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	504014	A. BUILDING _____ B. WING _____	10/13/2022

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SHELBY HEALTH AND REHABILITATION CENTER	46100 SCHOENHERR RD SHELBY TOWNSHIP, MI 48315

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F0000 SS=	INITIAL COMMENTS Shelby Health and Rehabilitation Center was surveyed for a Recertification and Abbreviated survey on 10/13/2022. Intakes: MI00130665, MI00130704, MI00131091, MI00131282, MI00131416, MI00131431, MI00131735. Census= 189.	F0000		
F0550 SS= E	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The	F0550	F550: Resident Rights/Exercise of Rights The facility staff did not knock on door before entering resident□s rooms on the 500 Hall. Element #1 No cited residents. Element #2 Residents residing in the facility have the potential to be affected in a similar manner. Administrator requested an opportunity to conduct a resident council meeting to identify additional concerns. Concerns obtained will be taken through the concern/grievance process. Element #3 Admin/DON reviewed Promoting and Maintaining Resident Dignity Policy and deemed it appropriate. Staff was educated on this policy and acknowledged an understanding. Resident Council meetings continue monthly with concerns corrected through the grievance/concern process. Managers during rounds will monitor staff knocking and announcing self and will immediately address any concerns at time of findings.	11/8/2022

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

Electronically Signed | 11/15/2022

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	resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: This citation pertains in part to intake MI00131416 and MI00130665. Based on observation, interview, and record review, the facility failed to knock/ask for permission before entering resident rooms and failed to promote/provide a general atmosphere of dignity and healing, affecting multiple residents on the 500 unit and four confidential group residents, resulting in resident and family dissatisfaction and actual/potential decreased feelings of self-worth. Findings include: On 10/11/22 at 10:19 AM and again at 10:22 AM, Agency Certified Nursing Assistant (CNA) "L" walked into room 518 without knocking or announcing herself. Two residents were noted to occupy the room. On 10/11/22 at 12:19 PM, during an interview regarding their loved one's care at the facility, Confidential Witness "E" stated, "There are wonderful workers...and then there are ones that just come drop off the food, don't say hi, or anything." On 10/11/22 at 1:06 PM, during an interview regarding their loved one's care at the facility, Confidential Witness "C" stated, "The agency staff are nasty, they will snap at you...[They] won't do anything they don't want to do."		Email sent to both agencies regarding dress code requirements. Sticker ID tags left at staff entrance for agency staff to utilize. Element # 4 Unit Managers will round frequently, and audit results will be completed weekly x 4 weeks and then monthly x 3 months thereafter. Areas of concern will be addressed at time of findings. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter	

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	On 10/11/22 at 3:48 PM, Agency CNA "M" walked into room 522 without knocking or announcing herself. Two residents were noted to occupy the room. Agency CNA "M" did not have a visible name tag and was wearing a regular (street clothing, not scrubs/uniform to be easily identified as staff) sweatshirt with writing and graphics on it. Agency CNA "M" indicated this was not her first time working at the facility, but it was her first time working on this unit (high 500 hall). On 10/12/22 at 3:44 PM, during an interview, LPN "K" (not an agency staff member) was queried regarding any concerns he has heard from residents in the facility. LPN "K" stated that he has heard complaints from the residents residing in the high 600 hall regarding the agency staff. LPN "K" elaborated that the residents have told him that the agency staff who come to the facility "Don't seem to care...there is a lack of caring." On 10/12/22 at 3:50 PM, Confidential Witness "F" approached and was visibly upset with various aspects regarding their loved one's care at the facility. Witness "F" did indicate that they wished for themselves and their loved one to be anonymous at this time. Part of Witness "F" complaints included, "A lot of the aides are temps (agency staff). How do they get the shifts on the same page? A lot of staff, I will tell them something (regarding their loved one who resides in the facility) and they will say, 'Well I didn't know that.'" Witness "F" further indicated that they had concerns that agency staff would not know their loved one well enough to realize if something was wrong or abnormal, and that their loved one was unable to communicate any of those types of issues. On 10/13/22 at 1:30 PM, the Nursing Home Administrator (NHA) was interviewed during the			

