STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634560	A. BUILDING _____ B. WING _____	11/4/2021

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

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E0000 SS=	Initial Comments SKLD-Bloomfield Hills was surveyed on 11/4/21 for the purpose of the COVID 19- Focused Infection Control Survey. They were found to be in compliance with 42 CFR Part 483.73(b)(6) Requirements for Long Term Care Facilities. Census=143	E0000		
F0000 SS=	INITIAL COMMENTS SKLD-Bloomfield Hills was surveyed on 11/4/21 for the purpose of an abbreviated and COVID 19-Focused Infection Control Survey. Census=143. Intakes: MI00119537, MI00119630, MI00119906, MI00120161, MI00120572, MI00121284, MI00121429, MI00121576, MI00121906, MI00122011, MI00122192, MI00122228, MI00122855, MI00123299, MI00123402, MI00123450, MI00123476, MI00123792, MI00123797.	F0000		
F0600 SS= D	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s):	F0600		

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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MI00119630 and MI00119537.

Based on observation, interview and record review, the facility failed to protect a resident from a nonconsensual sexual act by a resident who had documented sexually inappropriate behaviors. This involved two (R914 and R915) of eight residents reviewed for abuse and resulted in R914 fondling R915's breast. Findings include:

A complaint was submitted to the State Agency that alleged the following: "...On 4.20.21 (R914)..placed his hands under (R915's) shirt and touched her right breast. (R915's) boyfriend was sitting next to her when this occurred and yelled, as (R915) froze, and alerted the staff at the nursing home...This is not the first time (R914) has inappropriately touched a female there, as he has been touching the female staff inappropriately as well...His family was initially contacted regarding (R914) touching the staff members inappropriately and were advised it would be in the best interest to have (R914) moved to a facility with only men. Initially his family was not ok with that, but after the incident with (R915) it is not going to be a choice...The administration at the [facility name redacted] also contacted Licensing (State Agency) to notify them of this incident. On 4.19.21 (R915) was in the dining room and was observed to be exposing herself to the other residents in the facility. It is unknown what parts of her body (R915) exposed. The staff...witnessed (R915) do this..."

A Facility Reported Incident (FRI) was submitted to the State Agency that alleged the following: "... (R914) allegedly fondled (R915's) breasts under her shirt."

On 11/2/21 at 1:05 PM, R915 was observed seated in the lounge with another resident playing cards.

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	On 11/2/21 at 1:20 PM, R915 was observed lying in bed. At that time, an interview was conducted with R915. When asked about any incidents that occurred with other residents, R915 reported "a long time ago" she was sitting with her boyfriend in the lounge and a male resident put his hand up her shirt and touched her breast. R915 gestured how it was done by rubbing her breast. R915 reported her boyfriend yelled at the resident to stop. Review of the facility's investigation into the allegation of R914 fondling R915's breast revealed the following: A "Verification of Investigation" form dated 4/21/21 documented, "...Resident Name: (R914)...Alleged sexual abuse...Summary of Factual Investigative Findings:...On Tuesday, April 20, 2021, at approximately 4:30 pm administrator was notified by (Occupational Therapist - OT "I") with OT that while working on the second floor she heard some yelling coming from the dining room. Upon entering the room found (R915) and another resident...sitting at the table coloring. She observed (R914) sitting in WC (wheelchair) at the table. Both (R915) and (other resident) stated that (R914) put his hand up (R915) shift 3 times touching her breast...Approximately 5:30 pm the police arrived at the facility; (R914) stated she would like to press charges at which time the report was filed... (R915) stated that she felt 'uncomfortable' when she was touched inappropriately...Upon completion of the investigation, the facility was able to substantiate that physical contact occurred..." A "Statement for Administrator and AIT (Administrator in Training) signed by both parties documented, "On 4/20/21 Occupational therapist reported to admin (administrator) and AIT that			

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	there was a commotion in the 2E dining room and that (another resident) had a raised voice at (R914) for allegedly touching (R915)...Upon interviewing resident (R915) with the police in 2E dining room it was reported that her breast were being 'fondled' by (R914). (R915) reported that (R914) wheeled himself over to her table in his wheelchair on the right side of (R915) and began to fondle her. Per report (the other resident, R915's boyfriend) was on the left side of (R915) in which he did not realize what was going on until after a little bit, in which he responded with raising his voice at (R914) to cease his actions in which he did and wheeled away. After the officer got done questioning (R915) he asked if she would like to charge him, and she responded 'yes'...(R915's boyfriend's) story was identical to the above interview with (R915)..." A handwritten statement by OT "I" dated 4/20/21 documented, "Writer heard yelling from lounge. Resident (R915's boyfriend) informed me that resident (R914) put his hands under shirt of (R915) and fondled her breast 3 xs (times)..." Review of R914's clinical record revealed R914 was admitted into the facility on 1/23/21 and was discharged from the facility on 5/4/21 with diagnoses that included: dementia without behavioral disturbances and mood disorder. Review of a Minimum Data Set (MDS) assessment dated 4/28/21 revealed R914 had severely impaired cognition, required limited assistance for walking and ambulation, and had physical, verbal, "other", and wandering behaviors. Review of an MDS assessment dated 1/26/21 revealed R914 did not have any behaviors. Review of R914's progress notes revealed R914 had multiple documented incidents beginning on 2/9/21, including, but limited to touching female			

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	staff inappropriately, "touching other resident in places they do not desire", "making inappropriate gestures to staff", "self stimulate" in front of staff and residents, as follows: A "General Progress Note" dated 2/9/21 at 10:28 AM documented, "Resident observed multiple times attempting to touch staff inappropriately, difficult to redirect. Management aware." A "Social Services Note" dated 3/5/21 at 6:27 PM documented, "...spoke to resident daughter...discussed resident behavior of touching others resident in places they do not desire, resident is refusing to take some of his medications, NP (Nurse Practitioner) from psych team consulted with resident with interpreter today and he stated that he does not like the set up here and that he likes to caress people he is not trying to harm anyone, resident was advised that type of BH (behavior) is not acceptable, resident daughter is open to working with someone to assist with placement to a smaller setting and possibly a setting with others whom speaks and understand his native language..." A "General Progress Note" dated 3/7/21 at 4:35 PM documented, "Patient observed making inappropriate gestures to staff. Patient asked to stop and redirected, unsuccessful. Patient begin to yell at staff. Pt began to continue with inappropriate gestures, touching his private area..." A "Social Services Note" dated 3/8/21 at 4:22 PM documented, "...writer followed up with resident from incident over weekend, resident whom chose to self stimulate in from of other resident and staff...resident admits to touching others in areas that are private and that he thinks it's a joke, it was explained to him...this type of BH is inappropriate and that staff does not like being			

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	touch inappropriately resident touched writer thigh 4 times throughout this time with writer continuously reminding him stop (no) and re-directing resident hands away resident then began to laugh, interpreter did reinterate <sic> to resident that this is not an appropriate thing to do resident then apologize writer and within seconds went to touch thigh again, write<sic> request 2 person when providing care to resident...spoke to resident daughter [name redacted] to advise of conversation with interpreter today, resident continues to refuse medications, along with how resident touched writer serval <sic> times on thigh she stated that she is open to moving resident to another type of setting...she is supportive of resident moving to an environment smaller with recommendation of all males if possible as resident is not attempting to touch male staff inappropriately, discharge planning for an appropriate setting to continue resident re-directions as needed..." A "Social Services Note" dated 3/10/21 at 3:10 PM documented, "...resident was accepted to [facility name redacted] all male facility...writer spoke to resident daughter whom is receptive to this admission however stated that the distance maybe far for his son to bring him food she wants to contact the facility she also referenced that she think she may want him to go back to another facility that he was at previously, she apologized for her father's behavior and stated this has been going on for the past 3 years, she feels bad about his continued inappropriate touching of others, she will let writer know of discharge location in morning if she wants [facility name redacted] vs (versus) another facility..." A "General Progress Note" dated 4/19/21 at 11:47 AM documented, "Resident continues to sexually harass all female staff members. He will yell and slap his hand repeatedly on the nurse's station demanding one come to him. He will start to			

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masturbate while yelling at the female staff members. He also grabs the rears and genitalia of female staff members after being told to stop. When they back away, he screams and grunts. When put back in his room, he immediately comes back to the station to demand sexual attention again."

