STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	834070	A. BUILDING _____ B. WING _____	9/8/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD NURSING CENTER	16588 SCHAEFER DETROIT, MI 48235

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F0000 SS=	INITIAL COMMENTS Westwood Nursing Center was surveyed for a Recertification survey on 9/8/22. Intakes: MI00124940, MI000125493, MI000125845, MI000126146, MI000126155, MI000126316, MI0001216409, MI000126529, MI000126926, MI000127866, MI000127970, MI000128819, MI000129192, MI000129956, MI000130077, MI000130120, MI000130207, MI000130261, MI000130869. Census=73	F0000		
F0578 SS= E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an	F0578		

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

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

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	adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure competent residents and/or the resident's legal representatives were involved in the formulation of an advance medical directive (AMD) to grant and/or withhold life sustaining treatment (Cardiopulmonary Resuscitation/CPR, Artificial Nutrition/Peg Tube, Artificial Hydration/ IV, and Diagnostic Testing) according to their wishes for 9 residents (R13, R14, R31, R36, R38, R41, R62, R65, and R66) of 17 residents reviewed for AMDs, potentially resulting in the denial of the resident's right to formulate an advance medical directive and the potential for unmet resident health care decisions. Findings include: On 8/31/22 at 3:18 PM the Nursing Home Administrator (NHA) was asked where the resident's AMDs forms were located. The			

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	NHA explained the AMD forms should be in the resident's Electronic Medical Record (EMR) but the facility recently hired a Social Worker and some (AMDs) may be in her office. The NHA was asked to locate the following 9 residents AMD forms. Resident 14: According to R14's face sheet he was a "full code" (all resuscitation procedures will be provided). There was no 'code status' or Advance Medical Directive (AMD) form in R14's EMR. There was no documentation or information to indicate R14 had a Legal Guardian (LG) or Family Representative. R14 was identified as his own financial responsible party. Review of the EMR revealed R14 admitted to the facility on 2/4/22 with diagnoses that included unspecified dementia with behavior disturbance. The Minimum Data Set (MDS) dated 8/15/22 indicated R14 had severe cognition impairment with a Brief Interview for Mental Status (BIMS) score of 2/15. There are no social work notes or assessments in R14's EMR regarding the formulation of an AMD. On 9/02/22 at 1:00 PM the NHA provided a paper AMD form dated 2/4/22 signed by a Legal Guardian service organization that indicated R14 was a full code. The Administrator could not provide any documentation to support R14 had a valid			

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	LG. The NHA acknowledged that R14's EMR indicated that the resident was his own responsible party. Resident 36: According to R36's face sheet he was a "full code" (all resuscitation procedures will be provided). There was no 'code status' or Advance Medical Directive (AMD) form in R36's EMR. R36 was identified to have a LG and Family Representative with contact information on the face sheet. Review of the EMR revealed R36 admitted to the facility on 6/16/22 with diagnoses that included schizophrenia and vascular dementia. The Minimum Data Set (MDS) dated 6/23/22 indicated R36 had severe cognition impairment with a Brief Interview for Mental Status (BIMS) score of 7/15. There were no social work assessments or progress notes in R36's EMR. On 9/7/22 at approximately 1:00 PM Social Worker (SW) "C" confirmed there was no AMD form and no social service progress note or assessment for R36 at this time. Resident 41: According to R41's face sheet he was identified as a "CPR/full code" (all resuscitation procedures will be provided). R41 was identified to have a LG and Family Representative with contact information.			

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Review of the EMR revealed R41 had an AMD form dated 6/19/19 signed by R41, his LG, a family member, and a public notary that indicated he was a "Do Not Resuscitate" (an order that instructs healthcare provided not to do CPR if a person's heart stops beating or they stop breathing).

The Minimum Data Set (MDS) dated 7/4/22 indicated R41 had no cognition impairment with a Brief Interview for Mental Status (BIMS) score of 15/15 without behaviors. There were no social work notes or assessments regarding R41's AMD form.

On 9/02/22 at 1:37 PM the NHA acknowledged the discrepancy of code status for R41 in the EMR. The NHA said the Social Worker would "Look into the resident's code status" with R41's LG and update the medical record.

R38

On 9/1/22 at 2:14 P.M. review of the Admission Record, revealed the resident was admitted to the facility on 3/7/2012 with diagnoses which included chronic obstructive pulmonary disease, dementia, heart failure, peripheral vascular disease, type 2 diabetes mellitus, epilepsy, convulsion, chronic kidney disease, dependence on renal dialysis and deformity of the lower leg.

According to Minimum Data Set (MDS) dated 6/25/22, R38 was moderately impaired in cognition, had a deficit in memory, judgement and decision-making and required limited

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	assistance with set up for Activities of Daily living (ADL's). **Further record review documented on the Resident's Profile, the Resident's Code Status as Full Code/CPR, however there was no evidence of an Advance Directive, or any information provided or presented to the resident's current legal guardian.** **R62** **On 9/1/22 at 2:30 P.M. review of the Admission Record, for R62 revealed the resident was admitted to the facility on 2/8/22, with diagnoses of contusion and laceration of cerebrum, dementia with behavioral disturbance, hypertension, heart failure and atherosclerotic heart disease** **According to the quarterly MDS dated 8/14/22 R62 alert and oriented 1-2, able to make his needs known, required assistance and supervision, and set up for all activities of daily living.** **The Resident's Profile documented the resident's Code status as Full code/CPR.** **Review of the Clinical record documented the facility had applied for guardianship for the resident.** **There was no evidence(Copy) of Advanced Directive or discussion of facility's staff informing the resident's representative of their right to establish and Advanced Directive on behalf of the resident.** **R66** **On 9/1/22 at 4:00 P.M. Review of the**			

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	Admission record for R66 revealed the resident was admitted to the facility on 1/25/22, with diagnoses quadriplegia, central cord syndrome, cervical myelopathy, and idiopathic peripheral neuropathy. The quarterly Minimum Data Set (MDS) dated 8/7/22, indicated the resident was independent in cognition and required extensive assistance with one-person physical assist with Activities of daily living (ADLs). **Review of the Advance Directive section of the Admission Record documented CPR/full Code. There was no evidence that the resident (who was his own responsible party) was given an opportunity to formulate and discuss an Advance Directive until 9/7/22 when a request was made from Social Worker to review the document. A Social Service note dated 9/7/22 indicated the resident had decline a full code.** R31 According to R31's face sheet he was a "CPR/full code". There was no 'code status' or AMD form in R31's EMR. R31 was identified to have a LG and Family Representative with contact information on the face sheet. Review of the EMR revealed R31 admitted to the facility on 5/11/20 and re-admitted on 3/12/21 with diagnoses that included dementia without behavior disturbance, anxiety and restlessness. The MDS dated 6/10/22 indicated R31 had severe cognition impairment. There are no social work notes or assessments in R31's EMR regarding the formulation of an AMD. R65			

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	According to R65's face sheet she was a "CPR/full code". There was no 'code status' or AMD form in R65's EMR. R65 was identified to have a LG and Family Representative with contact information on the face sheet. **Review of the EMR revealed R65 admitted to the facility on 1/29/22 and re-admitted on 7/9/22 with diagnoses that included asthma, Schizophrenia (mental health disorder), and seizures. The MDS dated 8/7/22 indicated R65 had intact cognition. There are no social work notes or assessments in R65's EMR regarding the formulation of an AMD.** **On 9/02/22 at 9:19 AM, during an interview with the Administrator, it was reported that R31 did not have any advanced directives, and will have the Social Worker get resident advanced directives.** **On 9/02/22 at 9:21 AM, during an interview with Social Worker "C" it was reported to her to "get the residents advanced directives".** Resident #13 - A review of the clinical record for Resident #13 (R13) documented an initial admission date of 2/9/2022 and readmission date of 5/15/2022. R13's diagnoses included hemiplegia and hemiparesis, cerebral infarction, and schizoaffective disorder bipolar type. A MDS dated 5/21/2022 documented moderate cognitive impairment. The clinical record identified R13 had a LG. The "Code Status" on R13's Face Sheet was blank and an AMD was not available upon review of R13's clinical record. Review of the facility policy titled, "Resident's Rights Regarding Treatment and Advanced			

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	Directives" dated 9/1/22 documented, " 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. 3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff".			
F0580 SS= E	Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A	F0580		

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	change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: This citation pertains to intakes; MI00130207, MI000126155 and MI00130261. Based on observation, interview, and record review, the facility failed to notify Legal Guardians (LG)/ Resident Representatives of a change in condition or room change for eight residents (R4, R25, R31, R34, R51, R52, R70, and R123), out of 11 residents reviewed for notification of changes resulting in the LG/Resident Representatives being unaware of a change in the resident's medical condition or physical location (room change) and therefore unable to participate in resident care decisions. Findings include: Resident 123:			

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On 9/1/22 at approximately 11:00 AM, R123's LG said resident (R123) was sent out to the hospital on 8/1/22 and the facility staff did not notify him. The LG said he was made aware on 8/3/22 when the hospital staff notified him that the resident (R123) had been in the hospital for two days.

According to the Electronic Medical Record (EMR) R123 admitted to the facility on 4/22/22 with multiple diagnoses that included Cerebral Insufficiency and History of Alcohol Dependence. R123 had a LG with the accurate contact information on the 'face sheet'. The Minimum Data Set (MDS) dated 5/5/22 indicated R123 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15/15 and no behaviors.

A nursing note on 8/1/22 at 12:18 PM indicated R123 was transferred to the local hospital by the local police because of aggressive behaviors. There was no documentation to support the resident's LG was notified of the 'change in condition' in the resident's medical condition or transfer out of the facility.

A psychiatric note on 8/1/22 at 12:20 PM documented R123 was transferred out to the local hospital due to aggressive behaviors by local police. There was no documentation to support the resident's LG was notified of the 'change in condition' in the resident's medical condition or transfer out of the

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facility.

On 9/1/22 at approximately 2:00 PM Social Worker (SW) "C" was asked if R123's LG had been notified of the change in his condition. SW "C" said she was not working at the facility during that time, but could not provide any documentation to support the resident's LG had been notified. SW "C" confirmed that all resident representatives should be notified if there is a change in condition which included transfers out of the facility.

Resident #4 -

A review of the clinical record for Resident #4 (R4) documented an initial admission date of 4/15/2020 and readmission date of 9/16/2020. R4's diagnoses included human immunodeficiency virus, gastrointestinal hemorrhage, and schizophrenia. A Minimum Data Set assessment dated 8/10/2022 documented severe cognitive impairment.

A further review of R4's clinical record documented the following:

1. Nurse progress note of 4/30/2022 at 11:40 AM: "Resident observed having coffee ground emesis, and projectile vomiting. Unable to notified (sic) Dr. left a message to call regarding resident...DON notified will continue to monitor patient."

2. Nurse progress note of 5/1/2022 at 8:14 AM: "Received a new order to send resident out. All care will be endorsed to oncoming nurse."

3. Nurse progress note of 5/1/2022 at 12:09 PM:

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"Per report from previous nurse, resident had two episodes of brown emesis and orders was given to send resident out 911. EMS (emergency medical service) called and resident left the building and was transferred to (local hospital) at 0830."

During an interview and review of R4's clinical record on 9/8/2022 beginning at 11:28 AM, DON said the guardian was not notified when R4 went to the hospital. The DON stated it was important to notify the resident representative because "they may have a preference of hospital and or treatment."

A review of the facility policy titled, "Notification of Changes", dated 9/2/2022, was reviewed and revealed in part the following:

- The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification.

- Circumstances requiring notification include...A transfer or discharge of the resident from the facility.

R25

Record review revealed that R25 moved from Room 205-1 to Room 219-1 on 7/2/22.

According to the medical record R25 admitted to the facility on 12/1/21 with multiple diagnoses that included dementia, kidney disease and alcohol abuse. R25 had a LG with the accurate contact information on the 'face sheet'. The MDS dated 6/13/22 indicated R25 had severely impaired cognition.

