute respiratory failure with hypoxia, other viral pneumonia, and essential hypertension. There were only entry and discharge return anticipated MDS assessment dated 4/19/20 documented R449 had intact short term memory with independent cognitive skills for		catheters. The facility policy has been reviewed and deemed appropriate. By 5/24/21, nursing staff will be educated on foley catheter cares and positioning to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on foley catheters are being followed as presented. The DON/designee will conduct random foley catheter audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure residents with foley catheters receive proper cares and positioning The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	

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daily decision making, had no behavior concerns, and was occasionally incontinent of bowel and bladder.

On 4/22/21 at 1:20 PM, the Director of Nursing (DON) was requested to provide toileting documentation as the current clinical record was only able to review the most recent past 30 days. The DON indicated they would follow up.

On 4/22/21 at 2:45 PM, the DON provided R449's toileting documentation from 4/11/20 to 4/19/20 and upon review reported there was no documentation (blank) on 4/11/20 for the 11pm-7am shift, and 4/12/20 for the day shift from 7am-3pm. Documentation indicated R449 had last been toileted on 4/11/20 at 8:20 PM and not again until 4/12/20 at 4:22 PM. The DON reported according to the documentation R449 had not been toileted for about 16 hours.

Based on observation, interview, and record review the facility failed to ensure proper care and positioning for a urinary catheter for one (R#31) of two residents reviewed for urinary catheters, resulting in the potential for infection. Findings include:

On 4/21/21 at 8:30 AM R#31 was observed in bed and was receiving enteral feeding. The resident's urinary drainage bag for the catheter was observed to be resting on the floor, and the resident's bed was observed to be in a low position.

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	On 4/21/21 at 3:07 PM the urinary drainage bag for R#31's catheter was observed to be on the floor. On 4/21/21 at 3:24 PM, Unit Manager Unit Manager 'H' was queried in regard to placement of the resident's urinary drainage bag and explained that it was hanging but the bed was too low. Unit Manager 'H' explained they would try to put it where it could be up a little bit, and explained they were going to get another anchor to keep it off the floor. On 4/21/21 review of physician orders for R#31 did not reveal orders present for a catheter device. Also, review of task documentation in the electronic clinical record on this date did not reveal task documentation related to a catheter. Review of physician orders for R#31 revealed multiple orders pertaining to catheter care were present in the resident's clinical record with a start date of 4/22/21. On 4/22/21 at 12:16 PM the facility's Director of Nursing (DON) acknowledged placement should be up off the ground.			
F0692 SS= D	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	Resident #98 will be offered fluids to promote appropriate hydration and staff will ensure call light is within reach. All residents who requiring extensive assistance have the potential to be affected	5/24/2021

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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: Based on observation, interview, and record review, the facility failed to ensure residents received fluids and/or assistance with consuming fluids for one (R#98) of four residents reviewed for hydration, resulting in the potential for increased thirst and dehydration. Findings include: On 4/20/21 at 3:02 PM, R#98 was observed in bed awake. R#98 appeared anxious and restless, was mumbling softly, was holding onto pillows, and trying to throw her legs over the side of the bed attempting to climb out. An over the bed table was observed on the other side of the room. An undated cup was observed on the table and it was almost full and warm and not within reach of the resident. R#98 pointed to the cup placed on the table and softly spoke about not wanting		and will be offered fluids to promote appropriate hydration. The facility policy has been reviewed and deemed appropriate. By 5/24/21, nursing staff will be educated on the offering of fluids to resident to promote appropriate hydration to ensure that the policy is being followed for continued compliance. Facility managers will be providing focused oversight and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on hydration and call light placement are being followed as presented. The DON/designee will conduct random hydration audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure residents are offered fluids to promote appropriate hydration. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	

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to be alone and reported she was thirsty. R#98's call light was not within reach of the resident. At that time, Certified Nursing Assistant (CNA) "BB" brought a fresh cup of water and placed it on the overbed table across the room from the resident. The straw was inserted into the cup and the straw wrapper covered the top portion of the straw.

On 4/20/21 at 4:00 PM, R#98 was observed in bed, pointed at the water cup, was mumbling softly, and appeared restless. The wrapper remained covering the top portion of the straw.

On 4/20/21 at 4:45 PM, R#98 continued to appear restless and reached toward the water and was attempting to shift her body in the bed. The cup of water remained on the over bed table across the room and the straw remained covered with the wrapper. At that time, CNA "Z" who was identified as R#98's assigned CNA, was interviewed. When queried about the placement of R#98's water and the resident's restlessness, CNA "Z" nervously answered that he was pulled to work on that hallway and did not know much about the residents. CNA "Z" began moving R#98's bed up and down with the remote and stated, "What do you want me to do?" When queried about whether R#98 was able to reach the water or able to drink on her own, CNA "Z" said he did not know. When queried about where the CNAs would look to find out about a resident's care, CNA "Z" reported he did not know. When queried

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about who the assigned nurse was, CNA "Z" reported he did not know.

At that time, Registered Nurse (RN) "AA" was interviewed. RN "AA" reported she was R#98's assigned nurse. When queried about R#98, RN "AA" reported the resident was a "fall risk" and required one to one assistance with eating and drinking. At that time, CNA "Z" came out of R#98's room. CNA "Z" reported he was the one who passed water to R#98 at 3:00 PM (CNA "AA" was observed to pass water at approximately 3:00 PM). When queried about whether R#98 was offered any water at the time it was placed in her room, CNA "Z" did not offer a response. When queried about why the straw wrapper remained on the straw at 4:45 PM when the water was passed at 3:00 PM, CNA "Z" did not offer a response.

R#98's clinical record was reviewed and revealed the following:

R#98 was admitted into the facility on 11/13/20 and readmitted on 2/10/21 with diagnoses that included: parkinsons disease, chronic obstructive pulmonary disease, Moderate protein calorie malnutrition, osteoporosis, osteoarthritis, psychotic disorder, dysphagia, and dementia. A MDS assessment dated 3/16/21 documented R#98 signed onto hospice services, was severely cognitively impaired, had no behaviors, and required extensive assistance with bed mobility, transfers, and eating.

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	The "POC Response History" task for "Fluids Consumed" for R#98 was reviewed for the past 14 days. On 4/20/21, it was documented R#98 was offered and consumed fluids at 6:19 AM and 10:12 PM. There was no additional documentation of fluids offered or consumed on that date. The "Visual Bedside Kardex" for R#98 documented, "Eating:...encourage self feed/1:1 feed as needed...Encourage and assist as needed to consume...fluids offered...Encourage fluid intake..." A facility policy titled "Hydration", dated 7/11/18 documented, "...It is the policy that this facility to provide each resident with sufficient fluid intake to maintain proper hydration and health...The nursing staff will encourage each resident to consume all fluids provided on their meal trays...Each resident is provided a large container of fresh water, which is located on the resident's bedside stand, unless contraindicated..."			
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 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	F0693	Resident #33□s formula will be appropriately labeled. Resident #110 no longer resides in the facility. Resident #145 was assessed for any adverse reactions to medication administration via PEG Tube. Resident #145□s formula will be appropriately labeled. All like residents in the facility have the potential to be affected. Like residents were assessed to ensure they have not had any adverse reactions to medication	5/24/2021

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	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: Based on observation, interview and record review, the facility failed to ensure proper management of tube feeding including proper positioning during active administration, documentation of monitoring for placement of a nasogastric (NG) tube, and labeling on the formula to ensure appropriate administration in accordance with physician orders for three (R33, R110 and R145) of four residents reviewed for tube feeding, resulting in the increased potential for aspiration pneumonia, and inaccurate tube feeding administration. Findings include: According to the facility's policy "Enteral Nutrition - Resident Care" dated 7/11/18, "...Head of bed should be elevated at a 30-45 degree angle during feeding and for at least one (1) hour after feeding is completed to prevent gastric reflux and possible aspiration...Document all appropriate information in medical record..."		administration via PEG Tube and that their formula was appropriately labeled. Residents receiving Tube Feed have had their beds set at the correct angle and nurses are checking for tube placement to prevent aspiration. The facility policy has been reviewed and deemed appropriate. By 5/24/21, Licensed Nurses will be educated on Enteral Feeding Administration- Medication Administration (7/2018), which will include but not limited to medication administration, formula labeling, tube placement and proper bed angle to prevent aspiration to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight, observation, and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on Enteral Tube Feeding and medication administration is being followed as presented. The DON/designee will conduct random audits on 5 residents with Enteral Feeding weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure medications are administered via PEG Tube per policy and the formula is appropriately labeled. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	

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Resident #33:

On 4/20/21 at 11:06 AM, R33 was observed lying in bed with a nasogastric (NG) tube (a tube that is passed through the nose and down through the nasopharynx and esophagus into the stomach). The mechanical pump used to deliver the formula via NG tube indicated the rate was set to 60 ml/hr (milliliters/hour). The bottle of "Osmolite" formula had approximately 200 ml remaining in the bottle, which indicated 800 ml of formula had been administered to the resident at some time. The label attached to this bottle only contained R33's name and was dated "4/19". There was no indication on this label of the rate at which the pump should be running, or the time it was hung. Continued observations on 4/20/21 at 12:36 PM, 2:26 PM, and 4/21 at 8:41 AM, revealed the label did not identify the time it was hung, or the rate.

On 4/21/21 at 8:41 AM, R33 was observed in the same manner as on 4/20/21, but the bottle of "Osmolite" had approximately 400 ml remaining which indicated 600 ml of formula had been administered to the resident at some time. The label attached to this bottle only contained R33's name and was dated "4/20". There was no indication on this label of the rate, or time it was hung.