A "Social Services Note" dated 4/20/21 at 5:36 PM documented, "Writer informed of allegation that resident inappropriately touched another resident, authorities and family notified...resident put on 1:1 to ensure safety of all peers..."

Review of R914's care plans revealed the following:

A care plan initiated on 1/24/21 and revised on 4/21/21 that documented, "Resident has a behavior concern r/t (related to) disease process. Resident is grabbing and groping staff, and recently his female peers. Resident will grab at female staff in inappropriate areas i.e. Buttocks, Breast. Resident family stated that he exhibited this behavior at home, prior to coming into the facility. Resident told interpreter that he thinks that this type of BH is a joke."

On 11/2/21 at 4:00 PM, Social Services Technician (SST) "A' was interviewed about R914 and any behaviors he exhibited. SST "A" reported R914 was "demented" and had a "history of wanting to touch ladies". SST "A" further reported R914 had been touching female staff members inappropriately and "progressed to the resident (R915)." When queried about any interventions that were in place to ensure R914 did not inappropriately touch any residents, SST "A" reported R914 had not touched residents before 4/20/21 but had masturbated when at the nurses station with residents present. SST "A" reported that staff would redirect R914 when

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behaviors like that occurred. When queried about supervision provided to R914 to ensure he was not sexually inappropriate with other residents, knowing his history with staff, SST "A" stated, "We can't put him in a room and lock him in there." When queried about whether R914 should have been in the lounge unsupervised, SST "A" reported OT "I" was "close by so that was good." SST "A" reported R914 could be redirected at times, was a social person, but because his sexual drive was so high it was difficult to control his behaviors. SST "A" further reported that she was trying to get R914 placed in an all male facility. When queried about what was put into place to ensure sexually inappropriate behavior did not affect females in the facility when it was determined R914 was not in an appropriate setting for his behaviors, SST "A" did not offer a response.

On 11/3/21 at approximately 3:00 PM, the Administrator, who was identified as the Abuse Coordinator of the facility, was interviewed. When queried about the outcome of the facility's investigation into R914 touching R915's breast, the Administrator reported it was substantiated. When queried about what was in place prior to the incident to ensure female residents were not affected by R914's known sexual behaviors, the Administrator reported R914 had not touched residents before, only female staff. When queried about whether the sexual abuse that occurred between R914 and R915 could have been prevented with more supervision after it was determined the facility was not an appropriate placement for R914, the Administrator did not offer a response.

On 11/4/21 at 12:00 PM, OT "I" was interviewed. When queried about what they recalled or witnessed on the date it was alleged R914 touched R915's breast, OT "I" reported they were in the lounge completing paperwork and heard

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	R915's boyfriend yelling 'Get out of here!'. OT "I" reported she looked up and R915's boyfriend reported R914 had been fondling R915's breast. OT "I" reported she did not see the touching occur, but R915 also reported the same story. When queried about any other staff member who were in the lounge at that time and if R914 was supervised, OT "I" reported they did not recall any other staff members in the lounge and stated, "I do know that this resident grabbed staff members' butts and was a very touchy hands on guy." Review of a facility policy titled, "Abuse and Neglect", revised 6/17/19 revealed the following: "...It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, involuntary seclusion, misappropriation of property, exploitation, neglect, or mistreatment...Prevention...Identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident properly is more likely to occur...This include analysis of: ...The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors. Residents who have behaviors such as entering other residents' room, residents with self-injurious behaviors, residents with communication disorders, those that requires heavy nursing care and/or are totally dependent on staff..."			
F0608 SS= D	Reporting of Reasonable Suspicion of a Crime §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include	F0608		

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	but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00123792 and MI00123797 Based on interview and record review, the facility failed to report allegations of stolen money to local law enforcement in a timely manner for two residents (R902 and R904) of two residents reviewed for misappropriation. Findings include: R902 Review of facility reported incident (FRI)			

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submitted to the State Agency indicated that on 10/6/21 R902 alleged they had $240.00 stolen from them.

Review of the medical record revealed that R902 was initially admitted to the facility on 9/20/21.

On 11/2/21 at approximately 12:58 PM, R902 was observed in their room lying in their bed. R902 was queried if they had any concerns while staying at the facility and they indicated the care is good, but they did have an issue with their money being stolen. R902 indicated that a few days after they were admitted to the facility, she asked her friend to bring up her wallet and they put their wallet in the nightstand drawer. R902 indicated a few days later they decided to check their wallet and realized they were missing 240.00 dollars. R902 indicated they believed a Nursing aide stole it because they woke up and saw an aide looking at their phone. R902 indicated the aide told them they were looking for their lost phone.

Review of the facility's investigative summary pertaining to R902's allegation of stolen money revealed the following: "On 10/6/2021 [R902] reported that she is missing $240.00 from his <sic> dresser drawer that he <sic> last noticed 5-6 days ago. She alleged Certified Nursing Assistant "K" (CNA "K") took the money because he was in her room reaching for her phone. Actions Taken- [CNA "K"] was suspended pending investigation.

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	Administrator, Director of Nursing and State of Michigan notified · [local police department]. Notified...Staff interviewed. [R902] received a dresser with a locked drawer and the facility will replace the $240.00. Investigation On 10/6/21 the Social Worker interviewed [R902]. She stated she sometimes get her days mixed up. She recall last seeing her money 5 - 6 days ago. She stated she withdraw the money from her bank account prior to her going out to the hospital. She stated she has not been out of her room and her wallet has not been out of her sight. She also stated to staff that she felt [CNA "K"] took her money because she observed him reaching for her phone..." Further review of the facility's investigative summary pertaining to R902's allegation of stolen money revealed law enforcement was not notified until 10/13/21, one week after the allegation was first made. R904 Review of a FRI that was submitted to the State Agency on 10/6/21 revealed "(R904) alleged he is missing $105.00 from his dresser drawer. He stated he last seen it 5 days ago. He alleged that (CNA "K") took the money because sometimes he will come in the room and eat pizza with him..." On 11/4/21 at 1:10 PM, R904 was interviewed. R904 was observed lying on his bed. R904 was alert and participated in the			

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	interview. When queried about the reported allegation of missing money, R904 reported that "on approximately 10/1/21" he had "Five 20 dollar bills, one five dollar bill, and a bunch of singles" in his nightstand drawer next to his bed. R904 reported that when he woke up in the morning, he noticed the drawer was open a little bit and when he looked in the drawer there were only two dollar bills, and the rest of the money was gone. R904 reported he thought CNA "K" took the money because "he was always coming into my room to get food." R905 explained that he often ordered pizza and offered a piece to CNA "K" one time and after that CNA "K" would just come in and help himself. R904 stated, "He (CNA "K") was the only one coming into my room at the time it disappeared. I know he was in my room when I was sleeping because when I woke up I had a fresh cup of water." R904 reported he reported the missing money to staff around the same day he noticed it missing and the Administrator reimbursed the money. Review of the facility's investigation into R904's allegation of stolen money revealed the following: A summary of the investigation documented, "On 10/6/21 (R904) reported that he is missing $105.00 from his dresser drawer that he last noticed 5 days ago. He alleged (CNA "K") took the money because sometimes he will come in the room and eat pizza with him."			

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Further review of the facility's investigative summary pertaining to R904's allegation of stolen money revealed law enforcement was not notified until 10/13/21, one week after the allegation was first made.

On 11/4/21 at 9:20 AM, the Administrator, who is the Abuse Coordinator for the facility, was interviewed. When queried about when law enforcement should be notified when residents alleged stolen money, the Administrator reported they should be contacted right away.