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	There was no documented evidence in the medical record that the resident's LG was made aware of the room change. R31 Record review revealed that R31 moved from Room 210-3 to Room 218-2 on 7/2/22. According to the medical record R31 admitted to the facility on 5/11/20 and re-admitted on 3/12/21 with multiple diagnoses that included dementia, protein calorie malnutrition and anxiety. R31 had a LG with the accurate contact information on the 'face sheet'. The MDS dated 6/10/22 indicated R31 had severely impaired cognition. There was no documented evidence in the medical record that the residents LG was made aware of the room change. R34 Record review revealed that R34 moved from Room 207-1 to Room 220-1 on 7/2/22. According to the medical record R34 admitted to the facility on 3/2/20 with multiple diagnoses that included Schizophrenia (mental health disorder), pain and muscle wasting. R34 had a LG Company with the accurate contact information on the 'face sheet'. The MDS dated 6/16/22 indicated R34 had severely impaired cognition. There was no documented evidence in the medical record that the resident's LG was made aware of the room change. R51			

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	Record review revealed that R51 moved from Room 201-1 to Room 108-1 on 7/2/22. According to the Medical Record R51 admitted to the facility on 1/7/22 with multiple diagnoses that included chronic obstructive pulmonary disease (COPD), heart failure, and liver disease. R51 had a LG Company with the accurate contact information on the 'face sheet'. The MDS dated 7/8/22 indicated R51 had intact cognition. There was no documented evidence in the medical record that the resident's LG was made aware of the room change. R52 Record review revealed that R52 moved from Room 205-3 to Room 219-2 on 7/2/22. According to the medical record R52 admitted to the facility on 1/5/22 with multiple diagnoses that included high blood pressure, Schizophrenia, and high blood sugars. R52 had a LG Company with the accurate contact information on the 'face sheet'. The MDS dated 7/14/22 indicated R52 had intact cognition. There was no documented evidence in the medical record that the resident's LG was made aware of the room change. R70 Record review revealed that R70 moved from room 207-3 to room 220-3 on 7/2/22. According to the Medical Record R70 admitted to the facility on 2/6/20 with multiple			

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	diagnoses that included Schizophrenia, high blood pressure and hallucinations. R70 had a LG Company with the accurate contact information on the 'face sheet'. The MDS dated 8/10/22 indicated R70 had severely impaired cognition. **There was no documented evidence in the medical record that the resident's LG was made aware of the room change.** **On 9/2/22 at 10:35 AM during an interview with the facility's Administrator, it was reported that the Legal Representatives were notified of the room changes. The Administrator was unable to provide documentation of the room change notification for R25, R31, R34, R51, R52 and R70.** **Review of the facility's policy titled, "Change of Room or Roommate: dated 5/24/22 documented, "...4. Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible".**			
F0582 SS= D	Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii)	F0582		

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	Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:			

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Based on interview and record review, the facility failed to provide evidence that a resident was issued a NOMNC (Notice of Medicare Non-Coverage - Form 10123 [explanation of appeal rights]) and SNF ABN (Skilled Nursing Facility Advance Beneficiary Notice - Form 10055) for one resident (R50) of three residents who were reviewed for notices of Medicare non-coverage and appeal rights, resulting in the resident not being fully informed of their Medicare rights or the potential liability of estimated cost in order to make a decision to appeal or continue therapy treatments. Findings include:

On 9/2/2022 at 10:34 AM, the Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse "I" indicated that Resident #50 (R50) was discharged from a Medicare covered Part A stay, had Medicare benefit days remaining, and continued to reside in the facility past the last covered day for their Medicare services. When MDS Coordinator "I" was queried about the NOMNC and SNF ABN for R50 she stated, "I just got here, and we did not have a business office manager. So (R50's) was not done."

A review of the clinical record for R50 revealed an initial admission date of 9/28/2018 and readmission date of 8/23/2022. R50's diagnoses included schizophrenia, dementia, and epilepsy. A MDS assessment dated 7/13/2022 documented severe cognitive impairment.

During an interview beginning on 9/8/2022 at 12:08 PM the Nursing Home Administrator said ABN notifications are necessary so the residents can know exactly when they will be cut from Medicare and to give them options.

The facility policy titled, "Advance Beneficiary Notices", dated 9/2/2022, was reviewed and revealed in part the following:

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	- It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. - The facility shall inform Medicare beneficiaries of his or her potential liability for payment. - A NOMNC, Form CMS-10123, shall be issued to the resident/representative when Medicare covered service(s) are ending, no matter if resident is leaving the facility or remaining in the facility.			
F0584 SS= E	Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a	F0584		

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temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

This citation pertains to Intake number MI00126409.

Based on observation and interview, the facility failed to ensure residents' bed linens were in good condition and bed was free from excessive dirty linen and clothes for resident (R48), bed side tables were clean, floors free from trash, trash cans overflowing with garbage, and rooms free from urine like smell for residents (R55, R57, and R59) and failed to maintain furniture in good condition for residents (R23 and R49) from a total of 22 residents reviewed for safe, clean, comfortable homelike environment, resulting in a resident expressing displeasure and residents' environment not being homelike. Findings include:

R48

During the initial tour of the facility on 8/31/2022 at 9:37 a.m., R48 was lying in bed alert and able to be interviewed. R48 was observed lying on dirty sheets, pillowcases, and a pile of what appeared to be dirty linen and clothes on the bed.

During an interview, R48 said, "They change my bed linen sometimes, but I would like to be lying on clean linen. I will get around to washing those clothes on the bed soon." R48 was informed the facility will wash his clothes for him. R48 said, "Okay, I didn't know." R48 was unable to recall the last time his bed

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linen was changed, and someone assisted him with washing and putting his clothes away.

On 8/31/2022 at 9:44 a.m., Room 103, with three occupants, was observed with sticky substances on overbed tables, garbage cans were filled and overflowing, paper and other trash was on the floor, and a urine like smell was noted. The occupants of Room 103 were not in the room and not available for interviews.

Certified Nursing Assistant (CNA) "L" walked into the room picking up paper and other trash off the floor and cleaning off the overbed tables. During an interview CNA "L" said, "Housekeeping should be doing this."

R55

On 8/31/22 at 9:30 A.M., in R55's room the resident complained the room was nasty and there was an odor in the room. The resident's floor was littered with pieces of paper and track marks from a wheelchair. The resident stated, "This room should be cleaned every day but once you all leave it will go back. The staff will come in here now and clean, but it will not last". R55 was observed with a bag of dirty laundry positioned in the corner which he indicated he sent out for cleaning rather than the facility laundry clean his clothing.

R57

On 8/31/22 at 10:00 A.M., in the resident's room, the overbed table had an opened carton of milk. On the window seal an opened pop bottles, snack foods and a urinal that was half filled with dark yellow urine were observed. A strong urine odor permeated the room. The blinds had gapping

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	holes and missing slots. The resident's floor was observed sticky. R59 On 9/2/22 at 1:13 P.M. during an interview on the left side of R59's bed was a pile of personal clothing which the resident had stored with opened cans of pop and snacks (crackers, chips, and milk). Flies were observed flying in the room resting on the opened pop container. During the initial tour of the facility on 8/31/2022 at 10:20 AM, Resident #23 (R23) was observed awake and sitting in her room. The closet for R23 was missing a door. R23 stated, "I need one (a closet door) because my roommate gets into my stuff." R23 said she has been without a closet door since February 2022. On 8/31/22 at 11:03 AM, the closet door for Resident #49 was observed propped up against a wall. During an interview on 9/8/2022 beginning at 12:08 PM the Nursing Home Administrator mentioned the importance for residents to "have a comfortable and homelike environment."			
F0604 SS= E	Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F0604		

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includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to periodically release a restraint (secured table top attached over a recliner) for one (R31) of one resident reviewed for restraint use resulting in the restriction of freedom of movement.

Findings include:

During observations on the second floor nursing unit the following was observed for R31.

Day 1:

-8/31/22 at 10:10 AM, R31 was in the Memory Lane dining room sitting in recliner with table top secured over the resident's midsection. R31 was pulling on the secured table, and yelling out. R31 was asked to release the table and continued to incoherently pull at the table.

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	-8/31/22 at 12:18 PM, R31 remained in dining room with table top over the recliner. R31 was noted sleeping in the recliner at this time. -8/31/22 at 2:15 PM, R31 remained in the recliner in the dining room with the table top secured at the midsection region. Day 2: -9/01/22 at 8:58 AM, R31 observed awake and fidgety, up in recliner in Memory Lane dining room with the table top secured over the recliner. -9/01/22 at 9:15 AM, Certified Nurse Aide (CNA) "E" was observed feeding R31 with table top over the recliner. When queried, CNA "E" reported that R31 could ambulate with 1 person staff assistance. CNA "E" was asked about the table top restraint and reported "It was to keep her from falling". -09/01/22 at 11:14 AM, R31 remained in Memory Lane dining room, sleeping with top table in place over recliner. Staff members observed walking in and out of room. -09/01/22 at 1:16 PM, R31 observed being fed lunch by CNA "E" with the table top restraint in use. -09/01/22 at 3:16 PM, R31 observed pulling on table top restraint and yelling out. Day 3: -09/02/22 at 9:22 AM, R31 in Memory Lane dining room with table top restraint over recliner.			

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	Day 4: -09/07/22 at 9:26 AM, R31 in her room in recliner with table top restraint in place. R31 appeared restless, pulling on table and talking nonsensically. -09/07/22 at 11:26 AM, R31 remained in her room in recliner with table top restraint in place. R31 was anxiously pulling on the table. During the 4 days of observation, the table top restraint was not observed to be released or offered to be released. Review of the clinical record for R31 revealed an admission into the facility on 5/11/20 and re-admission on 3/12/21 with pertinent diagnoses which included dementia and behavioral disorder, anxiety, and restlessness and agitation. Review of the quarterly Minimum Data Set (MDS) Assessment dated 6/10/22 documented severely impaired cognition. The MDS documented R31 required one person staff assistance for ambulation. Review of a 10/11/21 care plan titled, "Use of Restraint(s) for safety and comfort of (name of R31), related to: (Name of recliner) with tray, (name of resident) rocks and pounds on chair while up in wheelchair and table top use keeps her positioned in place while up in chair". Interventions included: "Offer and encourage to ambulate as tolerated every 2 hours during restraint release, offer and encourage to be toileted at least every (q) 2 hours, and			

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	reposition in chair or device after release period and as needed, to improve comfort and safety of (R31's name) while restraint device is being used". Review of a 9/6/21 physician's order documented, "(Brand name of recliner) with table top as needed throughout the day, check every 15 minutes & release every 2 hours". Along with the Director of Nursing (DON) on 9/07/22 at 1:04 PM, R31 was observed restrained with the table top in place while CNA "F" was feeding resident. The DON asked CNA "F" how often R31 was released from restraints, to which the CNA responded, "On day shift, once a day when we change her". The DON said she was going to check the "CNA task guide" (a guide for the CNA to use to provide individualized resident care) to see if "releasing the restraint every 2 hours was on the guide". The DON confirmed the "CNA task guide" dated 8/31/21 for R31 did indicate, "Release restraint at least every 2 hours, ROM (range of motion) or assist ambulate, check resident every 15 minutes while up in chair. Promote rest periods". There was no documentation of the release of the restraint prior to 9/7/22. Review of the facility's policy tiled, "Restraint Free Environment" dated 5/24/22 documented, "5. Before a resident is restrained, the facility will determine the presence of a specific medical symptom that would require the use of restraints, and determine:...b. The length of time the restraint is anticipated to be used to treat the			

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	medical symptom, who may apply the restraint, and the time and frequency that the restraint will be released, as this will vary with each individual...".			
F0640 SS= E	Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of	F0640		

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MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to submit Minimum Data Set (MDS) assessments in a timely manner, affecting 4 residents (R1, R2, R6, R16) out of 4 residents reviewed for resident assessments, resulting in the delay of time sensitive information used to monitor each residents decline or progress overtime.

Findings include:

Record review on 9/2/22 at 12:30 P.M. of residents' MDS data revealed the following:

R1= Admission MDS assessment, Admission date 5/9/2018, MDS record revealed overdue 120 days, completed 7/6/22, but the facility could not verify submission date.