On 4/21/21 at 8:48 AM, Nurse Manager 'C' entered the room and began to check on the

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	resident's tube feeding. When asked how staff were monitoring placement of the NG tube to ensure proper positioning, Nurse Manager 'C' pointed to the blue clamp near R33's nostril and indicated that had been placed due to the resident pulling it out recently. When asked about what the process was to ensure the correct rate of tube feeding was being administered, Nurse Manager 'C' reported, "It should be written on this (label on bottle of tube feeding formula)." At that time, the Nurse Manager 'C' confirmed there was no rate and again reported, "It should've been written on here." On 4/21/21 at 9:09 AM, Nurse Manager 'C' was observed inside R33's bathroom with the sink water running. At that time, R33 was observed lying completely flat on their back while in bed, which was now pulled away from the wall in an elevated position with the tube feeding actively infusing. Nurse Manager 'C' was asked about the positioning of R33 and whether the resident should be lying completely flat while the tube feeding was actively infusing, and Nurse Manager 'C' reported, "Normally, should be off." When asked why that was not done, Nurse Manager 'C' offered no further response. R33's clinical record was reviewed and revealed the resident was admitted into the facility on 1/13/21 and readmitted on 3/26/21. A Minimum Data Set (MDS) assessment dated 2/12/21 documented R33 had severely impaired cognitive skills for daily			

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	decision making, was dependent on staff for all aspects of care, and received nutrition via tube feeding. Review of R33's physician orders included: "Enteral Feed Order one time a day Osmolite 1.5 at rate 60ml/hr until 1200 ml infused per day with autoflushes 20ml/hr while TF (tube feeding) infusing. Start 1800 (6:00 PM). End 1400 (2:00 PM) or when total amount infused." "Assess and change NG securement site; remove previous securing tape, cleanse with warm water & mild soap (may use adhesive remover prn/as needed), assess skin condition, reapply securing tape every shift for management 7AM and 7PM" which began on 4/7/21. There were nine blank entries as to whether this had been done on: 4/10 at 7AM, 4/12 at 7AM, 4/13 at 7AM, 4/15 at 7AM and 7PM, 4/16 at 7AM and 7PM, 4/17 at 7PM, and 4/18 at 7PM. "Check placement of NG: verify has not moved from permanent mark on the tube/measurements have not changed>1 inch. If any concerns with placement, notify medical provider immediately, every shift for proper placement monitoring at 7AM and 7PM" which began on 4/7/21. There were eight blank entries as to whether this had been done on: 4/10 at 7AM, 4/12 at 7AM, 4/13 at 7AM, 4/15 at 7AM and 7PM, 4/16 at 7AM and 7PM, 4/17 at 7PM, and 4/18 at			

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7PM.

Resident #110:

On 4/21/21 at 8:36 AM, R110 was observed lying in bed in with tube feeding infusing. The mechanical pump used to deliver the formula via PEG tube (Percutaneous Endoscopic Gastrostomy - a tube passed into the stomach through the abdominal wall) indicated the rate was set to 100 ml/hr. The bottle of "Jevity 1.5" formula had approximately 200 ml remaining in the bottle, which indicated 800 ml of formula had been administered to the resident at some time. The label attached to this bottle contained R110's name, was dated "4/20", indicated the time it was hung was "1800" (6:00 PM) but there was no indication on this label of the rate at which the pump should be running.

R110's clinical record was reviewed and revealed the resident was admitted into the facility on 9/13/18 and readmitted on 12/26/20. A MDS assessment dated 3/22/21 documented R110's cognition was severely impaired, was dependent on staff for all aspects of care, and received nutrition via tube feeding.

Review of R110's physician orders included:

"Enteral Feed Order one time a day jevity 1.5 at rate 100ml/hr until 1400 ml infused per day with autoflushes 35ml q (every) hr (hour)

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while TF infusing. Start: 1800. End: 0800 or when total amount infused".

On 4/22/21 at 10:00 AM, an interview was conducted with the Director of Nursing (DON). When informed about the observations of lack of labeling on the tube feeding formula and positioning of R33, the DON reported that should not have occurred and that the name, date, rate and time should be labeled on the tube feeding formula bottle and R33's tube feeding should have been turned off if positioned flat.

Resident #145:

On 4/20/21 at 9:15 AM, R#145 was observed lying in bed. R#145 made eye contact but did not verbally respond when spoken to. Oxygen was infusing via nasal cannula. A bottle of Glucerna with Carb Steady 1.5 calorie tube feeding formula was hung on the tube feeding pole but was not infusing and the tube was not inserted into the resident's PEG tube. There was no label on the tube feeding formula bottle that indicated the resident's name, rate of the tube feeding, and the date and time it was hung. There was 750 milliliters of formula remaining in the bottle which indicated 250 milliliters of formula had been administered to the resident at some time. At 3:50 PM, the tube feeding formula bottle remained on the pole with no label.

A review of R#145's clinical record revealed the following:

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	R#145 was admitted into the facility on 6/28/19 and most recently readmitted on 3/14/21 with diagnoses that included: pneumonia, bronchitis, Parkinson's Disease, and history of malignant neoplasm of the brain (cancerous brain tumor). R#145's resident census revealed the resident was transferred to the hospital on 10/9/20, 10/31/20, 11/13/20, 2/26/21, and 3/14/21. A Minimum Data Set (MDS) assessment dated 4/1/21 documented R#145 had severely impaired cognition, no behaviors, and was totally dependent on staff for bed mobility, transfers, and all activities of daily living. The MDS indicated R#145 received intravenous (IV) medications during the assessment period, required oxygen therapy, and received all nutrition via a Percutaneous Endoscopic Gastrostomy (PEG) tube (feeding tube). Physicians orders for R#145 were reviewed and revealed R#145 was to receive Glucerna with Carb Steady 1.5 calorie one time a day at a rate of 100 ml/hr (milliliters per hour) until 1300 ml were infused. It was documented the tube feeding was to start at 6:00 PM and end at 7:00 AM or when the total amount was infused.			
F0695 SS= D	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal	F0695	Resident #32□s suctioning canister has been changed and will be changed weekly and as needed. All like residents in the facility have the potential to be affected. Like residents were assessed to ensure their suctioning canister	5/24/2021

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	suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to change a suction canister according to physicians orders for one (R#32) of one resident reviewed for tracheostomy care, resulting in the potential for growth of bacteria. Findings include: On 4/20/21 at 3:11 PM, R#32 was observed lying in bed. R#32 was observed to have a tracheostomy (breathing tube) and a Percutaneous Endoscopic Gastrostomy (PEG - feeding tube). When spoken to R#32 did not make eye contact and did not respond verbally. The suction machine was observed with a suction canister dated 4/8/21 and was one half to three quarters full of sputum. On 4/21/21 at 7:50 AM, R#32's suction canister remained one half to three quarters full of sputum and was dated 4/8/21. On 4/21/21 at 12:45 PM, Registered Nurse (RN) "S" was observed providing tracheostomy care to R#32. When queried about the suction canister dated 4/8/21 that was approximately three quarters of the way full of sputum, RN "S" stated, "That needs to be emptied." When queried about how often		has been changed weekly and as needed. By 5/24/21, Licensed Nurses will be educated on changing suctioning canisters weekly or as needed. The DON/designee will conduct suction cannister audits on all residents with suction machines weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure suctioning canisters are changed weekly or as needed. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	

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	the suction canister was changed, RN "S" stated, "When it gets full." R#32's Physician's Orders were reviewed and revealed the following order: "Oxygen Equipment Management--change out, date & label all trach cool air mist and suction canister, tubing/bags/set ups...clean filter and wipe down machine every day shift every Thu (Thursday) for cleaning routine". On 4/23/21 at approximately 3:30 PM, the Director of Nursing (DON) was interviewed. When queried about when suction canisters should be changed, the DON reported they were changed weekly and as needed.			
F0697 SS= D	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00119118. Based on observation, interview and record review, the facility failed to implement effective pain management which adequately assessed, identified, and addressed unresolved pain for one (R135) of two residents reviewed for pain management, resulting in the voiced feelings of frustration	F0697	Resident #135 has had a proper evaluation completed using the pain assessment tool in the electronic monitoring system. Resident 135□s pain is being assessed and follow up occurring to ensure her pain is being resolved, pain medication has been scheduled to promote consistent pain management. All like residents in the facility have the potential to be affected. Like residents were assessed to the residents have adequately had their pain assessed, identified, and managed. The facility policy has been reviewed and deemed appropriate. By 5/24/21, Licensed Nurses will be educated on the facility pain management policy and how to adequately assess pain, identify pain and follow up to ensure it is managed to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight and guidance to the nursing staff to follow the facility□s policy to ensure that the	5/24/2021

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	and unalleviated pain. Findings include: Review of a complaint reported to the State Agency included concerns that the facility was not adequately addressing R135's condition following a recent fall with multiple fractures and decline in overall health. According to the facility's policy "Pain Management" dated 7/11/18, "...Document all findings in nurse's progress note...Medication(s) received, refused and response to medication will be documented on the Medication Administration Record (MAR)...1. Monitor pain status and treatment effects on a regular basis, e.g., during routine medication pass and after administration of analgesics for effectiveness 2. Consult physician for additional interventions if pain is not relieved by currently ordered treatment modalities and comfort measures 3. The care plan will reflect the location and type of pain, pharmacological, and non-pharmacological interventions, with evaluation and revision as indicated". On 4/20/21 at 10:30 AM, R135 was observed lying in bed on their right side facing the window. R135 reported they had not been at the facility long but had several concerns which included not receiving pain medication on time and that their friend had called in the complaint because "I couldn't take it anymore". R135 reported they had to ask for the pain medication and at times would have to beg for it. The resident further reported		in-services on pain management are being followed as presented. The DON/designee will conduct random pain audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the residents have adequately had their pain assessed, identified, and managed. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	

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	there were occasions they had to wait four to five hours beyond when it was due and were not able to do anything such as therapy due to the lack of pain control. Review of the clinical record revealed R135 was admitted into the facility on 4/1/21 with diagnoses that included: displaced bimalleolar fracture of left lower leg, other nondisplaced fracture of upper end of right humerus, encounter for other orthopedic aftercare, dislocation of left ankle joint, history of falling, pain in left ankle and joints of left foot, and major depressive disorder single episode. According to the Minimum Data Set (MDS) dated 4/4/21, R135 had intact cognition, no behavior concerns, was dependent upon two plus persons physical assist for bed mobility, transfers, toilet use, had a fall prior to admission, was not on scheduled pain medication, received as needed pain medication, and complained of frequent pain at a worst pain level of 9/10. Review of physician orders included one analgesic which was ordered as needed (PRN) on 4/1/21 (upon admission) for "Roxicodone Tablet 5 MG (oxyCodone HCl) Give 1 tablet by mouth every 4 hours as needed for moderate pain". Review of R135's MARs revealed the resident had not received this medication consistently every four hours.			

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Review of the Nursing admission assessment dated 4/1/21 documented "...Resident has pain? Yes...Describe location and type of pain: sharp and chronic pain...Numerical Rating Scale (for verbal/able residents). 1 Mild pain to 10 Worst possible pain...8..."