On 11/4/21 at approximately 3:54 PM, The Director of Nursing (DON) was queried regarding the facility's investigations of R902's and R904's alleged stolen money by CNA "K". The DON indicated the facility became aware of the allegation on 10/6/21 and launched investigations regarding it. The DON indicated that the facility abuse coordinator was on vacation and that they were the identified designee for the investigation of misappropriation of resident money. The DON was queried why the local police department was notified of the allegation on 10/13/21 when the facility had identified the allegation on 10/6/21 and they indicated that they had forgotten to notify the police. The DON was queried how soon should local law enforcement be notified after an allegation of theft is identified to conduct their investigation and they indicated that law enforcement should have

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	been notified immediately.			
F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00123797 and MI00122228. Based on interview, and record review, the facility failed to report an allegation of misappropriation of resident property and physical abuse to the	F0609		

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	Abuse Coordinator and/or State Agency in the required timeframe for two (R904 and R909) of eight residents reviewed for abuse. Findings include: R904 On 11/3/21 at 1:10 PM, R904 was interviewed. R904 was observed lying on the bed and was alert and engaged in conversation. When queried about any concerns with missing money or property, R904 reported that another resident wandered into his room when his privacy curtain was closed. R904 could not see the resident, could not remember his name, but reported he had a "rough voice". R904 explained he asked the resident, "Who is it?" and they replied, "It's just me". R904 further explained the other resident said he was "separating his stuff from mine" and was in R904's bathroom. R904 reported the next time he went into his bathroom his electric beard trimmers, a bottle of body wash, and three bags full of items purchased from a local department store were missing. R904 stated, "I turned in my statement to (Registered Nurse "B") and she said she would look into it, and I haven't heard anything else since." R904 reported he had receipts for all of the items that went missing. R904 reported he asked Social Services Technician (SST) "A" about the status of the missing items he reported and was told by SST "A" that she did not have anything to do with that process. On 11/4/21 at 2:10 PM, RN "B" was interviewed. When queried about the facility's protocol when residents express a concern regarding missing property, RN "B" reported it would be documented on a concern form and given to the Administrator. When queried about any complaints of missing personal items expressed by R904, RN "B" stated, "It's sounds familiar, but			

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I can't recall. The Administrator would have the concern form."

On 11/4/21 at 2:30 PM, RN "B" provided a "Grievance and Satisfaction Form" dated 10/6/21 and explained they forgot they had the form. RN "B" explained the Administrator was on vacation and did not receive it in a timely manner. Review of the "Grievance and Satisfaction Form" revealed the following: The form documented the concern was received by RN "B" on 10/6/21 at 2:00 PM. It was documented that, "Resident (R904) stated that clippers and other items from [department store name redacted] were missing. Thinks a resident may have taken them..." It was documented that the Administrator received the form on 10/14/21, eight days after the concern was reported by R904 to RN "B". The following was documented in the "Investigation" section: "Room and bathroom checked for items. No items found, also checked the soiled and clean utility rooms and laundry. No items found in the accused resident's room and resident was discharged at the time of the concern." The following was documented in the "Resolution" section: "Items will be replaced." The section to document when the complainant was notified of the resolution and if they were satisfied was left blank. The Administrator Acknowledgement section was left blank.

On 11/3/21 at 3:14 PM, SST "A" was interviewed. When queried about any complaints from R904 regarding missing property allegedly taken by another resident, SST "A" reported there was a resident who was wandering in and out of other resident's rooms and R904 thought that resident stole his electric shaver "and some other stuff". When queried about what was done when that information was reported by R904, SST "A" stated, "(R904) said, 'It's not a big deal. He (the other resident) is gone anyway." SST "A" reported since R904 said it was not a big deal, she

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	did not report it to anyone. On 11/4/21 at 9:20 AM, the Administrator, who is the facility's Abuse Coordinator, was interviewed. When queried about the facility's protocol when a resident alleged abuse or misappropriation of property, the Administrator reported he educated all staff that he had a two hour window to report allegations to the State Agency and therefore he should be notified directly of all allegations immediately after they ensured the resident was safe. The Administrator reported after he was notified an investigation would be started. The Administrator further reported that sometimes staff might report to the nurse, but regardless he must be notified because "it is not up to them to decide it the allegation is credible or not." When queried about the facility's grievance process, the Administrator reported all resident or family concerns were documented on a concern form and brought to the daily "stand up meeting". Then, the Administrator reviews them and disperses the forms to the appropriate department to resolve the concern, follow up with the resident, and come back to me to be signed. The "Grievance and Satisfaction Form" provided by RN "B" regarding R904's allegation of another resident taking his clippers and other items from a local department store was reviewed with the Administrator. When queried about whether the concern met the definition of misappropriation of property, the Administrator reported it did. When queried about whether it should have been reported immediately to the Abuse Coordinator, the Administrator reported he was on vacation at that time, but the Director of Nursing (DON) should have been notified. The Administrator did not know who the alleged perpetrator was who was reported to have stolen R904's property and there was no evidence that R904 had been followed up with regarding what items were missing. Review of a facility policy titled, "Abuse and			

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	Neglect" revised 6/17/19 revealed the following: "...All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee...All allegations of abuse will be reported to the appropriate State Agencies immediately after the initial allegation is received..." R909 Review of the medical record revealed R909 was admitted into the facility on 3/26/21 with diagnoses that included cirrhosis of liver and acute kidney failure. A MDS assessment dated 6/29/21 documented a BIMs score of 8, indicating moderately impaired cognition and required staff assistance for all ADLs. R909 expired in the facility on 8/11/21. Review of a facility investigation report documented in part, " ...On 8/2/2021 (R909) reported he had a skin tear to the right hand ... approximately three days ago on 7/30/21 a male cena (Certified Nursing assistant- CNA "R") was being ruff <sic> with him during care. When asked how was the male cena being ruff <sic> he stated the cena gave him an Indidana <sic> burn. When asked how did the cena give him an Indiana burn. He stated the cena took both their hands and placed one hand on his hand and the other hand on his wrist then twist ... (R909 name redacted) then stated, "Look what you did to my hand". (CNA "R" name redacted) then told (R909) that he did not do that ... "(CNA "R") then exits the room and reported the incident to the nurse ..." Review of the clinical record revealed no documentation of the incident that occurred between R909 and CNA "R".			

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	Review of a progress note dated 7/30/31 at 1:36 PM, documented in part " ... Resident has a skin tear on right hand. Wound Care nurse notified. Cleaned with normal saline. Xeroform and gauze applied." This note was written by LPN "S", the dayshift nurse assigned to R909 on 7/30/21. On 11/3/21 at 9:24 AM, LPN "S" was interviewed via telephone and asked about the note documented on 7/30/21 and stated in part, " ... No, no one told me. I'm sure I seen it (skin tear) during a medication pass because I always check my resident's during that time ..." When asked if they asked R909 how they obtained the skin tear, LPN "S" stated they could not recall. LPN "S" then stated CNA "R" worked a different shift then them, so they were not the nurse that CNA "R" reported the incident to. Review of R909 Medication Administration Records (MARs) for July 2021 revealed LPN "T" was assigned to the resident at the time of the incident that occurred between CNA "R" and R909. On 11/4/21 at 8:12 AM, LPN "T" was interviewed and asked about the incident involving CNA "R" and R909 on 7/30/21 and stated in part, " ... I recall (CNA "R") ... upon shift change telling me that (R909) had a skin tear ... I don't recall being told the incident between the resident and CNA "R" ... (LPN "S") said she would go in there ... Our DON (Director of Nursing) was on her to get the incident report done ..." On 11/3/21 at 9:18 AM, an attempt to conduct an interview with CNA "R" was made, however CNA "R" did not answer their phone and a return phone call was not made by the end of survey. Review of a facility "Witness Statement"			

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	conducted with CNA "R" documented in part, " ... I was doing my last walking rounds on my residents. When I enter [R909's] room, I observed that his brief was wet and needed to be change. I told [R909] that I was going to change his brief. During the brief change [R909] became combative, hitting, kicking, and using profanity. I reached for his hands to stop him from hitting me and jump <sic> out the way. I told [R909] that I was only trying to change his brief. [R909] then stated, "Look what you did to my hand". I then stated, [R909] I did not do that. I then ask him would he like a bandage for his hand and to see the nurse. I then exit the room and reported the incident to the nurse ..." The facility's investigation report revealed CNA "R" acknowledged that R909 made an allegation regarding CNA "R" causing a skin tear to R909's right hand. CNA "R" acknowledged the allegation and exited the room to report the incident to the nurse on 7/30/21. The progress note dated 7/30/21 completed by LPN "S" documented the skin tear and treatment obtained for the right-hand skin tear. The facility reported the incident to the SA on 8/2/21, despite CNA "R" acknowledging in their statement letter provided to the facility that R909 stated "Look what you did to my hand" and CNA "R" documenting that they "reported the incident to the nurse". On 11/4/21 at 9:29 AM, an interview conducted with the Administrator (who also serves as the facility's abuse coordinator) and was asked why the incident was not reported to the SA on 7/30/21 when R909 alleged that CNA "R" hurt their right hand. The Administrator stated they were unaware that the resident made that allegation until yesterday on 11/3/21 when initially asked about the incident by the SA, despite the facility investigation report that documented the resident made the allegation and CNA "R" admitting that the R909 made the			

