STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824519	A. BUILDING _____ B. WING _____	2/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NSG & REHAB CANTON	7025 LILLEY ROAD CANTON, MI 48187

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Promedica of Canton was surveyed for a Recertification survey on 2/23/22. Intakes: MI00125611, MI00125731, MI00126122, MI00126181, MI00126182, MI00126519. Census = 103.	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of	F0550	F-550 Resident Rights/Exercise of Rights Element I: The facility identified resident #79 and provided psychosocial follow-up from the facility social worker who confirmed that he was being treated with dignity and did not feel he was inconveniencing staff by using his call light. No affect to mood or routine was noted. LPN “N” received 1:1 education regarding talking to/treatment of residents with dignity and respect. Speech Therapist “O” and CENA “E” were educated on abuse reporting. Resident #79 has successfully discharged home from the facility on 3/3/22. Element II: The facility identified like patients as interviewable residents residing at the facility. On 3/8/2022 a baseline audit was conducted by interviewing those residents for feelings of being treated with dignity and respect with no concerns expressed to ensure residents were able to exercise their rights and have a dignified existence. Element III: The QAPI Committee reviewed the Resident Rights document and found it to be appropriate. The administrator and department managers completed online education on resident rights, dignity and abuse reporting. The IDT educated their respective staff members on resident rights to include dignity and respect. Element IV: The social worker/designee will	3/23/2022

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

Electronically Signed | 03/07/2022

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

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	interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake number MI00012519. Based on observation, interview and record review the facility failed to ensure one sampled resident (R#79) was treated with dignity from a total sample of 21, resulting in feelings of inconveniencing staff when using call light for staff assistance. Findings include: Resident #79 During a tour of the first floor nursing unit on 2/16/22 at 12:34 PM, R79 was observed in bed with the call light hanging on the drawer of the dresser next to the bed. R79 anxiously reported a midnight female staff member, unknown, told him that he "uses the call light too much... she yelled at me...I only use it when I need to". R79 indicated he reported incident to Speech Therapist (ST) "O" and Certified Nurse Assistant (CNA) "E". Review of an "Admission Record" face sheet revealed R79 was admitted to the facility on 1/29/22, with pertinent diagnoses which included cerebral palsy (incurable abnormal movement of muscles due to abnormal brain development),		audit 5 random patients weekly, times four weeks, to ensure residents are being treated with dignity and respect. Findings will be reviewed by the administrator who will submit to the QAPI committee for further review and recommendations. Element V: The administrator will be responsible for achieving and sustaining compliance. The compliance date is: 3/23/2022	

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cardiac disease, gastritis and high blood pressure.

Review of an admission "Minimum Data Set" (MDS) assessment for R79, with a reference dated of 2/2/22, revealed a "Brief Interview for Mental Status" (BIMS) score of 12, out of a total possible score of 15, which indicated moderately impaired cognition. The MDS indicated the resident required extensive, one person assistance with all activities of daily living (ADL's).

Review of the care plan "falls" dated 1/30/22 had an intervention to "Assist with activities as needed".

Review of the care plan "Cognitive loss as evidenced by BIMS Score of 12" dated 1/31/2022 had interventions of "Allow adequate time to respond. Do not rush or supply words; Approach/speak in a calm, positive/reassuring manner; Explain each activity/ care procedure prior to beginning it; Explain each activity/ care procedure prior to beginning it".

Review of the care plan "Difficulty communicating related to slight speech impairment, difficulty expressing words at times" dated 2/4/2022 had an intervention to "Gain individual's attention before beginning to converse".

During an interview with ST "O" on 2/16/22 at 3:30 PM, she reported visiting with R79 around 8:45 AM (morning of incident). ST "O" reported R79 "mentioned" an incident about the call light. "He said a staff member told him he pushes (the call light) to often...staff tells him he uses the call light too much." ST "O" denied reporting the incident to anyone saying, "I should have reported it."

During an interview with Administrator "A" (who

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is also the abuse coordinator) on 2/16/22 at 3:42 PM, he reported "No that (call light incident with R79) was not reported to me".

During an interview with CNA "E" on 2/17/22 at 1:30 PM, she reported R79 told her that "someone" from midnight shift (2/15/22 into 2/16/22) told R79, "Your on the call light too much." CNA "E" reported R79 "seemed sad" when reporting incident. CNA "E" reported she did not report incident to anyone saying "I didn't know I needed to."