Review of an admission nursing pain tool dated 4/1/21 indicated a score of "0.0" which documented, in part: "...Left lower leg (front) cast...Right shoulder (rear) sharp pain...Pain score out of 10 where 1 is mild pain and 10 is worst pain possible...8...What makes the pain better? medication...Answer one of the below. What is the level of pain at its worst?...Pain score out of 10 where 1 is mild pain and 10 is worst pain possible...8..."

Review of R135's pain care plans initiated 4/9/21 without any further revisions included:

"The resident has multiple fractures/trauma r/t (related to) Fall down stairs in her home".

Interventions included:

"Monitor/document pain on a scale of 0 to 10 before and after implementing measures to reduce pain." There was no identified pain goal included in this care plan.

Initiated 4/9/21, "Resident has acute/chronic pain r/t reduced mobility, fractures".

Interventions included:

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	"Resident will verbalize and/or exhibit that pain is at a tolerable level and not have pain interfere with daily routine through the review date." There was no resident specific pain goal to indicate what was "a tolerable level" for R135. "Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition." "Monitor/record/report to Nurse any s/sx (signs/symptoms) of non-verbal pain: Changes in breathing. (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing)." Review of the prn pain medication and corresponding documentation on the MAR revealed on 4/11/21 at 4:49 PM, R135's pain level was noted by Nurse 'E' as a "6" and was also noted as "ineffective". The next documented pain medication was on 4/11/21 at 9:47 PM with a pain level noted as "5" by Nurse 'QQ'. There was no documentation			

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that Nurse 'E' had contacted the physician to inform them of the ineffective results, and/or that any alternate pharmacological /non-pharmacological pain management had been attempted.

Review of R135's progress notes since admission identified R135's complaints of pain including other clinical issues (pressure ulcer, indwelling urinary catheter) which were documented by nursing staff as well as in the medical practitioner notes with Nurse Practitioner (NP 'R' and NP 'Q'). Documentation reflected in each of these to continue the prn medication as indicated above and did not identify alternate pain management interventions to specifically address the complaint of pain.

A most recent entry on 4/21/21 at 3:37 PM by NP 'R' documented, "...Pt. seen today for c/o (complaints of) pain around her Foley (indwelling urinary catheter) and occasional leaking with pain...as well as sacral pain. Pt is more confused on exam from baseline stating that 'she has written her own order for more pain meds and needs to have it changed' she has a difficult time staying on topic of conversation..." NP 'R' indicated they were ordering a urine and blood test, but there were no changes made to the current pain medication regimen.

On 4/21/21 at 2:55 PM, an interview was conducted with R135's assigned nurse (Licensed Practical Nurse/LPN 'J'). When

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	asked about the resident's pain management, LPN 'J' reported the resident requested pain medication every four hours. When asked if there was an identified pain goal for effective pain management, LPN 'J' reported their conversation with R135 identified a goal for pain control of four or below. When asked if that was documented anywhere such as on the medication administration records or care plans, LPN 'J' reported they were not sure. When asked if the resident had to request pain medication every four hours, was there ever any consideration to see about having the physician evaluate the medication to something that was scheduled, or whether there was anything for breakthrough pain, LPN 'J' reported they were not sure. When asked about the admission pain tool with a score of "0.0" despite identification or pain at an 8/10, LPN 'J' was unable to offer any explanation. On 4/22/21 at 9:56 AM, a phone interview was conducted with NP 'R' to review R135's pain management and evaluation as documented on 4/21/21. At that time, NP 'R' confirmed they had seen R135 on 4/21 and that the resident seemed more confused, so they had ordered a urine test to rule out infection. When asked about the resident's unresolved complaints of pain and documentation from nursing and medical practitioner staff of continued issues with pain and whether any changes had been considered, or if so, why there were no changes made, NP 'R' reported they worked			

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only part time and would have NP 'Q' who worked full time follow up regarding R135's pain management.

On 4/22/21 at 10:00 AM, the Director of Nursing (DON) was queried about concerns regarding R135's pain management. The DON reported there should be an identified pain goal and would look to see if there was any additional documentation. The DON was informed that although there were pain care plans initiated, there were no identified pain goals specific to R135. The DON reported they were not sure but recalls a resident having some hospital documentation as to why they were not on a scheduled pain medication and would look to see if that was for R135 and provide any documentation if that was for R135. (There was no additional documentation or clarification provided by the DON by the end of the survey.) When asked about what should be done if the resident's pain medication was ineffective, the DON reported the nurse should have called the Physician for further instruction and documented that in clinical record. The DON reported they would pull the actual pain medication log (controlled med sheets) to see if there was additional documentation on there as they had issues with staff not documenting on both the pain medication log and the MAR.

On 4/22/21 at 2:40 PM, the DON reported they had spoken to Physician 'U' and would be in to see the resident today and would be

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	scheduling the pain medication. The DON was requested to provide any corresponding documentation following this, however there was no further documentation provided by the end of the survey on 4/23/21.			
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. 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 #s: MI00118238 and MI00119118.	F0755	Resident #82 and #135 controlled medication signature logs were reviewed to ensure there was no misappropriation of property concerns or drug diversion. An audit was completed of all controlled medication signature logs to review to ensure there was no misappropriation of property concerns or drug diversion. The shift-to-shift controlled medication signature logs were audited to ensure reconciliation and compliance with the Controlled Drug Policy. To ensure continued compliance, controlled substance discrepancies will be investigated to rule out diversion by a clinical manager and the investigation of the discrepancy will be documented at the bottom of the reconciliation sheet. The facility policy has been reviewed and deemed appropriate. By 5/24/21, Licensed Nurses will be educated on the Controlled Drugs Policy (5/2020) to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight, observation, and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on controlled drugs are being followed as presented. 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 there was no misappropriation of property or drug	5/24/2021

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	Based on observation, interview, and record review the facility failed to maintain accurate proof of use for a prescribed narcotic medication, failed to ensure narcotic medication was appropriately stored, and failed to ensure narcotic medications were counted upon receipt of medication cart keys for two (R#82 and R#135) residents reviewed for controlled substances, resulting in the potential for misappropriation and diversion of controlled substances. Findings include: According to a facility policy with a subject of "Controlled Drugs" dated 7/11/18 and updated 5/14/20 documented, in part, "...Narcotic Count and Inventory: 1. Controlled drugs are counted every shift by the nurse reporting on duty WITH the nurse reporting off duty. 2. The inventory of the controlled drugs must be recorded on the narcotic records and signed for correctness of count. 3. The controlled drug checklist must be signed by the nurse coming on duty and the nurse going off duty to verify that the count of all controlled drugs is correct. 4. If a discrepancy is found, check the resident's order sheets and chart to see if a narcotic has been administered and not recorded. Check previous recordings on the control sheets for mistakes in arithmetic. If the cause of the discrepancy cannot be located and/or the count does not balance, report the matter to the Director of Nursing. 5. In counting controlled drugs, the nurse must be alert for any evidence of a substitution. Inspect tablets		diversions. The DON/designee will conduct random controlled medication audits on 3 medication carts weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that the nurses are completing controlled drug counts every shift by the nurse reporting on duty with the nurse reporting off duty. The results of controlled medication audits will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	

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and solutions closely, noting any defects in drug container. Any suspicion of substitution or tampering with controlled drugs must be reported to the supervisor immediately. Generate the appropriate incident statements..."

Resident #82:

On 4/23/21 at approximately 11:45AM an observation was made of the medication cart (labeled on exterior of cart as medication cart 2 west cart 8). The observation of the cart was made with Licensed Practical Nurse (LPN) 'II' present. LPN 'II' was asked to show the narcotic blister pack for R#82's gabapentin medication 800mg (milligram). One of the blister packs for this medication for R#82 was observed to have one pill pouch (present in spot number 15 on the card) where the foil backing to the blister pack had been disturbed, and tape was present on the back of the card securing a tablet of medication into an assigned spot in the narcotic blister package. LPN 'II' explained it looked like a mistake had been made and acknowledged it should have been thrown away.

Review of a physician order for R#82 dated 7/16/20 revealed the resident was prescribed Gabapentin Tablet 800 MG with directions to "Give 1 tablet by mouth every 8 hours for Nerve pain."

LPN 'II' was queried in regard to the count for the medication cart, explained that their

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	partner had counted the cart, and acknowledged she had not counted the cart (reconciliation of correct narcotic medication count process). On 11:55 AM LPN 'JJ" was queried about the medication count, acknowledged she had counted two carts for the 2 West unit, and had not identified concerns. On 4/23/21 at 12:01 PM the facility's Director of Nursing (DON) was queried in regard to counting narcotics and acknowledged at each shift count was supposed to occur. The DON acknowledged if taking the keys, the person would be responsible for doing a count. The DON also acknowledged that if a narcotic was not administered, another nurse, manager, or the Director of Nursing was to sign off and waste the medication. On 4/20/21 at 10:30 AM, R135 was observed lying in bed on their right side facing the window. R135 reported they had not been at the facility long but had several concerns which included not receiving pain medication on time and that their friend had called in the complaint because "I couldn't take it anymore". R135 reported they had to ask for the pain medication and at times would have to beg for it. The resident further reported there were occasions they had to wait four to five hours beyond when it was due and were not able to do anything such as therapy due to the lack of pain control.			

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	Review of the clinical record revealed R135 was admitted into the facility on 4/1/21 with diagnoses that included: displaced bimalleolar fracture of left lower leg, other nondisplaced fracture of upper end of right humerus, encounter for other orthopedic aftercare, dislocation of left ankle joint, history of falling, pain in left ankle and joints of left foot, and major depressive disorder single episode. According to the Minimum Data Set (MDS) dated 4/4/21, R135 had intact cognition, no behavior concerns, was dependent upon two plus persons physical assist for bed mobility, transfers, toilet use, had a fall prior to admission, was not on scheduled pain medication, received as needed pain medication, and complained of frequent pain at a worst pain level of 9/10. Review of physician orders included one analgesic which was ordered as needed (PRN) on 4/1/21 (upon admission) for "Roxicodone Tablet 5 MG (oxyCodone HCl) Give 1 tablet by mouth every 4 hours as needed for moderate pain". Review of R135's MARs revealed the resident had not received this medication consistently every four hours. On 4/22/21 at 10:00 AM, the Director of Nursing (DON) was queried about concerns regarding R135's pain management. The DON reported there should be an identified			

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pain goal and would look to see if there was any additional documentation. The DON was informed that although there were pain care plans initiated, there were no identified pain goals specific to R135. The DON reported they were not sure but recalls a resident having some hospital documentation as to why they were not on a scheduled pain medication and would look to see if that was for R135 and provide any documentation if that was for R135. (There was no additional documentation or clarification provided by the DON by the end of the survey.) When asked about what should be done if the resident's pain medication was ineffective, the DON reported the nurse should have called the Physician for further instruction and documented that in clinical record. The DON reported they would pull the actual pain medication log (controlled med sheets) to see if there was additional documentation on there as they had issues with staff not documenting on both the pain medication log and the MAR.

