

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 414290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 9/14/2021
NAME OF PROVIDER OR SUPPLIER SKLD BELTLINE			STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E BELTLINE SE GRAND RAPIDS, MI 49546		
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E0000 SS=	Initial Comments Skld Beltline was surveyed from 9/8/21 to 9/14/21 for the purpose of a COVID-19 Focused Infection Control and Abbreviated Survey. Census: 120 Intakes: MI00121639, MI00122020, MI00122104, MI00122400	E0000			
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F0677 SS= E	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 # MI00121639 Based on observation, interview, and record review, the facility failed to ensure showers/bed baths were provided per resident preference and plan of care in 7 of 9 residents (Resident #101, #107, #109, #104, #105, #106, & #112) reviewed for hygiene and showers/bathing, resulting in the	F0677			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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	<p>potential for dissatisfaction with care, hygiene concerns, skin irritation, and low self-esteem.</p> <p>Findings include:</p> <p>According to Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 50742-50744). Elsevier Health Sciences. Kindle Edition. "...Personal hygiene affects patients' comfort, safety, and well-being. Hygiene care includes cleaning and grooming activities that maintain personal body cleanliness and appearance. Personal hygiene activities such as taking a bath or shower and brushing and flossing the teeth also promote comfort and relaxation, foster a positive self-image, promote healthy skin, and help prevent infection and disease..."</p> <p>In an interview on 9/9/21 at 9:21 a.m., "Licensed Practical Nurse" (LPN) "H" reported CNA's are supposed to complete paper shower sheets with each shower/bed bath provided, and stated "...Very rarely I get them..." LPN "H" reported CNA's are also supposed to chart showers/bed baths completed in the electronic charting system.</p> <p>Resident #101</p> <p>Review of an "Admission Record" revealed Resident #101 was a female, with pertinent diagnoses which included chronic respiratory failure, diabetes, anemia, obesity, depression, and anxiety.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #101, with a reference date of 4/4/21, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.</p>				

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	<p>Review of a MDS assessment, with a reference date of 6/28/21, revealed Resident #101 was totally dependent on staff for bathing, with two staff to assist.</p> <p>Review of a current "Care Plan" for Resident #101 revealed the focus "...Resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) acute and chronic respiratory failure, morbid obesity, immobility and activity intolerance..." with interventions which included "...Showering/Bathing per schedule or as needed..." both revised 5/10/21.</p> <p>In an observation and interview on 9/8/21 at 1:17 p.m., Resident #101 was noted in bed in her room. Resident #101 reported staff rarely wash her hair with a bed bath, and stated "...I haven't had a bed bath in a couple weeks..." Resident #101 stated "...I think that is because of short staff..." Observed Resident #101's hair appeared greasy, messy, and unkempt, and noted a noxious odor within Resident #101's room.</p> <p>Review of the past 30 days of CNA documentation for Resident #101, completed on 9/8/21, for the task "SHOWER/BATH: Monday Days" revealed bed baths were documented on 8/16/21, 8/30/21, and 9/6/21. No documentation of a shower/bed bath was noted on Monday 8/23/21, a scheduled shower/bath day.</p> <p>Review of the past 30 days of CNA documentation for Resident #101, completed on 9/8/21, for the task "SHOWER/BATH: Thursday Days" revealed documentation of "Not Applicable" was completed on 8/26/21. No documentation of a shower/bed bath was noted on Thursday 8/12/21, Thursday 8/19/21, or Thursday 9/2/21, all scheduled shower/bath days.</p> <p>Review of the past 30 days of CNA</p>						

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	<p>documentation for Resident #101, completed on 9/8/21, for the task "SHOWER/BATH: PRN (As Needed)" revealed no additional shower documentation.</p> <p>In an observation on 9/9/21 at 8:58 a.m., Resident #101 was noted in bed in her room. Observed Resident #101's hair appeared greasy, messy, and unkempt, and noted a noxious odor within Resident #101's room.</p> <p>In an observation and interview on 9/9/21 at 3:56 p.m., Resident #101 was noted in bed in her room. Observed Resident #101's hair appeared greasy and messy. Resident #101 reported she has not been offered a bed bath or a shower today (Thursday), or had her hair washed.</p> <p>In an observation and interview on 9/13/21 at 9:43 a.m., Resident #101 was noted in bed in her room. Observed Resident #101's hair appeared greasy and messy. Resident #101 reported she has not received a shower or a bed bath since we last spoke on 9/9/21.</p> <p>Review of the past 14 days of CNA documentation for Resident #101, completed on 9/13/21, for the tasks "SHOWER/BATH: Monday Days", "SHOWER/BATH: Thursday Days", and "SHOWER/BATH: PRN" revealed documentation of "Not Applicable" was completed on 9/9/21. No documentation was noted to indicate if a shower or bed bath was offered or provided to Resident #101 between 9/8/21 and 9/13/21. Note per the CNA charting, Resident #101 had a scheduled shower day on 9/9/21.</p> <p>Review of the nursing "Progress Notes" for Resident #101, from 8/12/21 to 9/13/21, revealed no documentation related to showers provided or refusals of showers/bed baths.</p>				

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	<p>Resident #107</p> <p>Review of an "Admission Record" revealed Resident #107 was a female, with pertinent diagnoses which included chronic respiratory failure, obesity, diabetes, dementia, muscle weakness, joint pain, anxiety, and depression.</p> <p>Review of the "Census" information for Resident #107 revealed she was hospitalized from 9/1/21 to 9/4/21.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #107, with a reference date of 8/3/21, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.</p> <p>Review of a current "Care Plan" for Resident #107 revealed the focus "...ADL (Activities of Daily Living) self care deficit as evidenced by muscle weakness, impaired mobility, incontinence, pain, disease process..." revised 2/23/21, with interventions which included "...ADLs: 2 assist..." revised 6/2/21, and "...Per preference, takes bed baths not showers..." revised 5/28/20.</p> <p>In an observation and interview on 9/8/21 at 9:41 a.m., in the resident's room, Resident #107 reported she prefers bed baths, and would like to get a bed bath twice a week. Resident #107 reported she has not received a bed bath since her readmission from the hospital on 9/4/21. Noted Resident #107's hair appeared messy and greasy. Resident #107 stated "...I like a real old-fashion hair wash...I don't get my hair washed hardly ever. I like it washed clean and shiny...I'm lucky if I even get it washed..."</p> <p>Review of the past 30 days of CNA</p>				

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	<p>documentation for Resident #107, completed on 9/8/21, for the task "SHOWER/BATH: Wednesday Nights" revealed no documentation.</p> <p>Review of the past 30 days of CNA documentation for Resident #107, completed on 9/8/21, for the task "SHOWER/BATH: Saturday Nights" revealed no documentation.</p> <p>Review of the past 30 days of CNA documentation for Resident #107, completed on 9/8/21, for the task "SHOWER/BATH: PRN (As Needed)" revealed documentation of "Not Applicable" was completed on Wednesday 8/11/21 and Friday 8/20/21. A bed bath was documented as completed on Monday 9/6/21. Note the bed bath documented on 9/6/21 is the only documentation of bathing in the past 30 days.</p> <p>In an observation and interview on 9/9/21 at 9:10 a.m., noted Resident #107 in bed in her room. Observed Resident #107's hair appeared messy and oily. Resident #107 reported she is supposed to have a bed bath on Wednesdays and Saturdays, however "...they miss me..." Resident #107 reported she is "...very seldom..." offered a bed bath. Resident #107 reported she did not have a bed bath or get her hair washed yesterday (Wednesday).</p> <p>Review of the past 14 days of CNA documentation for Resident #107, completed on 9/13/21, for the tasks "SHOWER/BATH: Wednesday Nights", "SHOWER/BATH: Saturday Nights", and "SHOWER/BATH: PRN" revealed no documentation that a shower or bed bath was completed on Wednesday 9/8/21. Note per the CNA charting guide, Resident #107 had a scheduled shower/bed bath on Wednesday 9/8/21.</p> <p>Review of the nursing "Progress Notes" for</p>				