During an interview with the Director of Nursing (DON "B") on 2/18/22 at 11:13 AM, she indicated that on 2/16/22 at 5:48 PM the facility reported the incident (to the State Agency) and are currently doing an investigation. The DON reported the LPN "N" was the staff member involved in the incident.

During a phone interview on 2/18/22 at 12:51 PM, LPN "N" reported she was in the hallway around 7 am (on 2/16/22) and R79 had the call light on "several times." LPN "N" reported 1-2 times R79 was asking for a pain pill and one time was putting on the call light for his roommate (total of 3 times).

LPN "N" reported she told R79 "he can tell me everything he needs in one visit." LPN "N" reported she was familiar with R79 she had "taken care of him before...I cannot remember any other time (when the resident frequently used the call light)".

During an interview with Administrator "A" on 2/23/22 at 11:48 AM, he reported, "We were able to substantiate the allegation, but it was not the intention of the message, it was how it was said".

Review of a facility provided document titled

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	"Resident Rights" dated 11/28/16 documented, "4. Respect and dignity-The resident has the right to be treated with respect and dignity...".			
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: Based on observation, interview and record review, the facility failed to provide timely incontinence care and provide showers for two resident (Resident #22, #36) of eight residents reviewed for Activities of Daily Living (ADL), resulting in the potential for skin breakdown and infection. Findings include: Resident #22 Review of an Admission Record revealed, Resident #22 admitted to the facility with pertinent diagnosis which included Vascular Dementia and Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side (weakness and paralysis). Review of a "Minimum Data Set" (MDS) assessment, with a reference date of 12/29/21 revealed Resident #22 had severe cognitive impairment and required extensive assistance of one with toileting. In an observation on 2/16/22 at 9:55 a.m., Resident #22's brief was heavily soiled indicated by dark blue lines in the middle of the brief. Certified Nursing Assistant (CNA) "D"	F0677	F-677 ADL Care Provided for Dependent Residents Element I: The facility identified resident #22 and provided incontinent care at the time of observation. CNA I received 1:1 education regarding providing timely incontinence care. Patient #22 continues to reside at the center and is in no distress. Resident #36 was identified offered a shower and refused. A bed bath was given on 2/25/22. Resident #36 continues to reside at the center and is in no distress. Element II: Like residents were identified as residents that are incontinent and who require assistance with showering or bathing. The facility conducted a baseline audit on patients shower tasks to ensure they matched the patients scheduled shower day, updates were made as needed. Interviewable residents were interviewed for receiving desired showers/baths with no issues identified. Non-interviewable residents were observed for the provision of routine baths/showers. No issues were identified. A baseline audit on incontinent residents was completed for provision of timely incontinence care as indicated with no issues identified. Element III: The QAPI Committee reviewed the facility incontinence care and bathing policies and found to be appropriate. The DON/Designee provided education to nursing staff CENA's on providing timely incontinence care and showers as scheduled. Element IV: The DON/Designee will complete 3 random weekly audits, times 4 weeks, of incontinence care and provision of showers to ensure ADL care is delivered as indicated/scheduled. The administrator will	3/23/2022

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	performed incontinent care on Resident #22. In an observation and interview on 2/17/22 at 1:22 p.m., CNA "H" removed Resident #22's blankets to perform a bed bath. Resident #22's brief was heavily soiled indicated by dark blue lines in the middle of the brief. CNA "H" reported she is in the facility twice a week to perform care on Resident #22. CNA "H" then reported Resident #22 is "always" soiled when she comes. In an interview on 2/18/22 at 10:39 a.m., CNA "D" reported residents are checked and changed every two hours. CNA "D" then reported residents that are incontinent more frequently are checked every hour. In an interview on 2/18/22 at 1:49 p.m., Director of Nursing (DON) "B" reported residents should be checked and changed every two hours. DON "B" reported a dark blue line indicates there is moisture in the brief. Resident #36 Review of an Admission Record revealed, Resident #36 admitted to the facility with pertinent diagnosis which included Schizoaffective Disorder and Major Depressive Disorder. Review of a "Minimum Data Set" (MDS) assessment, with a reference date of 1/10/22 revealed Resident #36 had no cognitive impairment with a "Brief interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15. Resident #22 required total dependence of one staff with bathing. In an interview on 2/16/22 at 9:51 a.m., Resident #36 reported they get one bed bath a week. Resident #36 then reported they would like to get		review findings and submit to the QAPI Committee for further review and recommendation. Element V: The administrator will be responsible for achieving and sustaining compliance. The compliance date is: 3/23/2022	

