STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414290	A. BUILDING _____ B. WING _____	**5/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0000 SS=	INITIAL COMMENTS SKLD Beltline was surveyed for an Abbreviated survey from 5/11/22-5/13/22. Intakes: MI00127136, MI00127840, MI00128206, MI00128210, MI00128321, & MI00128407. Census: 116	F0000		
F0561 SS= D	Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00128321.	F0561		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Based on observation, interview and record review the facility failed to allow the right to leave the facility for 1 resident (Resident #103) of 4 residents reviewed for self determination, resulting in Resident #103 not being allowed to leave the facility and feelings of anger and resentment.

Findings include:

Review of an "Admission Record" revealed Resident #103 was originally admitted to the facility on 2/12/21, with pertinent diagnoses which included: acquired absence of left leg (amputation). Resident #103 was her own responsible party.

Review of a "Minimum Data Set" (MDS) assessment for Resident #103, with a reference date of 3/30/22 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #103 was cognitively intact. Review of the "Functional Status" revealed that Resident #103 was independent in locomotion on and off the unit.

Review of Resident #103's "Care Plan" revealed, "Resident is independent for meeting emotional, intellectual, physical, and social needs r/t (related to) Able to make independent choices and preferences known, Prefers independent activities such as reading, word puzzles, t.v., being with family/friends, music, using computer. Date Initiated: 04/13/22 Created on: 02/18/21. INTERVENTIONS:...Provide with activities calendar, offer social visits, encourage participation in room to room activities and provide leisure supplies as needed/requested. Date Initiated: 02/18/21..."

Review of Resident #103's "Care Plan" revealed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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"Resident has the functional ability to be at risk for elopement r/t history of noncompliance to smoking policy, anxiety, depression, ability to ambulate and self propel in w/c (wheelchair)...Date Initiated: 03/03/22. GOALS: Resident will not leave facility unattended through the review date. Date Initiated: 03/03/22..."

During an interview on 5/11/22 at 4:09 P.M., Resident #103 reported that the facility refused to allow her to leave the facility on her own. Resident #103 reported that she was young, of sound mind and did not have a lot to look forward to in life, considering her family history of disease and death at a young age. Resident #103 reported that the only thing she looked forward to was leaving the facility to smoke cigarettes and stated, "...they took that away from me because I came back intoxicated...and they were worried about me..." Resident #103 expressed frustration with the facility and multiple staff members and stated, "...if they would let me go out I would have no problem with them...that's all I want...I don't bother anyone..."

Review of Resident #103's "Physician Orders", no orders for leaving the facility were found.

During an interview on 5/12/22 at 10:05 A.M., "Nursing Home Administrator in Training" (NHA-T) "C" reported that Resident #103 abused her order for LOA (leave of absence), therefore the facility took the privilege away. NHA-T "C" reported that Resident #103 would leave the facility to smoke, but then return intoxicated. NHA-T "C" reported that Resident #103's physician order is not in the computer anymore because it was discontinued.

During an interview on 5/13/22 at 4:56 P.M., NHA-T "C" reported that Resident #103 was her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414290	A. BUILDING _____ B. WING _____	**5/13/2022**

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	own responsible party and did not have a guardian. Review of Resident #103's "General Progress Note" dated 5/1/22 19:06 (7:06 P.M.) revealed, "Resident returned from LOA approx 1845 (6:45 P.M.), resident smelled of alcohol and was slurring words. Spoke with resident in depth in regards to possible interactions with medications, adverse side effects of alcohol. Resident stated, "I'm going to die anyway, why does it matter anymore." Resident tearful throughout conversation..." Review of Resident #103's "Physician Progress Note" dated 5/2/22 revealed, "...Advise suspension of LOA as she has an increase in health and safety concerns and instances of poor judgement r/t alcohol and marijuana use..." Review of Resident #103's "Social Services Note" dated 5/3/22 at 15:45 (3:45 P.M.) revealed, "Supportive visit with (Resident #103), DON and Administrator in training present. Educated (Resident #103) her LOA has been revoked by the physician. (Resident #103) was upset and stated "I'm going to smoke no matter what"..." Review of Resident #103's "Medical Practitioner Progress Note" dated 5/4/22 revealed, "She is seen today after CT (can scan) abdomen and pelvis results reviewed...mass on liver seen on abdominal ultrasound and concern for pancreatic cancer based on family history...Also had a lengthy conversation regarding the recent loss of LOA privilege...She is very upset and emotional, but is willing to have a productive conversation..." Review of Resident #103's "Medical Practitioner Progress Note" dated 5/5/22 at 9:17 A.M. revealed, "LOA privilege revoked per physician			

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order on 5/3/22, as patient has risked her health and safety by leaving the premises for long periods of time and returning intoxicated twice since 4/23/22. Alcohol found in her possessions and she admits to marijuana use. Substance use and altered mental state resulted in a fall on 4/30/22. History of alcohol abuse noted. Patient informed of change in LOA status, upset that she is unable to smoke even though she is aware of the facility's non-smoking policy.." There was no indication that Resident #103 was smoking on facility premises only that she would leave the facility to smoke.