Review of R135's controlled drug receipt/record/disposition form for "oxycodone IR TAB 5 MG 1 TABLET BY MOUTH EVERY FOUR HOURS AS NEEDED" revealed a quantity of 30 pills had been provided to the facility on 4/13/21. Review of the MARs compared to the actual controlled drug record revealed conflicting documentation of administrations. The controlled drug record documented on 4/17 at "1200" (12:00 PM) there was one pill

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	retrieved with 20 pills remaining. The next documented entry on 4/17 at "11.44 <sic>" (11:44 unsure if AM or PM) documented there was one pill retrieved with 18 pills remaining. The rest of the remaining 18 pills were signed out between 4/18 to 4/22 with the last retrieval on 4/22 at 9:03 AM. On 4/23/21 at 12:09 PM, the DON was queried about the conflicting documentation for R135's controlled medication and reported they had noticed similar concerns upon providing this surveyor a copy. The DON reviewed the actual MAR and the controlled substance record and confirmed they did not match. When asked what the process was to ensure the medications were actually administered and not diverted or misappropriated, the DON reported the process was when medications were given, they should be documented on both the controlled substance record and the MAR at the time of administration. The DON further reported that staff have been educated and this was an ongoing issue they were working on.			
F0756 SS= D	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director	F0756	Resident #69 MMR dated 1/15/21 has been followed-up on and deemed unnecessary to implement at this time due to multiple changes An audit was completed on all residing residents most recent MMR□s to ensure there has been appropriate follow-up on all recommendations. The facility policy has been reviewed and deemed appropriate. By 5/24/21, Licensed	5/24/2021

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	and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to promptly implement an accepted medication regimen review (MRR) recommendation for one (R#69) of five residents reviewed for unnecessary medications, resulting in the potential for adverse medication side effects. Findings include:		Nurses will be educated on the Medication Regimen Review (MMR) Policy (7/2018). Pharmacy recommendations are sent to the DON and attending physician, the DON will review the recommendations and ensure that the MMR is placed in the physician book for review. MMRs will be reviewed for follow-up by the DON/Designee to ensure timely physician follow-up. Pharmacy consultant reports on MMR compliance monthly at QAPI for additional compliance tracking. The DON/designee will conduct random MMR audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure there has been appropriate follow up on all accepted MMR recommendations. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	

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	Review of an accepted "Pharmacist Recommendation to Prescriber" form for R#69 with an MRR date of 1/15/21 documented, "Dear Dr. [Name Redacted], This resident receives lacosamide (Vimpat) 200mg (milligram) bid (twice a day) and has high lacosamide levels based on this dose-level of 16.6 (range 5-10). Recommendation: Please consider decreasing this medication to lacosamide (Vimpat) 150 mg bid..." It was documented per the "Physician/Prescriber Response" that this recommendation was agreed upon, and next to the box marked agreed it was documented (Please enter new order into Electronic Chart -[Electronic Medical Record System Name]- or flag for nurse). This document was signed on the response line on 1/20/21. Review of the resident's physician orders for this medication revealed the medication dosage had not been decreased following this accepted pharmacist recommendation. Per a physician order active 12/9/20 through 3/17/21 the resident had been ordered, "Vimpat Tablet 200 MG (Lacosamide) Give 1 tablet by mouth two times a day for seizure". Review of the clinical record for R#69 revealed the resident was admitted to the facility 1/14/19 and was readmitted 10/8/19 with diagnoses which included, in part, cerebral infarction, delusional disorders, and hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side. Review of the resident's			

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	minimum data set (MDS) assessment dated 3/3/21 revealed the resident scored 12 out of 15 on a brief interview for mental status (BIMS) exam, which indicated the resident was moderately cognitively impaired. On 4/23/21 at 10:08 AM the Director of Nursing (DON) was queried in regard to the above situation, and explained that it had to have gotten missed. Per the DON, the MRR would be given to the doctor to agree or disagree, it would be signed off and then give to the Unit Manager. The Unit Manager would then input the orders, and it would be faxed to pharmacy. Review of a facility policy with the subject "Medication Regimen Review (MRR)" dated 7/11/18 it was documented, in part, "It is the policy of this facility that: 1. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist and 2. The pharmacist must report any irregularities to the attending physician, facility medical director and the Director of Nursing Services 3. These reports must be acted upon..."			
F0758 SS= D	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv)	F0758	Resident #101 had an IDT review of psychotropic medications to ensure there are no mood/behavior or fall concerns related to the medication. Resident #135 psychotropic were reviewed to ensure appropriate diagnoses, stop dates and plan of care. All like residents in the facility have the potential to be affected. Like residents were	5/24/2021

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	Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure two residents (R#101 and R#134) of seven residents reviewed for psychotropic medication use, were free of unnecessary psychotropic medications, resulting in the		reviewed to ensure appropriate psychotropic usage, dosage, stop dates, monitoring and indication for use. The facility policy has been reviewed and deemed appropriate. By 5/24/21, Licensed Nurses and Social Service Workers will be educated on the Psychotropic Drug Use Policy (7/2018) to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight and guidance to the nursing and social work staff to follow the facility□s policy to ensure that the in-services on psychotropic medications are being followed as presented to ensure compliance for correct prescribing. Psychoactive drug orders will be reviewed for an appropriate diagnosis and behaviors to ensure compliance with prescribing practices. The DON/designee will conduct random psychotropic medication audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure appropriate psychotropic usage, dosage, stop dates, monitoring and indication for use. The results will be presented to the QAA committee for review and consideration of further corrective actions. Physicians found to not be complying with the policy will be referred to the Medical Director for further action. The DON and Medical Director will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	

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	potential for adverse reactions. Findings include: Resident #134 On 4/21/21 at approximately 11:04 a.m., R#134 was observed in their room, lying in their bed. R#134 was observed to be lethargic. On 4/21/21 the medical record for R#134 was reviewed and revealed the following: R#134 was initially admitted to the facility on 3/29/21 and had diagnoses including stage 4 pancreatic cancer, shortness of breath, and anxiety. A review of R#134's Minimum Data Set (MDS) assessment with an ARD (assessment reference date) of 4/1/21 revealed R#134 needed extensive assistance with most of their activities of daily living. R#134's BIMS score (brief interview of mental status) was 11 indicating moderately impaired cognition. A physician's order dated 3/30/21 revealed the following: Ativan Tablet 0.5 MG (LORazepam) *Controlled Drug* Give 1 tablet by mouth every 4 hours as needed for Sleep/Agitation." Further review of R#134's order revealed the stop date as "indefinite." A review of R#134's MAR (Medication Administration Record) for April 2021 revealed R#134 was administered the PRN (as needed) Ativan on 4/2, 4/8, 4/9 and 4/20.			

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	A review of R#134's administration notes for the PRN Ativan on 4/2, 4/8, 4/9 and 4/20 revealed the Ativan was administered but no documentation of resident specific-non-pharmacological interventions being attempted were documented prior to the administration. A review of R#134's careplan revealed the following: "Resident uses anti-anxiety medications r/t (related to) Anxiety disorder...Interventions-Administer anti-anxiety medications as ordered by physician. Monitor/document side effects and effectiveness q (every) shift and prn. Report abnormal's to medical provider and adjust as directed. Date Initiated: 04/08/2021...NURSE-Monitor, document and report any adverse reactions to anti-anxiety therapy, such as, drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision, mania, hostility, rage, aggressive or impulsive behavior, delusions, hallucinations. Report and adjust as directed. On 04/23/21 at approximately 11:03 a.m., during a conversation with the Social Worker (SW "KK") was queried regarding R#134's PRN Ativan and they reported that they should have an appropriate diagnosis and the Ativan should have had a stop date with it on the order so it can be re-evaluated for			

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	continued use. SW "KK" was queried regarding if non-pharmacological interventions should be attempted prior to the administration of the PRN Ativan and they indicated they should be. Resident #101: On 4/20/21 at 3:33 PM, R101 was observed seated in a gerichair recliner in a reclined position across from the second floor east nursing desk. R101 was observed to have two bandages to the forehead and the left knee was observed to have an open abrasion without any bandage. R101 was unable to participate in an interview due to significant cognitive limitations. Review of the clinical record revealed R101 was admitted into the facility on 2/25/21 and readmitted on 3/22/21 with diagnoses that included: multi-system degeneration of the autonomic nervous system, pain in left ankle and joints of left foot, insomnia, mood disorder due to known physiological condition with depressive features, dementia in other diseases classified elsewhere with behavioral disturbance, and Parkinson's disease. According to the Minimum Data Set (MDS) assessment dated 3/25/21, R101 had moderately impaired cognition with trouble concentrating, had no behavior concerns including no hallucinations or delusions, received no antipsychotic medication, but did receive antianxiety medication for four of the seven days during this review period. Review			

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of the care plans revealed the only behaviors identified were wandering and at risk for side effects from use of antidepressant and antianxiety medication. There were no resident specific care plans to address any actual or potential problem behaviors.

Review of the physician orders revealed R101 was prescribed a one-time order for "Quetiapine Fumarate (Seroquel - an antipsychotic medication) 12.5 MG by mouth one time only for Combative behavior for 1 day". According to the Medication Administration Record (MAR), R101 received the antipsychotic medication on 4/7/21 at 3:56 PM.

Review of R101's behavior documentation from 3/23/21 to 4/23/21 revealed there was only one behavior of kicking/hitting noted on 4/11/21 at 6:10 AM.

Review of the psych consultations revealed the most recent evaluation had been completed on 3/25/21 which discussed the discontinuation of an antidepressant and read, "...The patient attempts to get up and move around without staff assistance and needs to be monitored closely...He does not appear to be actively hallucinating..."

Review of the progress notes revealed R101 had 12 fall occurrences between 3/3/21 and 4/22/21. Documentation for these falls included a fall with injury that occurred following the administration of the

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antipsychotic medication on 4/7/21. Documentation included:

On 4/7/21 at 3:32 PM, Registered Nurse (RN 'S') documented they had contacted Nurse Practitioner (NP 'Q') regarding R101's "combative behavior and anxiety", but there were no details of what these specific behaviors were, or any other circumstances of any contributing factors.