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	allegation on 7/30/21. On 11/421 at 3:52 PM, the DON was interviewed and asked why the incident was not reported within the required time frame and the DON acknowledged that the staff should have reported the incident on 7/30/21 when it happened. A facility policy titled "Abuse and Neglect" Revised 6/17/19 documented in part, " ... Physical abuse includes but not limited to infliction of injury that occur than by accidental means. Examples: hitting, slapping, kicking, squeezing, grabbing, pinching, poking, twisting, roughly handling. Any person may potentially cause harm to a resident ... All allegations and/or suspicions of abuse must be reported to the Administrator immediately ... The abuse coordinator must submit a preliminary investigation report to the appropriate State Agencies immediately once assurances for the resident's or other resident's safety have been established. However, if the event that caused the allegation involved abuse or resulted in serious bodily injury, the allegation of abuse must be reported to appropriate state agencies immediately and not later than 2 hours after receiving the allegation of abuse ..."			
F0610 SS= D	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	F0610		

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of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:

This citation pertains to intake #MI00123792, MI00123797.

Based on interview and record review, the facility failed to complete a timely and thorough investigation of alleged misappropriation of money for two residents (R902 and R904) and failed to prevent further potential abuse for one resident (R909) of eight residents reviewed for abuse/neglect/misappropriation. Findings include:

R902

A facility reported incident submitted to the State Agency on 10/8/21 was reviewed and indicated that on 10/6/21 R902 alleged they had $240.00 stolen from them.

Review of the medical revealed R902 was initially admitted to the facility on 9/20/21.

On 11/2/21 at approximately 12:58 PM, R902 was observed in their room lying in their bed. R902 was queried if they had any concerns while staying at the facility and they indicated the care is good, but they did have an issue with their money being stolen. R902 indicated that a few days after they were

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	admitted to the facility, she asked her friend to bring up her wallet and they put their wallet in the nightstand drawer. R902 indicated a few days later they decided to check their wallet and realized they were missing $240.00. R902 indicated they believed a Nursing aide stole it because they woke up and saw an aide looking at their phone. R902 indicated the aide told them they were looking for their lost phone. An investigative summary pertaining to R902's allegation of stolen money was reviewed and revealed the following: "On 10/6/2021 [R902] reported that she is missing $240.00 from his <sic> dresser drawer that he <sic> last noticed 5-6 days ago. She alleged Certified Nursing Assistant "K" (CNA "K") took the money because he was in her room reaching for her phone. Actions Taken- [CNA "K"] was suspended pending investigation. Administrator, Director of Nursing and State of Michigan notified · [local police department]. Notified...Staff interviewed. [R902] received a dresser with a locked drawer and the facility will replace the $240.00. Investigation On 10/6/21 the Social Worker interviewed [R902]. She stated she sometimes get her days mixed up. She recall last seeing her money 5 - 6 days ago. She stated she withdraw the money from her bank account prior to her going out to the hospital. She stated she has not been out of her room and her wallet has not been out of her sight. She also stated to staff that she felt [CNA "K"] took her money because she			

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	observed him reaching for her phone..." Further review of the facility investigation revealed statements pertaining to the allegation from other staff who worked during the estimated time of the allegation. No statements from other residents in the facility to ascertain the scope of the allegation were in the facility investigation. R904 An FRI submitted to the State Agency on 10/6/21 that alleged the following: "(R904) alleged he is missing $105.00 from his dresser drawer. He stated he last seen it 5 days ago. He alleged that (CNA "K") took the money because sometimes he will come in the room and eat pizza with him..." On 11/4/21 at 1:10 PM, R904 was interviewed. R904 was observed lying on his bed. R904 was alert and participated in the interview. When queried about the reported allegation of missing money, R904 reported that "on approximately 10/1/21" he had "Five 20 dollar bills, one five dollar bill, and a bunch of singles" in his nightstand drawer next to his bed. R904 reported that when he woke up in the morning, he noticed the drawer was open a little bit and when he looked in the drawer there were only two dollar bills, and the rest of the money was gone. R904 reported he thought CNA "K" took the money because "he was always coming into my room to get food." R904 explained that he often ordered pizza and			

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offered a piece to CNA "K" one time and after that CNA "K" would just come in and help himself. R904 stated, "He (CNA "K") was the only one coming into my room at the time it disappeared. I know he was in my room when I was sleeping because when I woke up I had a fresh cup of water." R904 reported he reported the missing money to a CNA around the same day he noticed it missing and the Administrator reimbursed the money.

Review of the facility's investigation into R904's allegation of stolen money revealed the following:

A summary of the investigation documented the following: "...Description of Incident: On 10/6/21 (R904) reported that he is missing $105.00 from his dresser drawer that he last noticed 5 days ago. He alleged (CNA "K") took the money because sometimes he will come in the room and eat pizza with him..." The "Investigation" section documented, "On 10/6/21 the Social Worker interviewed (R904). He stated that he last seen the money in his top drawer and that he seen it 5 days ago. He stated he has not been out of his room and does not know what could have happened. He admitted to other residents will sometimes come in and out of his room. (R904) also stated that he sometimes eats pizza with (CNA "K") and he thinks that he may have taken the money while he was sleep...The Director of Nursing interviewed (CNA "K"). He stated that (R904) offered him a slice of pizza and he took it and exit the

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	room...When asked did he see (R904) with any money, he stated no...The Director of Nursing then interviewed all midnight unit staff. No staff members have seen or heard anything regarding (R904's) money. The Director of Nursing reviewed the Nursing Assistant assignment sheet for 5 days prior to the date the incident was reports. (CNA "K") was not working on the date in question...Conclusion...During the investigation (R904) did not observe (CNA "K") going in his dresser drawer or his personal belongings. The facility Nursing Assistant sheet for 5 days prior to the date the incident was reported. (CNA "K") was not working on the day in question. Based on the facility investigation the facility could not substantiate Misappropriation of funds/abuse." Further review of the facility's investigation did not reveal who R904 initially reported the allegation of stolen money to. There were multiple statements from various staff members, but there was no statement from the staff member R904 reported the allegation to. There was no documentation in the investigation that other residents were interviewed to ensure they were not affected by misappropriation of money. Review of the nursing staff schedule from 10/1/21 through 10/6/21 revealed CNA "K" worked on 10/1/21, 10/2/21, and 10/3/21. On 11/3/21 at 3:53 PM, the DON who conducted the investigation into R904's			

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	allegation, was interviewed. The DON reported the Administrator/Abuse Coordinator was on vacation and she received a report from RN "B" that R904 alleged stolen money. When queried about who R904 initially reported the allegation to, the DON stated, "He told the CNA, and the CNA told the manager and the manager told me." The DON was unable to recall who the CNA was that R904 reported the allegation to and reported they did not interview that CNA and had SST "A" interview R904. When queried about the facility's process for conducting an investigation, the DON reported if someone reported allegation they would have someone else interview the resident to ensure a consistent story. The DON reported all people involved would be interviewed and statements taken. When queried about how it was determined other residents were not affected after two residents (R902 and R904) both alleged CNA "K" stole money from them, the DON reported she thought the unit manager (RN "B") talked to other residents. The DON reported she did not have any evidence of the other residents' interviews. At that time, the DON was asked to provide the name of the CNA that R904 reported the allegation of stolen money to. On 11/3/21 at 4:30 PM, the Administrator, who was the facility's Abuse Coordinator was interviewed. When queried about who R904 reported the stolen money to and when he made the initial report, the Administrator			

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reported he was on vacation during the incident and is unaware of that information.