Review of the Progress Notes dated 4/30/22 at 6:40 am. revealed at the time of the fall, Resident #103's neurological exam and vital signs were within normal limits.

Review of a facility policy "Resident Rights" dated 7/11/18 revealed, "It is the policy of this facility that all resident rights be followed per state and federal guidelines as well as other regulative agencies. The Resident has the right: 1. To be treated with consideration, respect, and full recognition of his or her dignity and individuality...4. To participate in social, religious and community activities that do not interfere with the right of other resident's in the Nursing Center. 5. To be encouraged and assisted throughout his or her stay in the Center to exercise these Resident Rights as well as those which residents are entitled as a U.S. citizen....11...unless adjudicated incompetent or otherwise found incapacitated under state law, participate in planning medical treatment..."

Review of the facility Leave of Absence (LOA) Procedure (no date), "Any resident who expresses the desire to exit the Facility, whether for extended periods or for brief interludes on facility grounds, must have physician authorization to do

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	414290	A. BUILDING _____ B. WING _____	5/13/2022

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	so in the form of a leave of absence (LOA) order that specifies any restrictions/limitations to the leave." The policy does not address what is to occur for a resident who is their own responsible party and would have the ability and authority to exercise their rights as a U.S citizen.			
F0684 SS= G	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00128407. Based on interview and record review, the facility failed to perform post fall assessments according to professional standards for 1 resident (Resident #104) of 4 residents reviewed for quality of care, resulting in a delay in treatment of a serious injury (leg/foot fractures), and ongoing pain and suffering. Findings include: Resident #104 Review of an "Admission Record" revealed Resident #104 was originally admitted to the facility on 4/22/22, with pertinent diagnoses which included: COPD (chronic obstructive pulmonary disease) and unsteadiness on feet.	F0684		

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	Review of a "Minimum Data Set" (MDS) assessment for Resident #104, with a reference date of 4/25/22 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #104 was cognitively intact. Review of the "Functional Status" revealed that Resident #104 was totally dependent requiring 2 person physical assistance during transfers (how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position). During an interview on 5/11/22 at 2:24 P.M., Resident #104 reported that he had fallen on 5/3/22 during a therapy session, and sustained multiple fractures to his right leg. Resident #104 reported that he had heard a loud ripping noise when he fell, followed by feeling severe pain in his legs and stated, "...they used the hoyer to get me up...I screamed in pain...they put me to bed and gave me Norco (pain medication)...I think I was in shock...I should have gone to ER (emergency room)..." Resident #104 reported that staff did not ask him about where his pain was, or assess his legs for pain and/or ROM (range of motion). Resident #104 reported that the next day 5/4/22, the therapist found swelling in his right leg, and therefore the doctor ordered an x-ray. Resident #104 reported that the x-ray did not show any fractures. Resident #104 reported that the facility wanted to restart physical therapy on 5/5/22, but he refused due to the excruciating pain in his right leg, and then he requested to be sent to the hospital for further evaluation. Review of Resident #104's "Hospital Records" from Emergency Department visit on 5/5/22 at 11:20 A.M. through discharge on 5/5/22 at 9:50 P.M. revealed, "...Chief Complaint: LEG PAIN Right leg swelling and pain...Leg feels warm...Physical Exam:...Musculoskeletal:...There is tenderness at the right knee, right ankle, and right foot. There is also mild tenderness at the			

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	414290	A. BUILDING _____ B. WING _____	**5/13/2022**

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	anterior aspect of the left knee and left ankle. There is edema of the right knee when compared to the left. There is ecchymosis (bruise) in the plantar (bottom) aspect of the right foot...complaining of right leg pain since a fall couple of days ago. He does appear uncomfortable on initial examination and has tenderness primarily in the knee and the ankle. X-rays apparently had been performed at the rehabilitation facility but then not able to access these...I did order a CT (CAT Scan: images) of the patient's right lower extremity to evaluate for hemarthrosis (bleeding in joint spaces) or large hematoma (collection of blood under the skin due to trauma). This showed: 1. Fractures of the proximal fibular diaphysis (main or mid-section of the lower leg bone). Lateral and posterior malleolus (bone on the side of the ankle) fractures at the ankle. Fractures at the tarsometatarsal (joints in the foot) joints including likely Lisfranc (injury of bones and ligaments of the foot) injury. 2. Large knee joint effusion with possible hemorrhagic component..." During an interview on 5/12/22 at 8:56 A.M., PT "G" reported that Resident #104 had fallen on 5/3/22 during a therapy session in the residents room. PT "G" reported that Resident #104 reported that his head hurt and complained of pain in both of his legs after the fall and stated, "...I put a pillow under his head...I went and got the nurse...I did not do any assessments...he was not doing well...moving him to get back into bed was very painful for him..." During an interview on 5/12/22 at 10:23 A.M., "Licensed Practical Nurse" (LPN) "O" reported that Resident #104 had a witnessed fall on 5/3/22 during therapy and that LPN "O" assisted PT "G" to get Resident #104 onto the hoyer lift pad and then transferred to bed after the fall. LPN "O" reported that Resident #104's vital signs were assessed prior to transferring him to bed and			