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	<p>Resident #107, from 8/12/21 to 9/9/21, revealed no documentation related to showers provided or refusals of showers/bed baths.</p> <p>Resident #109</p> <p>Review of an "Admission Record" revealed Resident #109 was a male, with pertinent diagnoses which included stroke, dementia, and high blood pressure.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #109, with a reference date of 8/10/21, revealed a "Brief Interview for Mental Status" (BIMS) score of 3, out of a total possible score of 15, which indicated severe cognitive impairment.</p> <p>In an observation on 9/8/21 at 1:03 p.m., Resident #109 sat in his wheelchair in the hallway on the 300 Hall. Noted Resident #109's wheelchair was heavily soiled, with visible build up of dust and debris on the bars and wheel spokes. Observed Resident #109's hair appeared greasy and unkempt.</p> <p>Review of a current "Care Plan" for Resident #109 revealed the focus "...ADL (Activities of Daily Living) Self care deficit as evidenced by requiring assist with ADLs as needed..." revised 3/3/21, with interventions which included "...Assist resident with shower twice weekly and as needed Wednesday/Saturday-Evening..." revised 5/30/21, and "...Resident frequently refuses showers/bed baths-continue to encourage good hygiene..." initiated 10/8/20.</p> <p>Review of the past 30 days of CNA documentation for Resident #109, completed on 9/8/21, for the task "SHOWER/BATH: Saturday Evenings" revealed documentation of "Resident Refused" was completed on Saturday 8/21/21 and</p>				

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	<p>Saturday 9/4/21.</p> <p>Review of the past 30 days of CNA documentation for Resident #109, completed on 9/8/21, for the task "SHOWER/BATH: Wednesday Evenings" revealed documentation of "Not Applicable" was completed on Wednesday 8/11/21 and Wednesday 8/25/21. A shower was documented as completed on Wednesday 9/1/21.</p> <p>Review of the "Skin Observation Shower" sheets for Resident #109, revealed documented refusals of showers/bed baths on Wednesday 8/11/21, Saturday 8/14/21, Wednesday 8/18/21, Saturday 8/21/21, Saturday 8/28/21, Wednesday 9/1/21 (Note a discrepancy based on charting above), and Saturday 9/4/21. No additional documentation was provided to clarify the documentation of "Not Applicable" on 8/25/21.</p> <p>Review of the past 30 days of CNA documentation for Resident #109, completed on 9/8/21, for the task "SHOWER/BATH: PRN" revealed no additional documentation.</p> <p>Review of the nursing "Progress Notes" for Resident #109, from 8/12/21 to 9/8/21, revealed no documentation related to showers provided or refusals of showers/bed baths.</p> <p>In an interview on 9/13/21 at 1:25 p.m., Unit Manager "DD" reported residents should receive showers/bed baths "...at minimum two times a week..." Unit Manager "DD" reported these showers/bed baths should be documented in the electronic charting system and on a paper shower sheet. Unit Manager "DD" reported the floor nurses should be monitoring for shower/bed bath completion, and stated "...if it can't get done needs to be passed on to the next shift..." Unit Manager "DD" reported wheelchairs should also be cleaned on a resident's scheduled shower day.</p>				

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	<p>Unit Manager "DD" reported in regard to staff charting "Not Applicable" for the electronic bathing documentation, this was done in error by aides who meant to chart "Refused". Note there is an option for "Refused" in the charting. Unit Manager "DD" reported she has completed some education with the CNA's in regard to shower/bed bath documentation.</p> <p>In an interview on 9/13/21 at 2:33 p.m., Unit Manager "CC" reported residents should receive scheduled showers/bed baths at least two times per week, and as requested in between. Unit Manager "CC" reported the specific days scheduled are noted in the CNA charting in the computer. Unit Manager "CC" reported the CNA's should also complete paper shower sheets with each shower/bed bath, even for refusals. Unit Manager "CC" reported "Not Applicable" is charted in the electronic bathing documentation when a resident is out for an appointment or not in the building. Unit Manager "CC" stated the option of "Not Applicable" for electronic bathing documentation is for "...unforeseen circumstances..." Unit Manager "CC" reported a lot of residents refuse showers/bed baths and stated "...The CNA's) should still be documenting that..."</p> <p>In an interview on 9/13/21 at 3:12 p.m., "Registered Nurse" (RN) "M" reported in regard to CNA's charting "Not Applicable" for the bathing documentation, this is because "...they can't get to those showers when there is only one aide on the unit..." RN "M" reported the CNA's chart "Not Applicable" because if they charted anything else they would be "...lying..."</p> <p>In an interview on 9/13/21 at 4:29 p.m., with "Director of Nursing" (DON) "B", noted the missing shower documentation for Resident #101, #107, and #109 and requested all available</p>				

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	<p>documentation of showers/bed baths completed for Resident #101, #107, and #109 for August and September 2021. Additional documentation was provided in the form of paper "Skin Observation Shower" sheets for Resident #109 (all refusals noted above), however no "Skin Observation Shower" sheet was provided for the 8/25/21 scheduled shower date. No additional documentation of showers/bed baths was provided for Resident #101 or Resident #107 prior to survey exit on 9/14/21 at 2:15 p.m.</p> <p>Resident #104</p> <p>Review of an "Admission Record" revealed Resident #104 was a female, with pertinent diagnoses which included: diabetes, peripheral vascular disease (poor blood circulation), high cholesterol, high blood pressure, chronic obstructive pulmonary disease (lung disease), end stage renal disease, dependence on renal dialysis, and acute osteomyelitis (infection in the bone).</p> <p>Review of an "Minimum Data Set" (MDS) assessment for Resident #104, with a reference date of 3/16/2021 revealed a "Brief Interview for Mental Status" (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #104 was cognitively intact.</p> <p>In an observation and interview on 9/13/2021 at 9:11 AM, Resident #104 was up in wheelchair dressed appropriately for the day, thinking about self-transferring back to bed, stated "I can't do it with you watching". Resident #104 reported that there was a CNA that will help her with showers when she ask if he has time so she usually will get one about every 2 weeks. Resident stated that "her showers are scheduled on Tuesdays and Saturdays, but those are dialysis days and I am so tired, it is hard to get up to take a shower."</p>				

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	<p>In an interview on 9/13/2021 at 2:10 PM, Registered Nurse (RN) Unit Manager (UM) "MM" stated "everyone complains about showers", I have tried to adjust (Resident #104's) showers because of the resident's dialysis days and if showers are moved the schedule does not fit with her liking, we have not found a happy medium. RNUM "MM" reported that she could not locate the August "Skin Observation Shower" sheets.</p> <p>Review of the "Shower Logs" for the past 30 days, revealed out of 12 opportunities Resident #104 had 2 showers, 1 bed bath, 2 refused, and 9 not applicable.</p> <p>Review of the "Skin Observation Shower sheet" dated 9/1/2021, revealed CNA comments: "Just wanted hair washed., refused shower."</p> <p>Review of the "Skin Observation Shower sheet" dated 9/8/2021, revealed sticky note "tasks signed refused."</p> <p>Review of the "Posted Shower Schedule", revealed Resident #104 was scheduled for a shower on Wed/Saturday evenings 2nd shift.</p> <p>In an interview on 9/13/2021 at 12:04 PM, Certified Nursing Assistant (CNA) "NN" reported that out supervisors told us when we are to document "not applicable" because the shower days in the computer do not match what we are following on the master shower sheets, and then we just document the showers on the prn documentation.</p> <p>Resident #105</p> <p>Review of a "Admission Record" revealed Resident #105 was a female, with pertinent diagnoses which included: diabetes, peripheral</p>				

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	<p>vascular disease (poor blood circulation), high cholesterol, epilepsy (neurological disorder), contracture's, dementia, and heart disease.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #105, with a reference date of 5/10/2021 revealed a staff assessment of mental status, which indicated Resident #105 was severely impaired.</p> <p>In an interview on 9/13/2021 at 2:10 PM, RNUM "MM" stated that Resident #105 was in quarantine, but that was no excuse not to give her a shower." RNUM "MM" reported that she did not have any of the August "Skin Observation Shower sheets."</p> <p>Review of the "Skin Observation Shower sheet" dated 9/6/2021 and 9/9/2021, revealed resident was given a complete bed bath.</p> <p>Review of "Shower Logs" since Resident #105 readmission 8/30/2021, revealed 3 bed baths and 1 not applicable, the first bed bath was documented on a "Skin Observation Shower sheet" and not on the "Shower Logs" 7 days after admission.</p> <p>Resident #106</p> <p>Review of an "Admission Record" revealed Resident #106 was a male, with pertinent diagnoses which included: diabetes, chronic obstructive pulmonary disease (lung disease), muscle wasting and atrophy, paraplegia (incomplete), depression, chronic pain syndrome, and ulcerative colitis.</p> <p>Review of an "Minimum Data Set" (MDS) assessment for Resident #106, with a reference date of 6/25/2021 revealed a "Brief Interview for Mental Status" (BIMS) score of 13, out of a total</p>				