On 4/7/21 at 9:40 PM, Licensed Practical Nurse (LPN 'T') documented, "Resident was observed on the floor lying on the left side of his face in a pool of blood. upper lip broken and tooth appear chipped...Doctor and DON contacted without response. 911 called and resident will be taken to the hospital in suspicion of trauma to the head..."

On 4/8/21 at 9:00 AM, the post fall documentation for the R101's fall on 4/7/21 at 9:00 PM documented, "Falls in past 90 days and/or since admission: 7...Root Cause (s) and Contributing Factors as determined by IDT: attempted to self transfer from bed, impulsive with poor cognition...What changes do we need to make when caring for resident to prevent him/her from experiencing the same type of fall? 15 minute monitoring until psych evaluates medication with concern for recent GDR (gradual dose reduction)..." There was no mention of the one-time use of the antipsychotic medication. There was no further documentation provided by the facility by the end of the survey to indicate

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	R101 had been evaluated by psych services following the fall on 4/7/21 as indicated above. On 4/8/21 at 10:04 AM, the social services care conference note did not identify any mood or behavior concerns or use of psychotropic medication. On 4/8/21 at 2:12 PM, Nurse Practitioner (NP 'Q') documented, "...Nursing staff called yesterday afternoon reporting that pt was being defiant and combative. Nursing staff reported that she was concerned that resident was going to fall. Verbal order given for psych consult and Seroquel 12.5 mg PO x 1 for chronic dementia w/ behaviors. Per nursing documentation, it was noted that pt had a fall on last night and was sent to the ED. Pt returned last night w/ no new orders. Pt seen and examined today. Pt reports wellbeing and is w/o (without)complaint...Diagnosis/Status/Plan...Acute lip laceration s/p fall...Lip laceration noted. No other injury noted during full body exam..." There was no identification of the one-time antipsychotic medication as a potential contributor to the fall in the post fall documentation on 4/8/21. On 4/23/21 at 11:16 AM, an interview was conducted with the Director of Nursing (DON) to review R101's falls and psychoactive medication use. At that time, upon review of the available documentation, the DON confirmed the documentation as noted did			

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	not identify any specific behavior concerns to warrant the use of the one-time antipsychotic and when asked if that may have contributed to the fall with injury on 4/7/21, the DON reported that had been a consideration as well but confirmed documentation did not reflect that. According to the facility's policy "Psychoactive Drug Use" dated 7/11/18, "...It is the policy of this facility to use psychoactive drugs based on a comprehensive assessment of the resident, the facility must ensure that...Residents who have not used a psychoactive drug are not given these drugs unless psychoactive drugs therapy is necessary to treat a specific condition as diagnoses and documented in the clinical record...(psychoactive medications) shall not be administered for the purpose of discipline or convenience...Psychotropic PRN (as needed) orders are limited to 14 days...Assessment will include the medical symptoms and specific conditions necessitating need for the drug, results of behavior monitoring and interventions, as well as how the use of the drug is attaining the resident's highest level of functioning..."			
F0759 SS= D	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as	F0759	Resident #145 was assessed for any adverse reactions to medication administration via PEG Tube. An audit was completed on all current residents to ensure that medications are being administered via PEG Tube according to	5/24/2021

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	evidenced by: Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5% when five medication errors were observed from a total of 28 opportunities, resulting in a medication error rate of 17.86%. This deficient practice affected one (R145) of three resident observed during medication administration. Findings include: On 4/22/21 at 8:04 AM, during an observation of medication administration for R145, Registered Nurse (RN) "AA" prepared oral medications that included: aspirin 81 milligrams (mg), Vitamin D-3 2,000 units, sodium chloride 1 gram (g), Eliquis 5 mg, and Vitamin B-12 100 micrograms (mcg). RN " AA " was then observed placing the five oral medications into a small, rectangular plastic sleeve and crushed all five pills together. RN "AA" poured the five crushed medications into an approximately six ounce clear water cup, added water and stirred the contents with a plastic spoon. RN "AA" also prepared liquid medications into separate medicine cups. RN "AA" was observed entering R145's room, preparing R145's percutaneous endoscopic gastrostomy (PEG - a tube that is passed into the stomach through the abdominal wall) for medication administration. Then RN "AA" was observed attaching an enteral medication syringe to R145's PEG tube, pour the entire contents of		physician orders. The facility policy has been reviewed and deemed appropriate. By 5/24/21, Licensed Nurses will be educated on Medication Administration Administration of Drugs (7/2018) to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight, observation, and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on medication administration via PEG Tube is being followed as presented The DON/designee will conduct random medication administration audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that residents are receiving medication via PEG Tube according to physician orders. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	

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the five crushed medications and water into the syringe and began to administer the medications. R145 was observed to begin coughing and RN "AA" stopped the medication administration and explained she would give R145 an hour to "feel better".

On 4/22/21 at 9:16 AM, RN "AA" was interviewed and asked about crushing five oral medication together to give through a PEG tube. RN "AA" explained she was supposed to crush each medication separately and she did not know which of the medications R145 had received before she stopped the administration.

Review of the clinical record revealed R145 was originally admitted into the facility on 6/28/19 and readmitted 3/30/21 with diagnoses that included: pneumonia, Parkinson's Disease, and seizures. According to the Minimum Data Set (MDS) assessment dated 4/1/21, R145 scored 00 on the Brief Interview for Mental Status (BIMS) exam, indicating severely impaired cognition. The MDS also indicated R145 had a feeding tube.

On 4/22/21 at approximately 11:30 AM, the Director of Nursing (DON) was interviewed and asked about medication administration via PEG tube. The DON explained all medications should be crushed separately and given one at a time.

Review of a facility policy titled, "Enteral Feeding Administration - Medication

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	Administration" dated 7/26/18 read in part, "... c. verify that tablet/capsules are approved for crushing... Once verified, dissolve medication in medicine cup using 10 to 30 cc (cubic centimeter) of water. d. Keep medication separate... 11. Instill each medication separately..."			
F0761 SS= E	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were appropriately labeled	F0761	An audit was completed by the DON/Designee to ensure the following items were completed on the identified refrigerators, medication carts and throughout the facility. The food items noted in the medication refrigerator were discarded. The medications were removed for discharged residents out of the medication carts. The expired medications were removed/discard per policy. The insulins and glucose strips were reviewed to ensure all were appropriately labeled with dates, stored appropriately and items noted unlabeled or expired were removed from use. All like residents in the facility have the potential to be affected. On 5/5, 5/6 and 5/7/21, the pharmacy technician was at the facility to review all medication carts, medication rooms and storage areas for medications to ensure compliance with labeling/storage of medications to ensure compliance for existing residents who reside in the facility. Nurses will remove medications from med carts for discharged residents as part of the completed discharge process to ensure continued compliance. Clinical managers will be providing focused oversight, observation, and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on medication refrigerators, labeling and storage is being followed as presented The facility policy has been reviewed and	5/24/2021

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	and/or stored in three of five medication carts and two of two medication rooms reviewed, resulting in: (1) food stored in the medication refrigerator; (2) discharged resident's medications left in medication cart; (3) expired stock medications; and (4) undated insulins and glucometer test strips. Findings include: On 4/23/21 at 9:58 AM, a review of the first floor East medication room was conducted with Registered Nurse (RN) "I". A refrigerator was observed to have two styrofoam containers, one on top of the other in the middle of the lower shelf. There were medications observed on either side of the styrofoam containers, on the shelf above and the shelf below. RN "I" was asked about the purpose of the refrigerator. RN "I" explained it was for medications requiring refrigeration. RN "I" was asked what was in the styrofoam containers. RN "I" removed the containers and opened them to reveal food. RN "I" was asked if food was kept in the refrigerator. RN "I" explained he did not know whose food it was, or who had put it in the refrigerator. On 4/23/21 at 10:02 AM, a review of the first floor West medication cart 6 was conducted with Licensed Practical Nurse (LPN) "X". Upon reviewing opened dates on insulins, one insulin was found undated. A Lantus SoloStar, confirmed with LPN "X" the pen was opened and undated. LPN "X" was asked when pens should be dated. LPN "X" explained insulin should be dated when used for the first time.		deemed appropriate. By 5/24/21, the staff will be educated ensuring no food items are stored in the medication refrigerators, Licensed Nurses will label/store medications and glucose strips per protocol, expired medications will be discarded, and discharge residents□ medications will be removed from the medication carts to ensure that the policy is being followed for continued compliance. The DON/designee will conduct random medication cart audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	

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	In the bottom right drawer of the medication cart, a large plastic bag with multiple medication bottles was observed. LPN "X" was asked what was in the plastic bag. LPN "X" explained it contained the medications for a discharged resident that they had brought from home when they were admitted. It was confirmed with LPN "X" there were 16 medication bottles and one inhaler. LPN "X " was asked what should happen to home medications when a resident was discharged. LPN " X " explained the facility's medications were removed from the medication cart, but she did not know about home medications. Review of the discharged resident whose medications were still in the medication cart revealed the resident discharged on 3/1/21. On 4/23/21 at 11:26 AM, the 2 West medication room was reviewed. At this time, a bottle of Aspirin 325 with an expiration date of 3/21 was observed to be present stored in an upper cabinet in the medication room. On 4/23/21 at 11:33 AM, review of the 2 center medication cart with LPN 'J' revealed three insulin pens present inside the medication cart which had not been dated when opened. All were confirmed to be in use by LPN 'J'. On 4/23/21 at 11:36 AM, the 2 East cart 3 medication cart was reviewed. An undated			

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

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container of glucometer test strips were present inside of the medication cart.

Review of the medication cart labeled 2 West cart 8 with Nurse 'II' present revealed a container of undated glucometer test strips present inside the cart.

On 4/23/21 at 12:01 PM, the facility's Director of Nursing (DON) acknowledged insulin pens and glucometer test strips were supposed to be labeled when opened.

On 4/23/21 at 12:03 PM, the Director of Nursing (DON) was interviewed and asked if food could be kept in a medication refrigerator. The DON explained food should not be in a medication refrigerator. The DON was asked about a resident's home medications. The DON explained if a resident comes to the facility with their own medications, it is placed in a bag and they try to have a family member to take the medications back home. The DON was asked what happens to the home medications when a resident is discharged. The DON explained if the medication is still at the facility, it should be given to the resident when they go home.