R2= Quarterly MDS assessment, Admission date 1/19/22, MDS record revealed overdue 180 days Completed 8/9/22, but the facility could not verify submission date.

R6= Annual MDS assessment, Admission date 7/7/2021, MDS record revealed 120 days overdue, Completed 8/9/22. The facility could not verify the submission date, only the completion date could be viewed.

R16= Quarterly MDS assessment, Admission

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	date 3/29/22, MDS record revealed overdue 180 days. The facility could not verify the submission date. **During the record review of the MDS assessments for the residents, MDS Coordinator "I" was queried concerning the delay in submitting of the MDS assessments to the State Agency and Centers for Medicare & Medicaid Services. The MDS coordinator stated prior to her accepting the current position, the position was vacant. When she assumed the position there was a back log of MDS assessments not completed. The MDS coordinator would not provide a number or quantify the number of incomplete MDS assessments left.** **On 9/8/2022 at 1:00 P.M. a policy was requested. The Administrator indicated there was no policy, but the facility followed the guidelines developed by the Center for Medicare and Medicaid (CMS). The Administrator commented the Corporate Office was aware of the delay in submitting the MDS assessments.**			
F0644 SS= E	Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder,	F0644		

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	intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete a Preadmission Screening and Resident Review (PASARR) Mental Illness/Intellectual Disability Related Condition Level 1 Screening and/or failed to complete a Level II evaluation for four (R10, R13, R14, and R58) of six residents reviewed for PASARR screening, resulting in the potential for unmet mental health and psychiatric care needs. Findings include: According to the PASARR form, if a resident had a "Mental Illness" or "Dementia" diagnosis, "The person screened shall be determined to require a comprehensive Level II OBRA evaluation if any of the above items are "Yes" UNLESS a physician, nurse practitioner or physician's assistant certifies on form DCH-3878 (Level II exemption form) that the person meets at least one of the exemption criteria." (OBRA, Omnibus Budget Reconciliation Act of 1993, evaluates persons with MI diagnosis to determine most appropriate 'placement' for services to receive specialized behavior programs) . Resident 14:			

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	Review of the Electronic Medical Record (EMR) revealed R14 was admitted to the facility on 2/4/22 with diagnoses that included psychotic disorder with delusions, anxiety, depression, and unspecified dementia with behaviors . The Minimum Data Set (MDS) dated 8/15/22 indicated R14 had severe cognition impairment with a Brief Interview for Mental Status (BIMS) score of 2/15 along with behaviors of rejecting care 4-6 days per week. R14 was prescribed two antipsychotic medications every day of the week. On 4/10/22 the physician ordered a psychiatric consult for R14. There were no PASSAR screenings, no psychiatric assessments or progress notes, and no social service assessments or progress notes in R14's EMR. On 9/07/22 at 9:48 AM Social Worker (SW) "C" confirmed there were no PASSAR assessments in R14's EMR. SW "C" said there was no evidence to support that R14 had been screened for Mental Illness or Intellectual Disability or assessed for any potential psychiatric needs. Resident #10 - Review of the clinical record for Resident #10 (R10) documented an initial admission date of 11/25/2016 and readmission date of 8/23/2018. R10's diagnoses included major depressive disorder, alcohol abuse with alcohol-induced psychotic disorder with delusions, and bipolar disorder. A MDS dated 8/11/2022 documented			

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intact cognition.

A review of R10's most current Level 1 Annual Resident Review (Form 3877), dated 12/22/2020, revealed Section II, Numbers 1, 2, 3, and 4 were checked "Yes" and R10 had a current diagnosis of and was receiving treatment for mental illness. The explanation for the "Yes" responses included:

- a diagnosis of major depression and bipolar disorder

- medication regimen included Seroquel, Trazadone, and Mirtazapine

There was no Level II Screening (Form 3878) available for R10.

Resident #13 -

Review of the clinical record for Resident #13 (R13) documented an initial admission date of 2/9/2022, discharge date of 5/8/2022, and readmission date of 5/15/2022. R13's diagnoses included schizoaffective disorder bipolar type. A MDS dated 8/17/2022 documented moderate cognitive impairment.

A review of R13's most current Level 1 Annual Resident Review (Form 3877), dated 4/6/2021, revealed Section II, Numbers 1, 3, and 4 were checked "Yes" and R13 had a current diagnosis of mental illness and dementia. The explanation for the "Yes" responses included: "Pt has a limited history of psychiatric hospitalization. Recent medical challenges are representing the need for supervised medical and psychiatric care."

The most current Level II Screening (Form 3878) available for R13 was dated 4/6/2021.

Resident #58

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According to the EMR, R58 was admitted to the facility on 9/7/2018 with diagnoses of generalized anxiety, adjustment disorder with mixed anxiety and depressed mood, and other specified depressive episodes. R58's quarterly MDS with a reference date of 7/22/22 indicated intact cognition with a BIMS (brief interview for mental status) score of 15. A care plan initiated on 7/23/22 for "Mood/behavioral/psychosocial well-being" documented, "I am at risk for changes in my mood/behavior/psychosocial well-being related to restrictions of visitors and outside activities from the community ...Interventions: Refer to psych services as needed."

Review of the physician's medication orders revealed, "Lorazepam tablet 1 milligram give one tablet by mouth every 12 hours for anxiety, and psych consult."

Review of R58's 5/28/2021 Level I PASARR-Form 3877, dated 8/31/2022, revealed, Section II, Numbers 1, 2 and 3 were checked "Yes" with the diagnoses of "Mental Illness" circled. The explanation for the "Yes" responses included: Major Depressive Disorder, anxiety and one anti-anxiety medication that R#58 was prescribed.

According to the Level I PASARR-form 3877 Notes: The person screened shall be determined to require a comprehensive level II OBRA evaluation if any of the above items are "Yes" Unless a physician, nurse practitioner or physician's assistant certifies on form DCJ-3877 that the person meets at least one of the exemption criteria.

section II:

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	1. The person has a current diagnosis of mental illness: "Yes". 2. The person has received treatment for mental illness: "Yes". 3. The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days: "Yes". The explanation for the "Yes" responses included: "Bipolar II disorder, adjustment disorder with mixed anxiety and depressed mood. RX (medication): Alprazolam, Ativan (Anxiety medications)." Being that Section II (Numbers 1, 2 and 3) were checked "Yes", the Level II OBRA 3878 was searched for in the EMR but could not be located. The EMR revealed a written request "Facility Intake Referral" for the Level II (3878) dated 5/28/2021. On 8/31/2022 at 1:10 PM during an interview with the Director of Nursing (DON), a hard copy of R58's Level II (3878) was requested. On 8/31/2022 at 2:30 p.m. a copy of the Level I (3877) was presented but no Level II (3878). According to the facility's "Resident Assessment - Coordination with PASARR Program", last revised on 9/1/22; This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the			

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	most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I - initial pre-screening that is completed prior to admission i. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level I Screen - necessitates a PASARR Level II evaluation prior to admission. a. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. 2. The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission.			

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	3. A record of the pre-screening shall be maintained in the resident ' s medical record. **4. Exceptions to the preadmission screening program include those individuals who:** **a. Are readmitted directly from a hospital.** **b. Are admitted directly from a hospital, requires nursing facility services for the condition for which the individual received care in the hospital, and has been certified by the attending physician before admission that the individual is likely to require less than 30 days of nursing facility services.** **5. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days:** **a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate state- designated authority for Level II PASARR evaluation and determination.** **b. The Level II resident review must be completed within 40 calendar days of admission.** **6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority.**			
F0656 SS= D	Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F0656		

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	care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record			

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	review, the facility failed to develop and implement a comprehensive person-centered care plan to meet the medical and psychosocial needs for two (R14, R19) of 22 residents reviewed for care planning, resulting in the potential for R14 not receiving proper psychosocial care and R19 not receiving proper urinary catheter care. Findings Include: Resident 14: During an observation on 8/31/22 at approximately 9:30 AM R14 was observed wandering throughout the second floor secured unit. R14 was oriented to self only. During interview R14 said, "I don't know what I'm suppose to be doing here." Review of the Electronic Medical Record (EMR) revealed R14 was admitted to the facility on 2/4/22 with diagnoses that included psychotic disorder with delusions, anxiety, depression, and unspecified dementia with behaviors. The Minimum Data Set (MDS) dated 8/15/22 indicated R14 had severe cognition impairment with a Brief Interview for Mental Status (BIMS) score of 2/15 along with behaviors of rejecting care 4-6 days per week and wandering 1-3 days per week. Section V, Care Area Assessment indicated 'use of antipsychotic medications', and 'behavioral symptoms'. R14 was prescribed two separate antipsychotic medications every day of the week.			

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On 4/10/22 the physician ordered a psychiatric consult for R14. On 4/12/22 a social work note documented the following; "Resident is prescribed antipsychotic medications r/t (related to) his diagnoses. He will be followed by psychiatric services and all care plans followed." There was no documentation to support R14 was seen by psychiatric services. There was no care plan to address R14's use of antipsychotic medications or behavioral needs. There were no psychiatric assessments or progress notes. There were no further social service assessments or progress notes in R14's EMR after 4/12/22.

On 9/07/22 at 9:48 AM Social Worker (SW) "C" confirmed there was no psychosocial care plan for R14 to address his psychiatric or behavioral needs. SW "C" said there was no documented evidence to support that R14 had been seen by Psychiatric services, screened for Mental Illness or Intellectual Disability, or assessed for any potential psychiatric needs.

Resident 19:

On 8/31/22 at 11:20 AM R19 was observed laying in bed. R19 was observed to have a supra-pubic urinary catheter (an indwelling flexible tube that is surgically inserted through the abdomen directly into the bladder to drain urine into a collection bag) attached to a leg bag (a small urinary

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collection bag that is attached to the leg) that was strapped to his left thigh. There was no anchoring device to secure the catheter to the resident's thigh.

On 9/07/22 at 11:28 AM R19 was observed laying in bed with a supra-pubic urinary catheter draining into a leg bag attached to his left thigh/knee area. Certified Nursing Assistant (CNA) "F" repositioned resident and confirmed that R19 had a urinary catheter that was draining into a leg bag while laying in bed and did not have any anchoring device. CNA "F" said R19 did not have any other type of urinary collection bag in his room, only a leg bag.

Review of the EMR revealed R19 admitted to the facility on 8/16/21 with multiple diagnoses that included benign prostatic hyperplasia, urinary tract infection, and end stage renal failure. The MDS dated 6/1/22 indicated R19 had severe cognition impairment and required extensive assistance from one staff person for all activities of daily living. R19 was identified to have an indwelling urinary catheter. Section V Care Area Assessments indicated 'urinary incontinence/indwelling urinary catheter'.

On 7/30/22 the physician ordered urinary catheter care every shift and to change the urinary catheter every 30 days on the 1st of each month. There was no care plan related to indwelling urinary catheter care. There were no progress notes regarding indwelling

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	urinary catheter care. On 9/7/22 at 11:37 AM during an interview with unit manager Licensed Practical Nurse (LPN) "J" she reviewed R19's EMR and confirmed there was no 'urinary catheter' care plan or documentation to indicate urinary catheter care had been provided to the resident. According to the facility's policy for "Comprehensive Care Plans" revised on 5/24/22: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment.			

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	c. Any specialized services or specialized rehabilitation services the nursing facility will provide. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.			
F0684 SS= D	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: Based on interview and record review, the facility failed to ensure appropriate monitoring and timely treatment for a resident with projectile vomiting of coffee ground emesis (coagulated [thick like gel] blood in vomit) for one (R4) of one resident reviewed for quality of care, resulting in a delay in medical treatment and the potential for unmet care needs. Findings include:	F0684		

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A review of the clinical record for Resident #4 (R4) documented an initial admission date of 4/15/2020 and readmission date of 9/16/2020. R4's diagnoses included human immunodeficiency virus, gastrointestinal hemorrhage, and schizophrenia. A Minimum Data Set assessment dated 8/10/2022 documented severe cognitive impairment.