On 11/4/21 at 7:45 AM, the DON followed up and reported RN "C" was the nurse who R904 reported the allegation of stolen money to, but that she did not interview him as part of the investigation.

On 11/4/21 at approximately 9:20 AM, The facility Administrator who also served as the abuse coordinator was queried regarding the facility process for the investigations pertaining to the multiple allegations of alleged money being stolen from R902 and R904. The Administrator indicated that they should be notified immediately and after then had reported the allegation to the appropriate authorities but would interview the alleged victim to narrow down the potential perpetrators. They would then interview staff who worked during the estimated time of the alleged theft and finally interview other residents in the facility to determine if a pattern or other residents were affected by the allegation. The Administrator was queried if any other residents were interviewed to ascertain the scope of the allegation and they indicated they did not know. The Administrator was then provided the facility investigation folder containing only statements from staff and they indicated they did not see any interviews from any other residents.

A facility policy titled, "Abuse and Neglect"

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	revised 6/17/19 revealed the following: "...The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations..." R909 Review of the medical recored revealed R909 was admitted into the facility on 3/26/21 with diagnoses that included cirrhosis of liver and acute kidney failure. A MDS assessment dated 6/29/21 documented a BIMs score of 8, indicating moderately impaired cognition and required staff assistance for all ADLs. Review of a facility investigation report documented in part, " ...On 8/2/2021 (R909) reported he had a skin tear to the right hand ... approximately three days ago on 7/30/21 a male cena (Certified Nursing assistant) was being ruff <sic> with him during care. When asked how was the male cena being ruff <sic> he stated the cena gave him an Indidana <sic> burn. When asked how did the cena give him an Indiana burn. He stated the cena took both their hands and placed one hand on his hand and the other hand on his wrist then twist ... (R909) then stated, "Look what you did to my hand". (CNA "R" name redacted) then told (R909 name redacted) that he did not do that ... "(CNA "R") then exits the room and reported the incident to the nurse ..." The facility report did not identify the person R909 reported the incident to on 8/2/21. Review of a facility "Witness Statement" conducted with CNA "R" documented in part, " ... I was doing my last walking rounds on my residents. When I enter [R909's] room, I observed that his brief was wet and needed to be change. I told [R090] that I was going to change his brief. During the brief change [R909] became combative, hitting, kicking, and using profanity. I			

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reached for his hands to stop him from hitting me and jump <sic> out the way. I told [R909] that I was only trying to change his brief. [R909] then stated, "Look what you did to my hand". I then stated, [R909] I did not do that. I then ask him would he like a bandage for his hand and to see the nurse. I then exit the room and reported the incident to the nurse ..."

On 11/3/21 at 9:18 AM, an attempt to conduct an interview with CNA "R" was made, however CNA "R" did not answer their phone and a return phone call was not made by the end of survey.

Review of a progress note dated 7/30/31 at 1:36 PM, documented in part " ... Resident has a skin tear on right hand. Wound Care nurse notified. Cleaned with normal saline. Xeroform and gauze applied." This note was written by LPN "S", the dayshift nurse assigned to R909 on 7/30/21.

On 11/3/21 at 9:24 AM, LPN "S" was interviewed via telephone. When asked how they were informed of the resident injury to their hand, LPN "S" stated in part, " ... I don't work the same shift as (CNA "R"), so it wasn't me that (CNA "R") reported it to ..."

Review of R909 Medication Administration Records (MARs) for July 2021 revealed LPN "T" was assigned to the resident at the time of the incident that occurred between CNA "R" and R909.

On 11/4/21 at 8:12 AM, LPN "T" was interviewed and asked about the incident involving CNA "R" and R909 on 7/30/21 and stated in part, " ... I recall (CNA "R") ... upon shift change telling me that (R909 name redacted) had a skin tear ... I don't recall being told the incident between the resident and CNA "R" ... (LPN "S" name redacted) said she would go in there ... Our

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	DON (Director of Nursing) was on her to get the incident report done ..." When asked, LPN "T" stated they were not questioned or interviewed by the DON or Administrator of the facility regarding the incident that occurred on 7/30/21 with CNA "R" and R909 prior to 11/3/21. LPN "T" was never interviewed by the abuse coordinator or designee during the investigation process (although LPN "S" was the assigned nurse to R909 when the incident occurred with CNA "R" on 7/30/21). Review of CNA "R" time sheets revealed CNA "R" worked their full shift on 7/30/21, 7/31/21 and 8/1/21. Although the allegation was made against CNA "R", the CNA was continued to work in facility as the investigation was completed. A facility policy titled "Abuse and Neglect" revised 6/17/19 documented in part, " ... If abuse/neglect is suspected the facility will ... Take immediate steps to assure the protection of the resident(s). This may involve separation from the alleged abuser and/or provision of medical care ... Conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses ... The abuse coordinator along with the interdisciplinary team will assess the next appropriate steps to assure resident safety and regulatory compliance ..." R909 expired in the facility on 8/11/21 and could not be interviewed by the State Agency. On 11/3/21 at 12:20 PM, the Administrator was asked why a thorough investigation was not completed and why CNA "R" remained working throughout the investigation and the Administrator offered no response.			

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F0677 SS= D	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 intakes #MI00120161, MI00119906 and MI00121284. Based on observation, interview and record review the facility failed to ensure regular bathing was provided per resident preference for one resident (R913) of three residents reviewed for activities of daily living. Findings include: On 11/2/21 at approximately at 11:31 a.m., R913 was observed in their room, laying in their bed. R913 was queried how the care in the facility was for them and the indicated they have been having issues receiving bathing. R913 indicated they have almost never received a shower and do not get regular bed baths. R913 indicated they were supposed to receive bathing twice a week, but they had not, and they cannot reach their legs to clean them. The medical record for R913 was reviewed and revealed the following: R913 was initially admitted to the facility on 2/4/2020 and had diagnoses including Morbid obesity and Lymphedema. R913's MDS (Minimum Data	F0677		

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	Set) with an ARD (Assessment Reference Date) of 9/28/21 revealed R913 needed extensive assistance from facility staff with most of their activities of daily living. R913's BIMS (brief interview of mental status) score was 15 indicating intact cognition. A review of R913's care plan revealed the following: "Focus-The resident has an ADL (activities of daily living) self-care performance deficit. contributing medical conditions include: lymphedema, morbid obesity, CKD (chronic kidney disease) stage 3...Interventions-BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse...BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated...Showering/Bathing per schedule or as needed..." A review of R913's CNA (Certified Nursing Assistant) bathing documentation for October 2021 in the electronic medical record revealed R13 was provided bathing on 10/7 and 10/11. Showers were not documented as being provided. Bed baths were provided on 10/7 and 10/11. A review of R913's paper bathing documentation provided by Unit Manager "B" (UM "B") for October 2021 revealed R913 had bathing sheets dated 10/4 and 10/8. The bathing sheet for 10/8 indicated R913 was provided a bed bath. The bathing sheet for 10/4 did not indicated what type of bathing			

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	was provided. On 11/4/21 at approximately 3:20 p.m., The Director of Nursing was queried regarding the lack of bathing being provided for R913 and the DON indicated that bathing should be provided twice a week. A facility document titled "POLICY: It is the policy of this facility to promote cleanliness, stimulate circulation and assist in relaxation...Dependent Residents: 1. Adjust water to a comfortable temperature before turning stream toward resident. 2, Protect hair with shower cap, or shampoo hair. 3.Wash resident's body (from top to bottom), giving special attention to skin folds and bony or reddened areas; also wash between and under toes. 4. Dry well. 5. Apply lotion, or other toiletries. 6. Assist resident to dress or protect well with bath blanket. Cover feet. 7. Thoroughly towel dry or blow dry hair.			
F0689 SS= D	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 Number(s): MI00120572.	F0689		