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	Quality Assurance (QA) task review. The NHA identified staffing as an area of concern and added, "We are trying very hard to remove agency staff, and are trying to bring in staff of our own." A review of resident council meeting minutes from 5/19/2022 revealed the following, "Some aides argue with resident, when [they] tell them how to take care of [them]." On 10/12/22 at 2:02 PM, a confidential group meeting was held with eight residents. Of the eight residents, four expressed their concerns related to dignity and respect. One resident explained that they have been told to "Shut up and sit down" which made them feel like a "Piece of [expletive]." Another resident explained that the tone in which they are spoken to by staff is "disrespectful" and has been told by agency staff that, "They are lucky they are even here." This same resident indicated that there is no consistency with staff, it takes hours for someone to respond, and when they do come, they lack manners and have a bad attitude. Another resident stated, "This should be a sanctuary for healing. I'm not happy with the people that come in, they are disrespectful." They further explained that staff don't care if you're upset, it's either their way or no way, and it's frustrating. A review of the facility's policy/procedure titled, "Promoting and Maintaining Resident Dignity," dated 01/2018, revealed, "POLICY: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. PROCEDURE: 1. All staff members are involved in providing care to residents to promote and maintain resident			

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	dignity and respect resident rights...10. Speak respectfully to residents;...11. Respect the resident's living space and personal possessions...12. Maintain resident privacy..."			
F0558 SS= D	Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to accommodate a resident by having their call light out of reach, affecting one resident (R524) of one resident reviewed for accommodation of needs, resulting in the inability to use the call light and the potential for unmet care needs. Findings include: On 10/11/22 at 12:20 PM, an observation was made in R524's room of their call light hanging over a metal pole, out of reach of the resident. R524 was interviewed about the call light being out of their reach and had no response. On 10/12/22 at 4:03 PM, an observation was made of R524's call light being on the floor out of their reach. On 10/12/22 at 4:10 PM, Certified Nursing Assistant (CNA) "L" was shown the location of	F0558	F558: Accommodation of Needs Element #1 The staff did not place resident #524 call light in reach resulting in delay in provision of services. Bedside audit conducted to ensure resident #524 has a functional call light with clip attached and in reach. Element #2 Residents residing in the facility have the potential to be affected in a similar manner. DON/designee conducted an audit to ensure call lights were within each and answered timely. Concerns were addressed at time of findings. A house audit was conducted by Maintenance to ensure that call lights have appropriate cord length and clips attached to ensure they can be secured to blanket for use by resident as needed. Element #3 Admin/DON reviewed Call Light Response Monitor Policy and deemed it appropriate. Staff was educated on this policy and acknowledged understanding. Resident council who meets monthly will review call light responses and report findings to the Administrator for follow up. Concerns will be addressed through concern/grievance process. Element # 4 DON/designee will audit 20 random residents weekly to ensure their call lights are within reach and secured in some fashion to allow an ease of reach (i.e. clip or securing to a	11/8/2022

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	R524's call light and interviewed regarding where R524's call light should be located. CNA "L" indicated that R524's call light should be within reach of the resident. CNA "L" was observed attaching R524's call light to their bedsheet next to the resident. On 10/13/22 at 10:40 AM, the Director of Nursing (DON) was interviewed about their expectation on where call lights should be positioned for residents and stated, "The call light should be positioned over the resident or clipped to the resident so it is within reach." On 10/13/22 at 10:55 AM, a review of R524's electronic medical record (EMR) revealed that R524 was admitted to the facility on 10/7/22 with diagnoses that included Heart disease and Chronic obstructive pulmonary disease (COPD) (Breathing related difficulty). R524's Brief interview for mental status exam on 10/8/22 revealed that R524 had a severely impaired cognition. On 10/13/22 at 11:00 AM, a facility policy titled "Call Light Response Monitor Issue Date: 6/8/18" was reviewed and stated the following, "PROCEDURE: 2. A resident's call light should be within reach when they are in their room. 'Within reach' also includes those residents who use independent locomotion to move about the room and may be defined as within the resident's capacity to attain or achieve the call light independently."		frame, etc.). This will be completed weekly x 4 weeks and then monthly x 3 months thereafter. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter	

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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 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	F0656	F656: Develop/Implement Comprehensive Care Plan Element #1 Residents #94 did not have comprehensive care plans in place to ensure interventions are in place for showers. Resident # 94 care plan has been reviewed and updated to reflect bathing assistance and preference. Residents # 577 did not have comprehensive care plans in place to ensure interventions are in place for diabetic management. Resident # 577 care plan has been reviewed and updated to reflect diabetes management. Element #2 Residents residing in the facility have the potential to be affected in a similar manner. An audit of residents ADL care plans was conducted to ensure residents assistance was included. Any resident not in compliance was corrected. Residents who reside in the facility with a diagnosis of diabetes have the potential to be affected in a similar manner. An audit was conducted of residents with a diagnosis of diabetes to ensure interventions were in place and care plans updated as indicated. Element #3 Admin/DON reviewed Comprehensive Person-Centered Care Plan and deemed it appropriate. ADON/designee, will educate Licensed nursing staff on the facility policy for implementing a comprehensive person-centered care plan for residents. Comprehensive care plan is developed after completion of the comprehensive assessment. Care plans are reviewed, revised and updated at 48hr, quarterly, annual care conferences and as indicated after change in status.	11/8/2022