A further review of the clinical record documented the following nursing progress notes:

- 4/30/2022 at 11:40 PM: "Resident observed having coffee ground emesis, and projectile vomiting. Unable to notified (sic) Dr. Left a message to call regarding resident. Vital signs are as follow 108/74 (blood pressure), 98% (oxygen saturation), 98.2 (body temperature), 18 (respiratory rate). DON (Director of Nursing) notified will continue to monitor patient."

- 5/1/2022 at 8:14 AM: "Received a new order to send resident out. All care will be endorsed to oncoming nurse."

- 5/1/2022 at 12:09 PM: "Per report from previous nurse, resident had two episodes of brown emesis and orders was given to send resident out 911. EMS (Emergency Medical Service) called and resident left the building and was transferred to (local hospital) at 0830."

- 5/1/2022 at 1:39 PM: "Resident returned from (local hospital) ER (Emergency Room), MD made aware and verified medication orders that the resident returned with, new medication orders placed into (electronic health record)."

During an interview and review of R4's clinical record on 9/8/2022 beginning at 11:28 AM, the DON said R4 did not receive follow up

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monitoring on 5/1/2022 related to the coffee ground emesis, and there should have been documentation of nursing observations. The resident's doctor should have been notified right away and if that doctor was not available, the nurse should have called our medical director but did not. The DON stated, "I would not have waited, (R4) would have gone right out. I would not have endorsed (this situation/concern) to the next shift." The DON said there was a possibility that R4 was bleeding on the inside, and this required immediate care. The DON stated, "It's an urgent need." The DON indicated this was a delay in treatment.

On 9/8/2022 at approximately 2:50 PM, an interview and review of R4's 5/1/2022 Emergency Department (ED) visit was conducted with the DON. The hospital document titled "Final Report" revealed the following:

Reason for visit: "Vomiting"

History of present illness: "...Nursing home reports 1 or 2 episode of coffee-ground emesis yesterday/overnight..."

Examination: "Gastrointestinal...A digital rectal examination was performed....Stool burden in rectal vault. Attempted digital disimpaction. Brown stool was present on gloved finger. No frank blood noted. FOBT (fecal occult blood test to determine if blood was in the stool) negative."

Medical decision making and course in the ED: "...Concern for constipation or obstruction, though less concern for the latter given vital signs, non-toxic appearance, and benign abdominal exam. FOBT was negative but there is appreciable firm but not hard stool in the rectal vault. Some digital disimpaction performed."

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F0688 SS= D	Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement interventions to address range of motion (ROM) concerns for one resident (R13) out of three residents reviewed for ROM, resulting in the potential for contracture development to occur. Findings include: During an observation and interview on 8/31/2022 at 10:16 AM, Resident #13 (R13) was observed awake and lying in her bed. R13's left hand appeared to be slightly bent at the wrist and the fingers on her left hand were noted to be flexed over and towards her palm. When asked if she was able to open and spread her fingers on her left hand without assistance, R13 said she was not. R13 demonstrated that she was able to open her fingers on the left hand using her right hand. During an observation and interview on 9/8/2022	F0688		

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beginning at 9:27 AM, R13 was awake and lying in her bed. R13 said she used her hands to move about the building in her wheelchair and wanted to keep the current ability of her hands.

During an interview on 9/8/2022 at 9:40 AM, Rehab Manager (RM) "S" said R13's left hand was not contracted because "you can range it out, but it's not in great shape. Performing range of motion (exercises) with her hand daily will prevent contractures. We want (R13) to start getting out of bed to be more active and as functional as possible. (R13's) left hand needs (ROM exercises) to maintain current ROM and prevent her from becoming contracted."

A review of the clinical record for R13 revealed an initial admission date of 2/9/2022 and readmission date of 5/15/2022. R13's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. A Minimum Data Set assessment dated 8/17/2022 documented moderate cognitive impairment and no current functional limitation in ROM.

During an interview and record review on 9/08/2022 beginning at 11:57 AM, the Director of Nursing (DON) said they were revamping the restorative program and that there was a restorative aide that primarily obtains resident's weights. A review of R13's clinical record revealed there were no CNA (Certified Nurse Aide) tasks designated to perform ROM activities with R13. The DON stated, "There should have been because the CNAs have more contact with the resident. They more often notice changes in the patient, and they can alert the nurse to put interventions in place." The DON stated R13 would benefit from ROM activities because "she's prone to contractures due to limited mobility. Doing the ROM motion would help to prevent

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	contactures and increase mobility and circulation." A review of R13's current care plans did not include a focus or intervention related to increasing and/or maintaining ROM. A review of the facility policy titled, "Prevention of Decline Range of Motion", dated 9/8/2022, revealed in part the following: - "Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable." - "The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systematic approach for prevention of decline in range of motion including the assessment, appropriate care planning, and preventive care."			
F0690 SS= D	Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F0690		

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	indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide appropriate supra-pubic (s/p) indwelling urinary catheter (tube inserted through the abdominal wall into the bladder to drain urine) care for one (R19) of two residents reviewed for indwelling urinary catheter care resulting in R19's supra-pubic catheter not being changed according to physician's orders, not being kept below the level of his bladder, not being securely anchored to his thigh with the potential for injury to the stoma, (insertion site of the catheter) dislodgement, and urinary tract infection. Findings include: Resident 19:			

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	On 8/31/22 at 11:20 AM R19 was observed laying in his bed on his right side. R19 was observed to have a supra-pubic urinary catheter attached to a leg bag (a small urinary collection bag that is attached to the leg) that was secured to the outside of his left thigh, which was higher than the level of his bladder. The catheter was pulled tight from out the top of his brief to his leg bag. There was no securement device anchoring the catheter to his thigh, the tubing went directly from the stoma to the leg bag. The leg bag contained a small amount of dark amber colored urine. On 9/07/22 at 11:28 AM R19 was observed laying in bed on his left side with a supra-pubic urinary catheter draining into a leg bag attached to his left thigh/knee area. The resident was laying on the leg bag. At this time Certified Nursing Assistant (CNA) "F" repositioned resident and confirmed that R19 had a urinary catheter that was draining into a leg bag while laying in bed and did not have any anchoring device. The leg bag contained a small amount of dark amber colored urine. CNA "F" said R19 did not have any other type of urinary collection bag in his room and always used a leg bag even when laying in bed. CNA "F" said that R19 usually had a securement device to anchor the catheter tubing, but it may have been removed for a shower. Review of the Electronic Medical Record (EMR) revealed R19 admitted to the facility			

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on 8/16/21 with multiple diagnoses that included benign prostatic hyperplasia, urinary tract infection, and end stage renal failure. The Minimum Data Set (MDS) dated 6/1/22 indicated R19 had severe cognition impairment and required extensive assistance from one staff person for all activities of daily living. R19 was identified to have a supra-pubic indwelling urinary catheter. On 7/30/22 the physician ordered; "urinary catheter care every shift", and to "change the urinary catheter every 30 days on the 1st of each month."

A review of R19's July 2022, August 2022, and September 2022 Medication Administration Records (MAR) and Treatment Administration Records (TAR) had no documentation to indicate R19's urinary catheter care was completed every shift or that the catheter was changed every 30 days. There were no progress notes, assessments, or any documentation regarding R19's indwelling urinary catheter care. There was no care plan related to indwelling urinary catheter care.

On 8/19/22 R19 was diagnosed with a urinary tract infection and was prescribed an antibiotic from 8/12/22 - 8/18/22. There was no additional documentation in the EMR regarding the urinary tract infection aside from antibiotic administration on the MARs.

On 9/7/22 at 11:37 AM during an interview with unit manager Licensed Practical Nurse (LPN) "J" she reviewed R19's EMR and

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confirmed there was no 'urinary catheter' care plan or documentation to indicate urinary catheter care had been provided to the resident. LPN "J" said the physician's order for catheter care was not transcribed onto the resident's MAR or TAR.

On 09/08/22 at 11:35 AM during an interview with Regional Clincial Nurse Consultant Registered Nurse "H" she confirmed that physician's order had not been transcribed onto R19's MAR or TAR and no care plan had been implemented for R19's catheter care.

According to the facility's "Catheter Care" policy revised on 5/24/22.

Policy:

It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.

Policy Explanation:

1. Catheter care will be performed every shift and as needed by nursing personnel.

4. Leg bags may be used for ambulatory residents or per resident request.

5. Legs bags may be worn during the day, but need to be removed and a bedside drainage bag replaced on the catheter at night.

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	6. Legs bags will be attached to the resident ' s thigh or calf making sure to have slack on the tubing to minimize pressure and tension. Ensure straps are snug but not tight. 7. Leg bags may be stored in a clean, plastic bag when not in use or as per facility policy. 8. Empty drainage bags when bag is half-full or every 3 to 6 hours. 9. Ensure drainage bag is located below the level of the bladder to discourage backflow of urine. A review of the web site "Agency for Healthcare Research and Quality" accessed on 6/6/22 and located at https://www.ahrq.gov/hai/quality/tools/cauti-ltc/modules/resources/tools/prevent/maintenanc e-checklist.html, read in part: With regard to care and maintenance of a urinary catheter in long-term care, you should ensure: "...3. A catheter securement device is in place to prevent catheter movement and urethral traction... 10. Ensure that the drainage bag is secured below the level of the bladder at all times...".			
F0691 SS= D	Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or	F0691		

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	ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: **This citation pertains to Intake# MI00126926.** **Based on observation, interview, and record review, the facility failed to obtain a physician's order for colostomy care and failed to provide care for a colostomy for one (R61) of one resident reviewed for a colostomy, resulting in the potential for excoriation of the skin and the potential for infection. Findings include:** **On 9/1/2022 at 2:51 p.m., R61 was observed lying in bed alert and able to be interviewed. A colostomy bag half filled with feces was observed on the right side of R61's abdomen. During an interview, R61 stated, "They (the nurses) never change it or even ask to change my colostomy bag. I change my colostomy bag myself."** **According to R61's electronic medical record, he was initially admitted to the facility on 10/19/2021and readmitted on 5/16/2022 with diagnoses of quadriplegia C5-C7 and colostomy status (a colostomy is an opening to divert one end of the colon (part of the bowel) through an opening in the abdomen. The opening is called a stoma. A pouch can be placed over the stoma to collect stool). R61's quarterly Minimum Data Set (MDS) with a reference date of 8/4/2022 indicated**			

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	R61 was moderately impaired cognition with a BIMS (brief interview for mental status) score of 12. The MDS also indicated R61 required extensive assistance with Activity Daily Living (ADLs), had an indwelling catheter for urine, and a colostomy for bowel. A review of R61's care plan, initiated on 10/19/2021, documented the following: - "R61 has a self-care deficit and needs assistance with ADLs related to impaired physical mobility, weakness, and quadriplegia right and left phalanges (fingers) contracture near palm, hand deformities. -Colostomy care plan interventions: Observe for diarrhea, constipation, dehydration, pain, and abdominal swelling. Observe skin around stoma for breakdown. Staff to empty the pouch when it's a third half full. -Nutritional care plan focus: R61 has altered nutritional status as evidence by and related to having a colostomy ...constipation. -Skin care plan focuses: R61 is at risk for skin breakdown ...Interventions: Assess skin during care, report any redness, bruised, or open areas promptly to the charge nurse." Further review of the electronic medical records revealed no active physician's orders for colostomy care. No colostomy care was noted on the medication administration records. No progress notes documented colostomy care. During an interview on 9/1/2022 at 3:30 p.m., the Director of Nursing (DON) confirmed residents with colostomies should have			

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	physician's orders for continuing care and for the stoma site to be assessed by the nurses. The DON was informed that there were no physician's orders for the care of R61's colostomy for the months of July, August, and September and no documentation of the colostomy care on the medication administration records. The DON was asked to review the physician's orders and the medication administration record for validation and to present a hard copy of the physician's orders for the month of July, August, and September and the medication administration records. The DON presented hard copies of R61's physician's orders and the medication administration records with no physician's orders and documented care for R61's colostomy care. According to the facility's "Pouch Changes-Colostomy, Urostomy, and Ileostomy" policy, reviewed May 24, 2022: "It is the policy of this facility to ensure that residents who require colostomy, urostomy, or ileostomy services receive pouch changes consistent with professional standards of practices to minimizes occupational exposure and the resident's skin exposure to fecal matter or urine. Policy Explanation and compliance Guidelines:1. Ostomy care will be provided by licensed nurses under the orders of the attending physician. The order should include the type of ostomy, frequency of pouch change, and type of equipment. 2. The frequency of pouch changes will depend on the unique characteristics of the resident, including but not limited to: A. The type and location of the stoma. B. The type and amount of drainage from the stoma. C. The resident's activity level, body shape, and amount of perspiration. D. the type of pouching system."			