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	<p>possible score of 15, which indicated Resident #106 was cognitively intact.</p> <p>In an interview and observation on 9/8/2021 at 2:12 PM, Resident #106 was in his room lying in bed dressed in a gown able to reach his call light and items needed for care Resident #106 reported that I am missing my showers, they are supposed to be twice a week, but when they do not have more than 1 staff member per hall then I do not get 2 showers. This week I did, I would tell the nurse managers about my missed showers, and they would find an aid and have them give me a shower, I just don't understand why we cannot have them when we are scheduled. What happens to the residents who don't complain?</p> <p>In an interview on 9/13/2021 at 4:10 PM, RNUM "DD" stated "I do not have any shower sheets for Resident #106."</p> <p>Review of the "Shower Logs" for the past 30 days, revealed out of 10 opportunities Resident #106 had 5 showers (4 of which were prn), 1 bed bath, and 2 non applicable.</p> <p>Review of the "Master Shower Schedule", revealed Resident #106 was to have a shower on Tuesday/Friday Day 1st shift.</p> <p>Resident #112</p> <p>Review of an "Admission Record" revealed Resident #112 was a male, with pertinent diagnoses which included: hemiplegia, depression, and enterocolitis (inflammation of the small intestine and the colon).</p> <p>Review of an "Minimum Data Set" (MDS) assessment for Resident #112, with a reference date of 5/14/2021 revealed a "Brief Interview for Mental Status" (BIMS) score of 12, out of a total</p>				

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F0725 SS= E	<p>possible score of 15, which indicated Resident #112 was moderately intact.</p> <p>In observations and interviews on 9/9/21 at 4:20 PM and 9/13/2021 at 9:40 AM, Resident #112 stated "I was lucky enough to get a shower twice a month, been here 3-4 month and I have been down to the shower twice, they have given me spit baths in the bed the same amount of times as I have been in the showers, no one offers, I have ask to take a shower."</p> <p>In an interview on 9/13/2021 at 4:10 PM, RNUM "DD" stated that she heard Resident #112 state "that he had been wearing the same clothing for the past 5 days and offered him a shower today, looking at the shower sheet noted that it was his shower day." RNUM "DD" reported that the resident did not want any clothing from the donation box. RNUM "DD" stated "that she does not have any shower sheets and reports the last time resident he had a shower was on 9/9/2021.</p> <p>Review of the "Shower Logs" for the past 30 days, revealed out of 10 opportunities Resident #112 had 1(prn) shower, 5 bed bath (1 prn bed bath), 1 refused shower, and 4 non applicable.</p> <p>Review of the "Master Shower Schedule", revealed Resident #106 was to have a shower on Wednesday/Saturday Day 1st shift.</p> <p>Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and</p>	F0725					

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	<p>diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to Intake # MI00121639 & # MI00122400.</p> <p>Based on observation, interview, and record review, the facility failed to provide sufficient staff to meet resident needs in 8 of 10 residents (Resident #101, #107, #108, #109, #104, #105, #106, & #112) reviewed for sufficient staffing, resulting in missed baths/showers, long call light wait times, and the potential for unmet needs.</p> <p>Findings include:</p> <p>According to Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 1589-1592). Elsevier Health Sciences. Kindle Edition. "...Time management, therapeutic communication, patient education, and compassionate implementation of bedside skills are just a few of the essential skills you need. It is important for your patients to leave the health care setting with a positive image of nursing and</p>				

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	<p>a feeling that they received quality care. Your patients should never feel rushed. They need to feel that they are important and are involved in decisions and that their needs are met..."</p> <p>Review of the policy/procedure "Staffing", dated 7/11/18, revealed "...Our facility provides adequate staffing to meet needed care and services for our resident population...Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan. Other support services (e.g., dietary, activities/recreational, social, therapy, environmental, etc.) are adequately staffed to ensure that resident needs are met..."</p> <p>In an interview on 9/9/21 at 12:02 p.m., Ombudsman "FF" reported staffing has been brought up by residents/families as a frequent concern. Ombudsman "FF" stated there is "...definitely a pattern..." of staffing concerns, and complaints of long call light wait times.</p> <p>Resident #101</p> <p>Review of an "Admission Record" revealed Resident #101 was a female, with pertinent diagnoses which included chronic respiratory failure, diabetes, anemia, obesity, depression, and anxiety.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #101, with a reference date of 4/4/21, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was</p>				

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	<p>cognitively intact.</p> <p>Review of a MDS assessment, with a reference date of 6/28/21, revealed Resident #101 was totally dependent on staff for bathing, with two staff to assist.</p> <p>Review of a current "Care Plan" for Resident #101 revealed the focus "...Resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) acute and chronic respiratory failure, morbid obesity, immobility and activity intolerance..." with interventions which included "...Showering/Bathing per schedule or as needed..." both revised 5/10/21.</p> <p>In an observation and interview on 9/8/21 at 1:17 p.m., Resident #101 was noted in bed in her room. Resident #101 reported there is not enough staff at the facility to care for the residents, and stated "...I've had my call light on, they come in and say (they will) go get someone to help me...I will be waiting and waiting and waiting..." Resident #101 reported at times the staff report they will be back after they deactivate the call light and never return. Resident #101 reported she has "...sat in urine and feces..." for extended periods of time while waiting for staff to respond to her call light. Resident #101 reported she frequently has to wait 30-45 minutes for staff to respond to her call light. Resident #101 reported the staff assist her with bed baths at times and stated "...but I don't feel clean..." Resident #101 reported staff rarely wash her hair with a bed bath, and stated "...I haven't had a bed bath in a couple weeks..." Resident #101 stated "...I think that is because of short staff..." Observed Resident #101's hair appeared greasy, messy, and unkempt, and noted a noxious odor within Resident #101's room.</p> <p>In an observation on 9/9/21 at 8:58 a.m., Resident</p>				

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	<p>#101 was noted in bed in her room. Observed Resident #101's hair appeared greasy, messy, and unkempt, and noted a noxious odor within Resident #101's room.</p> <p>In an observation and interview on 9/9/21 at 3:56 p.m., Resident #101 was noted in bed in her room. Observed Resident #101's hair appeared greasy and messy. Resident #101 reported she has not been offered a bed bath or a shower today (Thursday), or had her hair washed.</p> <p>In an observation and interview on 9/13/21 at 9:43 a.m., Resident #101 was noted in bed in her room. Observed Resident #101's hair appeared greasy and messy. Resident #101 reported she has not received a shower or a bed bath since we last spoke on 9/9/21.</p> <p>Review of the shower/bed bath documentation for Resident #101 revealed missed showers/bed baths on Monday 8/23/21, Thursday 8/12/21, Thursday 8/19/21, Thursday 8/26/21, Thursday 9/2/21, and Thursday 9/9/21.</p> <p>Review of the nursing "Progress Notes" for Resident #101, from 8/12/21 to 9/13/21, revealed no documentation related to showers provided or refusals of showers/bed baths.</p> <p>Resident #107</p> <p>Review of an "Admission Record" revealed Resident #107 was a female, with pertinent diagnoses which included chronic respiratory failure, obesity, diabetes, dementia, muscle weakness, joint pain, anxiety, and depression.</p> <p>Review of the "Census" information for Resident #107 revealed she was hospitalized from 9/1/21 to 9/4/21.</p>				