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	evidenced by: Based on interview and record review, the facility failed to develop care plan interventions for a diagnosis of Diabetes, and showers for two of two residents (R94 and R577) reviewed for care planning, resulting in the potential for unmet care needs. Findings include: R94 On 10/11/22 at 4:17 PM, R94 was interviewed regarding their care at the facility and indicated that they didn't receive their showers on a consistent basis. On 10/13/22 at 1:40 PM, R94 was further interviewed about their showers and indicated that they received showers approximately once per week on average. R94 stated, "They just don't have enough staff." R94 further indicated that for the most part they feel clean, but that they would like to receive showers, "A little more often. Staff tell me that they are, 'Too busy'." On 10/13/22 at 1:55 PM, a review of R94's care plan located in their electronic medical record (EMR) revealed no indication of a goal/interventions related to showers on their care plan. On 10/13/22 at 2:05 PM, a further review of R94's EMR revealed that R94 was originally		Element # 4 Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator(s) and updated as indicated. DON/designee will complete random weekly audits of 5 residents care plans for six (6) consecutive weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents. Audit records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	

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	admitted to the facility on 1/28/21 with diagnoses that included Multiple sclerosis and Heart disease. R94's most recent minimum data set assessment (MDS) dated 9/6/22 revealed that R94 had an intact cognition and required limited assistance/supervision with all activities of daily living (ADLs) other than eating. R577 On 10/11/22 at 11:14 AM, R577 was observed sitting up in bed. Attempts to interview the resident were unsuccessful as they were pleasantly confused. A review of R577's medical record revealed that the resident was admitted into the facility on 8/10/22 with diagnoses that included Depression, Diabetes and Hypertension. Further review revealed a Minimum Data Set assessment dated for 9/28/22 revealing that the resident had a Brief Interview for Mental Status score of 13/15 indicating an intact cognition, and required limited to extensive assistance for Activities of Daily Living. Further review of R577's medical record revealed that the resident had a physician's order for the following dated for 9/19/22, "Metformin HCl (Anti-diabetic) Tablet 500 MG (milligrams). Give 1 tablet by mouth two times a day for Prophylaxis ... Further review of R577's medical record revealed that the resident did not have a diabetes care plan initiated until 10/12/22. On 10/13/22 at 2:34 PM, the Director of Nursing (DON) was interviewed and asked about their			

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	expectations regarding resident care planning, resident goals and interventions. The DON indicated that resident care areas should have goals and interventions listed on the care plan. The DON was further interviewed about R94's care plan not having a shower goal/interventions listed on the care plan. The DON left and returned with R94's ADL care plan with the following intervention listed on R94's care plan, "Interventions/Tasks Bathing/Showering: 1 person assist Date Initiated: 10/13/22." The DON indicated that they had placed the intervention on R94's care plan today (10/13/22). On 10/13/22 at 3:07 PM, a review of a facility policy titled "Baseline Plan of Care Issue Date: 09/17/2020" stated the following, "POLICY: The facility will develop and implement a...care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. 2. b. Interventions shall be initiated that address the resident's current needs including: ii. Any identified needs for...assistance with activities of daily living."			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: This citation pertains in part to intakes MI00131282, MI00131091, MI00130665 and MI00131416. Based on observation, interview, and record review, the facility failed to provide feeding	F0677	F 677 ADL Care provided for Dependent Residents Element #1 CENA did not provide incontinence care per plan of care for resident # 42. Resident□s # 42 plan of care has been reviewed and updated to ensure interventions are in place re: incontinence care. CENA did not provide feeding assistance per plan of care for resident # 107. Resident□s # 107 plan of care has been reviewed and updated to ensure interventions are in place re: feeding assistance. Element #2	11/8/2022