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F0725 SS= F	Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: **This citation pertains to intakes: MI00130869, MI00124940.** **Based on interview and record review the facility failed to maintain sufficient nursing staff to administer medications for 5 (R10, R46, R55, R57, and R59) of 24 residents, resulting in a potential for compromised health status and well- being.** **Findings include:**	F0725		

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	On 8/31/22 at 8:30 A.M., R55 stated, "The past weekend (8/26, 8/27, 8/28) all the nurses called off and the residents did not get their medications". R55 commented he searched the building and could not find a nurse or anyone to give him his medications. The corporate nurse and Director of nursing came in to help but neither one passed medications. When we realized, we were not going to get our medications some of us began calling our families, ombudsman and/or 911, hoping someone would come and see what was happening. R55 explained Saturday 8/27/22 as the day residents did not get medications. R55 continued to explain stating, "I was not the only resident that did not receive medications and other residents should be asked if they received theirs." **R46 who was the roommate of R55 interjected during the interview, "he is telling the truth, we did not get our medications, I did not get my pain medication until early afternoon. I asked for it in the morning when I was scheduled to get the medicine."** **R55** **On 8/31/22 at 2:00 p.m., Review of the Admission Record for R55 documented the resident was admitted to the facility on 9/30/2021, with diagnoses which included: Fusion of the spine, Convulsion, epilepsy, Seizure disorder, and adjustment disorder.** **On 9/1/22 at 1:00 P.M., review of the Medication Administration Record (MAR) for 8/27/22 the following pertinent medications were not administered:** **Tegretol Tablet 200 milligram (mg) 1 Tablet (T) morning dose, (medication given to control**			

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	epilepsy). **Letiracetum Tablet 500 mg 1 T morning dose, (used to control convulsions).** **Amitriptyline HCL 25 mg 1 T bedtime dose, (used for antidepressant)** **Toprol Tartrate Tablet 50 mg morning and afternoon dose, (used to control hypertension).** **R46** **On 9/1/22 at 2:00 P.M. review of the Admission Record documented R46 was admitted to the facility on 6/25/2015, with diagnoses of complete traumatic amputation at the knee level, hypertension, atrial fibrillation, heart failure, and peripheral vascular disease.** **Review of the MAR for 8/27/22, indicated the following pertinent medications were not administered to the resident:** **Amlodipine Tablet 10 mg 1 T, morning dose for hypertension.** **Gabapentin capsule 400 mg 1 T a day, morning dose (used for nerve pain)** **Xarelto 20 mg 1 T one time a day for Atrial fibrillation, morning dose (used for irregular heart rate, blood thinner)** **Amiodarone Tablet 200 mg 2 tablets one time a day, morning dose (used for Atrial fibrillation.)** **Norco Tablet 7.5-325 mg 1 T every 4 hours and as needed for pain , documented as given at 10:51 P.M. R46 had requested pain**			

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	medication that morning. **R57** **On 9/1/22 at 9:40 A.M., review of the Admission Record for R57 documented the resident was admitted to the facility on 1/19/2022 with diagnoses which included: chronic obstructive pulmonary disease, diabetes mellitus with diabetic polyneuropathy, chronic kidney disease, stage 3, Peripheral vascular disease, hypertension, acquired absence of left leg above the knee.** **Review of the MAR for 8/27/22, indicated the following pertinent medications were not administered to R57.** **Amlodipine Besylate Tablet 5 milligram 1 T once a day, morning dose (used to control hypertension)** **Aspirin 81 milligram 1 T, morning dose (used for heart failure)** **Colace capsule 200 milligram, morning dose (used to avoid constipation in residents with heart disease).** **Nedipine ER tablet 60 milligram 1 T one time a day, morning dose (used for hypertension)** **Brilinta 90 milligram (Ticagrelor) 1 T two times a day, morning or evening dose (used to prevent blood clotting)** **Lactulose Solution 30 milliliter every 12 hours, morning or evening dose (used to prevent constipation)** **Toprol Tartrate Tablet 50 milligram 1 T two times a day, morning or evening dose (used for**			

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	hypertension). **R59** **On 9/2/22 at approximately 12:30 p.m. R59 entered the surveyor's room insisting to speak with a surveyor. The resident was directed to go to his room where an interview was conducted.** **R59 reported on 8/27/22 he did not receive his medications and wanted to report what had happened. The resident explained he called 911 trying to get some help but was not sure if they responded.** **Review of the Admission Record for R59 documented the resident was admitted to the facility on 10/12/2018, with diagnoses which included: pain, diabetes mellitus, primary hypertension, chronic** **Kidney disease, atherosclerotic heart disease.** **Review of the MAR for 8/27/22 the following pertinent medications were not administered:** **Gabapentin Cap 100 milligram 1 Capsule three times a day, morning and evening dose (used for neuropathy (nerve) pain.** **Paroxetine tab 30 mg 1 T, morning dose (used to treat generalized Anxiety).** **Trazadone 1 Capsule twice a day, eveing dose (used for depression).** **On 9/8/22 at 9:00 A.M. during an interview the Director of Nursing (DON) acknowledged the weekend of 8/26, 8/27, and 8/28, the facility had experienced a challenge with staffing. The DON stated, on 8/26/22 all the nurses on the**			

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	first and second shift called off and the facility wasn't able to acquire anyone from the Agency to fill in and work. (This was part of the facility's emergency plan to address staffing shortages). The DON explained a staff nurse from their sister facility did come and assist the nurses on the unit for a while but could not stay for the entire shift. When the facility was informed of the staffing shortage a staff E-mail was sent out for all managers to return to the building. The DON reported Regional Clinical Nurse Consultant (RCNC) "H" and herself came into the facility and stayed and assisted staff. **In a confidential complaint made on "8/27/22 by "DD" while in the facility responding to a resident who called to 911, there was no nurse to be found. Upon further investigation, "DD" found that there was one nurse for both floors and the one nurse was on break. The complainant reported an estimated census of about 80 residents with no nurse."** **In a subsequent interview RCNC "H"verbally verified her present in the facility stating she worked on the locked unit on 8/26- 8/27/22 and left early in the morning on 8/27/ 22 . When asked were medications passed to all the residents RCNC "H" responded "I am not sure."** During an interview on 8/31/2022 at 11:20 AM, Resident #10 (R10) stated, "I get my nighttime pain meds late; about two to three hours late." Review of the clinical record for R10 documented an initial admission date of 11/25/2016 and readmission date of 8/23/2018. R10's diagnoses included major depressive disorder, alcohol abuse with alcohol-induced psychotic disorder with delusions, and bipolar disorder. A MDS dated			

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	8/11/2022 documented intact cognition. A further review of R10's clinical record revealed that the following medications were not documented as administered on 8/27/2022: - Aspercreme lidocaine patch for pain at 8:00 AM - Atorvastatin for cholesterol maintenance at 9:00 PM - Clopidogrel for prevention of blood clots at 9:00 AM - Cyclobenzaprine for muscle spasm at 6:00 AM and 2:00 PM - Glipizide for blood sugar management at 9:00 AM and 5:00 PM - Novolog, insulin given according to a sliding scale for blood sugar management, at 6:30 AM, 10:30 AM, and 4:00 PM.			
F0726 SS= E	Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified	F0726		

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	through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: **Based on interview and record review the facility failed to ensure nursing competencies were performed for 5 of 5 current nurse aide staff resulting in the potential for unmet care needs.** **Findings Include:** **On 9/2/2022 at 11:00 A.M., a list of Nurse Aides names was presented to the Administrator for review of Nurse Aide competencies. The list provided included a random selection of Nurse Aides with the dates of hire for each staff member.** **A. DOH- 9/5/2000** **B. DOH- 4/7/2021** **C. DOH- 3/3/2021** **D. DOH-8/21/2006** **E. DOH- 1/3/2019.**			

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	On 9/2/22 at 3:30 P.M. it was disclosed via an confidential interview the Nurse Aide competencies were not available. **On 9/7/2022 at approximately 11:00 A.M., the Director of Nursing (DON) presented two large notebooks, titled: Staff Education Record and Inservice Book. Review of the notebooks provided, did not correspond to the list of nurse aides presented on 9/2/2022.** **On 9/8/2022 at 12:30 P.M., further review of the Inservice notebooks outlined training schedules for the entire facility. There was no evidence or documentation of evaluation of the current Nurse Aides clinical skills and techniques used for rendering resident care.** **In a follow-up interview at 12:50 P.M, the DON acknowledged no other information was available related to nurse aide competencies. The facility's policy was requested related to Nurse Aide competencies, but not provided upon exiting the facility.**			
F0744 SS= D	Treatment/Service for Dementia §483.40(b) (3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a social service assessment, treatment, and individualized dementia care interventions for one of one resident (R14) reviewed for	F0744		

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	dementia care, resulting in the lack of identification of resident's needs and treatments with the potential for inadequate medical care and services. Findings include: Resident 14: During an observation on 8/31/22 at approximately 9:30 AM R14 was observed wandering throughout the second floor secured unit. R14 was oriented to self only. During interview R14 said, "I don't know what I'm suppose to be doing here." Review of the Electronic Medical Record (EMR) revealed R14 was admitted to the facility on 2/4/22 with diagnoses that included psychotic disorder with delusions, anxiety, depression, and unspecified dementia with behaviors . The Minimum Data Set (MDS) dated 8/15/22 indicated R14 had severe cognition impairment with a Brief Interview for Mental Status (BIMS) score of 2/15 along with behaviors of rejecting care 4-6 days per week and wandering 1-3 days per week. Section V, Care Area Assessment indicated 'use of antipsychotic medications', and 'behavioral symptoms'. R14 was prescribed two separate antipsychotic medications every day of the week. R14's social service assessment was incomplete and 205 days past due. On 4/10/22 the physician ordered a			

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	psychiatric consult for R14. On 4/12/22 a social work note documented the following; "Resident is prescribed antipsychotic medications r/t (related to) his diagnoses. He will be followed by psychiatric services and all care plans followed." There was no documentation to support R14 had ever been seen by psychiatric services. There was no care plan to address R14's use of antipsychotic medications, dementia, or behavioral needs. There were no PASSAR screenings (Preadmission Screening and Resident Review for Mental Illness/Intellectual Disability), psychiatric assessments or progress notes related to psychosocial needs of the resident. There were no social service progress notes in R14's EMR after 4/12/22. On 9/07/22 at 9:48 AM Social Worker (SW) "C" confirmed there were no PASSAR assessments, psychosocial/dementia care plan for R14 to address his psychiatric or behavioral needs. SW "C" said there was no evidence to support that R14 had been seen by Psychiatric services, screened for Mental Illness or Intellectual Disability, or assessed for any potential psychiatric/psychosocial needs.			
F0745 SS= F	Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical,	F0745		

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	mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake numbers MI00130207 and MI00130261. Based on interview and record review, the facility failed to timely complete comprehensive Social Service (SS) assessments for 23 residents (R1, R4, R9, R10, R12, R13, R14, R19, R23, R28, R29, R31, R35, R38, R45, R46, R47, R55, R57, R58, R61, R65, and R123) out of 24 residents reviewed for assessments resulting in the potential for unmet resident needs related to advocation for residents, assistance with grievance procedures, mental and psychosocial health needs, education on healthcare options, assistance with referral services, assistance with financial and legal matters, and/or assistance with discharge planning. Findings include: R1 Review of the clinical record for R1 revealed an admission into the facility on 5/9/18 and re-admission on 3/26/20 with pertinent diagnoses which included dementia and psychotic disorder with delusions. Review of the quarterly Minimum Data Set (MDS) Assessment dated 6/17/22 documented severely impaired cognition. The MDS documented R1 required one person staff assistance for all activities of			

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	daily living (ADL's). Review of a comprehensive assessment titled, "Social Service Evaluation" was last completed on 9/28/2021 (one year prior to the survey). R31 Review of the clinical record for R31 revealed an admission into the facility on 5/11/20 and re-admission on 3/12/21 with pertinent diagnoses which included dementia, anxiety disorder, restlessness and agitation, and mood disorder. Review of the quarterly MDS Assessment dated 6/10/22 documented severely impaired cognition. The MDS documented R31 required one person staff assistance for all ADL's. Review of a comprehensive assessment titled, "Social Service Evaluation" was last completed on 12/17/2021 (9 months prior to the survey, 169 days overdue). R47 Review of the clinical record for R47 revealed an admission into the facility on 4/18/19 and re-admission on 7/11/22 with pertinent diagnoses which included restlessness and agitation, Schizoaffective Disorder (mental health disorder), and dementia with behavioral disturbance. Review of the quarterly MDS Assessment dated 7/22/22 documented moderately impaired cognition. The MDS documented R47 required one person staff assistance for			

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all ADL's.