Review of a facility policy titled, "Medication Access and Storage" dated 7/11/18 read in part, "...12. Refrigerated medications are kept in closed and labeled containers, with internal and external medications separated, and separate from fruit juices, applesauce, and

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	other foods used in administering medications. Other foods (e.g., employees lunches, activity department refreshments) are not stored in this refrigerator..."			
F0791 SS= D	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.	F0791	Resident #111 has been assessed by attending physician and an oral surgeon consultant appointment has been completed. An audit was completed on all current residents to ensure outside dental consultant appointments have been scheduled per physician order. The facility policy has been reviewed and deemed appropriate. By 5/24/21, Licensed Nurses and Social Services Workers will be educated on Dental Services (7/2018) to ensure that the policy is being followed for continued compliance. Clinical managers will be providing focused oversight of acute reported dental needs to ensure timely dental scheduling to follow the facility□s policy to ensure that the in-services on dental services is being followed as presented 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 that residents are scheduled for outside consultant appointments per physician referral. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	5/24/2021

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	This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure an oral surgery consultation/appointment was scheduled in a timely manner for one resident (R#111) of one resident reviewed for dental services, resulting in a delay for treatment for lesions in the mouth. Findings include: On 4/20/21 the medical record for R#111 was reviewed and revealed the following: R#111 was admitted to the facility on 9/8/2014 and had diagnoses including Stiffness of right knee and contracture of muscle-multiple sites. R#111's MDS (Minimum Data Set) with an Assessment Reference Date of 3/23/21 revealed R#111 needed supervision with most of their activities of daily living. A referral for oral surgery dated 1/6/21 revealed the following: "Please evaluate and treat lesion on the lateral and ventral surface of the tongue along with white lesions in the mouth." A Medical Practitioner Note (Physician/PA/NP) dated 1/11/2021 "- Evaluation and Management of Multiple Medical Problems-HPI (history of presenting illness)- Monthly evaluation...Pt (patient) recently saw dentist but was referred to oral surgeon for tooth impaction. Difficulty getting appointment with oral surgeon due			

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	to covid pandemic. Will have social work help locate an oral surgeon for [R#111]...Pt states tooth pain is frustrating but bearable..." A Medical Practitioner Note (Physician/PA/NP) dated 3/2/2021-Evaluation and Management of Multiple Medical Problems-HPI- Monthly evaluation..."Social work continuing to work on locating oral surgeon for tooth impaction, difficulty due to pandemic, pt states pain is tolerable..." A progress note dated 4/18/2021 at 5:30 pm revealed the following: "Patient complained of some oral pain. He was given a Tylenol to ease his discomfort. Will continue to monitor pain level." On 4/23/21 at approximately 10:31 a.m., R#111's oral surgery referral was reviewed with Social Worker "NN" (SW "NN"). SW "NN" was queried if they were aware of the oral surgery referral and they indicated they were not. SW "NN" was queried if they had any documentation that they had attempted to assist R#111 in securing an oral surgery appointment as requested by the dental referral and they reported they had not done anything as they were unaware of the need for the referral. SW "NN" was shown the medical provider notes that indicated Social Services was aware of the need for the oral surgery appointment and they indicated that they were not aware of it and indicated that the referral was from an outside dental appointment and that it was never provided			

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	to them before being scanned into R#111's medical record. SW "NN" indicated they should have been made aware of the need for the referral to the oral surgeon and that they would have to make one. SW "NN" was queried for any additional documentation regarding R#111's referral for the oral surgeon. None was received by the end of the survey. A facility document titled "Dental Services" was reviewed and revealed the following: "It is the policy of this facility to ensure routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care."			
F0880 SS= F	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national	F0880	Resident #33 and #110 room floor and room was immediately cleaned with the appropriate disinfectant by housekeeping department. Resident #33 signage for appropriate precautions was placed immediately on the new room door along with the appropriate PPE placed outside of Residents #33 doorway. The receptionist was educated on ensuring to use the correct form for contractual employees, employees and visitors to include all pertinent screening questions. The Transition/Observation Unit will have the appropriate signage to reflect the type of isolation, precautions and appropriate PPE to be worn on the unit per CDC guidelines. LPN X and Behavioral Staff CC were educated on ensuring the proper PPE is donned/doffed, hand hygiene, equipment disinfected and proper procedure for TBP is completed for those residents in the	5/24/2021

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	standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow guidelines from the Centers for Disease Prevention and		Observation Unit. The residents in TBP will have bins located outside of the room to ensure all PPE is available prior to entering the resident rooms including gloves. Contractual Employees will be tested per the CDC guidelines. Employees, Contractual Employees and Visitors will be screened to ensure meets criteria prior to entering into the facility. All like residents in the facility have the potential to be affected. The IP/designee will complete an audit of the residing residents in isolation/precautions to ensure appropriate signage is hung on doors, necessary PPE outside of the door and disinfectant available to disinfect equipment after use to ensure compliance. The IP/designee will ensure the appropriate screening form is utilized for contractual employees, employees and visitors is utilized and the testing will follow CDC guidance. The staff will be educated on IC and CDC guidelines pertaining to COVID 19 screening, testing, PPE donning/doffing for TBP, disinfecting equipment, hand hygiene, isolation protocols and ensuring the environment is clean and sanitary. Staff who have not received the education by 5/25/21will be removed from the schedule until the education is completed. Directed Plan of Correction- Infection Control Consultant Responsibilities " The facility has contracted with an outside Infection Control Consultant. " Exercise independent judgement in the performance of all duties under the consultant contract. " Meets the independent judgement requirement. " Have completed infection prevention and control training from a recognized source,	

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	Control (CDC) for screening contractual employees and visitors for possible exposure to and/or testing for COVID-19 (Coronavirus Disease 2019), follow procedures for residents on droplet precautions who were being monitored for signs and symptoms of COVID-19, and clean the environment of a resident with clostridium difficile. This resulted in the potential for spread of infection and could affect all residents who resided in the facility. Findings include: On 4/20/21 at approximately 9:00 AM, the Administrator and Director of Nursing (DON) were queried about infection control procedures in the facility. It was reported that there were two "transitional units" that housed residents who were recently admitted or readmitted into the facility and were being monitored for signs and symptoms of COVID-19 (1 East and part of 1 West). It was explained that an N-95 respirator mask was required to enter the units, along with goggles or a face shield, and upon entrance to each resident's room, a gown and gloves should be donned after performing hand hygiene. At that time, all policies pertaining to the facility's infection control program, including any policies related to COVID-19, were requested. On 4/20/21 at 11:30 AM, an observation of the 1 West Unit was conducted. A sign was posted on the closed double doors that led to the 1 West Unit. The sign indicated an N-95 mask must be worn to enter the unit.		such as the Centers for Disease Control and Prevention or American Health Care Association. " Will be contracted to work with the facility for a minimum of three (3) months of which must include onsite facility hours. " Assist the facility in completing the CMS infection control self-assessment. " Review all relevant facility infection control policies and procedures and make recommendations for revisions based on the RCA. " Work with the facility□s Infection Preventionist, Quality Assessment and Assurance (QAA) Committee to conduct a Root Cause Analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop an intervention or corrective action plan to prevent recurrence, as a part of the Quality Assurance and Performance Improvement (QAPI) program. " The QAA Committee will report the results of RCA and the plans for corrective action to the Governing Body. The facility will take immediate action to implement an infection prevention plan consistent with the requirements at 42 CFR ¿ 483.80 that includes corrective action for the affected residents identified in the CMS-2567, identification of other residents that may have been impacted by the noncompliant practices, and implementation of systemic changes. Staff have the tools and abilities to ensure residents practice appropriate social distancing; " Staff are provided with and use Personal Protective Equipment (PPE) in accordance with the Centers for Disease Control (CDC) guidelines; " Shared medical equipment is properly disinfected after each use;	

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	There were no signs on any doors on that unit that indicated the residents were on isolation precautions. Plastic bins were observed at random areas on the hallway and contained gowns and face shields. Licensed Practical Nurse (LPN) "X" reported all residents on that hallway were on isolation precautions due to being monitored for signs and symptoms of COVID-19. When queried about where gloves were located in order to don them prior to entering the residents' rooms, LPN "X" reported they were inside the bathroom, inside of the residents' rooms and there was a box on the medication cart. At approximately 11:55 AM, Behavioral Health Services Staff "CC" was observed entering R#95's room without donning a gown or gloves. Upon exit from the room, Behavioral Health Services Staff "CC" was interviewed. They indicated they were aware R#95 was on isolation precautions and stated, "I was just going to grab one of these (gowns), but she doesn't want to meet". Behavioral Health Services Staff "CC" then exited the unit through the closed double doors. On 4/20/21 at 1:21 PM, LPN "X" entered R#81's room wearing a gown that was not tied securely around the neck and waist and clothing underneath was exposed. LPN "X" exited R#81's room without removing the gown and brought the machine used to take vital signs out into the hallway. LPN "X" walked to the end of the hallway wearing the gown and removed it and threw it out at the end of the hallway. When queried about		" Residents impacted by the failure to maintain social distancing, use PPE appropriately, and clean shared medical equipment are identified for enhanced monitoring and/or precautions to minimize further spread of infection; " Required staff will receive instruction before they begin their next work shift. The instructions will include demonstration; " The facility developed a plan for monitoring the progress of the corrective action plan and tracking performance improvement. This plan will include requiring facility supervisors to conduct scheduled and objective rounds throughout the facility to ensure appropriate infection control procedures are followed. During these round, ad hoc education will be provided to persons who are not correctly utilizing equipment and/or infection prevention/control practices. The facility will provide training to all staff, including the Director of Nursing, Infection Preventionist, all staff that provide direct resident care, as well as staff that enter into resident rooms to provide for dietary needs or to perform therapy, social worker, activities, housekeeping, laundry, or maintenance services, to ensure staff are fully trained on infection prevention and control. The training covered the following topics, in addition to training needs identified by facility□s completed the RCA: " Nursing Home Infection Preventionist Training Course - https://www.train.org/cdctrain/training_plan/3814 " Targeted COVID-19 Training for Nursing Homes □ https://qsep.cms.gov/ProvidersAndOthers/home.aspx " Sparkling Surfaces -	