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	<p>Review of a "Minimum Data Set" (MDS) assessment for Resident #107, with a reference date of 8/3/21, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.</p> <p>Review of a current "Care Plan" for Resident #107 revealed the focus "...ADL (Activities of Daily Living) self care deficit as evidenced by muscle weakness, impaired mobility, incontinence, pain, disease process..." revised 2/23/21, with interventions which included "...ADLs: 2 assist..." revised 6/2/21, and "...Per preference, takes bed baths not showers..." revised 5/28/20.</p> <p>In an observation and interview on 9/8/21 at 9:41 a.m., in the resident's room, Resident #107 reported she prefers bed baths, and would like to get a bed bath twice a week. Resident #107 reported she has not received a bed bath since her readmission from the hospital on 9/4/21. Noted Resident #107's hair appeared messy and greasy. Resident #107 stated "...I like a real old-fashion hair wash...I don't get my hair washed hardly ever. I like it washed clean and shiny...I'm lucky if I even get it washed..."</p> <p>Review of the past 30 days of CNA documentation for Resident #107, completed on 9/8/21, for the task "SHOWER/BATH: Wednesday Nights", "SHOWER/BATH: Saturday Nights", and "SHOWER/BATH: PRN (As Needed)" revealed documentation of "Not Applicable" was completed on Wednesday 8/11/21 and Friday 8/20/21. A bed bath was documented as completed on Monday 9/6/21. Note the bed bath documented on 9/6/21 is the only documentation of bathing in the past 30 days.</p>				

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	<p>In an observation and interview on 9/9/21 at 9:10 a.m., noted Resident #107 in bed in her room. Observed Resident #107's hair appeared messy and oily. Resident #107 reported she is supposed to have a bed bath on Wednesdays and Saturdays, however "...they miss me..." Resident #107 reported she is "...very seldom..." offered a bed bath. Resident #107 reported she did not have a bed bath or get her hair washed yesterday (Wednesday).</p> <p>Review of the past 14 days of CNA documentation for Resident #107, completed on 9/13/21, for the tasks "SHOWER/BATH: Wednesday Nights", "SHOWER/BATH: Saturday Nights", and "SHOWER/BATH: PRN" revealed no documentation that a shower or bed bath was completed on Wednesday 9/8/21. Note per the CNA charting, Resident #107 had a scheduled shower/bed bath on Wednesday 9/8/21.</p> <p>Review of the nursing "Progress Notes" for Resident #107, from 8/12/21 to 9/9/21, revealed no documentation related to showers provided or refusals of showers/bed baths.</p> <p>Resident #108</p> <p>Review of an "Admission Record" revealed Resident #108 was a female, with pertinent diagnoses which included diabetes, high blood pressure, arthritis, and kidney disease.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #108, with a reference date of 9/8/21, revealed a "Brief Interview for Mental Status" (BIMS) score of 14, out of a total possible score of 15, which indicated she was cognitively intact. Further review of this MDS assessment, with a reference date of 9/8/21, revealed Resident #108 required extensive assistance of two staff members for toileting care.</p>				

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	<p>Review of a current "Care Plan" for Resident #108 revealed the focus "...The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) weakness, hx (history) of falls prior to admission, deconditioning, activity intolerance, left arm deformity..." revised 10/22/19, with interventions which included "...TOILETING: EXTENSIVE ASSIST X 2..." initiated 7/9/20.</p> <p>Review of a current "Care Plan" for Resident #108 revealed the focus "...The resident has occasional bladder incontinence..." revised 7/9/20, with interventions which included "...Encourage and provide reinforcement/education with resident in asking for assistance to use the toilet, bedpan, or urinal..." initiated 7/9/20.</p> <p>In an observation on 9/8/21 at 9:58 a.m., noted Resident #108's call light was activated. Observed "Registered Nurse" (RN) "L" exit a room at the far end of the hall and return to the nurses desk to chart at the computer. Noted Resident #108 was laying in bed in her room, with the lights dimmed.</p> <p>In an interview on 9/8/21 at 10:01 a.m., RN "L" reported there are two nurses and three "Certified Nursing Assistants" (CNA's) for the entire 600 Hall. RN "L" reported there "...ideally..." would be four CNA's on the unit for day shift.</p> <p>In an observation on 9/8/21 at 10:05 a.m., noted Resident #108's call light remained activated. Observed RN "L" remained at the nurses desk, working at the computer.</p> <p>In an observation on 9/8/21 at 10:07 a.m., observed RN "L" respond to Resident #108's call light. Resident #108 requested to use the restroom and get up for the day. RN "L" deactivated Resident #108's call light and reported to</p>				

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	<p>Resident #108 that a CNA would be notified of her request, and that it would be a few minutes.</p> <p>In an observation and interview on 9/8/21 at 10:13 a.m., RN "M" approached RN "L" at the nurses desk and requested assistance on a different unit. RN "L" stated "...the schedule is a mess..." RN "L" reported there should be a total of four nurses between the 100/200 Hall and the 600 Hall, but "...one didn't show up..." RN "L" reported a Unit Manager was working on the floor but is no longer able to, so they are going down the three nurses. RN "L" reported they can function with three nurses across the 100/200 and 600 Halls at night, but not typically during the day. Note no CNA has been notified of Resident #108's request to use the restroom and get up for the day, and her need has not been met.</p> <p>In an observation on 9/8/21 at 10:17 a.m., CNA "V" exited a room at the far end of the 600 Hall. Observed RN "L" notify CNA "V" that Resident #108 "...needs to use the bathroom..." CNA "L" acknowledged the request, obtained linens, and returned to the far end of the 600 Hall to finish care for a different resident.</p> <p>In an observation on 9/8/21 at 10:25 a.m., noted no CNA's have responded to Resident #108's room to assist her to use the restroom and get up for the day. The call light is no longer activated, however Resident #108's need has not been met.</p> <p>In an observation and interview on 9/8/21 at 10:28 a.m., CNA "V" entered Resident #108's room to assist her to use the restroom and get up for the day. Note 30 minutes have passed since the initial observation of Resident #108's activated call light. Resident #108 stated "...I got to go to the bathroom!" CNA "V" reported it would be a few minutes before they could get her (Resident #108) out of bed and to the bathroom,</p>				

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	<p>because there needs to be a second staff member to use the sit-to-stand lift and "...couldn't find anyone right now..." Observed CNA "V" assist Resident #108 to wash her face and get dressed. CNA "V" left the room to find a second staff member to assist with the transfer to the bathroom. Observed Resident #108 rock forward and backward as she sat on the edge of the bed. Resident #108 stated "...I have to go along with what they (the staff) can do..." Resident #108 reported she is rocking forward and backward "...because I need to go to the bathroom..." At 10:48 a.m., CNA "V" returned with CNA "U" to assist Resident #108 with a transfer to the bathroom. Note at this point 50 minutes have passed since the initial observation of Resident #108's activated call light.</p> <p>In an interview on 9/8/21 at 11:02 a.m., CNA "V" reported there are three CNA's at this time for the entire 600 Hall. Reported there were initially four CNA's scheduled, but one was pulled to another unit. CNA "V" reported this is not enough CNA's for the hall, and there is not enough time to complete scheduled showers when only three CNA's are on the unit.</p> <p>Resident #109</p> <p>Review of an "Admission Record" revealed Resident #109 was a male, with pertinent diagnoses which included stroke, dementia, and high blood pressure.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #109, with a reference date of 8/10/21, revealed a "Brief Interview for Mental Status" (BIMS) score of 3, out of a total possible score of 15, which indicated severe cognitive impairment.</p> <p>In an observation on 9/8/21 at 1:03 p.m., Resident</p>				

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	<p>#109 sat in his wheelchair in the hallway on the 300 Hall. Noted Resident #109's wheelchair was heavily soiled, with visible build up of dust and debris on the bars and wheel spokes. Observed Resident #109's hair appeared greasy and unkempt.</p> <p>Review of a current "Care Plan" for Resident #109 revealed the focus "...ADL (Activities of Daily Living) Self care deficit as evidenced by requiring assist with ADLs as needed..." revised 3/3/21, with interventions which included "...Assist resident with shower twice weekly and as needed Wednesday/Saturday-Evening..." revised 5/30/21, and "...Resident frequently refuses showers/bed baths-continue to encourage good hygiene..." initiated 10/8/20.</p> <p>Review of the shower/bed bath documentation for Resident #109 revealed a missed shower/bed bath on Wednesday 8/25/21.</p> <p>In an interview on 9/8/21 at 3:41 p.m., CNA "O" reported there are two CNA's and one orientee on second shift for the entire 600 Hall at this time. CNA "O" stated they "...work short sometimes..." CNA "O" reported it can be difficult to complete scheduled showers when only two CNA's are on the unit, and stated that they "...try to get to as many (showers) as possible..."</p> <p>In an interview on 9/8/21 at 3:50 p.m., CNA "R" reported there are only two CNA's and one orientee for the entire 600 Hall at this time. CNA "R" reported staffing is a major concern at this facility. CNA "R" reported a few years ago six CNA's was the standard on 600 Hall, then when the company changed ownership, they went down to four CNA's on the 600 Hall. CNA "R" reported now they are expected to work on the 600 Hall often with only two CNA's. CNA "R" stated that due to low staffing they "...don't have time to</p>				