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	Based on observation, interview, and record review, the facility failed to ensure one (R912) of two residents reviewed for falls, had appropriate interventions in place to prevent falls. Findings include: A complaint was submitted to the State Agency that alleged the following: "On Saturday May 29, 2021, around the time from 3:15 pm-3:45 pm, I received a call from the nurse stating (R912) fell and she sent her to the hospital. The nurse (Registered Nurse - RN "D") told me that two aides, (Certified Nursing Assistant - CNA "P" and "F") found her on the floor...She said that there was a wedge on one side of her and a pillow on the other side. We came to the conclusion that when (R912) coughed she may have fell off the bed on to the floor, which I have always feared. (R912) has spasms when she coughs, or sneezes and the staff knows that....I also spoke to the DON (Director of Nursing) (Former DON "Q") that day and she apologized and said that she will be getting her a bigger bed. She also stated that the material of the mattress is slippery...The reason why (R912) fell out of the bed is because her bed is small. She doesn't have enough room for them to turn or reposition her. When they moved her to another room last September, the bed she had was broken. When they replaced it, it was a smaller bed. I spoke to (DON "Q"), and at that time she said she would try but it has to be a justification for why she needs a bigger bed or bariatric bed. The only way to justify it would be if she fell. I told her that I want to prevent that from happening. Now, nine months later she has fallen. I have always said that because of her condition, the aides and nurses should be checking in on her a lot more often to make sure she's ok. It only takes a moment for something to happen and I'm afraid for her because she is nonverbal and immobile. I have been on Zoom with her plenty times and had to call on another phone to get them to help her because she			

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	coughed herself to the edge...It's unfortunate that my sister had to fall in order for them to get another bed. It could've been fatal, but it wasn't. I hope there will be some changes from now on and this could help someone else in the facility that may be a fall risk..." On 11/3/21 at 10:37 AM, R912 was observed lying in a larger sized bariatric bed. R912 had a tracheostomy tube (a tube inserted into a surgically place hole in the windpipe to assist with breathing) and feeding tube, and a catheter. R912 did not respond when addressed. Review of R912's clinical record revealed R912 was admitted into the facility on 8/1/19 with diagnoses that included: chronic respiratory failure with hypoxia, dysphagia, aphasia, tracheostomy status, contractures, type 2 diabetes mellitus, seizures, and anemia. A Minimum Data Set (MDS) assessment dated 8/6/21 revealed R912 had severely impaired cognition and was totally dependent of staff for bed mobility and activities of daily living (ADLs). Review of incident and accident reports for R912 revealed the following: An incident report dated 5/29/21 that documented, "Resident was observed on floor laying on her right side with pillow positioned under her elbow (next to bed) at 3:15 pm by nursing assistant during round...Patient unable to give description...42 inch mattress with bolsters due to uncontrolled spasms during coughing..." On 11/3/21 at approximately 10:00 AM, RN "D" was interviewed via the telephone regarding R912's fall on 5/29/21. R912 reported she did not remember a lot of details because it was a long time ago, but R912 was found on the floor by the CNAs. When queried about how R912 fell, RN			

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	"D" stated, "We think because when she coughs her whole body spasms and moves around in the bed which caused her to fall out." RN "D" reported R912 has a bigger bed with bolsters to prevent her from falling out. RN "D" reported R912 had a standard sized bed at the time of the fall but could not remember if she had a larger bed before. On 11/3/21 at 11:30 AM, the DON was interviewed regarding any changes in beds R912 had prior to her fall on 5/29/21. The DON reported she would look into it, but she did not work in the facility at the time of the fall. On 11/3/21 at 11:54 AM, CNA "F" was interviewed about R912's fall on 5/29/21. CNA "F" reported it occurred after 3:00 PM when she did final rounds waiting for the next shift to arrive. CNA "F" reported that herself and CNA "P" did a bed check and when they got to R912's room she was on the floor. CNA "F" stated, "She has been known to spasm from coughing. Her whole body spasms." CNA "F" reported R912 had a standard bed at the time of the fall on 5/29/21 and it was at times difficult to position the resident in that size bed. R912 further reported that when R912 coughed, her legs would sometimes end up hanging over the edge of the bed. When queried about whether R912 ever had a larger bed, CNA "F" reported when R912 was in a different room she had a bigger bed and then was switched to a standard sized bed but was not sure why it was switched from the bigger bed. On 11/3/21 at 12:45 PM, and interview with Maintenance Assistant "E" was conducted. Maintenance Assistant "E" reported R912 was in a 42 inch bed when she was in room [room number redacted], then went to the hospital or had a room change and was placed in a 36 inch bed. Maintenance Assistant "E" reported DON			

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	"Q" said R912 did not need a 42 inch bed, but the CNAs were all in agreement that a bigger bed was needed for safety and ease of care. R912 was changed to a 42 inch bed after she fell on 5/29/21. On 11/4/21 at approximately 2:30 PM, the DON was interviewed. When queried about where it would be documented if R912 had a special sized bed in the past and if there would be a care plan or assessment, the DON reported she did not work in the facility at that time and none of the current nurse managers did either. The DON reported she could ask the Administrator. On 11/4/21 at approximately 2:40 PM, the Administrator was interviewed. When queried about where it would be documented if R912 had a special sized bed in the past and if it would be in a care plan or assessment, the Administrator reported he would not know, and the current DON and nurse managers did not work in the facility at that time. On 11/4/21 at approximately 3:00 PM, Maintenance Director "G" was interviewed. When queried about any knowledge of R912's use of different sized beds, Maintenance Director "G" reported he recalled R912 was in a 42 inch bed previously and then when her room was changed she was placed in a regular bed. Maintenance Director "G" stated, "Apparently she had strong coughing fits and fell out of bed and then required a 42 inch bed again."			
F0758 SS= D	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		

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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: This citation pertains to Intake #: MI00123402. Based on interview and record review the facility failed to document the indication for administration of a as needed Ativan order, implement non-pharmacological interventions, and provide documentation of the evaluation of			

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	the appropriateness of the Ativan order for one (R905) of four residents reviewed for medication administration. Findings include: A complaint submitted to the State Agency documented concerns that R905 received medications that they were not supposed to such as Ativan (Lorazepam), which caused the resident to be "incoherent" and unable to function. Review of the medical record revealed R905 was admitted into the facility on 9/22/21 with diagnoses that included endocarditis and heart failure. A Minimum Data Set (MDS) assessment dated 9/27/21 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition and required staff assistance for Activities of Daily Living (ADLs). Review of the Medication Administration Record (MAR) for September and October 2021 revealed a physician order for Lorazepam (Ativan) tablet 1 MG (milligram), give 1 tablet by mouth every 8 hours as needed for anxiety for 14 days. The Ativan was administered to the resident on 9/26, 9/28 and 10/3. Review of R905's medical record revealed no documentation of an anxiety diagnosis. Review of a "Social Services" noted dated 9/26/21 at 12:06 PM, documented the following in part, " ... Resident has no mood or behavior problems ..." Review of the progress notes failed to document the indication for administration of the as needed Ativan administered on 9/26 and 9/28. Further review of the progress notes revealed a "Nursing" note dated 10/3/31 at 4:40 PM, documented the following in part, " ... Pt. (patient) seems confused, family states pt. is confused. Spoke to			

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	MD (Medical Doctor) and reported anxiety. Pt given Ativan and effective, vitals and O2 (oxygen) stable ..." Confusion is not the indicated use for the Ativan administration. The documentation failed to note any non-pharmacological interventions attempted prior to the administration of the as needed Ativan. Review of a care plan titled "Resident uses anti-anxiety medications r/t (related to) Chronic breathing difficulties" initiated 10/1/21, was reviewed and documented no non-pharmacological interventions for staff to implement before administering the Ativan. Review of the "O2 Sats Summary & Respiration Summary" revealed no documentation of any abnormal oxygen saturation levels or respirations for R905. Review of a "Clinical Discharge Summary" from the hospital provided to the facility upon the admission of R905 documented in part, " ... Lorazepam (Ativan 1mg oral tablet) 0.5 tab (s) Oral 3 times a day as needed Anxiety. Refills 0 ..." The Ativan was initially ordered in the hospital and the resident admitted into the facility with the Ativan. The facility failed to review the need, indication for use, implement a care plan documenting non-pharmacological interventions prior to administration of the as needed Ativan and provide documentation of the prescribing practitioner evaluation of appropriateness of the Ativan medications. Review of the clinical record revealed no consultations with the facility's behavioral group, psychiatrist, or psychologist. On 11/2/21 at 4:09 PM, Social Services Technician (SST) "A" was interviewed and asked if the facility obtain consents for the			