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stated, "...I did not do any specific ROM assessment...he said that he had pain all over...it was very painful to him when we transferred him to bed...if he had needed to go to ER or have an x-ray I think he would have made that clear...no, the doctor did not see him until the next day..." LPN "O" reported that she did not document the neurological checks and the incident report accurately following Resident #104's fall and stated, "...I did not do the best ROM assessment...". LPN "O" reported that as the day went on Resident #104 continued to complain of pain and was emotionally upset knowing that he was not going to be able to stay at the facility now for therapy.

Review of Resident #104's "Incident Report" dated 5/3/22 at 13:00 (1:00 P.M.), revealed, "....Attended fall...Therapist came and got this nurse stating that he assisted pt (patient) onto floor during a therapy transfer...Pt states that his legs felt weak and knees buckled...Immediate Action Taken: PT (patient) assisted back into bed, Vitals and Neuro (neurological) checks initiated. Patient Taken to Hospital? N (no). Injuries Observed at Time of Incident: Abrasion, Right Upper Arm...Injuries Report Post Incident: No injuries Observed Post Incident. Level of Pain: (not documented)...Witnesses Statement: (PT "G"): I was assisting pt from his bed to his w/c (wheelchair). We were using the walker and he felt weak, knees buckled and I assisted his (sic) to the floor and got the nurse..." This report was inconsistent with interviews with Resident #104 and PT "G".

Review of Resident #104's "Post Fall Report" dated 5/3/22 at 13:00 (1:00 P.M.) revealed, "...Is there a previous history of fall? YES...Was this fall an isolated event? Yes...Was this fall an assisted fall? Yes...Injuries related to this fall? Yes...Is there any pain during ROM or ambulation? YES...New Interventions: IDT

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	414290	A. BUILDING _____ B. WING _____	**5/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	(interdisciplinary team) will determine the most appropriate intervention: We are leaning toward having this resident as a +2 assist during therapy transfers...Initiated neurological assessment for an unwitnessed fall or fall resulting in head injury? No." Review of Resident #104's "Post Fall Neurological Evaluation" documentation from 5/3/22 at 13:00 (1:00 P.M.) through 5/6/22 at 9:00 A.M. revealed, "Yes" for Motor Movement Evaluation of all 4 extremities, indicating that Resident #104 was able to move all 4 extremities (which was directly negated by the hospital CT scan). Review of Resident #104's "Progress Notes" dated 5/3/22 at 15:14 (3:14 P.M.) revealed, "Event Note: Therapist came to this nurse and stated that pt had an assisted fall...Nursing staff assisted pt into bed using hoyer lift. VS (vital signs) assessed and stable. Neuro checks initiated and WNL (within normal limits). Pt obtained a skin abrasion to RUE (right upper extremity). He c/o (complains of) general soreness and pain 10/10 from fall. PRN (as needed) Tylenol given followed by PRN Norco (pain medication) shortly after..." Review of a facility policy "Fall" dated 7/11/18 revealed, "It is the policy of this facility to evaluate extent of injury after a fall, prevent complications and to provide emergency care. PROCEDURE: 1. Resident will not be moved until a nurse evaluates the resident's condition. 2. Check resident for any abnormalities: i.e. a. Deformed, discolored or painful body parts...4. Complete Range of Motion (ROM) to unaffected extremities only without overt signs of fracture. 5. Initiate neurological checks for any fall where a resident hit his/her head or for any unwitnessed fall..."			