Review of a comprehensive assessment titled, "Social Service Evaluation" was last completed on 10/10/2021 (11 months prior to the survey).

R65

Review of the clinical record for R65 revealed an admission into the facility on 1/29/22 and re-admission on 7/9/22 with pertinent diagnoses which included Schizoaffective Disorder and psychotic disorder with hallucinations.

Review of the quarterly MDS Assessment dated 8/7/22 documented intact cognition. The MDS documented R65 required one person staff assistance for all ADL's.

Review of the Initial Social Service assessment was not completed and was 211 days overdue.

During an interview with the facility's Administrator on 9/02/22 at 9:19 AM, she reported that comprehensive Social Service Assessments should be done on admission, quarterly and with a significant change in a resident's status. The Administrator acknowledged that some aspects of the Social Service role were not being completed.

During an interview with the Social Service Director (SSD) "C" on 9/02/22 at 9:21 AM, she confirmed that she had only worked at the facility for 4 days and "had not gotten to the (SS) assessments".

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	During an interview with Chief Operating Officer (COO) "G" and the Regional Clinical Nurse Consultant (RN) "H" on 9/08/22 at 10:50 AM, they reported that the facility had been attempting to hire a full time Social Worker since the last Social Worker left on 6/17/22 (over 2 months ago). COO "G" reported that the facility had hired 2-3 full and part time Social Workers, all who have quit. RN "H" reported that she and the DON have been "filling in" working as Social Workers. COO "G" acknowledged that all aspects of the Social Service department were "bigger than we thought" and had not been completed timely (per facility's policies). Resident 12: Review of the clinical record documented R12 admitted to the facility on 2/4/20 with pertinent diagnoses of vascular dementia with behaviors and end-stage renal disease that required dialysis. The Minimum Data Set (MDS) dated 8/20/22 indicated R12 had severe cognition impairment with verbal behaviors 4-6 days per week and was prescribed antipsychotic medications daily. The last Social Service assessment was on 11/11/21 with the next assessment due on 5/5/22. R12 had no care plan that addressed behaviors, mood, use of antipsychotic medications, or psychosocial needs. There was no documentation to support behavior monitoring, psychiatric services, or ancillary services had been provided. **Resident 14:**			

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Review of the clinical record documented that R14 admitted to the facility on 2/4/22 with pertinent diagnosis of unspecified dementia with behavioral disturbances and major depressive disorder. The MDS dated 8/15/22 indicated R14 had severe cognition impairment with verbal behaviors 4-6 days a week, wandering 1-3 days a week, and was prescribed antipsychotic medications daily. The resident had no Social Service assessment nor any care plans that addressed behaviors, mood, use of antipsychotic medications, or psychosocial needs.

There was no documentation to support behavior monitoring, psychiatric services, or ancillary services had been provided.

Resident 19:

Review of the clinical record documented that R19 admitted to the facility on 8/16/21 with pertinent diagnoses of unspecified dementia and seizures. The MDS dated 6/1/22 indicated R19 had severe cognition impairment with verbal behaviors 4-6 days a week and was prescribed antipsychotic medications daily. The resident had a Social Service assessment on 11/29/21 and the next assessment was due on 5/17/22.

Resident 123:

On 9/1/22 at approximately 11:00 AM R123's Legal Guardian (LG) said that the Social Worker had never contacted him even

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though requests were left on the social worker's voice mail. R123's LG said he was not able to participate in any plan of care for the resident.

Review of the clinical record documented that R123 admitted to the facility on 4/22/22 with pertinent diagnoses of cerebral insufficiency and history of alcohol dependence. The MDS dated 5/5/22 indicated that R123 had intact cognition without behaviors. R123 was prescribed antipsychotic medications daily. On 4/22/22 the physician ordered for a psychiatric consult. There was no documentation to support there was psychiatric consultation, social service assessment, or social service progress notes for R123 from 4/22/22 - 8/1/22. On 8/1/22 R123 was petitioned out to the local hospital for aggressive behaviors and did not return to the facility.

R38

On 9/1/22 at 2:14 P.M. review of the Admission Record, revealed the resident was admitted to the facility on 3/7/2012 with diagnoses which included chronic obstructive pulmonary disease, dementia, heart failure, peripheral vascular disease, type 2 diabetes mellitus, epilepsy, convulsion, chronic kidney disease, dependence on renal dialysis and deformity of the lower leg.

A Minimum Data Set (MDS) dated 6/25/22, R38 was moderately impaired in cognition, had a deficit in memory, judgement and decision-making and required limited assistance with set up for Activities of Daily living (ADL's). The last

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	Quarterly Social Service Evaluation was completed on 2/8/21, There were no other Social Service notes. R46 On 9/1/22 at 2:00 P.M., review of the Admission Record documented the resident was admitted to the facility on 6/25/2015, with diagnoses of complete traumatic amputation at the knee level, hypertension, atrial fibrillation, heart failure, and peripheral vascular disease. A Quarterly MDS dated 7/22/22 indicated R46 was cognitively intact (thought process), required supervision and one-person physical assistance with ADLs. Review of the Social service Evaluation dated 6/9/22, was incomplete. The last completed Social Service Evaluation was dated 11/1/21. No other assessments were documented from the social Worker. R55 On 8/31/22 at 2:00 P.M., review of the Admission Record documented the resident was admitted to the facility on 9/30/2021, with diagnoses which included: Fusion of the spine, convulsion, epilepsy, seizure disorder, adjustment disorder and somatization disorder. A Quarterly MDS dated 7/15/22 indicated the resident was cognitively intact (thought process) and required limited assistance with one-person physical assistance to perform ADL's. Review of the Social Service Evaluation indicated, R55 assessment was 160 days overdue. R55's clinical record documented that a Social Service Evaluation was due 4/5/22.			

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R57

On 9/1/22 at 9:00 A.M. review of the admission Record for R57 documented the resident was admitted to the facility on 1/19/22, with diagnoses which included: chronic obstructive pulmonary disease, diabetes mellitus with diabetic polyneuropathy, chronic kidney disease.

According to Quarterly MDS dated 7/30/22, R57 was cognitively intact (thought process), required supervision and one-person physical assist to perform ADL's

Review of the Social Service Evaluation indicated the last Quarterly assessment was completed 10/21/21. No other notes or evaluations by the Social worker were documented.

Resident #4 -

Review of the clinical record for Resident #4 (R4) documented an initial admission date of 4/15/2020 and readmission date of 9/16/2020. R4's diagnoses included schizophrenia and anxiety disorder. A MDS dated 8/10/2022 documented severe cognitive impairment. R4's current medication regimen included quetiapine fumarate (an antipsychotic) for schizophrenia. The most recent Social Service Evaluation for R4 was dated 12/15/2021. R4's clinical record documented that a Social Service Evaluation was due on 3/15/2022.

Resident #9 -

Review of the clinical record for Resident #9 (R9) documented an initial admission date of 8/20/2010 and readmission date of 10/18/2021. R9's diagnoses included major depressive disorder, anxiety disorder, and Alzheimer's

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disease. A MDS dated 8/17/2022 documented severe cognitive impairment. R9's current medication regimen included alprazolam (sedative to treat anxiety) for major depressive disorder. The most recent Social Service Evaluation for R9 was dated 10/22/2021. R9's clinical record documented that a Social Service Evaluation was due on 4/22/2022.

Resident #10 -

Review of the clinical record for Resident #10 (R10) documented an initial admission date of 11/25/2016 and readmission date of 8/23/2018. R10's diagnoses included major depressive disorder, alcohol abuse with alcohol-induced psychotic disorder with delusions, and bipolar disorder. A MDS dated 8/11/2022 documented intact cognition. R10's current medication regimen included mirtazapine (an antidepressant) for depressive disorder, quetiapine fumarate for psychotic disorder with delusions, and trazodone (an antidepressant and sedative) for major depressive disorder. The most recent Social Service Evaluation for R10 was dated 11/25/2021. R10's clinical record documented that a Social Service Evaluation was due on 2/25/2022.

Resident #13 -

Review of the clinical record for Resident #13 (R13) documented an initial admission date of 2/9/2022, discharge date of 5/8/2022, and readmission date of 5/15/2022. R13's diagnoses included schizoaffective disorder bipolar type. A MDS dated 8/17/2022 documented moderate cognitive impairment. R13's current medication regimen included olanzapine (antipsychotic) for behaviors. No Social Service Evaluations were completed for R13's per review of the resident's clinical record. R13's clinical record documented

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	that a Social Service Evaluation was due on 5/20/2022. Resident #23 - Review of the clinical record for Resident #23 (R23) documented an admission date of 2/9/2022. R23's diagnoses included alcohol abuse, opioid abuse with intoxication, and end stage renal disease. A MDS dated 8/22/2022 documented intact cognition. No Social Service Evaluations were completed for R23's per review of the resident's clinical record. R23's clinical record documented that a Social Service Evaluation was due on 2/14/2022. Resident #35 - Review of the clinical record for Resident #35 (R35) documented an admission date of 12/3/2021, discharged date of 3/17/2022, readmission date of 4/6/2022, discharge date of 6/16/2022, and readmission date of 6/17/2022. R35's diagnoses included bipolar disorder, schizophrenia, and anxiety disorder. A MDS dated 6/17/2022 documented intact cognition. R35's current medication regimen included citalopram hydrobromide (antidepressant) for depression, lorazepam (antianxiety) for anxiety, olanzapine for anxiety, ativan gel (a combination of lorazepam, diphenhydramine, and haloperidol) for agitation, and depakene solution for schizophrenia. The most recent Social Service Evaluation for R35 was completed on 12/8/2021. R35's clinical record documented that a Social Service Evaluation was due on 3/8/2022. Resident #28 - Review of the clinical record for Resident #28 (R28) documented an initial admission date of 4/1/2020 and readmission date of			

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	4/26/2022. R28's diagnoses included Alzheimer's disease and Major Depressive Disorder. A MDS dated 6/4/2022 documented R28 was moderately cognitively impaired. R28's current medication regimen included Mirtazapine (an antidepressant) for depression. The Social Service Evaluation indicated, R28's assessment was 124 days overdue. R28's clinical record documented that a Social Service Evaluation was due on 5/1/2022. Resident #29 - Review of the clinical record for Resident #29 (R29) documented an initial admission date of 12/16/2016. R29's diagnoses included mood disorder due to known physiological condition with depressive features. A MDS dated 6/27/2022 documented intact cognition. The Social Service Evaluation indicated R29's assessment was 206 days overdue. R29's clinical record documented that a Social Service Evaluation was due on 2/8/2022. Resident #45 - Review of the clinical record for Resident #45 (R45) documented an initial admission date of 4/6/2022. R45's diagnoses included chronic viral hepatitis c and congestive heart failure. A MDS dated 7/13/2022 documented intact cognition. R45's current medication regimen included Ambien (sedative hypnotics). The Social Service Evaluation indicated R45's assessment was 144 days overdue. R45's clinical record documented that a Social Service Evaluation was due on 4/11/2022. Resident #58 -			

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Review of the clinical record for Resident #58 (R58) documented an initial admission date of 9/7/2018. R58's diagnoses included generalized anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, and malignant neuroleptic syndrome. A MDS dated 7/22/2022 documented intact cognition. R58's current medication regimen included Lorazepam (antianxiety). The Social Service Evaluation indicated R58's assessment was 87 days overdue. R58's clinical record documented that a Social Service Evaluation was due on 6/7/2022.