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	<p>provide quality care..." CNA "R" stated "...The residents don't understand...Can take upwards of 40 minutes to respond to call lights...(We) don't have time to perform showers, have to do bed baths..." CNA "R" reported staff have expressed their concerns to management but "...nothing is done..."</p> <p>In an interview on 9/9/21 at 9:21 a.m., "Licensed Practical Nurse" (LPN) "H" reported she worked a full 12-hour shift as the only nurse assigned to the entire 600 Hall. LPN "H" reported this occurred on a weekend, on 8/21/21, and described the situation as "...not safe..." LPN "H" reported management was contacted in regard to the staffing concerns that day and no coverage was provided. LPN "H" reported when only one nurse is assigned to work the entire 600 Hall, there is not enough time to complete scheduled treatments. LPN "H" stated it "...took me over a week to recover from that shift..." LPN "H" reported they have occasionally worked with only one nurse on the 600 Hall for night shift when there is a call-in, but should never have only one nurse on the 600 Hall for day shift. LPN "H" reported CNA's are supposed to complete paper shower sheets with each shower/bed bath provided, and stated "...Very rarely I get them..." LPN "H" reported CNA's are also supposed to chart showers/bed baths completed in the electronic charting system.</p> <p>In an interview on 9/9/21 at 4:13 p.m., CNA "O" reported today on the 600 Hall for second shift there are four CNA's. CNA "O" reported that is what the staffing should be for the unit, and that today is much better than yesterday when they only had two CNA's on second shift. CNA "O" reported there are several residents on the unit that require assistance for meals, and when there are only two CNA's residents often have to wait for 20 minutes or more before someone can get in their room and provide meal assistance. CNA "O"</p>				

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	<p>stated that is "...not fair..." for the residents who have to wait to eat their meals. CNA "O" reported first shift and second shift should have four to five CNA's on 600 Hall.</p> <p>In an interview on 9/13/21 at 1:25 p.m., Unit Manager "DD" reported the schedulers handle the staffing on the units, and the managers oversee the staffing and try to fill holes in the schedule as needed. Unit Manager "DD" reported the Unit Managers share an on-call schedule, and if unable to fill an open position are expected to come in and work the shift themselves. Unit Manager "DD" reported for the 100/200 Hall, there typically will be two nurses and between four and five CNA's for day shift. Unit Manager "DD" reported on night shift the nurses "...split..." with the 600 Hall, and there will be a total of three nurses sharing the 100/200 and 600 Halls. Unit Manager "DD" reported they have gone down to one nurse on 100/200 Hall on day shift for a brief period of time, and reported this was only until someone could come in to fill the open position. Unit Manager "DD" reported the minimum number of nurses for day shift on the 100/200 and 600 Halls would be three, and they would work the "...split..." assignment. Unit Manager "DD" stated "...that's as low as we can go..." Unit Manager "DD" reported residents should receive showers/bed baths "...at minimum two times a week..." Unit Manager "DD" reported these showers/bed baths should be documented in the electronic charting system and on a paper shower sheet. Unit Manager "DD" reported the floor nurses should be monitoring for shower/bed bath completion, and stated "...if it can't get done needs to be passed on to the next shift..."</p> <p>In an interview on 9/13/21 at 1:53 p.m., with Scheduling Coordinator "AA" and Scheduling Coordinator "BB", Scheduling Coordinator "AA" reported their primary focus is scheduling of the nursing and CNA staff. Scheduling Coordinator</p>				

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	<p>"AA" reported they determine the number of nurses/CNA's to schedule based on the census by referencing a "Staffing Grid", noted on the wall of their office. Scheduling Coordinator "AA" reported this number can be adjusted based on the care needs of the residents. Scheduling Coordinator "AA" reported they are notified of call-ins throughout the day, and in the evening the managers are on-call. Scheduling Coordinator "AA" reported on Mondays they review the staffing from the previous weekend and look for any issues that occurred. Scheduling Coordinator "AA" reported if a unit is short-staffed, the on-call Unit Manager should come in and fill the position if unable to find coverage. Scheduling Coordinator "AA" reported per her records, there were no call-ins for nursing staff on 8/21/21.</p> <p>In an interview on 9/13/21 at 2:21 p.m., LPN "H" reported in regard to staffing on 8/21/21, there was only one nurse for the entire 600 Hall, and one nurse for the 100/200 Hall. LPN "H" reported there were no call-ins that day for nursing, and stated "...it was just scheduled that way..." LPN "H" reported the workload that day was "...overwhelming..."</p> <p>In an interview on 9/13/21 at 2:57 p.m., Scheduling Coordinator "AA" reported four nurses were scheduled in the building for Saturday 8/21/21, with one open position noted. Scheduling Coordinator "AA" reported the Unit Managers would normally fill in for the open position. Scheduling Coordinator "AA" checked her documentation, and reported there is no record of a Unit Manager working the open position on day shift, 8/21/21. Scheduling Coordinator "AA" reported there should be between 5-6 nurses scheduled in the building for day shift, and stated "...Somebody should have come in to fill (the open position)..." on 8/21/21.</p>						

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	<p>In an interview on 9/13/21 at 3:03 p.m., Unit Manager "DD" reported she was the on-call manager for the weekend of 8/21/21 to 8/22/21. Unit Manager "DD" reported she could not recall any issues with day shift staffing on Saturday 8/21/21, and could not recall any open positions on the schedule. Unit Manager "DD" stated the facility would "...never go down to four nurses (for the entire building)...not with where our census is at..."</p> <p>In an interview on 9/13/21 at 3:12 p.m., RN "M" reported on 8/21/21 for day shift there were only four nurses scheduled for the entire building, and stated "...that wasn't safe..." RN "M" reported she contacted management several times to ask for help, however no one came in to cover the open nursing position. RN "M" reported she had approximately 45 patients assigned to her on the 100/200 Hall, and only two CNA's for the 100/200 Hall. RN "M" stated "...it was basically survival mode..." RN "M" reported there were no showers or bed baths done that day. RN "M" reported she also had a new admission that evening and there was documentation she was unable to complete. RN "M" reported she had an orientee nurse that day, who was brand new. RN "M" reported 8/21/21 was the orientee's second day and she did not have her own assignment. RN "M" reported in regard to CNA's charting "Not Applicable" for the bathing documentation, this is because "...they can't get to those showers when there is only one aide on the unit..." RN "M" reported the CNA's chart "Not Applicable" because if they charted anything else they would be "...lying..."</p> <p>In an interview on 9/13/21 at 4:29 p.m., with "Director of Nursing" (DON) "B" and Assistant Administrator "D", DON "B" reported staffing at the facility is a concern. DON "B" reported the facility stopped accepting new admissions due to not having enough available staff to cover the</p>				

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	<p>shifts. DON "B" reported bonuses are offered to provide incentives for staff to pick up open shifts, and a new scheduling system has been implemented. Assistant Administrator "D" reported additional contracts have been signed with staffing agencies, however, minimal agency staff are available to pick up open shifts. DON "B" stated "...We can't use staffing as an excuse to not give care..."</p> <p>Review of an email message from DON "B", dated 9/14/21 at 11:00 a.m., revealed a list of actions taken in an attempt to alleviate the staffing concerns at the facility. This list included "...On 8/10/21 the facility stopped taking new admissions..." Review of the "Facility Matrix" revealed two new admissions were accepted to the facility on 8/26/21 and 8/28/21.</p> <p>Resident #104</p> <p>Review of an "Admission Record" revealed Resident #104 was a female, with pertinent diagnoses which included: diabetes, peripheral vascular disease (poor blood circulation), high cholesterol, high blood pressure, chronic obstructive pulmonary disease (lung disease), end stage renal disease, dependence on renal dialysis, and acute osteomyelitis (infection in the bone).</p> <p>Review of an "Minimum Data Set" (MDS) assessment for Resident #104, with a reference date of 3/16/2021 revealed a "Brief Interview for Mental Status" (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #104 was cognitively intact.</p> <p>In an interview on 9/8/2021 at 9:20 AM, Resident #104 reported that "there was never enough help, it can take up to 2 hours on any shift to get someone here (to the room) depending on who is working and the rent a nurses are the worst,</p>				