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	administration of Ativan. SST "A" stated the facility does obtain consents for Ativan. SST "A" also stated that psych services are implemented as soon as possible for any resident on psychotropic medications. SST "A" was asked to provide the Ativan consent and psych consultation report for R905. SST "A" stated they would look into it, but also stated that the Social Worker (SW) who quit a week and a half prior to the survey was the SW that worked with this resident. SST "A" stated although the previous SW was no longer employed with the facility they would look into their files and see what they could find. At 4:48 PM, SST "A" returned and stated they could not find a consent or consultation report for R905. On 11/3/21 at 9:04 AM, the DON was interviewed and asked about the indication for administration of Ativan for R905, the non-pharmacological interventions that are supposed to be utilized before the administration of the Ativan, and the consent for the administration of Ativan. The DON reviewed the clinical record and acknowledged all concerns and stated in part, " ... confusion is not a reason to give the Ativan, it's for anxiety ..." Review of a facility policy titled "Psychoactive Drug Use" dated 7/11/18 documented in part, " ... To ensure that no drug is used in excessive dose, for an excessive duration, or without adequate monitoring, or without adequate indications for its use ... Psychoactive drugs will be used to enable the resident to attain or maintain his or her highest practicable level of functioning ... Psychoactive drugs will be considered only after alternative measures and/or consultation with appropriate health professionals has been made ... All residents and/or responsible parties will be asked to make an informed choice concerning the use of a psychoactive drug. In order for an informed choice to be made, potential negative outcomes (risks) and benefits of the drug use will			

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	be explained ... Each resident with a potential need for a psychoactive drug and/or currently receiving a psychoactive drug will be assessed upon admission and according to resident's condition ... Assessment will include the medical symptoms and specific conditions necessitating need for the drug, results of behavior monitoring and interventions ..."			
F0760 SS= D	Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: This citation pertains to MI00123402. Based on interview and record review the facility failed to prevent significant medication errors, when a blood pressure medication (Metoprolol Tartrate) was administered multiple times outside of the parameters given by the physician and a pain medication (Oxycodone) administered when the resident was not experiencing pain for one (R905) of four residents reviewed for medication administration. Findings include: A complaint submitted to the State Agency documented the concerns of the administration of Oxycodone and other noted medications, which caused the resident to be "incoherent" and unable to function. Review of the medical record revealed R905 was admitted into the facility on 9/22/21 with diagnoses that included endocarditis and heart failure. A Minimum Data Set (MDS) assessment dated 9/27/21 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition and required staff assistance for	F0760		

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	Activities of Daily Living (ADLs). Review of the Medication Administration Record (MARs) for September and October 2021 revealed the following: An order for Metoprolol Tartrate Tablet 50 MG (Milligram) Give 1 tablet by mouth every 12 hours for htn (hypertension- high blood pressure) hold if sbp (Systolic blood pressure) <110 hr (heart rate) <60. R905's blood pressure was documented as 107/66 on 9/24, as 108/61 on 9/25 and 109/68 on 10/5, all three blood pressures did not meet the criteria for administration as documented by the physician, however R905 received all three doses of Metoprolol Tartrate. Further review of the MAR's revealed an order for Oxycodone HCl Tablet 30 MG Give 1 tablet by mouth every 8 hours as needed for pain. On 9/26 the pain level for R905 was documented at a "0", however the as needed Oxycodone was administered to the resident. On 11/3/21 at 9:04 AM, the Director of Nursing (DON) was interviewed and asked about the administration of the Metoprolol that didn't meet criteria for administration and the Oxycodone administered with a pain level of zero. The DON reviewed the MARs and stated that neither medication should have been administered. On 11/4/21, Registered Nurse (RN) "C" (identified as the nurse that administered multiple Metoprolol doses that did not meet the indicated parameters) was interviewed and asked about the administration of Metoprolol outside of the indicated parameters. RN "C" reviewed the MAR and stated in part, " ... I'm not sure. I shouldn't have given it."			

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	Review of a facility policy titled "Administration of Drugs" dated 12/19/19, documented in part " ... It is the policy of this facility that medications shall be administered as prescribed by the attending physician ..."			
F0812 SS= E	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00121429 Based on observation, interview, and record review, the facility failed to ensure sanitary conditions in the kitchen, resulting in the increased potential for foodborne illnesses. This deficient practice had the potential to affect all residents in the facility that received food from the kitchen. Findings Include: A complaint submitted to the State Agency	F0812		

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	was reviewed and indicated the facility had spoiled and expired food in the kitchen. On 11/4/21 at approximately 12:27 p.m., during the tour of the kitchen with Food Service Director "L" (FSD "L"), the Reach in Refrigerator was observed to contain the following: 1. An opened and undated veggie burger. 2. An opened bag of cheese slices that was undated. 3. A bottle of Ketchup with used by date of 9/21. 4. A plastic container of gravy with a "used by" date of 10/31. A plastic container of evaporated milk with a "used by" date of 10/31 and plastic container of opened thousand island dressing with expiration date of 09/21. FSD "L" was queried regarding the observations made with them of the undated and expired food in the reach in refrigerator and they indicated that the kitchen staff are supposed to check it daily and that they are supposed to check it behind them. FSD "L" indicated that they would have to do an in-service with their staff to ensure appropriate labeling of foods and that foods past their "used by" date should be discarded. According to the 2013 FDA Food Code Section 3-501.17: "Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated,			

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	ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety."...3-501.18: "Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition: (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen;(2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is appropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17(A)..."			
F0880 SS= E	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	F0880		

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	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 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.			

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	§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: This citation pertains to intake #MI00121429 Based on observation, interview and record review, the facility failed to ensure infection control practices in accordance with the Centers for Disease Control (CDC) protocol were followed, in regard to the proper usage of Personal Protective Equipment (PPE) for residents requiring isolation, resulting in the increased potential for transmission of infection. Findings include: On 11/2/21 a complaint submitted to the State Agency was reviewed which indicated that facility staff were not following proper infection control practices. On 11/3/21 at approximately 1:39 p.m., Certified Nursing Assistant "M" (CNA "M") was observed to enter R917's room (a room on the transition unit that requires full personal protective equipment to be worn in the room including gloves, isolation gown and N95 mask) without out any PPE besides a surgical mask. R917's room was observed to have a bin containing personal protective equipment for use while in the room. A sign on R917's door was observed to indicate that the type of precautions needed to enter was "droplet" (A type of infection protocol that			

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includes wearing gloves, N95 mask, gown and either faceshield or goggles when entering the room). When CNA "M" came out of R917's room, they were queried regarding their lack off PPE. CNA "M" indicated they were bringing in food for R917 who was in the room and reported they do not usually work on the transition unit.

On 11/3/21 at approximately 1:43 p.m., Nurse "N" was observed entering R916's room (another room on the transition unit that requires full personal protective equipment to be worn in the room) without donning gloves, any eye protection or gown. When Nurse "N" came out of the room, they were queried why they did not put on any gloves, gown or eye protection when entering and they indicated that it must have "slipped their mind." Nurse "N" was queried regarding the requirements for using PPE in R916's room and they indicated they were supposed to put on gloves, gown and either goggles or a faceshield in addition to their mask when in the room.

On 11/3/21 at approximately 1:47 p.m., CNA "O" was observed to enter R916's room without putting on any eye protection, gown or gloves. CNA "O" was observed to walk up to the resident's bed and drop off clean linen then leave the room without washing their hands or using hand sanitizer. CNA "O" was queried regarding their lack of PPE use while in the room and indicated they only had to wear the gloves, gown and eye protection

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	when providing care to the resident. On 11/3/21 at approximately 2:02 p.m., CNA "O" was again observed to enter R916's room and bring them a drink. CNA "O" was observed to be only wearing an N95 mask. No eye protection, gown or gloves were observed to be applied before entering R916's room. Upon exiting the room, CNA "O" was observed to not use any hand sanitizer or wash their hands. On 11/3/21 at approximately 2:06 p.m., Nurse "N" was queried regarding their donning and doffing of their mask when working on both the transition unit and the general population unit that does not require droplet precaution PPE. Nurse "N" indicated they do not change their mask when working on both of the units. Nurse "N" was queried if they were providing care for residents residing on the transitional unit as well as the general unit and they indicated they were. Nurse "N" was queried if it was proper infection control procedure to wear the same mask while caring for both the residents on droplet precautions unit and the residents in the general population and they stated, "probably not." On 11/3/21 the medical record for R916 was reviewed and revealed a Physician's order dated 10/28/21 which indicated the following: "Resident is on droplet precautions every shift for COVID 19 observation monitoring for 14 Days.."			