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	assistance per the plan of care and failed to provide timely incontinence care to a dependent resident affecting two residents (R42 and R107) of ten reviewed for activities of daily living (ADLs) resulting in unmet care needs and the potential of further decline. Findings include: Resident #42 (R42) A review of 42's Minimum Data Set (MDS) assessment dated 8/4/22 revealed that the resident was admitted into the facility on 6/23/2020, is severely cognitively impaired, and has medical diagnoses including Fracture of Lumbar Vertebra (history of), Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Anxiety Disorder, Depression, Pulmonary Hypertension, Osteoarthritis, Alzheimer's Disease, Dementia, Dysphagia, Heart Failure, Muscle Weakness, Glaucoma, Muscle Weakness, and Need For Assistance With Personal Care. On 10/12/22 at 11:56 AM, upon entering the room, R42 was observed lying in bed on her back with the head of the bed in high fowler's position. R42 was moaning/calling out. The resident's blanket was pushed off of her, exposing her incontinence brief. R42 motioned to this surveyor to come closer. R42 was making crying/moaning sounds but was unable at this time to verbalize what was wrong. On 10/12/22 at 11:59 AM, Licensed Practical Nurse (LPN) "G" and Therapy Staff "H" entered R42's room. LPN "G" asked the resident if she was having pain to which she said, "Yes, my back, my back." R42 was observed with no offloading devices other than foam boots on her feet. R42 continued to moan out. R42's brief was observed to be saturated with urine, which could be seen from the outside of the brief. LPN "G" and Staff "H" boosted the resident up in bed and		Residents residing in the facility who are dependent for toileting and feeding have the potential to be affected in a similar manner. An audit was completed by the DON/designee of dependent residents to ensure residents are changed per plan of care as well as receive feeding assistance as needed. Element #3 Admin/DON reviewed ADL Policy and deemed it appropriate. The nursing staff was educated on this policy including incontinence care and feeding assistance. Task lists have been reviewed to ensure incontinence care and feeding assistance is appropriate for each dependent resident requiring assistance. Task lists, and care plans were updated as indicated. Element # 4 DON/designee will conduct random audits at bedside of 10 residents per week x 6 weeks to ensure residents are receiving incontinence care and feeding assistance as deemed appropriate per plan of care. Areas of concern will be addressed at time of findings and staff will be given 1:1 education as needed. Audit results will be reported to the QAPI committee for review. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	

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slightly adjusted her positioning. LPN "G" asked if that helped R42 feel any better to which the resident responded, "Yes, a little bit, not much, not much, not much." The resident was positioned as turned towards her right side but still on her back. R42 indicated that her back still hurt to which LPN "G" offered medication. R42 accepted and as LPN "G" went to gather the medication, she was queried regarding the resident's brief being wet. LPN "G" looked at Staff "H" and both indicated that they had not even looked at the resident's brief to see if it was wet.

On 10/12/22 at 12:05 PM, Agency Certified Nursing Assistant (CNA) "I" entered the hallway and was queried if R42 had been changed yet this shift (day shift). CNA "I" indicated that the resident had not yet been changed on this shift. CNA "I" further indicated that in addition to R42, she had not yet provided morning care to R42's roommate, the two residents in room 523, nor the resident in 522 bed B. CNA "I" indicated that she was just getting back from her break after finishing the first half of her set, and was assigned to care for 16 residents this shift. LPN "G" indicated at this time that R42 has skin breakdown and entered back into the resident's room to administer pain medication to the resident.

On 10/12/22 at 12:15 PM, LPN "G" and CNA "I" provided incontinence care to R42. R42's brief was observed to be saturated with urine, and the resident did have a dressing in place (not intact) for a pressure ulcer on the sacrum. R42 was cleaned up, a new brief was applied, and CNA "I" changed the resident's gown. R42 indicated that she now felt a little bit better. Staff did not replace the soiled wound dressing with with a new one.

A review of R42's care plan revealed:

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-"The resident has bladder incontinence r/t (related to) Alzheimer's, Impaired Mobility Date Initiated: 06/29/2020."

-"BRIEF USE: The resident uses disposable briefs. Change often and prn (as needed). Date Initiated: 06/29/2020."

-"Clean peri-area with each incontinence episode. Date Initiated: 06/29/2020."

-"Risk for Pressure Ulcer Formation related to: generalized debility and weakness as evidenced by: decreased mobility in bed and wheelchair, incontinence of bowel and bladder. Resident need staff assistance with incontinence care, turning and re positioning...Date Initiated: 08/08/2022."