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	in the shower "every once in a while." Review of a "Documentation Survey Report" for the last 60 days revealed, Resident #36 had scheduled showers on Tuesday and Friday on the day shift. Resident #36 had documented showers on 1/25, 2/4, 2/8, and 2/11/22. There were no documented showers on 1/28, 2/1, 2/15, 2/18, or 2/22/22. In an interview on 2/23/22 at 11:22 a.m., Resident #36 reported not receiving a shower yesterday (2/22/22). Resident #36 stated, "No", regarding if a shower or bed bath was offered. In an interview on 2/23/22 at 11:27 a.m., CNA "D" reported residents receive a shower or bed bath twice a week. Review of Daily Assignment Sheet with a date of 2/22/22 for day shift revealed, Resident #36 had a scheduled shower. In an interview on 2/23/22 at 12:49 p.m., DON "B" reported residents are scheduled two showers per week. DON "B" then reported showers are documented on the shower sheet and in the electronic medical record. DON "B" confirmed Resident # 36 did not receive a shower twice a week for the last 60 days. Review of "Skin Worksheets" revealed, in the last for 60 days Resident # 36 received a shower on 12/28/21, 1/7, 1/18, 1/25, 2/4, 2/8, and 2/11/22.			
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	F0689	F-689 Free of Accident Hazards/Supervision/Devices Element I: Resident #15 was identified and medications were removed from bedside at the time of observation. Patient #15 continues to reside at the center and is in no distress.	3/23/2022

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	receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure medications were safely secured for one resident (Resident #15) out of a total sample of 21 residents, resulting in the potential for accidental ingestion of medication, improper administration, and infection control concerns. Findings include: In an observation on 2/16/22 at 9:28 a.m., a tray with medications sat on Resident #15's dresser. The medication included Fluticasone (nasal spray), two bottles of Timolol Maleate (eye drops), two bottles of Brimonidine Tartrate (eye drops), and unknown cream in a med cup. In an interview on 2/16/22 9:30 a.m., Licensed Practical Nurse (LPN) "I" reported medications are not normally left in a resident's room. LPN "I" then reported the medications were "just brought" in the room to give to Resident #15, but resident was eating breakfast. LPN "I" then reported the cream was left in the room last night. In an interview on 2/17/22 at 1:19 p.m., LPN "J" reported medications should not be left at the bedside unless there is a Physicians order. Review of an Admission Record revealed, Resident #15 admitted to the facility with pertinent diagnosis which included Acute Angle Closure Glaucoma (rapid increase of pressure in eye). Review of a "Minimum Data Set" (MDS)		Nurse received 1:1 education regarding Medication Administration including not leaving medications unattended at beside when patient unavailable for administration. Element II: Like patients were identified as those receiving medications while at the facility. Initial sweep was conducted on 3/1/2022 to ensure that no meds were found bedside with no findings to report. There are currently no patients with self-administration of medication orders. Element III: The QAPI Committee reviewed the Medication Administration procedure which includes disposition/safely securing medications when resident unavailable for administration and found it to be appropriate. The DON/designee educated licensed nurses on the Medication Storage Policy: Medication Pass to ensure medications are stored securely. Element IV: The DON/Designee will complete 3 random medication storage/self-administration audits weekly, times 4 weeks, to ensure medications are stored securely. The administrator will review findings and submit to the QAPI Committee for further review and recommendation. Element V: The administrator will be responsible for achieving and sustaining compliance. The compliance date is: 3/23/2022.	