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	<p>because they just are here to collect a paycheck, they don't care."</p> <p>In an interview on 9/8/2021 at 9:40 AM, Registered Nurse stated, "18 people with him and (2) Certified Nursing Assistants (CNA's), that was good today there had been just one CNA."</p> <p>In an observation and interview on 9/13/2021 at 9:11 AM, Resident #104 was up in wheelchair dressed appropriately for the day, thinking about self-transferring back to bed, stated "I can't do it with you watching". Resident #104 reported that there was a CNA that will help her with showers when she ask if he has time so she usually will get one about every 2 weeks. Resident stated that "her showers are scheduled on Tuesdays and Saturdays, but those are dialysis days and I am so tired, it is hard to get up to take a shower."</p> <p>In an interview on 9/13/2021 at 2:10 PM, Registered Nurse (RN) Unit Manager (UM) "MM" stated "everyone complains about showers", I have tried to adjust (Resident #104's) showers because of the resident's dialysis days and if showers are moved the schedule does not fit with her liking, we have not found a happy medium. RNUM "MM" reported that she could not locate the August "Skin Observation Shower" sheets.</p> <p>Review of the "Shower Logs" for the past 30 days, revealed out of 12 opportunities Resident #104 had 2 showers, 1 bed bath, 2 refused, and 9 not applicable.</p> <p>Review of the "Skin Observation Shower sheet" dated 9/1/2021, revealed CNA comments: "Just wanted hair washed., refused shower."</p> <p>Review of the "Skin Observation Shower sheet" dated 9/8/2021, revealed sticky note "tasks signed refused."</p>				

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	<p>Review of the "Posted Shower Schedule", revealed Resident #104 was scheduled for a shower on Wed/Saturday evenings 2nd shift.</p> <p>In an interview on 9/13/2021 at 12:04 PM, Certified Nursing Assistant (CNA) "NN" reported that out supervisors told us when we are to document "not applicable" because the shower days in the computer do not match what we are following on the master shower sheets, and then we just document the showers on the prn documentation.</p> <p>Resident #105</p> <p>Review of a "Admission Record" revealed Resident #105 was a female, with pertinent diagnoses which included: diabetes, peripheral vascular disease (poor blood circulation), high cholesterol, epilepsy (neurological disorder), contracture's, dementia, and heart disease.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #105, with a reference date of 5/10/2021 revealed a staff assessment of mental status, which indicated Resident #105 was severely impaired.</p> <p>In an interview on 9/13/2021 at 2:10 PM, RNUM "MM" stated that Resident #105 was in quarantine, but that was no excuse not to give her a shower." RNUM "MM" reported that she did not have any of the August "Skin Observation Shower sheets."</p> <p>Review of the "Skin Observation Shower sheet" dated 9/6/2021 and 9/9/2021, revealed resident was given a complete bed bath.</p> <p>Review of "Shower Logs" since Resident #105 readmission 8/30/2021, revealed 3 bed baths and</p>				

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	<p>I not applicable, the first bed bath was documented on a "Skin Observation Shower sheet" and not on the "Shower Logs" 7 days after admission.</p> <p>Resident #106</p> <p>Review of an "Admission Record" revealed Resident #106 was a male, with pertinent diagnoses which included: diabetes, chronic obstructive pulmonary disease (lung disease), muscle wasting and atrophy, paraplegia (incomplete), depression, chronic pain syndrome, and ulcerative colitis.</p> <p>Review of an "Minimum Data Set" (MDS) assessment for Resident #106, with a reference date of 6/25/2021 revealed a "Brief Interview for Mental Status" (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #106 was cognitively intact.</p> <p>In an interview and observation on 9/8/2021 at 2:12 PM Resident #106 was in his room lying in bed dressed in a gown able to reach his call light and items needed for care, Resident #106 stated "I don't feel safe in the facility there is a staffing shortage at night when I have to wait half hour to 45 minutes, I have to call out to get someone to get me off the bed pan." Resident #106 showed a steel thermos used hit against a what appeared to be a metal board on the wall beside his bed to try and get staffs attention to get him off the bed pan. Resident #106 stated that "he has ulcerative colitis and has very loose stools with blood so don't want a mess. so can't take himself off the bedpan and I don't want to sit on loose stool, it is like you are marinating on it there is only one staff besides the nurse working at night." Resident #106 stated "I am missing my showers, they are supposed to be twice a week, but when they do not have more than 1 staff member per hall then I</p>				

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	<p>do not get 2 showers. This week I did, I would tell the nurse managers about my missed showers, and they would find an aid and have them give me a shower, I just don't understand why we cannot have them when we are scheduled. What happens to the residents who don't complain?"</p> <p>In an interview on 9/13/2021 at 4:10 PM, RNUM "DD" stated "I do not have any shower sheets for Resident #106."</p> <p>Review of the "Shower Logs" for the past 30 days, revealed out of 10 opportunities Resident #106 had 5 showers (4 of which were prn), 1 bed bath, and 2 non applicable.</p> <p>Review of the "Master Shower Schedule", revealed Resident #106 was to have a shower on Tuesday/Friday Day 1st shift.</p> <p>Resident #112</p> <p>Review of an "Admission Record" revealed Resident #112 was a male, with pertinent diagnoses which included: hemiplegia, depression, and enterocolitis (inflammation of the small intestine and the colon).</p> <p>Review of an "Minimum Data Set" (MDS) assessment for Resident #112, with a reference date of 5/14/2021 revealed a "Brief Interview for Mental Status" (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #112 was moderately intact.</p> <p>In observations and interviews on 9/9/21 at 4:20 PM and 9/13/2021 at 9:40 AM, Resident #112 stated "I was lucky enough to get a shower twice a month, been here 3-4 month and I have been down to the shower twice, they have given me spit baths in the bed the same amount of times as I have been in the showers, no one offers, I have</p>				

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	<p>ask to take a shower, "if I wet myself there are 2 aids that will give me private care down there and there is one that will not, with my hand in the brace it is difficult to handle the urinal. It takes over an hour for them to answer the call light and I dosed off the last night and the aid came in emptied my urinal turned the light off and I let a bellow out of me, she came back, and I informed her that the light was on because she was needed, she stated that if we were sleeping they were not to disturb us. I told her I needed my brief changed."</p> <p>In an interview on 9/13/2021 at 4:10 PM, RNUM "DD" stated that she heard Resident #112 state "that he had been wearing the same clothing for the past 5 days and offered him a shower today, looking at the shower sheet noted that it was his shower day." RNUM "DD" reported that the resident did not want any clothing from the donation box. RNUM "DD" stated "that she does not have any shower sheets and reports the last time resident he had a shower was on 9/9/2021.</p> <p>Review of the "Shower Logs" for the past 30 days, revealed out of 10 opportunities Resident #112 had 1(prn) shower, 5 bed bath (1 prn bed bath), 1 refused shower, and 4 non applicable.</p> <p>Review of the "Master Shower Schedule", revealed Resident #106 was to have a shower on Wednesday/Saturday Day 1st shift.</p>				
F0804 SS= E	<p>Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.</p> <p>This REQUIREMENT is not met as</p>	F0804			