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	when to remove a gown after going into a resident's room who was on isolation precautions, LPN "X" stated, "After I leave the room". When queried about what was used to clean the vitals machine, LPN "X" reported she did not clean it prior to leaving the resident's room. On 4/22/21 at 8:22 AM, an interview was conducted with the facility's Infection Control Preventionist (ICP). When queried about the residents on the 1 West hallway beyond the double doors, the ICP reported they were being monitored for potential exposure and signs and symptoms of COVID-19 for 14 days after returning to the facility. The ICP was queried about the procedure for donning and doffing personal protection equipment on the "transitional unit". The ICP stated, "An N-95 mask is required and depending on what you are doing, if you are just answering a call light or something it would determine if you needed a gown and gloves." The ICP reported gown and gloves would be removed prior to exiting the resident's room and hand hygiene would be performed. On 4/22/21 at 9:10 AM, an interview was conducted with the DON. When queried about the requirements for PPE use on the "transition unit" (1 West), the DON reported all doors should have signage to indicate the residents were on isolation precautions, N-95 masks were required to enter the unit as well as goggles or a face shield, and a new gown and gloves were worn prior to entering the		https://youtu.be/t7OH8ORr5Ig " Clean Hands - https://youtu.be/xmYMUly7qiE " Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA " Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw " Lessons - https://youtu.be/YYTATw9yav4 " Standard Infection Control Practices " Transmission-Based Precautions " Isolation " Hand Hygiene " Disinfecting Shared Medical Equipment " Appropriate use of PPE Trainings will be completed by train the trainer (Director of Nursing, Infection Preventionist, Medical Director, or Infection Control Consultant). Upon completion of the training, the facility must validate staff competency using a post-training test. By 5/224/21, the DON/IP/Designee will ensure the appropriate signage is hung on the doors for residents in isolation/precautions, appropriate PPE in bins to include gloves, equipment will be disinfected after use, hand hygiene will be performed per guidelines, testing will be completed for contractual employees/employees per CDC guidelines, employees/contractual employees/visitors will be screened with the appropriate questions and staff will demonstrate donning/doffing PPE for residents in TBP. During the week of 5/25/21, the IP/Designee will conduct random audits on 5 employees weekly times 4 weeks and then monthly	

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	residents' rooms. The DON reported they were looking into a new place to keep the gloves to "prevent contamination from the environment". When queried about the PPE doffing procedures, the DON reported gloves and gown were removed prior to exiting the resident's room and hand hygiene was performed prior to exiting the room. On 4/20/21 at 8:40 AM and 4/21/21 at 7:35 AM, upon entrance into the facility, the receptionist took temperatures and required a form to be filled out that included the following questions: "Have you had close contact with anyone COVID-19 + (positive)? Circle (Y/N)" and " (-) (negative) COVID19 test Circle (Y/N)". On 4/22/21 at approximately 7:40 AM, upon entrance into the facility, the receptionist took temperatures and required a form to be filled out. However, the two questions mentioned above were no longer included on the form. On 4/22/21 at 8:22 AM, the ICP was interviewed about the facility's screening process related to COVID-19. The ICP reported that the DON facilitated the protocols for COVID-19 infection control. On 4/22/21 at 9:10 AM, the DON was interviewed. When queried about why the two questions mentioned above were removed from the screening form, the DON reported they were not removed, and the incorrect form was used. The DON was further interviewed about the facility's		thereafter times 3 months or until substantial compliance has been maintained to ensure compliance with hand hygiene, PPE for TBP are appropriately donned/doffed, equipment is disinfected after use and PPE supplied prior to entering room. During the week of 5/25/21, the IP/Designee will conduct random audit on 5 employees/visitors weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the screening and testing process is compliant with CDC recommendations for COVID 19. During the week of 5/25/21, the IP/Designee will conduct random audit on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the appropriate signage is hung on the door for those in isolation/precautions and the environment is clean/sanitary. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON/IP/ADM will be responsible for assuring substantial compliance is attained through this plan of correction on 5/25/21 and for sustained compliance thereafter.	

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	COVID-19 screening protocols for visitors and contractual employees that provided care and services in the facility. The DON reported that all contracted staff were required to be screened at the front desk and if they did not have a recent negative COVID-19 test, the receptionist should notify the DON to test the individual prior to seeing any residents. When queried about the responsibilities of the person who screened individuals who entered into the facility, the DON reported that in addition to taking their temperature, they should also be monitoring whether they appear sick, in addition to what was written on the form and acting, as needed. If a person documented they did not have a negative COVID-19 test, the facility would perform a rapid test in the facility, or the individual would have to provide evidence of recent negative results. The DON reported she was the person the receptionist would contact if a rapid COVID test was needed. When asked if she was contacted for any COVID-19 tests in the past two days, the DON reported she had not been contacted. At that time, all COVID-19 test results for visitors who were screened into the facility in the past week were requested. On 4/22/21 at 1:16 PM, the DON provided three COVID tests that were collected on 4/22/21. The DON reported the physicians and Nurse Practitioners were tested by the facility and were included in the staff testing documents. The DON reported she was still looking for the rest of the tests.			

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A review of the "Visitor Screening Logs", which did not differentiate between visitors and contractual employees, from 4/15/21 through 4/21/21 was conducted and the following was revealed:

On 4/15/21, one of 22 visitors who signed in indicated they had a negative COVID-19 test.

On 4/16/21, one of four visitors did not answer any of the screening questions, and the other three indicated they did not have a negative COVID-19 test.

On 4/17/21, four of four visitors indicated they did not have a negative COVID-19 test.

On 4/18/21, 11 of 11 visitors indicated they did not have a negative COVID-19 test.

On 4/19/21, 10 of 10 visitors indicated they did not have a negative COVID-19 test.

On 4/20/21, 9 of 17 visitors indicated they did not have a negative COVID-19 test.

On 4/21/21, 15 of 20 visitors indicated they did not have a negative COVID-19 test.

On 4/23/21 at 10:05 AM, the DON reported she was unable to find any additional tests for the contracted individuals that entered the building for the past week. When queried as to why, the DON reported the receptionist should always make sure to obtain a copy or

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have the facility provide a test and they must not have thoroughly screened the forms when entering the facility. At approximately 3:00 PM, the DON provided additional test results for contracted staff members but explained they were just verified today.

A review of the facility provided infection control program policies and procedures was conducted, however, it did not include a policy regarding screening for COVID-19.

According to the CDC guidance titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Screen and Triage Everyone Entering a Healthcare Facility for Signs and Symptoms of COVID-19", updated on February 23, 2021, "...Establish a process to ensure everyone (patients, healthcare personnel, and visitors) entering the facility is assessed for symptoms of COVID-19, or exposure to others with suspected or confirmed SARS-CoV-2 (Severe acute respiratory syndrome coronavirus 2) infection and that they are practicing source control..." https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

According to the CDC guidance titled, "Interim Guidance on Testing Healthcare Personnel (HCP) for SARS-CoV-2, Testing asymptomatic HCP without known or suspected exposure to SARS-CoV-2 as part of

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expanded screening", updated on February 16, 2021, "...Currently, testing asymptomatic HCP without known or suspected exposure to SARS-CoV-2 is recommended for HCP working in nursing homes..." https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html

On 4/22/21 at 8:05 AM, upon entry into the room occupied by R33 and R101, there was no bed in the room on the side that R33 resided and R33 was not in the room at this time. The flooring from just inside the room, over towards R101's side of the bed was observed with multiple splatters of brown colored substance of what appeared to be fecal matter. The room across from R33's room was observed to have an isolation cart placed just outside the door with no name on the door and a sign that indicated the resident was on isolation precautions. At that time, Licensed Practical Nurse (LPN 'J' who had been assigned to R33 on 4/21) was observed in the hallway nearby and when asked about why R33 was not in the room, they reported "I'm not sure, but I believe he was moved last night for c-diff." (Clostridium difficile is a bacteria that can be transmitted from person to person by spores which can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon.)

On 4/22/21 at 8:07 AM, a lab technician was observed to enter into the room with the brown substance while pulling a rolling cart full of lab supplies over the soiled flooring and over to R101 and stated they were there to obtain a blood draw.

On 4/22/21 at 8:09 AM, the Assistant Administrator (Staff 'O') was next door and upon entry into the center hallway was asked to observe the room and confirmed the soiled flooring.

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	On 4/22/21 at 8:20 AM, an interview was conducted with the Administrator and Director of Nursing (DON) in regard to the above observations. The DON reported they would like to review their 24 hour log and upon review, reported R33 had been moved last night at approximately 8:30/9:00 PM due to suspected c-diff and further reported that staff should have cleaned up the room last night. The DON asked, "How many other rooms did that lab tech go into?" and reported they would reach out to the lab company to follow up. At that time, the DON was requested to provide any specimen results when R33's stool specimen results returned. When asked for a policy for facility practices, the Administrator reported that should be in the Infection Control policies provided already, however there were no specific details in regard to this observation. On 4/23/21 at approximately 4:30 PM, the DON was queried if R33's stool specimen results had been received and provided a copy of R33's lab report which documented, "Toxin producing C. difficile DETECTED..."			
F0883 SS= F	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident	F0883	Resident #110 no longer resides in the facility. Resident #19 no longer residents in the facility Resident or the responsible person for #21, #26, #76, #81, #95 and #135 will be educated on the pneumococcal vaccinations to make an informed decision on consent or declination and will be documented on the vaccination consent form. The Licensed Nurses will obtain MD orders, administer the appropriate pneumococcal vaccination per resident/responsible person consent and document in the medical record. All like residents in the facility have the	5/24/2021

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	has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the		potential to be affected. The IP/designee will complete an audit of the current residing residents in the facility to provide education on influenza and pneumococcal vaccines and the vaccination consent/declination forms will completed for influenza and pneumococcal vaccines. New admissions will be educated on vaccinations on admission. Residents that consented to Pneumococcal Vaccines will have an MD order, administered by a Licensed Nurse, and documented in the medical Record. Influenza vaccinations will be administered at the beginning of each flu season. The facility policy has been reviewed and deemed appropriate. By 5/24/21, the Licensed Nurses will be educated on providing education to the resident/responsible person regarding the influenza and pneumococcal vaccinations, ensuring the consent forms are completed for consent/declination, obtaining MD orders for those consenting to Pneumococcal Vaccination and administering the pneumococcal vaccines to ensure that the policy is being followed for continued compliance. DON/ADON and IP will be providing focused oversight of the IC process to follow the facility□s policy to ensure that vaccine education is provided, and vaccines are administered upon request. The IP/designee will conduct random pneumococcal vaccination audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the consent forms are completed for consent/declination, obtaining MD orders for those consenting to Pneumococcal Vaccination and administering the pneumococcal vaccines. The results will be presented to the QAA	

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	facility failed to ensure one (R#110) of five residents reviewed for influenza immunizations received the vaccination and failed to follow it's policy and ensure residents were assessed for eligibility to receive the pneumococcal vaccine, failed to provide education, and obtain consent for the pneumococcal vaccine for eight (R#19, R#21, R#26, R#76, R#79, R#81, R#95, and R#135) of eight residents reviewed for pneumococcal immunizations. This resulted in the potential for residents to contract pneumonia or influenza. Findings include: On 4/23/21 at approximately 8:30 AM, the Infection Control Preventionist (ICP) was asked to provide any consents and proof of administration for the influenza and pneumococcal vaccine for R#19, R#21, R#81, R#79, and R#110. On 4/23/21 at 10:30 AM, the ICP provided influenza vaccine consent forms for the requested residents. Resident #110: Review of the clinical record revealed R110 was initially admitted into the facility on 9/13/18 and readmitted on 12/26/20 with diagnoses that included: spastic quadriplegic cerebral palsy, abnormal posture, contractures of right and left knees, contractures of right and left hands, cognitive communication deficit, and anoxic brain damage. The consent form for R#110		committee for review and consideration of further corrective actions. The DON/IP will be responsible for assuring substantial compliance is attained through this plan of correction on 5/24/21 and for sustained compliance thereafter.	