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	assessment, with a reference date of 12/17/21 revealed Resident #15 had cognitive impairment with a "Brief interview for Mental Status" (BIMS) score of 3, out of a total possible score of 15. Review of Physician Orders revealed, Resident #15 did not have a self-administration of medication order. Resident #15 had medication orders which included, "Timolol Maleate Solution 0.5 % Instill 1 drop in both eyes every morning and at bedtime for glaucoma" with an order date of 11/22/17. "Brimonidine Tartrate Solution 0.2 % Instill 1 drop in both eyes every morning and at bedtime for glaucoma" with an order date of 11/22/17. "Fluticasone Prop 50 mcg spray 1 spray in both nostrils one time a day for allergy relief" with an order date of 4/19/19. In an interview on 2/18/22 at 11:00 a.m., Director of Nursing (DON) "B" reported Resident #15 does not have a medication self-administration assessment form. In an interview on 2/18/22 at 1:52 p.m., DON "B" reported medication should not be left at the bedside unless there is an order. Review of an "Medication Administration: Self-Administration of Medications" policy with a updated date of 03/2018 revealed, " ...Medication Storage and Security: Medications and biologicals are securely stored in a locked cabinet, cart, or medication room, accessible to only licensed nursing staff and pharmacist or authorized pharmacy staff, and maintained under a lock system when not actively utilized and attended to by nursing staff for medication administration, receipting, or disposal ..."			
F0760 SS= D	Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)	F0760	F-760 Residents are Free of Significant Med Errors	3/23/2022

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	(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to correctly administer physician's ordered insulin for one sampled resident (R#6) of 6 residents reviewed during medication pass resulting in the potential for a sub therapeutic amount of insulin. Findings include: FACILITY Medication Administration During an observation on 2/23/22 at 10:48 AM, a Novolog (rapid acting) insulin Flexpen was prepared by LPN "J" for administration to R6. Review of a Physician order dated 10/20/20: "NovoLOG FlexPen Solution Pen-injector 100 UNIT/ML (Insulin Aspart). Inject subcutaneously before meals and at bedtime for Diabetes Mellitus (DM-high blood sugar) Inject as per sliding scale: (R6's Random Blood Sugar= RBS-298); 251 - 300 = 4 units". LPN "J" dialed the flex pen to the order amount of insulin (4 units) with out first priming the pen with 2 units of insulin. LPN "J" injected the Novolog insulin into R6's left upper arm. LPN "J" inserted the needle, pressed and held the dose button until the dose counter reached "0" then removed the needle, without slowly counting to 6 to ensure complete dosing.		Element I: Resident #6 was identified and evaluated by her attending physician who determined there was no ill effect resulting from the med error. Resident #6 continues to reside at the center and is in no distress. LPN J was provided a one-to-one education on the proper insulin administration from an insulin pen injector, reverse demonstration observed. Element II: Like patients are identified are identified as residents who receive insulin via pen injectors. Initial sweep was conducted on 3/1/22 to establish patients that receive insulin via pen injectors. Each patient identified as receiving insulin via pen injectors were evaluated for potential subtherapeutic insulin dosage coverage by their attending physician with no findings to report. Nurses are to be educated and a skills validation completed to verify accurate administration techniques performed for administration of insulin via pen injectors. Element III: The QAPI Committee reviewed the Medication Administration: Injections procedure which includes administration of Insulin via Insulin Pens and found it to be appropriate. The DON/Designee educated licensed nurses on the Medication Administration: Injections Procedure - to include insulin pen injectors per manufacturer guidelines. Element IV: The DON/Designee will complete random weekly audits 3 times per week, times four weeks to verify insulin via injector pens is administrated appropriately. The administrator will review findings and submit to the QAPI Committee for further review and recommendation. Element V: The administrator will be responsible for achieving and sustaining compliance. The compliance date is: 3/23/2022.	

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	At 11:15 AM, LPN "J" was queried about the insulin administration and said, "No we don't have to prime prior to administering insulin." Review of an "Admission Record" face sheet revealed R6 was admitted to the facility on 5/12/20, with pertinent diagnoses which included Type 2 Diabetes Mellitus (high blood sugars). Review of the quarterly "Minimum Data Set" (MDS) assessment for R6, with a reference dated of 2/17/22, revealed a "Brief Interview for Mental Status" (BIMS) score of 0, out of a total possible score of 15, which indicated severely impaired cognition. Review of a "DIABETES" care plan dated 5/13/20 documented an intervention of, " Administer medication per physician orders". During an interview on 2/23/22 at 1:54 PM, during in interview with the facility's Director of Nursing (DON) she said that she was aware of Nurse "J" not priming the insulin pen and was providing 1:1 inservice for Nurse "J" and inservicing the rest of the nursing staff. Review of the 2019 manufactures guidelines documented, "...Prime your pen..Turn the dose selector to select 2 units. Press and hold the dose button. Make sure a drop appears...Please note that if the needle is removed before the 6 second count is completed after the dose counter returns to "0", then under dosing may occur by as much as 20%, resulting in the need for increasing the frequency of checking blood sugar and possible additional insulin administration". Review of the facility's undated policy titled "Using your Flexpen " documented, "Get your pen ready to use:			