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	414290	A. BUILDING _____ B. WING _____	**5/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS= G	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 intakes MI00128407 & MI00128206. Based on interview and record review the facility failed to prevent avoidable accidents for 2 of 4 residents (Resident #104 & #105) reviewed for accidents, when the facility 1). failed to provide a safe transfer for Resident #104, resulting in a fracture of Resident #104's leg, and 2). failed to implement care plan interventions for bed mobility for Resident #105, resulting in Resident #105 falling out of bed and sustaining a head laceration. Findings include: Resident #104 Review of an "Admission Record" revealed Resident #104 was originally admitted to the facility on 4/22/22, with pertinent diagnoses which included: COPD (chronic obstructive pulmonary disease) and unsteadiness on feet. Review of a "Minimum Data Set" (MDS) assessment for Resident #104, with a reference date of 4/25/22 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	#104 was cognitively intact. Review of the "Functional Status" revealed that Resident #104 was totally dependent requiring 2 person physical assistance during transfers (how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position). Review of Resident #104's "Care Plan" revealed, "FOCUS: Resident at risk for falls r/t (related to) hx (history) of falls, Morbid Obesity, pain in right shoulder, and tremors. Date Initiated: 4/25/22. Interventions:...Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 4/25/22. Follow facility fall protocol. Date Initiated: 4/25/22...FOCUS: Resident has limited physical mobility...Date Initiated: 4/25/22. INTERVENTIONS: Transfer: The resident is totally dependent on (2) staff for transferring. HOYER LIFT (a mechanical assistive device used for transfers) Date Initiated: 4/25/22..." Resident #104 was totally dependent for transfers prior to the fall on 5/3/22. During an interview on 5/11/22 at 2:24 P.M., Resident #104 reported that he had fallen on 5/3/22 during a therapy session, and sustained multiple fractures to his right leg. Resident #104 reported that he stood up next to the bed using his walker, then began to pivot into his wheelchair and stated, "...I have to quick fall into my chair, that's what I always do, but this time it wasn't there...("Physical Therapist" (PT) "G") was trying to move stuff out of the way and grab the chair...I had to go forward to get to the chair...my legs gave out...I went flying..." Resident #104 reported that he had never actually taken steps before and had only been out of bed twice with therapy since he had admitted to the facility. Resident #104 reported that he was not able to recall if there had been a gait belt around him and stated, "...(PT "G") wasn't even near me...he was trying to get the wheelchair...he should have had another			

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	414290	A. BUILDING _____ B. WING _____	**5/13/2022**

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

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	person in here..." Review of Resident #104's "Hospital Records" from Emergency Department visit on 5/5/22 at 11:20 A.M. through discharge on 5/5/22 at 9:50 P.M. revealed, "...Chief Complaint: LEG PAIN Right leg swelling and pain...Leg feels warm...Physical Exam:...Musculoskeletal:...There is tenderness at the right knee, right ankle, and right foot. There is also mild tenderness at the anterior aspect of the left knee and left ankle. There is edema of the right knee when compared to the left. There is ecchymosis (bruise) in the plantar (bottom) aspect of the right foot...complaining of right leg pain since a fall couple of days ago. He does appear uncomfortable on initial examination and has tenderness primarily in the knee and the ankle. X-rays apparently had been performed at the rehabilitation facility but then not able to access these...I did order a CT (CAT Scan: images) of the patient's right lower extremity to evaluate for hemarthrosis (bleeding in joint spaces) or large hematoma (collection of blood under the skin due to trauma). This showed: 1. Fractures of the proximal fibular diaphysis (main or mid-section of the lower leg bone). Lateral and posterior malleolus (bone on the side of the ankle) fractures at the ankle. Fractures at the tarsometatarsal (joints in the foot) joints including likely Lisfranc (injury of bones and ligaments of the foot) injury. 2. Large knee joint effusion with possible hemorrhagic component..." Review of "Physical Therapy Note" dated 5/2/22 revealed, "...Pt has improved bed mobility and transfer. Pt continues with limitations due to pain and shortness of breath. Pt with orthostatic (low blood pressure) changes with mobility with symptoms...Pt with dizziness with transitions, impaired strength, decreased balance and unable to ambulate...requires assist with mobility...fall risk...hx (history) of multiple falls..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414290	A. BUILDING _____ B. WING _____	**5/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BELTLINE	**2320 E BELTLINE SE GRAND RAPIDS, MI 49546**

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During an interview on 5/12/22 at 8:56 A.M., PT "G" reported that Resident #104 had fallen on 5/3/22 during a therapy session in the residents room. PT "G" reported that Resident #104 required stand by assist of one person contact during transfers with therapy and stated, "...it was just me in the room...I don't know if nursing staff did transfers with him...I believe his care plan was 1 person assist..." PT "G" reported that Resident #104 had done a "handful" of transfers with other therapist and stated, "...he has done side stepping and walking next to the bed...that's why we were doing some walking..." PT "G" reported that he was unaware that Resident #104 had been care planned for hoyer lift. PT "G" reported that normally walking is not attempted with someone that is a hoyer lift and stated, "...that would require 3 people and use of the parallel bars..." PT "G" reported that Resident #104 had fallen sideways, at the end of the bed, while walking towards the wheelchair. PT "G" reported that Resident #104 stated that his head hurt and complained of pain in both of his legs after the fall and stated, "...I put a pillow under his head...I went and got the nurse...I did not do any assessments...he was not doing well...moving him to get back into bed was very painful for him..."