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	On 11/4/21 at approximately 3:20 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding the observations of CNA's "O" and "M" and Nurse "N" entering the droplet precaution rooms without donning the appropriate PPE. The DON indicated that all staff must put on the required PPE which includes gloves, isolation gown, eye protection and an N95 mask prior to entering the rooms. A review of CDC guidance for PPE usage in Nursing Homes was reviewed and revealed the following: "Personal Protective Equipment-HCP (Healthcare Personnel) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face)..."			
F0883 SS= D	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 has already been immunized	F0883		

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	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 facility			

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	failed to consistently offer and administer the Pneumococcal and Influenza Immunizations to four (R's 918, 919, 920, & 921) of five residents reviewed for pneumococcal and influenza Immunizations. Findings include: Review of the clinical record, admission documentation, and Immunizations records for R's 918, 919, 920 & 921 revealed the following: R918 Signed a consent on 9/30/21 to receive the Influenza immunization further review of R918's medical record revealed the Influenza vaccination was never completed. R919 No documentation of the Pneumococcal vaccine offered. R920 No documentation of the Influenza vaccine offered. R921 No documentation of the Influenza vaccine offered. On 11/4/21 at 9 AM, the Director of Nursing (DON) was asked to provide documentation that R918 received the Influenza vaccine, R919 was offered the Pneumococcal vaccine and R920 and R921 were offered the Influenza vaccine. At 3:15 PM, the DON stated they were unable to provide documentation that R918 was given the Influenza vaccine and they could not provide informatoin indicating R919 was offered Pneumococcal vaccine and R's 920 and 921 were offered the Influenza vaccine. The DON stated the Infection Control nurse was responsible in ensuring all residents were offered the vaccinations, however the infection control nurse recently discontinued their employment with the facility. A facility policy titled "Immunizations-Influenza" dated 7/11/18 documented in part, " ...			

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	It is the policy of this facility that all residents, employees and volunteers who have direct contact with residents will be offered the influenza vaccine annually ... Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents ... 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 ... 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 ..." A facility policy titled "Immunizations-Pneumococcal" dated 7/11/18 documented in part, " ... It is the policy of this facility that all residents will be offered the pneumococcal vaccines to aid in preventing pneumonia ... Upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccines and when indicated, will be offered the vaccinations ... This information will be provided in the "Consent to Administered Pneumococcal Vaccine" ... A resident refusal of the vaccine shall be documented in the resident's medical record ..."			
F0886 SS= D	COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i)	F0886		

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	Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by:			

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Based on interview and record review the facility failed to conduct COVID-19 testing per current guidelines for three staff members- Certified Nursing Assistant (CNA) "U", Licensed Practical Nurse (LPN) "W", and Housekeeper "X" of five staff reviewed for COVID-19 testing. Findings include:

Review of the facility's staff vaccination status revealed CNA "U", LPN "W" and Housekeeper "X" as unvaccinated for COVID-19.

A Centers for Medicare & Medicaid Services (CMS) Memorandum- Ref: QSO-20-38-NH (revised 9/10/21) documented in part, " ... Routine testing of unvaccinated staff should be based on the extent of the virus in the community ... Facilities should use their community transmission level ... High (red) ... Minimum testing frequency of unvaccinated staff ... twice a week ..."

Review of Centers for Disease Control and Prevention (CDC) COVID Data Tracker, documented the "Community Transmission" as red (High) since September 2021.

Review of the facility's testing log revealed the following:

CNA "U" was tested on 9/22/21- negative and 10/5/21- positive.

Review of CNA "U" time sheet revealed that CNA "U" worked on September 2, 3, 4, 5, 6, 7, 9, 10, 14, 16, 17, 18, 19, 21. The facility tested CNA "U" one time in September despite working multiple days that month.

LPN "W" was not tested for the first two weeks of September.

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	Review of LPN "W" time sheet revealed LPN "W" worked on September 3, 5, 6, 7, 11 and 12th. Despite LPN "W" working in the facility for the first two weeks of September, LPN "W" first documented COVID-19 test date provided by the facility was 9/14/21. Housekeeper "X" had no documented COVID-19 tests completed for the month of September. Review of Housekeeper "X" timesheet revealed they worked in the facility on September 9, 10, 11, 12, 15, 16, 17, 20, 22, 23, 24, 25, 26, 27, 29 and 30th. On 11/4/21 at 3:45 PM, the Director of Nursing (DON) was asked about the COVID-19 testing that was not completed for CNA "U", LPN "W" and Housekeeper "X" according to CMS requirements and stated the Infection Control nurse had recently separated employment with the facility and they was trying their best to monitor it. The DON was then asked to provide all testing and test results for CNA "U", LPN "W" and Housekeeper "X" and no additional documentation was received by the end of survey.			
F0887 SS= E	COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives	F0887		

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	education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by:			

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	Based on interview and record review the facility failed to consistently provide education on the COVID-19 vaccination and offer the vaccine to R's 919, 920, 921 and 922 and staff members Certified Nursing Assistant (CNA) "U", CNA "V", Social Services Technician (SST) "A", Licensed Practical Nurse (LPN) "W" and Housekeeper "X". Findings include: Review of a Centers for Medicare & Medicaid Services (CMS) Memorandum Ref: QSO-21-19-NH dated 5/11/21 documented in part, " ... This includes new requirements for educating residents or resident representatives and staff regarding the benefits and potential side effects associated with the COVID-19 vaccine, and offering the vaccine ... health care personnel (HCP) and long-term care (LTC) facility residents be offered COVID-19 vaccination first ... Ensuring LTC residents receive COVID-19 vaccinations will help protect those who are most at risk of severe infection or death from COVID-19 ... Additionally, the facility must maintain appropriate documentation to reflect that the facility provided the required COVID-19 vaccine education, and whether the resident and staff member received the vaccine ..." Review of the admission documentation, immunizations, and medical record revealed no documentation of education, consents, or vaccination of COVID-19 for R's 919, 920, 921 and 922. On 11/4/21 at 9 AM, the Director of Nursing (DON) was asked to provide documentation that R's 919, 920, 921 and 922 received education on the COVID-19 vaccine and was offered the COVID-19 vaccine. At 3:15 PM, the DON stated they could not provide consents or documentation that the residents were offered the vaccination. The DON explained that up until a week prior,			

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	the Infection Control Nurse was responsible to ensure that this requirement was met, however the Infection Control Nurse was no longer employed by the facility. The DON stated they are trying their best to monitor the immunizations. On 11/4/21 at 12:36 PM, the DON was asked to provide documentation that staff employed by the facility, CNA "U", CNA "V", SST "A", LPN "W" and Housekeeper "X", received education on the COVID-19 vaccine and were offered the COVID-19 vaccine. On 11/4/21 at 3:47 PM, the DON returned and stated they were unable to provide documentation of the education, consents, or documentation that the COVID-19 vaccination was offered to the employees. A facility policy titled "Immunizations-COVID19 Vaccine" dated 5/21/21 documented in part, " ... It is the policy that all residents will be offered the COVID19 vaccines to aid in preventing COVID19 ... residents and staff members will be assessed for eligibility to receive the COVID19 vaccines ... will be offered the vaccinations, unless medically contraindicated or the resident has already been vaccinated ... the staff members, residents or responsible partied shall receive information and education regarding the benefits and potential side effects of the COVID19 vaccines ... The resident's medical record will include the following documentation ... That the resident/responsible party was provided education regarding the benefits and potential risks associated with the vaccine ... each dose of COVID19 vaccine administered ... If the vaccine was not received due to refusal or medical contraindications ... The facility will maintain documents related to staff members COVID19 vaccinations which includes ... That the staff member was provided education			

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	regarding the benefits and potential risks associated with the vaccine ... That they were offered the COVID19 vaccine or information on obtaining the COVID19 vaccine ..."			