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indicated, his responsible party consented to the influenza vaccine on 11/4/20 but did not receive it. The consent form titled, "CONSENT TO ADMINISTER INFLUENZA VACCINE--- UNDER 65" documented, "Yes I wish to receive the influenza vaccination" by R#110's responsible party and was signed on 11/4/20. The "Date Given" section was left blank.

During an interview on 4/23/21 10:30 PM when queried about why R#110 did not receive the influenza vaccine when his responsible party consented to it, the ICP reported R#110 went to the hospital in November and did not return until the end of December 2020. The ICP reported she would look into the reason why the influenza vaccine was not administered. At that time, the ICP reported she was unable to find any of the consent forms for pneumococcal vaccinations.

On 4/23/21 at approximately 1:15 PM, the ICP was interviewed about when the pneumococcal vaccinations were offered to residents. The ICP stated, "Per resident request."

On 4/23/21 at 2:28 PM, the Director of Nursing (DON) was interviewed. The consent form provided for R#110's influenza vaccine was reviewed by the DON. The DON reported R#110 should have received the vaccine upon consent on 11/4/20. When queried about the facility's process for educating residents and responsible parties and offering and

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	administering the pneumococcal vaccines, the DON reported residents and responsible parties are first asked upon admission and then it would be passed on to the nursing department. When queried about who was responsible for following up to ensure residents who consented to the pneumococcal vaccine received it and who was responsible for investigating whether residents were eligible for the vaccine, the DON reported anyone could do it, but the ICP was ultimately responsible for the program. At that time, the DON was given the name of the residents provided to the ICP earlier in the day and their consents for pneumococcal vaccinations was requested. On 4/23/21 at 2:42 PM, the DON reported that the binder that held the pneumococcal vaccine consent forms was missing, and they could not find it. At that time, the DON was asked to provide a list of all residents who received the pneumococcal vaccination within the past year. On 4/23/21 at 3:04 PM, the ICP provided an "Immunization Report" of all residents who received the pneumococcal vaccination between 4/1/2020 and 4/23/21 and no residents received the vaccination. On 4/23/21 at 3:23 PM, Admissions Coordinator "DD" was interviewed. When queried about how residents and their responsible parties were educated and how consent was obtained for vaccinations upon			

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admission, Admissions Coordinator "DD" stated, "That is not done in the admissions department". Admissions Coordinator "DD" reported they worked in the facility since July 2020 and obtaining consent for vaccinations had not been a part of the admissions process in that time.

On 4/23/21 at 3:30 PM, the DON was asked if she was aware that no pneumococcal vaccinations were administered in the past year. The DON reported she was not aware until she ran the report on that day.

Review of the CDC publication titled, "Adults Protect Yourself with Pneumococcal Vaccines" read in part: "Many adults may be at increased risk for pneumococcal disease and not know it. Two vaccines provide protection against this serious and sometimes deadly disease...Each year in the United States, pneumococcal disease kills thousands of adults. Thousands more end up in the hospital because of pneumococcal disease. It can cause severe infections of the lungs (pneumonia), bloodstream (bacteremia), and lining of the brain and spinal cord (meningitis). Vaccines are the best way to prevent pneumococcal disease. Two vaccines help prevent pneumococcal disease: PCV13 (pneumococcal conjugate vaccine); PPSV23 (pneumococcal polysaccharide vaccine)...CDC recommends PCV13 for: All adults 65 years or older; Adults 19 years or older with certain health conditions. CDC recommends PPSV23 for: All adults 65 years or older; Adults 19

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	through 64 years old with certain health conditions or who smoke cigarettes...Most pneumococcal infections are mild. However, some can be deadly, especially for adults 65 years or older: Pneumococcal pneumonia kills about 1 in 20 older adults who get it; Pneumococcal bacteremia kills about 1 in 6 older adults who get it; Pneumococcal meningitis kills about 1 in 6 older adults who get it...Pneumococcal Disease Is Contagious: Pneumococcal bacteria spread from person to person through coughing, sneezing, and close contact. People can carry the bacteria in their nose and throat without being sick and spread the bacteria to others..." A review of R#19's clinical record revealed R#19 was admitted into the facility on 1/29/21 with diagnoses that included hypertension and diabetes. The immunization report indicated R#19 "refused" the pneumococcal vaccination. No consent form was available to verify that information. A review of R#21's clinical record revealed R#21 was admitted into the facility on 6/17/19 and readmitted on 12/6/19 with diagnoses that included: chronic kidney disease, diabetes, and heart disease. R#21 was not included on the "Immunization Report" provided by the facility. R#21's clinical record indicated the resident was "not eligible" for "pneumovax dose 1" or "Prevnar 13". There was no consent provided and no available information regarding why R#21 was not eligible to receive the pneumococcal			

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	vaccines. According to the Centers for Disease Prevention and Control, based on R#135's age and diagnoses, the recommendations would be to give 1 dose of PCV13. Then give 1 dose of PPSV23 at least 8 weeks later if R#21 had never received the vaccination. No consent, education, or justification for not giving the pneumococcal vaccine according to CDC recommendations was provided by the facility. A review of R#26's clinical record revealed R#26 was admitted into the facility on 10/23/20 with diagnoses that included: diabetes. The Immunization Report documented R#26 received the PCV13 vaccine at another facility on 3/30/18 and documented R#26 was "not eligible". According to the CDC, based on R#26's age and diagnoses and having received the PCV13 in their lifetime, the recommendation was to give 1 dose of PPSV23 at least 1 year after previous PCV13 dose. A review of R#76's clinical record revealed R#76 was admitted into the facility on 4/7/20 with diagnoses that included: diabetes, chronic kidney disease, and chronic obstructive pulmonary disease. R#76 was not included on the immunization report and their clinical record did not indicate consent or eligibility for the pneumococcal vaccine. No consent form or information regarding why they did not receive the pneumococcal vaccine was provided by the facility. According to the CDC, based on R#76's age			

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and diagnoses, it was recommended to give 1 dose of PCV13. Then give 1 dose of PPSV23 at least 8 weeks later.

A review of R#79's clinical record revealed R#79 was admitted into the facility on 8/28/19 and readmitted on 3/9/21 with diagnoses that included: chronic respiratory failure, diabetes, and asthma. R#79 was not included on the immunization report. R#79's clinical record indicated he refused the "Pneumovax dose 1", but there was no date, and the facility did not provide the consent form to verify this.

A review of R#81's clinical record revealed R#81 was admitted into the facility on 2/27/20 and readmitted on 5/16/20 with diagnoses that included: chronic kidney disease, diabetes, and congestive heart failure. R#81 was not included on the immunization report provided by the facility. It was documented R#81 refused the "Prevnar 13" vaccine, but there was no date documented and the facility was unable to provide the consent form to verify this.

A review of R#95's clinical record revealed R#95 was admitted into the facility on 1/7/21 and readmitted on 4/11/21 with diagnoses that included: congestive heart failure and chronic obstructive pulmonary disease. The immunization report documented R#95 was not eligible for "Pneumovax Dose 1". According to CDC recommendations, based on R#95's age and diagnoses, 1 dose of

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	PCV13 followed by 1 dose of PPSV23 at least 1 year later should be considered after a discussion with a physician and if PCV13 was decided not to be appropriate, then give 1 dose of PPSV23. A review of R#135's clinical record revealed R#135 was admitted into the facility on 4/1/21 with diagnoses that included: coronary artery disease, diabetes, and kidney failure. The immunization report documented R#135 was not eligible for the pneumococcal vaccine, but it was unknown why. According to the Centers for Disease Prevention and Control, based on R#135's age and diagnoses, the recommendations would be to give 1 dose of PCV13 Then give 1 dose of PPSV23 at least 8 weeks later. No consent or education was provided by the facility. A review of a facility policy titled, "Immunizations - Pneumococcal" dated 7/11/18 documented, "...It is the policy of this facility that all residents will be offered the pneumococcal vaccines to aid in preventing pneumonia...1. Upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccines and when indicated, will be offered the vaccinations, unless medically contraindicated or the resident has already been vaccinated. 2. Before receiving the pneumococcal vaccines, the resident or responsible party shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccines. This information will be provided in			

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 _____	4/23/2021

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

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	the "Consent to Administer Pneumococcal Vaccine". Telephone consent from the responsible party is acceptable if the resident is unable to sign. 3. Pneumococcal vaccinations will be administered to residents (unless medically contraindicated, already given or refused) per the medical director's standing orders. 4. For those who receive the vaccine, the date of the vaccination and the electronic signature of the person administering will be documented in the resident's medical record. 5. A resident's refusal of the vaccine shall be documented in the resident's medical record..." The policy did not address the two different types of pneumococcal vaccinations and when they would be considered. A review of a facility policy titled, "Immunizations - Influenza" dated 7/11/18 documented, "...Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees who have direct contact with residents, unless the vaccination is medically contraindicated or the resident or employee has already been immunized...Before receiving the influenza vaccine, the resident or responsible party shall receive information and education regarding the benefits and potential side effects of the influenza vaccine. This information will be provided in the "Consent to Administer Influenza Vaccine". Telephone consent from the responsible party is acceptable if the resident is unable to sign.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Influenza vaccinations will be administered to residents (unless medical contraindicated, already given or refused) per the medical director's standing order..."			