Resident #107 (R107)

A review of R107's Minimum Data Set (MDS) assessment dated 9/1/22 revealed that the resident was admitted into the facility on 1/19/2016, is severely cognitively impaired, and has medical diagnoses including Alzheimer's Disease, Dementia, Depression, Anxiety, Muscle Weakness, Need For Assistance With Personal Care, Type 2 Diabetes Mellitus With Hypoglycemia Without Coma, and Moderate Protein-Calorie Malnutrition.

A review of R107's weights over the last three months revealed:

-Four weights in the month of July - 90.0 Lbs (pounds)

-8/3/2022 - 90.0 Lbs

-8/17/2022 - 90.2 Lbs

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	-8/24/2022 - 90.0 Lbs -8/31/2022 - 91.0 Lbs -9/21/2022 - 90.0 Lbs -10/5/2022 - 87.6 Lbs A review of R107's progress notes revealed the following: -"8/10/2022 10:16 (AM) Nutrition/Dietary Note... [R107] resides at [facility] long term, she has hx (history) of dementia, requires assistance with meals, can eat some foods independently, gets a sandwich and soft cookie with meals so she can pick it up and independently feed..." On 10/11/22 at 11:41 AM, 12:01 PM, and 12:14 PM, 12:38 PM, and 1:04 PM, R107 was observed sitting in her wheelchair, alone in her room. R107 appeared thin and did not respond to interview attempts. R107's breakfast tray was observed sitting in front of her with approximately 50% of the food eaten off the tray. No adaptive equipment was noted on the tray. On 10/11/22 at 1:19 PM, Licensed Practical Nurse (LPN) "G" was observed setting up R107's lunch tray. At 1:50 PM, R107 was observed in her room with no staff present. R107 was feeding herself a sandwich. The lunch tray in front of the resident now contained an adaptive scoop plate. None of the remaining food on the tray was noted to have been eaten. R107 did not respond to further interview attempts at this time. On 10/13/22 at 11:44 AM, R107 was observed sitting in her wheelchair in her room. R107's breakfast tray was observed sitting in front of her with almost all of the food appearing uneaten. R107 was not attempting to feed herself at this			

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time and no staff was present in the room. R107's tray included what looked like an omelette, scrambled eggs, a banana (with a couple bites taken), a full bowl of cereal (no spoon), a piece of toast, and juice. Nurse Unit Manager "D" was brought into R107's room at this time and queried if the resident required assistance during meals. Manager "D" indicated that it appeared the resident needed some help with eating this morning. Agency Certified Nursing Assistant (CNA) "J" was asked by Manager "D" about R107's level of assistance required during meals. CNA "J" stated that sometimes the resident could feed herself, but some days she needed a bit more encouragement. Upon inquiry as to when R107 received her morning meal, CNA "J" indicated she had set up the resident's breakfast tray at 10:30 AM. Manager "D" reviewed R107's chart and stated that the resident required 1:1 assistance and a scoop plate during meals per the care plan. Manager "D" directed CNA "J" to go assist R107 with eating breakfast.

A review of R107's care plan revealed:

-"The resident is at nutritional risk related to PMH (past medical history) including dementia, DM (diabetes mellitus), anxiety, HTN (hypertension), and PCM (protein-calorie malnutrition). BMI (body mass index) = underwt (underweight)...Requires feeding assistance with supervision...March 99lbs (pounds). BMI 17...5/18/22 wt. (weight) loss 10% at 90lbs...6/3/22 WT. LOSS per 6 Month Wt: 88.4...7/1/22: wt 90...8/1/22: 90 with MASD (moisture associated skin damage), albumin 3.3...9/1 wt 91 intake variable...Date Initiated: 11/24/2021."

-"Self feeding: x1 1:1 assistance, scoop plate...Date Initiated: 07/12/2022 Created by: ...OTR (Occupational Therapist)."

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	-"The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) Alzheimer's, Dementia Date Initiated: 04/17/2020." On 10/13/22 at 2:40 PM, the Director of Nursing (DON) was interviewed regarding ADL assistance and indicated that she expects residents to receive assistance from staff for ADLs if it is care planned. A review of the facility policy/procedure titled, "Activities of Daily Living," dated 4/1/22, revealed, "...Resident needs for ADL care will be met according to resident specific care plan...Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer and ambulation; 3. Toileting; 4. Eating to include meals and snacks...4) A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene..."			
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 observation, interview, and record review, the facility failed to follow a physician's order for a skin treatment for one resident (R577)	F0684	F684: Quality of Care Element #1 Resident # 577 did not have a physician order in place to address the skin altercation which resulted in potential delay in treatment. Resident # 577 chart was reviewed, physician order obtained and treatment administered as ordered. Resident currently has no skin issues. Care plans were reviewed, and interventions updated as indicated. Element #2 Residents residing in the facility with skin alterations requiring treatment have a potential to be affected in a similar manner. An audit was completed of residents who had	11/8/2022