During an interview on 5/12/22 at 10:23 A.M., "Licensed Practical Nurse" (LPN) "O" reported that Resident #104 had a witnessed fall on 5/3/22 during therapy and that LPN "O" assisted PT "G" to get Resident #104 onto the hoyer lift pad and then transferred to bed after the fall. LPN "O" reported that Resident #104's vital signs were assessed prior to transferring him to bed and stated, "...I did not do any specific ROM assessment...he said that he had pain all over...it was very painful to him when we transferred him to bed...if he had needed to go to ER or have an x-ray I think he would have made that clear...no, the doctor did not see him until the next day..."

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	LPN "O" reported that she did not document the neurological checks and the incident report accurately following Resident #104's fall and stated, "...I did not do the best ROM assessment...it was not an attended fall..." LPN "O" reported that as the day went on Resident #104 continued to complain of pain and was emotionally upset knowing that he was not going to be able to stay at the facility now for therapy. During an interview on 5/12/22 at 1:10 P.M., PT "M" reported that during therapy sessions, Resident #104 required physical assistance of one person for pivot transfers and stated, "...it required physically holding him up with the gait belt...with his walker he was able to side step down the bed and turn to sit in the chair..." PT "M" reported that Resident #104 had not yet progressed to taking forward steps and stated, "...when I saw him the day before his fall he took 5 side-steps along the bed...I didn't feel like it was safe for me to step away...he needed my support...if he wanted to walk I would have needed an extra person..." Review of Resident #104's "Incident Report" dated 5/3/22 at 13:00 (1:00 P.M.), revealed, "....Attended fall...Therapist came and got this nurse stating that he assisted pt (patient) onto floor during a therapy transfer...Pt states that his legs felt weak and knees buckled...Immediate Action Taken: PT (patient) assisted back into bed, Vitals and Neuro (neurological) checks initiated. Patient Taken to Hospital? N (no). Injuries Observed at Time of Incident: Abrasion, Right Upper Arm...Injuries Report Post Incident: No injuries Observed Post Incident. Level of Pain: (not documented)...Witnesses Statement: (PT "G"): I was assisting pt from his bed to his w/c (wheelchair). We were using the walker and he felt weak, knees buckled and I assisted his (sic) to the floor and got the nurse..." This report was inconsistent with interviews with Resident #104			

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	414290	A. BUILDING _____ B. WING _____	**5/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	and PT "G". Review of Resident #104's "Post Fall Report" dated 5/3/22 at 13:00 (1:00 P.M.) revealed, "...Is there a previous history of fall? YES...Was this fall an isolated event? Yes...Was this fall an assisted fall? Yes...Injuries related to this fall? Yes...Is there any pain during ROM or ambulation? YES...New Interventions: IDT (interdisciplinary team) will determine the most appropriate intervention: We are leaning toward having this resident as a +2 assist during therapy transfers...Initiated neurological assessment for an unwitnessed fall or fall resulting in head injury? No." Review of Resident #104's "Post Fall Neurological Evaluation" documentation from 5/3/22 at 13:00 (1:00 P.M.) through 5/6/22 at 9:00 A.M. revealed, "Yes" for Motor Movement Evaluation of all 4 extremities, indicating that Resident #104 was able to move all 4 extremities. Review of Resident #104's "Progress Notes" dated 5/3/22 at 15:14 (3:14 P.M.) revealed, "Event Note: Therapist came to this nurse and stated that pt had an assisted fall. Therapy was moving pt from the bed, using walker and gait belt, and walking to the w/c. When pt got close to the w/c and began to turn, pts (patient) legs became weak and his knees buckled. therapist assisted pt to floor. Nursing staff assisted pt into bed using hoyer lift. VS (vital signs) assessed and stable. Neuro checks initiated and WNL (within normal limits). Pt obtained a skin abrasion to RUE (right upper extremity). He c/o (complains of) general soreness and pain 10/10 from fall. PRN (as needed) Tylenol given followed by PRN Norco (pain medication) shortly after..." Review of Resident #104's "Fall Risk Assessment" dated 4/22/22 indicated that the			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BELTLINE	**2320 E BELTLINE SE GRAND RAPIDS, MI 49546**

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resident had not fallen in the past, had no ambulatory aids such as a walker, had a normal gait (walking), and was at low risk for falls. This information was not an accurate reflection of Resident #103's status prior to the fall on 5/3/22.