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	<p>evidenced by:</p> <p>This citation pertains to Intake # MI00121639 & # MI00122400.</p> <p>Based on observation, interview, and record review, the facility failed to provide palatable food products to 4 of 5 residents (Resident #104, #112, #101, and #107) reviewed for palatable food, resulting in the potential for decreased resident food acceptance and nutritional decline.</p> <p>Findings include:</p> <p>In a taste test on 9/8/2021 at 12:15 PM of the lunch meal, revealed the food was brought for testing directly from food service so the test tray was warm, the off-menu item was the grilled cheese which was still warm the cheese which appeared to be double cheese slices on the bread, was melted to the bread, which was well toasted, although the bread was very greasy on the fingers and quite salty tasting. The main meal was a sandwich on a bun, with extremely wet salad mixed with an Italian dressing, there was a generous amount of meat and one slice of cheese on the sandwich, with a tomato that could be added. With the amount of dressing added to the salad the bun was already becoming saturated with the dressing and unappetizing. The side dish was a broccoli salad that had a pea flavor when it hit my taste buds, but the liquids were less than appealing as were the textures of the combinations of the other items in the salad and I was unable to swallow the combination. The desert was a jell-o salad that appear to be mixed with low sugar fruit and lemon jell-o that had not set and the ratio did not include enough lemon jell-o to bring out the flavor, the fruit also did not have any flavor.</p>						

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	<p>In a taste test on 9/13/2021 at 12:02 PM of the lunch meal, revealed the food was brought for testing directly from food service so the test tray was warm, the main item was a chili which tasted as quite salty, the meat was small particle hidden in the sauce and beans not visible, but it was palatable, there was a piece of cornbread to go with the chili that was crumbly but had a good flavor. The side dish was a salad with quite a nice variety of vegetables added and the lettuce was fresh. The desert peaches with vanilla wafers and they were palatable.</p> <p>Resident #104</p> <p>Review of an "Admission Record" revealed Resident #104 was a female, with pertinent diagnoses which included: diabetes, peripheral vascular disease (poor blood circulation), high cholesterol, high blood pressure, chronic obstructive pulmonary disease (lung disease), end stage renal disease, dependence on renal dialysis, and acute osteomyelitis (infection in the bone).</p> <p>Review of an "Minimum Data Set" (MDS) assessment for Resident #104, with a reference date of 3/16/2021 revealed a "Brief Interview for Mental Status" (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #104 was cognitively intact.</p> <p>In an interview on 9/8/2021 at 9:20 AM, Resident #104 stated that "the food sucks, it is like dog food, it is cold, the food is blah, the substitutes are no better, the grilled cheese, the cheese is not melted, and hamburgers were like a piece of cardboard."</p> <p>In an interview on 9/13/2021 at 2:10 PM, Registered Nurse (RN) Unit Manager (UM) "MM" reported that there have not been any complaints about food.</p>				

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	<p>Resident #112</p> <p>Review of an "Admission Record" revealed Resident #112 was a male, with pertinent diagnoses which included: hemiplegia, depression, and enterocolitis (inflammation of the small intestine and the colon).</p> <p>Review of an "Minimum Data Set" (MDS) assessment for Resident #112, with a reference date of 5/14/2021 revealed a "Brief Interview for Mental Status" (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #112 was moderately intact.</p> <p>In observations and interviews on 9/9/21 at 4:20 PM and 9/13/2021 at 9:40 AM, Resident #112 stated "they have got a thing called stew here with little pieces of meat and potatoes and there is so much salt, and the dog food we had to eat as a kid during prohibition was better than what they have here way better than this, I am losing weight. Resident was up in chair dressed for the day reported that they had lost his menu for breakfast "which is not unusual it is cold half the time, but more was hot today because had 3 fried eggs (2 the yolk was runny) toast was like a brick egg were supposed to be over hard not medium. Resident reported that one of the girls helped me with the menu and it was supposed to be with cold cereal and 2 milk, did have the milk, but there was no cold cereal, he did not say anything about the cereal they had other things to do." Resident #112 reported that he was not able to eat the chili that was served for lunch on 9/13/21 because it was way too salty and he has high blood pressure.</p> <p>Review of the progress note revealed 9/13/2021 at 10:01 AM CNA came to kitchen this morning stating that resident did not receive a tray. CNA asked kitchen for two cream of wheat and two</p>						

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	<p>whole milks. Shortly after, another CNA came back stating that resident did not want what was brought to him. Resident asked for three fried eggs and two pieces of toast instead, which he received. Resident orders food via a select menu. He has a history of selecting items on his menu and refusing, often sending CNA's back for other food items multiple meals per day.</p> <p>In an interview on 9/13/21 at 3:58 PM, Dietary Manager (DM) "LL" and Dietitian "X" and "Y" reported that they had not had any food complaints lately, that activity goes door to door for their resident concerns monthly and if there are any food concerns, they will let us know, the menu was posted on the television channel and throughout the building well in advance of the meals.</p> <p>Resident #101</p> <p>Review of an "Admission Record" revealed Resident #101 was a female, with pertinent diagnoses which included anemia, diabetes, heart failure, depression, and anxiety.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #101, with a reference date of 4/4/21, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.</p> <p>In an interview on 9/8/21 at 1:17 p.m., Resident #101 stated "...I don't like the food here..." and reported the food is often undercooked and has no flavor.</p> <p>Resident #107</p> <p>Review of an "Admission Record" revealed Resident #107 was a female, with pertinent</p>				

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	<p>diagnoses which included diabetes, heart failure, depression, and anxiety.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #107, with a reference date of 8/3/21, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.</p> <p>In an observation and interview on 9/8/21 at 9:41 a.m., in the resident's room, Resident #107 reported the quality of the food served at the facility was poor, and stated "...They've got a lot of casserole type stuff and some of it is just junk...Last night I couldn't even finish it (the dinner), it was so bad...the flavor was so bad. I just picked at it and then pushed it aside..."</p> <p>In an interview on 9/8/21 at 3:50 p.m., "Certified Nursing Assistant" (CNA) "R" stated "...everything is about saving money..." CNA "R" reported there is only one option offered for each meal, and "...if the residents don't like the food the only other option is grilled cheese or a peanut butter sandwich..." CNA "R" reported many residents have expressed concerns over the quality of the food.</p>				
F0880 SS= E	<p>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,</p>	F0880			

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	<p>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 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.</p> <p>§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.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p>				

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	<p>This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to Intake # MI00121639, # MI00122020, & # MI00122104.</p> <p>Based on observation, interview, and record review, the facility failed to properly maintain infection control practices during a COVID-19 Infection Control Survey related to (1) accurate completion of rapid Covid-19 testing, (2) equipment cleaning and provision of a sanitary environment, (3) following the Standards of Infection Control Practices in 3 of 6 residents reviewed for infection control related to a lack of supervision of a wandering COVID-19 positive resident (Resident #111), a catheter bag not stored in a way to minimize the risk for infection (Resident #101), and a failure to clean a visibly soiled wheelchair (Resident #109), resulting in the potential for cross-contamination and the development and spread of disease.</p> <p>Findings include:</p> <p>Review of the manufacturer "Instructions for Use: BinaxNOWTM COVID-19 Ag CARD" revised 12/12/2020 revealed, "To perform the test, a nasal swab specimen is collected from the patient, 6 drops of extraction reagent from a dropper bottle are added to the top hole of the swab well. The patient sample is inserted into the test card through the bottom hole of the swab well, and firmly pushed upwards until the swab tip is visible through the top hole. The swab is rotated 3 times clockwise and the card is closed, bringing the extracted sample into contact with the test strip. Test results are interpreted visually at 15 minutes based on the presence or absence of visually detectable pink/purple colored lines. Results should not be read after 30 minutes.</p>				

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	<p>PRECAUTIONS: ...8. Proper sample collection, storage and transport are essential for correct results...13. Inadequate or inappropriate sample collection, storage, and transport may yield false test results...19. False Negative results can occur if the sample swab is not rotated (twirled) prior to closing the card.</p> <p>In observation and interview on 9/8/13 at 9:45 AM, 10:15 AM, and 11:13 AM Health Bar Nurse (HBN) "J" who was gowned and gloved and had cleaned her hands prior to entering the room placed the swab from the Binax Now Abbott Covid-19 test in the resident's left nostril swirled it 10 times and moved the same swab to the right nostril and swirled it 10 times then stepped to the doorway gave the swab to the HBN "K" in the hall who placed it in test card which was dry, she then added 6 drops of the reagent on top of the swab and sealed the card. HBN "J" and HBN "K" repeated this procedure 3 more times with 3 additional residents that was observed, they proceeded in this same exact procedure with each or the 3 rooms marking the cards with the room number and time and placing then in a pile. HBN "K" and HBN "J" reported that we are an outside source and had received the training to do their job through the office that employs them.</p> <p>In an interview on 9/8/2021 at 12:56 PM, Director of Nursing (DON) "B" and Nursing Home Administrator (NHA) "A" reported they did not monitor testing, they reported that the facility hired a contracted testing company that had been trained to do the Covid-19 tests. DON "B" reported that they were not aware that the testing company was not followed the guidelines for the test and that her nurses would have re-tested if the resident would have tested positive. DON "B" reported that she was going to contact the testing company and talk to them about the testing.</p>				