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	of four reviewed for skin conditions, resulting in unmet skin care needs. Findings include: On 10/11/22 at 11:14 AM, R577 was observed sitting up in bed with a wound dressing on their right arm dated "10/7". Attempts to interview the resident were unsuccessful as they were pleasantly confused. On 10/12/22 at 11:52 AM, R577 was observed sitting in their wheelchair. The wound dressing observed on their right arm the day prior remained dated "10/7". A review of R577's medical record revealed that the resident was admitted into the facility on 8/10/22 with diagnoses that included Depression, Diabetes and Hypertension. Further review revealed a Minimum Data Set assessment dated for 9/28/22 revealing that the resident had a Brief Interview for Mental Status score of 13/15 indicating an intact cognition, and required limited to extensive assistance for Activities of Daily Living. Further review of R577's medical record revealed that the resident had an order dated 9/19/22 indicating the following, "Site: RUE (right upper extremity, 2 skin tears) 1) Cleanse wound with NS (normal saline) 2) Pat Dry with Gauze 3) Apply foam dressing (date) every day shift every 3 day(s) for wound care AND as needed for wound care." A review of R577's Treatment Administration Record (TAR) revealed that the physician's order was documented as completed on 10/10/22.		orders specifically for skin care to ensure that the physician orders were in place and carried out as written. Anything that was found out of compliance was corrected. Element #3 Admin/DON reviewed Consulting Physician/Practitioner Orders and deemed it appropriate. ADON/designee educated the Licensed nurses on the policy. Upon completion of skin assessment and new wound occurrence the physician will be notified, and new orders obtained for wound consult, treatment and monitoring. Element #4 DON/designee will review 24hr report and skin assessments Monday-Friday during morning clinical meeting to ensure new skin issues have complete and accurate assessments, orders, monitoring and interventions care planned and in place to prevent worsening. Areas of concern will be addressed at time of finding. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	

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	On 10/13/22 at 11:13 AM, R577's wound dressing on their right arm was observed as dated "10/7". On 10/13/22 at 2:36 PM, the Director of Nursing (DON) was asked about wound care treatments and her expectation for ensuring that physician orders are followed. The DON explained that the wound care nurse is in the facility Monday through Friday and if wound treatments are not completed by the wound care nurse, the assigned nurse for the resident should be completing the wound care. A review of the facility's "Skin/Wound Policy" revealed the following, "...6. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change..."			
F0686 SS= G	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F0686	F 686: Skin treatment services to prevent/ heal pressure ulcers Element #1 The nurse did not properly assess, treat and implement interventions to prevent pressure ulcer from developing on resident□s # 42 and # 111. The DON/designee conducted full head to toe skin assessment on resident #42. Resident # 42 is being followed by wound care. Pressure ulcer identified on assessment has a complete order, treatment in place with interventions implemented to prevent further worsening. Care plan updated as indicated. The DON/designee conducted full head to toe skin assessment on resident #111. Resident # 111 is being followed by wound care. Each wound identified on assessment has a complete order, treatment in place with interventions implemented to prevent further	11/8/2022

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	review, the facility failed to prevent the development of pressure ulcers and implement pressure ulcer interventions for two (R42 and R111) of three residents reviewed, resulting in facility acquired pressure ulcers, the potential for the worsening of existing pressure ulcers, and/or the development of additional skin impairments. Findings include: R111 On 10/13/22 at 11:04 AM, R111 was observed lying in bed on their back with wound dressings observed on both their left and right elbow. R111 was asked about their wound dressings and explained that they are pressure ulcers that were acquired while staying at the facility. R111 detailed the number of pressure ulcers that they have, and explained that the facility staff are supposed to turn and reposition them, but it is not done consistently due to a lack of staffing. A review of R111's medical record revealed that they were admitted into the facility on 5/26/22 with diagnoses that included Stage 4 Pressure Ulcer of Sacral Region, Metabolic Encephalopathy, Legal Blindness and Hypotension. Further review of R111's medical record revealed a Minimum Data Set assessment dated for 8/30/22 that revealed a Brief Interview for Mental Status score of 14/15 indicating an intact cognition. In addition, R111 required extensive assistance		worsening. Care plan updated as indicated. Element #2 Residents residing in the facility with pressure ulcers have the potential to be affected in a similar manner. Residents with pressure ulcers and those identified at admission have had comprehensive chart reviews conducted, proper assessments, wound consult ordered, treatments, interventions implemented, and care plans updated as indicated. Element #3 Admin/DON reviewed Skin & wound Policy and deemed it appropriate. Licensed Nursing staff have been re-educated on the skin & wound policy. Wound nurse will review new admissions skin and conduct weekly wound rounds to ensure each resident has proper assessments, treatments and interventions implemented and documented accurately. Findings will be corrected and reported to the DON. Element #4 DON/designee will review 24hr report and skin assessments Monday-Friday during morning clinical meeting to ensure new skin issues have complete and accurate assessments, orders, monitoring and interventions care planned and in place to prevent worsening. Areas of concern will be addressed at time of finding. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	