During an interview on 5/12/22 at 12:35 P.M., Resident #104 reported that he was being discharged home today due to his health insurance not approving his stay any longer and stated, "...because I can't bear weight for 12 weeks I can't have therapy, and that's what I was here for..." Resident #104 expressed concern regarding being able to care for himself at home.

During an interview on 5/12/22 at 12:45 P.M. "Social Worker" (SW) "V" reported that Resident #104 came to the facility for therapy, but due to the fracture from his fall can no longer participate in therapy and therefore the insurance will no longer cover the stay.

Resident #105

Review of an "Admission Record" revealed Resident #105 was originally admitted to the facility on 10/27/18, with pertinent diagnoses which included: spastic quadriplegic cerebral palsy (muscle stiffness and spasm of all 4 limbs).

Review of a "Minimum Data Set" (MDS) assessment for Resident #105, with a reference date of 2/24/22 revealed a "Brief Interview for Mental Status" (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #105 was cognitively intact. Review of the "Functional Status" revealed that Resident #105 required extensive physical assistance of 2 people for bed mobility.

Review of Resident #105's "Care Plan" revealed, "The resident has an ADL (activities of daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414290	A. BUILDING _____ B. WING _____	**5/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	living) self-care performance deficit r/t (related to) balance/trunk control problems secondary to contractures to right shoulder, left shoulder, and left knee and right ankle...Date Initiated: 10/29/18, INTERVENTIONS:...Bed mobility: dependent on x2 staff members Date Initiated: 10/28/20..." Review of Resident #105's "Incident Report" dated 4/13/22 at 8:40 A.M. revealed, "...Patient fall out of bed at 0840 (8:40 A.M.). CNA (Certified Nursing Assistant) was changing patient's brief, in bed, rolled on his left side. The patient rolled out of bed and hit the left side of his head. Patient sustained a laceration on the left side of his scalp and was bleeding..." Review of Resident #105's "Emergency Room Visit" dated 4/13/22 revealed, "...Patient presents to the emergency room from skilled nursing facility after falling out of bed during brief changing this morning. He did have direct contact with his head to the floor. He has a laceration about an inch and a half in length and about a centimeter in depth which is repaired at bedside using 5 staples..." During an interview on 5/11/22 at 3:54 P.M., Resident #105 reported that his fall out of bed on 4/13/22 was unfortunate and resulted in him getting staples in his head. Resident #105 reported that he was not able to move at all and that the facility should require 2 people when they take care of him and stated, "...they never did until after the fall..." During an interview on 5/12/22 at 8:45 A.M., CNA "I" reported that Resident #105 fell out of bed during cares on 4/13/22 and stated, "...it was because we didn't have 2 people...we usually just have 1 person when we change him in bed..." CNA "I" reported that when he was changing his			

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	414290	A. BUILDING _____ B. WING _____	**5/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	gloves, Resident #105 fell off the side of the bed, between the bed and the wall. CNA "I" reported that according to Resident #105's care plan, Resident #105 only required assistance of 1 person for bed mobility and stated, "...I thought I was following the care plan...so I didn't do anything wrong..." CNA "I" reported that the facility talked to him after Resident #105's fall and explained that a resident who cannot move by themselves should be care planned for 2 person assistance at all times. During an interview on 5/11/22 at 3:45 P.M. "Occupational Therapist" (OT) "H" reported that Resident #105 does not have control of his body, except for his head. During an interview on 5/12/22 at 9:58 A.M. "Nursing Home Administrator in Training" (NHA-T) "C" reported that Resident #105's fall on 4/13/22 was determined to be the result of the CNA not following the care plan for bed mobility, and Resident #105 was sent to the emergency room for staples to repair a head laceration. NHA-T "C" reported that CNA "I" was suspended from work during the investigation and then educated regarding care plans. This surveyor requested documentation of the education that was provided. During an interview 5/13/22 at 8:49 A.M., NHA-T "C" reported that there was no specific education provided to staff following Resident #105's fall and stated, "...when (Resident #105) fell, we were already doing education throughout the facility as part of the POC (plan of correction) from the last survey..." NHA-T "C" reported that staff received general care plan education, and no specific education related to falls, or assistance for bed mobility and transfers. This surveyor requested any and all documentation to verify staff were education on falls after 4/13/22,			

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	414290	A. BUILDING _____ B. WING _____	**5/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BELTLINE	**2320 E BELTLINE SE GRAND RAPIDS, MI 49546**