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	<p>In an interview on 9/8/21 at 4:00 PM, DON "B" reported that the contract testing supervisor informed her that the person doing the testing card was new and today was her first time.</p> <p>In an interview on 9/9/21 at 10:32 AM, Abbott Representative "OO" stated, "The facility has conducted the test inaccurately. We would call that "off label" and not even consider it an accurate or inaccurate test. The health care facility would have to retest everyone that was tested in this manner as they received no information on the Covid status of those who were tested."</p> <p>Resident #111</p> <p>Review of an "Admission Record" revealed Resident #111 was a male, with pertinent diagnoses which included: chronic obstructive pulmonary disease (lung disease), depression, unsteadiness on feet, mild cognitive impairment, irregular heart rate, with possible positive Covid-19.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #111, with a reference date of 8/11/2021 revealed a "Brief Interview for Mental Status" (BIMS) score of 6, out of a total possible score of 15, which indicated Resident #111 was severely impaired.</p> <p>In observation on 9/8/2021 at 1:25 PM and 1:50 PM, Resident #111 was out in the hall ambulating with mask on just under his nose he stated, "I want to go look out the window" then turned and came back and asked, "will you give me a pen to write down my room number, it confuses me because there is a name on the door that's not mine." Nursing Manager brought him a pen. Surveyor went in a room to watch care. Resident #111 was alone in the hall when surveyor left the hall, when surveyor next observed him, he was in</p>				

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	<p>an empty room at the end of the hall and he had pulled out all the closet drawers, the bed was unmade prior to resident entering room, staff went in to tell him he was in the wrong room and showed him where his room was.</p> <p>In an interview on 9/9/2021 at 9:40 AM, Registered Nurse (RN) "N" reported that he was trying to keep (Resident #111) in his room on 9/8/2021 because he tested positive today and he has signs and symptoms of COVID 19, and that he usually knows when he was out of his room because he will wander to the closed door by the nursing desk and demand to call his guardian, RN "N" reported that he did not know (Resident #111) was out of his room on 9/8/2021 in the afternoon, "it is non stop redirecting him, I was not aware he was wandering in another room." Resident #111 room was at the farthest end of the hall away from the nurses station.</p> <p>Review of the policy/procedure "Cleaning, Disinfection and Sterilization", dated 7/11/18, revealed "...It is the policy of this facility to provide supplies and equipment that are adequately cleaned, disinfected or sterilized...Supplies and equipment will be cleaned after use. Gross blood, secretions and debris will be removed as soon as possible. Cleaning may be done in the resident's room or the soiled utility room..."</p> <p>In an observation on 9/9/21 at 9:46 a.m., observed a large plastic bin in the hallway near Room 624, across from the shower room door, which contained various types "Personal Protective Equipment" (PPE). Noted an empty, crushed medication cup on the top of the PPE bin, and several dried, brown, splattered stains on the top surface of the PPE bin, along with visible dust.</p> <p>In an observation on 9/9/21 at 9:54 a.m., observed</p>				

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	<p>a plastic PPE bin in the hallway outside Room 626. Noted the top surface of the bin appeared soiled with visible dust/debris, with a dried brown substance on the drawer handle of the bin. Observed the PPE bin contained clean gowns, gloves, and N95 masks.</p> <p>In an observation on 9/9/21 at 9:55 a.m., observed a plastic PPE bin in the hallway outside Room 628. Noted the top surface of the bin appeared soiled with visible dust and several small pieces of paper trash. Observed the PPE bin contained clean gowns and several pairs of eye protection. Noted the edges of the drawers appeared dusty/soiled.</p> <p>Resident #101</p> <p>Review of an "Admission Record" revealed Resident #101 was a female, with pertinent diagnoses which included anemia, diabetes, heart failure, chronic respiratory failure, high blood pressure, depression, and anxiety.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #101, with a reference date of 4/4/21, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.</p> <p>Review of an "Order Summary Report" for Resident #101 revealed a current physician order to "...Maintain 16Fr (French)/ 10mL catheter to gravity drainage every shift..." with a start date of 6/11/21.</p> <p>Review of a current "Care Plan" for Resident #101 revealed the focus "...Resident utilizes catheterization/ostomy r/t (related to): Catheter use..." revised 5/10/21, with interventions which included "...CATHETER: Resident has Foley</p>				

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	<p>catheter. Position catheter bag and tubing below the level of the bladder. Provide for privacy cover when out of room. provide catheter care every shift..." revised 5/30/21.</p> <p>In an observation and interview on 9/8/21 at 1:17 p.m., Resident #101 was noted in bed in her room. Observed Resident #101's Foley catheter drainage bag laying directly on the floor below her bed, with no barrier in use. Noted the bag was approximately half full with clear, yellow urine. Observed a dark colored cloth bag hanging on the side of the bed. Resident #101 reported the staff are supposed to place the Foley catheter drainage bag in the dark colored privacy bag on the side of the bed.</p> <p>According to Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 67711-67715). Elsevier Health Sciences. Kindle Edition. "...Catheter Drainage Systems. An indwelling catheter is attached to a urinary drainage bag to collect the continuous flow of urine. The drainage system should not be separated unless absolutely necessary to avoid introducing pathogens...Always hang the drainage bag below the level of the bladder on the bedframe or a chair so urine will drain down out of the bladder. The bag should never touch the floor to prevent accidental contamination during emptying..."</p> <p>Resident #109</p> <p>Review of an "Admission Record" revealed Resident #109 was a male, with pertinent diagnoses which included stroke, dementia, and high blood pressure.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #109, with a reference</p>				

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	<p>date of 8/10/21, revealed a "Brief Interview for Mental Status" (BIMS) score of 3, out of a total possible score of 15, which indicated severe cognitive impairment.</p> <p>In an observation on 9/8/21 at 1:03 p.m., Resident #109 sat in his wheelchair in the hallway on the 300 Hall. Noted Resident #109's wheelchair was heavily soiled, with visible build-up of dust and debris on the bars and wheel spokes.</p> <p>In an observation on 9/9/21 at 4:21 p.m., Resident #109 was in bed in his room. Noted his wheelchair positioned beside his bed, which appeared to be heavily soiled, with visible build-up of dust and debris on the bars and wheel spokes.</p> <p>In an observation on 9/13/21 at 10:08 a.m., Resident #109 was in his wheelchair in his room. Noted his wheelchair appeared to be heavily soiled, with visible build-up of dust and debris on the bars and wheel spokes.</p> <p>In an observation on 9/13/21 at 10:26 a.m., Resident #109 sat in his wheelchair in the hallway on the 300 Hall. Noted Resident #109's wheelchair was heavily soiled, with visible build-up of dust and debris on the bars and wheel spokes.</p> <p>In an observation on 9/13/21 at 1:21 p.m., Resident #109 propelled himself in his wheelchair down the 300 Hall. Noted Resident #109's wheelchair was heavily soiled, with visible build-up of dust and debris on the bars and wheel spokes.</p> <p>In an interview on 9/13/21 at 1:25 p.m., Unit Manager "DD" reported residents should receive showers/bed baths "...at minimum two times a week..." and wheelchairs should also be cleaned</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 414290		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 9/14/2021	
NAME OF PROVIDER OR SUPPLIER SKLD BELTLINE					STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E BELTLINE SE GRAND RAPIDS, MI 49546		
(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
	<p>on a resident's scheduled shower day.</p> <p>In an interview on 9/14/21 at 1:18 p.m., "Director of Nursing" (DON) "B" reported wheelchairs should be cleaned on scheduled shower days.</p>						