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	of two persons for bed mobility and transfers. Further review of R111's medical record revealed an admission skin assessment dated for 5/26/22 noting the following: Open Coccyx wound (infected), old surgical wound from knee down to ankle, right trochanter hip surgical incision, and chest, 2 small abrasions. Further review of R111's medical record revealed the following progress notes: "6/20/2022 12:46 (12:46 pm) Nursing - Skin/Wound Note. Writer assessed residents left elbow r/t (related to) wound care consult. Resident was admitted with scabs noted to bilat (bilateral) elbows, 'scab peeled off' according to resident. Tx (treatment) in place for wound and protection." "6/30/2022 09:00 (9:00 am) Type: Wound Rounds Note. [R111] seen for follow up wound management. [R111] has a unstageable to the sacrum. Has DTI (Deep Tissue Injury) to both heels. Now has an unstageable to [their] left elbow....On the left elbow there is an unstageable wound measuring 3.2cm (centimeters) x 1.5cm that has irregular edges, with slough (dead tissue), scant drainage, no odor, the periwound is intact....ASSESSMENT AND PLAN:...3. The patient needs to be turned frequently..." "7/26/2022 14:10 (2:10 pm) Type: Physician Team - Progress Note: Patient was seen today, since staff reported sacral wound			

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	worsening, also reported there was a scab on the R (right) -elbow that fell off, pt (patient) already on high protein supplements to promote wound healing." "7/28/2022 10:31 (10:31 am) Type: Nutrition/Dietary Note: Pressure ulcer/wound review. Resident has high protein needs for wound healing. Currently on high protein supplements to promote wound healing...Has stg. (stage) 3 rt. elbow (full thickness skin loss), stg. U (unstageable) left elbow..." "7/28/2022 21:08 (9:08 am) Type: Wound Rounds Note: Wound Consult Left elbow stg 4 ulcer (deep wound reaching the muscles, ligaments, or bones), refer to, [electronic medical record] moderate drng (drainage), no clinical evidence of infection, surrounding tissue intact, base granular, Recommend Tx: cleanse with 1/4 str (strength) dakins (topical antiseptic), apply silver alginate (wound dressing) cover with ABD QD (every day). Right elbow stg 4 ulcer, refer to [electronic medical record], moderate drng, no clinical evidence of infection, surrounding tissue intact, base granular, Recommend Tx: cleanse with 1/4 str dakins, apply silver alginate cover with ABD QD..." "10/6/2022 14:53 (2:53 pm) Type: Wound Rounds Note HPI (History of Present Illness): seeing pt re: multiple wounds...SKIN:...left elbow stg 4 ulcer, refer to [electronic medical record], moderate drng, no clinical evidence of infection, surrounding tissue intact, base			

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granular. Recommend Tx: apply silver collagen gel cover with foam dressing 3x/week.

Right elbow stg 4 ulcer, refer to [electronic medical record], moderate drng, no clinical evidence of infection, surrounding tissue intact, base granular. Recommend Tx: apply silver collagen gel cover with foam dressing 3x/week..."

A review of R111's care plan revealed the following: "Actual Pressure Ulcer Formation Related to: Resident was admitted with-- or has pressure ulcer____, with risk for delayed wound healing secondary to progressing comorbidities, Debility and generalized weakness with decreased physical mobility and bowel/ bladder incontinence daily...Date Initiated: 05/27/2022. Interventions: Frequent turning and repositioning Date Initiated: 07/21/2022 Provide surface support and pressure redistribution, position changes, and off loading daily. Date Initiated: 05/27/2022..."