Resident #61 -

Review of the clinical record for Resident #61 (R61) documented an initial admission date of 10/19/2021 and a readmission date of 5/16/2022. R61's diagnoses included anxiety disorder. A MDS dated 8/4/2022 documented R61 was moderately cognitively impaired. R61's current medication regimen included Buspirone HCL (antianxiety), duloxetine HCL (antianxiety). The Social Service Evaluation indicated R61's assessment was 131 days overdue. R61's clinical record documented that a Social Service Evaluation was due on 4/24/2022.

Review of the undated document titled "Social Service Director" job description documented, "The Social Services Director is responsible for overseeing the development implementation, supervision and ongoing evaluation of the Social Services Department designed to meet and assist residents in attaining or maintaining their highest practicable well-being. This includes identifying the need for medically-related social services and ensuring that these

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	services are provided in accordance with State and Federal regulations...The Social Services Director will complete and/or direct/delegate the completion of the social services component of the comprehensive assessment...".			
F0756 SS= E	Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F0756		

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	when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to respond timely to monthly medication regimen review (MRR) recommendations for noted irregularities for six residents (R14, R38, R47, and R65) of 24 residents reviewed for MRR, resulting in unnecessary and unmonitored medication use. Findings include: R47 Review of the clinical record for R47 revealed an admission into the facility on 4/18/19 and re-admission on 7/11/22 with diagnoses which included gastro-esophageal reflux disease. Review of the quarterly Minimum Data Set (MDS) Assessment dated 7/22/22 documented moderately impaired cognition. The MDS documented R47 required one person staff assistance for all activities of daily living (ADL's). Review of the "Pharmacy Medication Regimen Reviews" dated 4/24/22, 5/21/22, 7/24/22 and 8/27/22 revealed pharmacy recommendation to change prescribed medication, Pepcid (Famotidine-used for the			

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	treatment of gastric reflux disease) from "morning (AM) to prior to bedtime (HS)". Review of the Medication Administration Records (MAR's) from May, June, July, and August 2022 revealed Pepcid was being administered daily to R47 at 9:00 AM. R65 Review of the clinical record for R65 revealed an admission into the facility on 1/29/22 and re-admission on 7/09/22 with diagnoses which included age related osteoporosis (low bone mass). Review of the quarterly MDS Assessment dated 8/7/22 documented intact cognition. The MDS documented R65 required one person staff assistance for all ADL's. Review of the "Pharmacy Medication Regimen Review's" dated 6/21/22, 7/30/22, and 8/27/22 revealed pharmacy recommendation to reduce dose and obtain "25 OH D" (Vitamin D blood level) for prescribed medication, "Ergocalciferol Capsule (vitamin D) 1.25 MG (50000 UT). Give 1 capsule by mouth every day shift." Review of the June, July, and August 2022 MARS revealed R65 received the same dose of Vitamin D each month. The clinical record revealed no order to check the Vitamin D level.			

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During a phone interview on 9/07/22 at 11:15 AM with RPh "A", he reported that he believed pharmacy recommendations had not been followed up due to "a high turnover of Administrators and Director of Nursing (DON's). The physicians are not addressing the recommendations either".

During an interview with the DON on 9/07/22 at 11:35 AM, she reported, "We are going to hold the medication (Vitamin D) at this time (for R65), and draw the blood level. I don't know why it (pharmacy recommendations) were not done, I was not here at that time. That will not happen again on my watch".

R38

On 9/8/22 at 9:30 A.M. review of the Admission Record, revealed R38 was admitted to the facility on 3/7/2012, with diagnoses which included: chronic obstructive pulmonary disease, heart failure, peripheral vascular disease, Type 2 diabetes mellitus, epilepsy, convulsion, chronic kidney disease, dependence on renal dialysis and deformity of lower leg.

Review of the monthly Pharmacy Medication Review dated 6/21/22 Irregularities found, Pharmacy summary: "Diagnoses (Dx) : Apixaban should not be Heart Failure. (What is the proper diagnosis?)." The recommendation from the pharmacist had not been acted upon or responded to by the facility staff.

On 9/8/22 at 10:00 A.M., when the DON was queried about the recommendations from the monthly pharmacy reviews, the DON acknowledged the irregularities...but admitted

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there was no follow through because there was no system established in place to follow up with the pharmacist recommendations.

Resident 14:

Review of the clinical record documented R14 admitted to the facility on 2/4/22 with pertinent diagnoses of unspecified dementia with behaviors and adult failure to thrive. The MDS dated 8/15/22 indicated R14 had severe cognition impairment with behaviors of rejecting care 4-6 days a week.

Review of R14's "Pharmacy Medication Regimen Review's" dated 5/21/22, 6/21/22, 7/24/22 and 8/27/22 revealed pharmacy recommendation to change prescribed medication, Docu Liquid 50 MG (milligram)/5 ML (milliliter) (Docusate Sodium, a stool softener), from "Give 5 ml by mouth two times a day to Give 10 ml one time a day".

Review of the Medication Administration Records (MAR's) from May, June, July, and August 2022 revealed Docu Liquid 50 MG /5 ML was being administered twice a day.

On 9/2/22 at 1:57 PM the Director of Nursing (DON) said that she had recently been hired at the facility and was unaware of who had been managing the Pharmacist's monthly medication recommendations. The DON said she would ask the Corporate Nurse, Registered Nurse (RN) "H" how that process has been handled.

On 9/2/22 at 2:09 PM The DON said, "Going forward I will be receiving the Pharmacists's monthly reports and review them."

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	Review of the facility's policy titled, "Medication Regimen Review" dated 5/24/22 documented, "1. Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes: a. Review of the medical record in order to prevent, identify, report, and resolve medication- related problems, medication errors, or other irregularities. b. Collaboration with other members of the interdisciplinary team, including the resident, their family, and/or resident representative...Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities".			
F0758 SS= D	Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose	F0758		

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	reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: **Based on interview and record review, the facility failed to monitor for the effectiveness of an antidepressant and ensure mental health services for one resident (#28) of five residents reviewed for unnecessary medications, resulting in the potential for serious side effects, adverse reactions and inability to monitor the effectiveness of the prescribed treatment. Findings include:** **According to R28's electronic medical records, he was initially admitted to the facility on 4/1/2020 and readmitted on 4/26/2022 with diagnoses of encephalopathy, acute respiratory failure, diabetes mellitus type 2, Alzheimer's disease, osteoarthritis,**			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD NURSING CENTER	16588 SCHAEFER DETROIT, MI 48235

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	depressive episodes, heart disease, hypertension, hepatitis C, and chronic kidney disease stage 1. R28's annual Minimum Data Set (MDS) with a reference date of 6/4/2022 indicated R28 had moderate cognitive impairment with a BIMS (brief interview for mental status) score of 11. Review of the "Mood" Care plan initiated 4/27/2022 documented, "I am at risk for changes in my mood/behavior/psychosocial well-being related to restrictions of visitors and outside activities from the community. Interventions: Observe and report changes in mood or stressors ...refer to psych services as needed." On 9/2/2022 at 11:30 a.m., review of the physician's orders dated 4/27/2022 documented, "Psych consult, Mirtazapine tablet (used to treat depression) 15 mg give .05 mg tablet by mouth at bedtime for depression." Review of the social services progress notes revealed no documentation that R28 was evaluated by psych. No psych evaluation or GDR notes were available in the electronic medical records related to the diagnosis of depression and the antidepressant medication Mirtazapine. No documentation was available regarding monitoring the medication effectiveness or side effects was noted in the electronic medical records. On 9/2/10 at 10:34 AM, during an interview, the administrator stated that R28 should be seen by the psychiatrist due to the antidepressant medication and a "psychiatrist is scheduled to visit the facility monthly." According to the facility's "Behavioral Health			

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	Services" policy with revised date of May 24, 2022, documented, policy: **- "It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning.** **- Policy explanation and compliance Guidelines: Behavioral health encompasses a resident's whole emotional and mental well-being ...11. The Social Services Director shall serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrists, or neurologists."** **During an interview with Chief Operating Officer (COO) "G" and the Regional Clinical Nurse Consultant (RN) "H" on 9/08/22 at 10:50 AM, they reported that the facility had been attempting to hire a full time Social Worker since the last Social Worker left on 6/17/22 (over 2 months ago). COO "G" reported that the facility had hired 2-3 full and part time Social Workers, all who have quit. RN "H" reported that she and the DON have been "filling in" working as Social Workers. COO "G" acknowledged that all aspects of the Social Service department were "bigger than we thought" and had not been completed timely (per facility's policies).**			
F0770 SS= D	Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own	F0770		

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	laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure labs (blood draws) were obtained for two (R55 and R28) of 2 residents reviewed for Laboratory services per physician orders, resulting in the potential for ineffective therapeutic drug levels and ineffective treatment. Findings include: R55 On 9/7/22 at 11:50 A.M., review of the Admission Record for R55 documented the resident was admitted to the facility 9/30/21, with diagnoses that included: Fusion of spine, anxiety disorder, convulsion, major depression, epilepsy, abnormal weight loss and covid-19. Review of the Physician Orders dated 4/19/22 : Keppra Level every 3 Months. Review of the monthly Pharmacy Medication Regimen Review (MRR) from 4/24/2022 - 8/27/2022 revealed the facility did not follow through on the recommendations of the pharmacists. The irregularities identified were: 4/24/22 Irregularities found, Pharmacy response: Therapeutic Drug Monitoring (TDMs) due. 5/22/22 Irregularities found, 1. Still need TDMs (Registered Pharmacist) 6/23/22 Irregularities found, 1. Still need TDMs (request #3)			

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7/31/22 Irregularities found, 1. Still need TDMs (Registered Pharmacist).

8/27/22 Irregularities found 1. No (weights) in Point Click Care (PCC). 1. Still need TDMs (request #5).

On 9/8/22 at 10:00 A.M., the Director of Nursing (DON) said she had just received computer access to review labs for the residents and there were no base line labs for R55 or any of the residents in the facility. The DON explained the only labs the facility ordered were identified as "Stat Labs", any other labs requested were not done because the Laboratory was not allowed to enter the building. When queried about the recommendations from the monthly pharmacy reviews the DON acknowledged the irregularities and repeated requests for therapeutic drug monitoring but admitted she had not followed through because she had to start from scratch in establishing systems to follow up with the pharmacist recommendations.

Resident #28

According to R28's electronic medical record, he was initially admitted to the facility on 4/1/2020 and readmitted on 4/26/2022 with diagnoses of encephalopathy, acute respiratory failure, diabetes mellitus type 2, Alzheimer's disease, osteoarthritis, depressive episodes, heart disease, hypertension, hepatitis C, and chronic kidney disease stage 1. R28's annual Minimum Data Set Assessment (MDS) with a reference date of 6/4/2022 indicated R28 had moderate cognitive impairment with a BIMS (brief interview for mental status) score of 11.