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	including but not limited to education materials, sign-in sheets, and QAPI (quality assurance and performance improvement) meeting minutes. No documentation was provided prior to exit. Review of a facilit policy "Fall Prevention" dated 7/11/18 revealed, "It is the policy of this facility that the Fall Prevention Program is designed to ensure a safe environment for all residents....PURPOSE:...2. To gather accurate, objective and consistent data for the purpose of implementing an individualized Plan of Care designated to meet the resident's needs. 3. To ensure consistency in the implementation of preventive measures to assist with the reduction of falls...PROCEDURE:...4. The Interdisciplinary Team will be responsible for reviewing the Fall Risk Assessments, if assessed to be a high risk and/or is appropriate they will initiate fall prevention interventions...6. The Director of Nursing/designee will be responsible for ensuring that residents who have been identified at risk or who have experienced a recent fall have all recommended interventions in place as well as current assessments...7. The Director of Nursing/designee will conduct a weekly Fall Committee Meeting consisting of Interdisciplinary Team members. They will review the falls for the week to identify issues and/or trends. The minutes of all Fall Committee meetings will be documented on the FALL COMMITTEE MINUTES. The Fall Committee Meeting minutes will be maintained in the Fall Committee Manual..." Review of a facility policy "Fall" dated 7/11/18 revealed, "It is the policy of this facility to evaluate extent of injury after a fall, prevent complications and to provide emergency care. PROCEDURE: 1. Resident will not be moved until a nurse evaluates the resident's condition. 2. Check resident for any abnormalities: i.e. a. Deformed, discolored or painful body parts...4.			

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	414290	A. BUILDING _____ B. WING _____	5/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BELTLINE	2320 E BELTLINE SE GRAND RAPIDS, MI 49546

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	Complete Range of Motion (ROM) to unaffected extremities only without overt signs of fracture. 5. Initiate neurological checks for any fall where a resident hit his/her head or for any unwitnessed fall..."			
F0842 SS= D	Resident Records - Identifiable Information §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	F0842		

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	414290	A. BUILDING _____ B. WING _____	**5/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BELTLINE	**2320 E BELTLINE SE GRAND RAPIDS, MI 49546**

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	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 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: This citation pertains to intake #MI00128321. Based on interview and record review, the facility failed to maintain complete and accurate medical records for 1 (Resident #103) of 6 residents reviewed for medical records, resulting in inaccurate and incomplete documentation of vital signs and the potential for facility staff and providers not having all of the pertinent information to care for residents. Findings include: Review of an "Admission Record" revealed Resident #103 was originally admitted to the facility on 2/12/21, with pertinent diagnoses which included: acquired absence of left leg (amputation).			

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	414290	A. BUILDING _____ B. WING _____	**5/13/2022**

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Review of a "Minimum Data Set" (MDS) assessment for Resident #103, with a reference date of 3/30/22 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #103 was cognitively intact.

During an interview on 5/13/22 at 11:06 A.M., Resident #103 reported that the CNA's (certified nursing assistant) do not take her vital signs as ordered and stated, "...but they say they do it..." Resident #103 reported that she had informed "Licensed Practical Nurse" (LPN) "O" that her vital signs had not been taken last night and stated, "...she (LPN "O") told me that the computer showed they were taken..."

Review of Resident #103's "Physician Orders" revealed, "Monitor and Record Vital Signs every night shift. Active 02/14/22."

During an interview on 5/13/22 at 11:14 A.M., LPN "O" reported that a couple weeks ago, Resident #103 had reported her concern about the CNA's not taking her vital signs and stated, "...I do my own vital signs...because the aides sometimes come back with funky numbers...then I have to redo them anyway..." LPN "O" reported that vital signs are typically done by the CNA for this hall, and sometime during second shift.

Review of Resident #103's electronic health record of "Vital Signs" indicated that Resident #103's vital signs were taken twice a day on 5/12/22, 5/10/22, and 5/9/22, all with different results. This was inconsistent with what Resident #103 had reported regarding her vital signs not being taken at all specifically on 5/12/22. Furthermore, the record indicated that the vital sign results on 5/10/22 at 10:41 A.M. were duplicated from the previous vital signs taken on 5/9/2022 at 9:57 P.M., the vital sign results on