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	824519	A. BUILDING _____ B. WING _____	2/23/2022

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	1. Wash and dry your hands well. 2. Remove the pen cap.... 4. Wipe the rubber end of the pen with an alcohol swab. 5. Remove the seal from the new pen needle and screw it onto the end of the pen. 6. Remove the outer needle cap and set it aside. Remove the inner needle cap and throw it away. 7. Turn the knob on the pen to a dose of 2 units".			
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: **Based on observation, interview and record review, the facility failed to properly thaw food products, resulting in an increased risk for food borne illness that had the potential to**	F0812	F-812 Food Procurement, Store/Prepare/Serve-Sanitary Element I: The thawing roast beef was found to be still frozen and placed in a bowl under the water faucet with water running over the meat upon observation. DM K was provided a one-to-one education on the Thawing Foods policy. Element II: The facility identified patients that consume solid food from the facility kitchen as potentially affected residents. Element III: The QAPI Committee reviewed the Thawing Food policy and found it to be appropriate. The CDM/Designee educated the dietary staff on the Thawing Food Policy to ensure that frozen foods are properly thawed to ensure prepared food is safe for consumption. Element IV: The CDM/Designee will complete random weekly audits, times four weeks, to ensure that frozen food is properly thawed. The administrator will review findings and submit to the QAPI Committee for further review and recommendation. Element V: The administrator will be responsible for achieving and sustaining	3/23/2022

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	affect 99 of 103 resident's that ate meals from the kitchen. **Findings include:** During an initial tour of the kitchen on 2/16/22 at 8:37 AM with Dietary Manger (DM) "K" , it was observed that six partially thawed 5# (pound) roast beef packages were sitting in a compartment of the sink. DM "K" reported that the roast beef was "thawing" (at room temperature) for lunch the following day. DM "K" said, "It (the roast beef packages) should be thawing under cold running water" as she turned on the cold water so that it was running onto the roast beef in the sink. According to the 2013 FDA food code section 3-501.13 Thawing. Except as specified in (D) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be thawed: "(A) Under refrigeration that maintains the FOOD temperature at 5oC (41oF) or less; or (B) Completely submerged under running water; (1) At a water temperature of 21oC (70oF) or below, (2) With sufficient water velocity to agitate and float off loose particles in an overflow, and (3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise above 5oC (41oF)". Review of the facility's "Thawing Foods" policy dated 11/20 documented, "1. Foods are removed from the freezer and placed in the refrigerator for defrosting...8. While it is not recommended, foods can be defrosted fully submerged under running water at 70oF or lower. The force of the water needs to be great enough to wash any loose food particles in to an overflow drain. Ready-to-eat foods should not exceed 41oF during the thawing process...".		compliance. The compliance date is: 3/23/2022.	
F0842	Resident Records - Identifiable Information	F0842	F 842 Resident Records	3/23/2022

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SS= D	§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a		Element I: Resident # 198 no longer resides at the center. Nurses will be educated on the elements of a completed discharge progress note. Resident # 60 continues to reside at the center. A documented shower/bath was provided. Hospice CNAs will be educated to document ADL care provided to residents in the clinical record. Element II: Residents discharging from services/center and residents receiving Hospice Care for ADLs could be affected in a similar manner. Residents discharging from center/services will have progress note describing reason for discharge, contributing conditions and disposition completed. Residents receiving Hospice Care will have documentation available in the medical record (either electronic or paper copy) of care provided. Element III: DON/Designee will educate Nurses and Director of Rehab Services will educate Therapy Staff re: required discharge documentation. UM/Designee will educate Hospice CNAs document ADL care services provided. QAPI committee reviewed the Discharge Documentation expectations from the Medical Record Manual and Bathing procedure regarding documentation expectations and found them to be appropriate. Element IV: DON/Designee will audit Discharge records for completion of discharge progress notes and Hospice records for documentation of ADL care 3 times/week X 4 weeks. The administrator will review findings and submit to the QAPI Committee for further review and recommendation. Element V: The administrator will be responsible for achieving and sustaining compliance. The compliance date is: 3/23/2022.	