On 9/2/2022 at 10:06 a.m., review of R28's MRR by a licensed pharmacist from dates of 7/30/2022,

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	6/22/2022, and 5/22/2022 revealed a pharmacy recommendation of "irregularities found". Irregularities on 5/22/2022 documented,"TDM (Therapeutic drug monitoring): need Q6 month (Every 6 month) HgA1c (a hemoglobin A1C test is a common blood test used to diagnose type 1 and 2 diabetes ...Also used to monitor how well you're managing blood sugar levels), CMP (A comprehensive metabolic panel is used to check several body functions and processes, including: Liver and kidney health, blood sugar levels, blood protein levels, acid and base balance)." On 6/22/2022 and 7/30/2022, the MRR revealed another irregularities recommendation of "TDM still needed." Review of the physician's orders dated 4/23/2022, 4/26/2022, and 8/22/2022 for labs were as follow: A1C, CMP, CBC (A complete blood count is a blood test used to evaluate your overall health and detect a wide range of disorders, including anemia, infection and leukemia), TSH (A blood test that measures the hormones), Lipid Panel, Vitamin D, (for diabetes mellitus type 2). No labs results were noted in the electronic medical records for the above dates.			
F0812 SS= F	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	F0812		

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	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 implement the three-step manual warewashing procedure while using the three-compartment sink in the kitchen, resulting in the increased potential for food borne illness for all residents that eat from the kitchen. Findings include: During the initial observation of the kitchen on 8/31/2022 beginning at 8:40 AM the following occurred: 1. Kitchen staff were observed moving about the kitchen using flashlights due to an area wide power outage. The only items inside the kitchen hooked up to the emergency generator was a reach-in cooler and reach-in freezer. 2. AM Cook "P" said they were using disposable service ware such as hinged lid food containers, eating utensils, cups, and napkins. The facility did not have disposable serving trays and they were using the reusable fiberglass meal trays. The three-compartment sink was used to clean and sanitize the fiberglass trays. 3. Dietary Aide (DA) "Q" was observed using the three-compartment sink to wash, rinse, and sanitize soiled pots/pans and cooking utensils. Cleaned and rinsed pots/pans and cooking utensils were dipped in the sanitizing solution and immediately removed. During an interview and record review on			

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	9/8/2022 at 9:48 AM, Dietary Director (DD) "R" said a quaternary solution was used to sanitize dishware in the three-compartment sink. DD "R" said the specific sanitizing contact time was not met when DA "Q" immediately removed the kitchen ware items out of the sanitizing solution. DD "R" said dishware had to remain in the quaternary solution for some time to be effectively sanitized. The label of the sanitizing solution used in the kitchen was reviewed with DD "R" and revealed the following: "To sanitize mobile items such as drink glasses and eating utensils, immerse in a 200 ppm (parts per million) active quaternary solution for at least 60 seconds making sure to immerse completely." According to the 2013 FDA Food Code: Section 4-703.11 Hot Water and Chemical. "After being cleaned, equipment food-contact surfaces and utensils shall be sanitized in:...(C) Chemical manual or mechanical operations, including the application of sanitizing chemicals by immersion, manual swabbing, brushing, or pressure spraying methods, using a solution as specified under § 4-501.114. Contact times shall be consistent with those on EPA-registered label use..."			
F0835 SS= F	Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: **Based on interview, and record review, the facility's managing corporation failed to effectively administer daily operational processes to provide for the needs of**	F0835		

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	residents, ensure they attain or maintain the highest practical physical, mental and psychosocial well-being for 73 of 73 Residents residing in the facility, resulting in insufficient weekend staff (8/26/22), Director of Nursing unable to perform her job duties (reviewing Pharmacist recommendations), and the Social Service Director unable to perform her job duties (assessments, preadmission screening and resident review - PASARR, Advanced Directives, psych referrals, notification of room changes). Findings include: During a phone interview on 9/07/22 at 11:15 AM with Registered Pharmacist (RPh) "A", he reported that he believed pharmacy recommendations had not been followed up on due to "a high turnover of Administrators and Director of Nursing (DON's)...". A review of State Agency records revealed that since the facility's previous recertification date of 6/17/21, the position of Administrator was occupied by 5 different individuals for the duration indicated: Former Administrator "K" 6/17/21 to 8/8/21 Former Administrator "T" 8/9/21 to 1/23/22 Former Administrator "U" 1/24/22 to 2/7/22 Former Administrator "V" 2/8/22 to 5/17/22 Current Administrator 5/18/22 to present. Additionally, the position of DON was occupied by 8 different individuals for the duration indicated since the facility's previous			

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	recertification date of 6/17/21: Former DON "W" 6/17/21 to 9/1/21 Former DON "X" 9/2/21 to 9/22/21 Former DON "Y" 9/23/21 to 10/4/21 Former DON "Z" 10/5/21 to 3/7/22 Former DON "AA" 3/8/22 to 3/25/22 Former DON "BB" 3/26/22 to 4/20/22 Former DON "CC" 4/21/22 to 8/9/22 Current DON 8/10/22 to present. On 9/2/22 at 1:57 PM the Director of Nursing (DON) said that she had recently been hired at the facility and was unaware of who had been managing the Pharmacist's monthly medication recommendations. The DON said she would ask the Regional Clinical Nurse Consultant "H" how that process had been handled. On 9/2/22 at 2:09 PM The DON said, "Going forward I will be receiving the Pharmacists's monthly reports and review them." On 9/8/22 at 9:00 A.M. during an interview the Director of Nursing (DON) acknowledged the weekend of 8/26, 8/27, and 8/28, the facility had experienced a challenge with staffing. The DON stated, on 8/26/22 all the nurses on the first and second shift called off and the facility wasn't able to acquire anyone from the Agency to fill in and work. (This was part of the facility's emergency plan to address staffing shortages). The DON			

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	explained a staff nurse from their sister facility did come and assist the nurses on the unit for a while but could not stay for the entire shift. When the facility was informed of the staffing shortage a staff E- mail was sent out for all managers to return to the building. The DON reported Regional Clinical Nurse Consultant (RCNC) "H" and herself came into the facility and stayed and assisted staff. After the weekend staffing shortage the facility indicated that they went back to utilizing agency staff again. During an interview with Chief Operating Officer (COO) "G" and the Regional Clinical Nurse Consultant (RCNC) "H" on 9/08/22 at 10:50 AM, it was reported that COO "G" had been assisting at the facility since March of 2022 and RCNC "H" since May of 2022. They both reported the most important issue were policies and updating them to make sure they made sense and establish consistencies. COO "G" and RCNC "H" said they were at the building 3 days a week to provide oversight and support administration. RCNC "H" acknowledged that "it was going to take time" to get staff to take ownership and set a standard for the facility. COO "G" reported that facility administrative staff and Regional Operations staff met with the owner once a week to keep her informed of any concerns. They reported that the facility had been attempting to hire a full time Social Worker since the last Social Worker left on 6/17/22 (over 2 months ago). COO "G" reported that the facility had hired 2-3 full and part time Social Workers, all who have quit. RN "H" reported that she and the DON have been "filling in" working as Social Workers. COO "G" acknowledged that all aspects of the Social Service department were "bigger than we thought" and had not been			

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	completed timely (per facility's policies). **A policy regarding expectations of administrative oversight for daily operations was requested, but not received by the end of the survey.**			
F0888 SS= F	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 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	F0888		

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	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 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			

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	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 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			

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	considerations; This REQUIREMENT is not met as evidenced by: **Based on observation, interview, and record review, the facility failed to track staff COVID-19 vaccination status and implement a process ensuring that all staff were fully vaccinated for COVID-19, resulting in multiple staff and contract worker vaccination status being undocumented for monitoring and the potential for the spread of the COVID-19 virus infection to all residents. Findings include:** **On 8/31/2022 at 11:10 a.m., a request was made to the administrator for the facility's COVID-19 Staff Vaccination spread sheet.** **During an observation and interview on 9/1/2022 at 12:10 p.m., the Registered Nurse/Regional Clinical Nurse Consultant (RN/RCNC) "H", identified as the Infection Control nurse, was sitting in the dining area working on the staff vaccination spread sheet. A second request was made to RN/RCNC "H" who at the time stated, "The matrix for the staff vaccination status was not ready because it had some employees on the list that are not employed at the facility anymore. I am working on it now. I will have to go through and make sure the new employees are listed and take off the old employees. I do not know how to use that matrix they want us to use. I am over infection control now, but we had someone else doing infection control before me. The person that was over infection control left about three months ago." RN/RCNC "H" was asked, "How are you tracking and monitoring the staff and contract workers vaccination**			

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	834070	A. BUILDING _____ B. WING _____	9/8/2022

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status?" RN/RCNC "H" stated, "The new employees have to give their vaccination information at the time of hire. I know there is about six or seven exemptions, but I can't tell you who they are right now. We don't have anyone in the facility that's COVID positive." RN/RCNC "H" verbalized the interventions the non-fully vaccinated staff had to take to prevent the spread of the COVID-19 infection. RN/RCNC "H" was unable to provide a copy of the staff and contract workers vaccination status on this day.

During an interview on 9/2/2022 at 12:18 p.m., RN/RCNC "H" was approached in the dining room and another request for the staff vaccination spread sheet was made. RN/RCNC "H" said, "It is taking me longer than I thought to get this information for you because I had to go to MCIR (Michigan Care Improvement Registry) to get the staff information off there and then I had to get a copy of all the employees from Human Resource (HR)." RN/RCNC "H" was unable to provide a copy of the staff and contract workers vaccination status on this day.

During an interview on 9/2/2022 at 12:36 p.m., the administrator and the Chief Operating Officer (COO) "G" was informed of the staff vaccination information was not available. COO "G" stated, "There should be a spread sheet with that information on it." COO "G" was asked to present the sheet but did not.

According to the facility's policy, "Employee COVID-19 Vaccinations", revised date of May 24, 2022: "It is the policy of this facility to ensure that all eligible employees are vaccinated against COVID-19 as per applicable Federal, State and Local

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	guidelines. Compliance Guidelines: The facility will ensure that all eligible employees are fully vaccinated (CMS term) or up to date (CDC term) against COVID-19, unless religious or medial exemptions are granted as per CMS guided timeframes."			

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F0908 SS= D	Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: **Based on observation, interview, and record review the facility failed to ensure resident equipment was in good, clean condition for one of two crash carts resulting in the potential for injury due to lack of equipment maintenance.** **Findings Include:** **Obervation of the second floor nursing unit emergency crash cart with Registered Nurse (RN) "D" on 9/02/22 at 9:33 AM, the crash cart was observed to have on top, next to the back board, a foam bowl of black molded food, several cracker wrappers, several straw wrappers, a dried up slice of tomato, and an empty can of pop tipped on its side with mold noted where the sticky pop syrup spilled out.** **At this time RN "D" was asked about the monitoring for cleanliness of the crash cart to which she said, "Midnight staff is supposed to clean it." There was no crash cart check off log (a log that documents that staff checked the crash cart nightly).** **At 10:35 AM during an interview with the Director of Nursing (DON), she reported that the midnight staff nurse is responsible for checking the crash cart nightly, "It's part of they're duties".**	F0908		
F0919	Resident Call System §483.90(g) Resident	F0919		

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SS= E	Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: **Based on interview and record review, the facility failed to provide alternate means of alerting staff when the Resident Call System did not function as designed on 2 of 3 hallways (1 North and 2 South), resulting in the potential for delayed ability to contact staff for care needs.** **Findings Include:** **Upon entrance into the facility on 8/31/22 at 8:15 AM, it was noted that the facility was experiencing a "power outage" and the facility's power was being supplied by a generator.** **At 10:07 AM, during the entrance conference with the facility's Administrator she reported that "part" of the resident call light system was not on the generator, and residents with non-functioning call lights "should have a bell (so they can call for assistance)".** **At 10:35 AM, the 1 North and 2 South nursing units were checked for functioning call lights along with the Administrator. The call lights were non-functioning, nor did the residents have "bells" to call for assistance.** **At 11:10 AM, 1 North residents (R19) and (R51) were both interviewed regarding the**			

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	non-functioning call light system to which they reported they had no way to get ahold of staff, so they wheel themselves into the hallway to get staffs attention. At 11:28 AM, 2 South resident (R35) was interviewed regarding the non-functioning call light to which she said she walks down to the nurses station to get ahold of staff. During an interview on 9/01/22 at 8:50 AM, with Maintenance Director (MD) "B" he reported the power outage started on 8/30/22 approximately between 1 am and 6 am. MD "B" confirmed part of the call light system was not on the generator. He reported that Units 1 North (25 residents) and 2 South (24 residents) call lights were non-functioning saying, "We were trying to find bells, but we just got them in" (2 days after power outage began). Review of the facility's policy titled, "Call Lights: Accessibility and Timely Response" dated 7/20/22 documented, "...8. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. (Examples include: replace "call light", provide a bell or whistle, increase frequency of rounding, etc.)".			