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

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	5/9/22 at 12:18 P.M. were duplicated from the previous vital signs taken on 5/7/22 at 10:26 P.M., the vital sign results on 5/5/2022 at 2:35 P.M. were duplicated from the previous vital signs taken on 5/4/22 at 10:59 P.M., the vital sign results on 4/23/22 at 2:30 A.M. were duplicated from the previous vital signs taken on 4/22/22 at 10:59 P.M., the vital sign results on 4/22/22 at 12:59 A.M. were duplicated from the previous vital signs taken on 4/20/22 at 10:48 P.M., the vital sign results on 3/29/22 at 2:34 P.M. and 3/26/22 at 10:44 P.M. were duplicated from the previous vital signs taken on 3/25/22 at 10:34 P.M., and the vital sign results on 3/24/22 at 1:37 P.M. were duplicated from the vital signs taken on 3/24/22 at 4:47 A.M. This indicated at least 8 instances where the documentation of vital signs appeared to not be accurate. During an interview on 5/13/22 at 1:19 A.M., DON reported that if a resident has an order to obtain vital signs everyday, that the expectation is that the vital signs should be obtained each day. DON reviewed Resident #103's record with this surveyor and reported that the duplicate vital signs are concerning, and that it would be impossible for a resident to have the exact same vitals for multiple days. Review of Fundamentals of Nursing (Potter and Perry) 8th edition revealed, "High-quality documentation and reporting are necessary to enhance efficient, individualized patient care. Quality documentation and reporting have five important characteristics: they are factual, accurate, complete, current, and organized...Criteria for thorough communication exist for certain health problems or nursing activities. Your written entries in a patient's medical record describe the nursing care you administer and the patient's response..." Potter, P. A., Perry, A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St.			

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(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
	Louis: Mosby. p. 350-353. According to Legal and Ethical Issues in Nursing, 4th Edition, (Guido, G, 2006), "A major responsibility of all health care providers is that they keep accurate and complete medical records. From a nursing perspective, the most important purpose of documentation is communication. The standards for record keeping attempt to ensure, patient identification, medical support for the selected diagnoses, justification of the medical therapies used, accurate documentation of that which has transpired, and preservation of the record for a reasonable time period. Documentation must show continuity of care, interventions used, and patient responses. Nurses' notes are to be concise, clear, timely, and complete."			
F0888 SS= E	COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its	F0888		

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	414290	A. BUILDING _____ B. WING _____	**5/13/2022**

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	residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any			

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	booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facilitys COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for			

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	COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure facility staff fully implemented the policy and procedure for unvaccinated staff in 5 of 5 staff members reviewed for COVID-19 vaccination status, resulting in the potential for transmission of COVID-19 to all residents within the facility. Findings include: Review of a facility policy "Mandatory COVID-19 Vaccinations" dated 3/14/22 revealed, "...PURPOSE: To prevent the spread of the COVID19 virus and to ensure the health and safety of residents and staff members...PROCEDURE: 1. As a condition of employment all staff members must receive the COVID19 vaccination or possess an approved exemption...d. Accommodations Upon Receiving Exemption: If an exemption is granted the staff member will be informed of the following accommodations: i. Testing twice a week. ii. Staff members who do not work in direct patient care areas will utilize source control at all times while in the facility/company and/or within 6 feet of			

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	any other team members (i.e.: meal breaks, meetings). iii. Staff members who work in direct patient care areas will utilize a NIOSH approved N95 respirator while in patient care areas. When in non-direct patient care areas, the staff member will utilize source control at all times while in the facility/company and/or within 6 feet of any other team members (i.e.: meal breaks, meetings)..." Review of the facility "COVID-19 Staff Vaccination Matrix" indicated that "Certified Nursing Assistant" (CNA) "J", CNA "T", "Unit Secretary" (US) "Q", "Occupational Therapist" (OT) "H", and "Licensed Practical Nurse" (LPN) "K" were all unvaccinated, with granted exemptions. During an observation on 5/13/22 at 11:03 A.M. US "Q" was on the unit to assist with a resident transfer. US "O" was wearing a blue medical/surgical mask (not an N95 mask). During an observation and interview on 5/13/22 at 1:20 P.M., CNA "J" was on the unit wearing a blue medical/surgical mask (not an N95 mask). CNA "J" reported that all staff is required to wear the blue mask and stated, "...some people that want to be safer wear the N95 mask..." During an observation and interview on 5/13/22 at 1:31 P.M., CNA "T" was on the unit wearing a blue medical/surgical mask (not an N95 mask). CNA "T" stated, "...right now the surgical mask is all that is required...it is our choice to wear an N95 or not..." During an observation and interview on 5/13/22 at 1:37 P.M., OT "H" was in the therapy room, and was wearing a blue medical/surgical mask (not an N95 mask). OT "H" reported that she works full-time and stated, "...we have to wear this mask all the time...if a patient is not			

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	vaccinated then we take more precautions..." During an observation and interview on 5/13/22 at 2:39 P.M. LPN "K" was wearing a blue medical/surgical mask. LPN "K" stated, "...I wear an N95 mask for residents who are quarantined...otherwise the blue surgical mask..." During an interview on 5/13/22 at 2:48 P.M., "Infection Preventionist" (IP) "F" reported that all unvaccinated staff are supposed to be wearing an N95 mask except when they are eating or in an area by themselves. IP "F" reported that the nurse managers are supposed to be monitoring staff and stated, "...there are still people that need the reminder..."			