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	resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to maintain complete and accurate records for two of 21 sampled residents (R198, R60) , resulting in the potential for miscoordination of care and incomplete medical records. Findings include: Resident 198: A review of R198's EHR (Electronic Health Record) revealed the resident admitted to the facility on 12/14/21 at approximately 6:00 PM for rehabiliation after a laminectomy (surgical procedure of the spine) and was out of the facility by 12/16/21 at 9:35 AM. A progress note on 12/16/21 at 9:35 AM written by Physical Therapy reads as follows; "The resident is no longer in the facility." There is no additional documentation to indicate why R198 is no longer in the facility, or where she was discharged to. On 12/16/21 the physician			

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	wrote an order for R198 to go on a LOA (leave of absence) with family members. On 2/17/22 at 1:15 PM, Administrator "A" was interviewed regarding R198's EHR and confirmed there was no documentation to indicate the reason or type for discharge of R198. Admininistrator "A"said R198 insisted on going to the hospital for pain management because a nurse had pulled on her right leg too hard. R198 called '911' herself because the physician did not agree to transfer her to the hospital. The physician wrote an order for "LOA with family." An investigation was initiated immediately and the incident was reported to the State Agency. Administrator "A" confirmed that no documentation was in the EHR. A review of the 'investigation file' for R198 revealed details of the discharge but were not included in EHR. According to the facility's policy for "Requirements and Guidelines for Clinical Record Content" dated 1/31/2017; Progress notes are electronically documented in the EHR to reflect the patient's condition, significant care issues, response to treatment and changes in condition and treatment. Final Progress Notes: For each discharged patient, a final progress notes is entered into the EHR by each discipline at the time of the discharge or discontinuation of therapy. The final progress notes acknowledges the			

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patient's discharge and documents the progress, or lack of progress made by the patient since the previous comprehensive progress notes.

Resident #60

Review of an Admission Record revealed, Resident #60 admitted to the facility with pertinent diagnosis which included Dementia and Senile Degeneration of Brain (mental decline).

Review of a "Minimum Data Set" (MDS) assessment, with a reference date of 1/21/22 revealed Resident #60 had cognitive impairment with a "Brief interview for Mental Status" (BIMS) score of 3, out of a total possible score of 15. Resident #60 required extensive assistance of two staff with ADL (Activities of Daily Living) care.

Review of a "Documentation Survey Report" revealed Resident #60 had scheduled showers on Tuesday and Friday evenings. Resident #60 had a one documented shower on 1/25/22 in the last 60 days. Resident #60 refused the shower on 1/4/22 and 1/28/22. There were no other showers documented for January or February 2022.

In an interview on 2/23/22 at 11:32 a.m., Certified Nursing Assistant (CNA) "E" reported hospice completed Resident #60's weekly showers. CNA "E" then reported documentation for showers are completed on a shower sheet.

In an interview on 2/23/22 at 12:49 p.m., Director of Nursing (DON) "B" confirmed Resident # 60's shower documentation revealed showers were not given twice a week for the last 60 days.

Review of "Skin Worksheets" revealed, in the last

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	for 60 days Resident # 60 received or refused a shower on 12/21/21, 12/28/21, 1/5/22, 1/14/22, and 1/25/22 . In an interview on 2/23/22 at 1:04 p.m., DON "B" reported hospice provides showers for Resident #60. DON "B" then reported she had to "figure out" where hospice documented showers for Resident #60. In an interview 2/23/22 1:58 p.m., DON "B" provided documentation from hospice which revealed Resident #60 received scheduled showers in the past 60 days. DON "B" then reported the documentation for Resident #60's showers were not in the EHR (Electronic Health Record) or hard chart. According to the facility's policy for "Requirements and Guidelines for Clinical Record Content" dated 1/31/2017; Progress notes are electronically documented in the EHR to reflect the patient's condition, significant care issues, response to treatment and changes in condition and treatment. Final Progress Notes: For each discharged patient, a final progress notes is entered into the EHR by each discipline at the time of the discharge or discontinuation of therapy. The final progress notes acknowledges the patient's discharge and documents the progress, or lack of progress made by the patient since the previous comprehensive progress notes.			