Resident #42 (R42)

A review of 42's Minimum Data Set (MDS) assessment dated 8/4/22 revealed that the resident was admitted into the facility on 6/23/20, is severely cognitively impaired, and has medical diagnoses including Fracture of Lumbar Vertebra (history of), Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Anxiety Disorder, Depression, Pulmonary Hypertension, Osteoarthritis, Alzheimer's Disease, Dementia, Dysphagia, Heart Failure, Muscle Weakness,

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	Glaucoma, Muscle Weakness, and Need For Assistance With Personal Care. A review of R42's medical record indicated that the resident had recently been re-admitted to the facility on 10/10/22 after being in the hospital for just over a week with pneumonia. A review of R42's skin assessment dated 10/10/22 revealed that the resident now had a Stage III (full-thickness skin loss) pressure ulcer (no location listed, however, the assessment photo showed the wound on the resident's sacrum). The assessment indicated that the wound was new and present on re-admission from the hospital, however, the "After Visit Summary," dated 10/10/22 and corresponding hospital documentation indicated that R42 was admitted into the hospital on 10/2/22 with a Stage II (partial-thickness skin loss with exposed dermis) sacral pressure injury. R42's skin assessment dated 10/10/22 indicated that pressure ulcer care to be provided in addition to the wound treatment included, "Incontinence management...Positioning Wedge...Turning/repositioning program..." R42's current physician orders were reviewed and revealed: -"Wound Care Order Site: Buttocks 1) Cleanse wound with NS (normal saline) 2) Pat Dry with Gauze 3) Apply silver alginate 4) Cover with foam (date)...every day shift every Tue, Thu, Sat for wound care AND as needed for wound care...Active 10/10/2022." On 10/11/22 at 1:18 PM, R42 was observed lying in bed on her back with the head of the bed			

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	slightly elevated. No positioning wedges were being utilized. On 10/12/22 at 11:56 AM, upon entering the room, R42 was observed lying in bed on her back with the head of the bed in high fowler's position. R42 was moaning/calling out. The resident's blanket was pushed off of her, exposing her incontinence brief. R42 motioned to this surveyor to come closer. R42 was making crying/moaning sounds but was unable at this time to verbalize what was wrong. On 10/12/22 at 11:59 AM, Licensed Practical Nurse (LPN) "G" and Therapy Staff "H" entered R42's room. LPN "G" asked the resident if she was having pain to which she said, "Yes, my back, my back." R42 was observed with no offloading devices other than foam boots on her feet. R42 continued to moan out. R42's brief was observed to be saturated with urine, which could be seen from the outside of the brief. LPN "G" and Staff "H" boosted the resident up in bed and slightly adjusted her positioning. LPN "G" asked if that helped R42 feel any better to which the resident responded, "Yes, a little bit, not much, not much, not much." The resident was positioned as turned towards her right side but still on her back. R42 indicated that her back still hurt to which LPN "G" offered medication. R42 accepted and as LPN "G" went to gather the medication, she was queried regarding the resident's brief being wet. LPN "G" looked at Staff "H" and both indicated that they had not even looked at the resident's brief to see if it was wet. On 10/12/22 at 12:05 PM, Agency Certified Nursing Assistant (CNA) "I" entered the hallway and was queried if R42 had been changed yet this shift (day shift). CNA "I" indicated that the resident had not yet been changed on this shift. LPN "G" indicated at this time that R42 has skin			

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	breakdown and went back into the room to administer pain medication to the resident. On 10/12/22 at 12:15 PM, LPN "G" and CNA "I" provided incontinence care to R42. R42's brief was observed to be saturated with urine. A bordered foam dressing dated 10/11/22 was present on R42's sacrum at this time. The dressing appeared soiled and was not intact i.e. the edges were rolled up on one side, exposing the pressure ulcer. CNA "I" cleaned R42's skin, applied a clean dry brief, and changed the resident's gown. R42 indicated that she now felt a little bit better. The wound dressing was not replaced with a new dressing before staff left the room, and R42 was left lying in bed with no positioning devices to help offload pressure on her sacral pressure ulcer. On 10/13/22 at 8:49 AM, a wound care observation for R42 was conducted with Wound Care Nurse (WCN) "Y" and CNA "Z". Nurse "Y" stated that R42 recently went to the hospital and had "Excoriation," on her bottom at the time, but was re-admitted with, "A full blown pressure ulcer." R42 was observed lying in bed on her back. When queried about a positioning wedge(s) for the resident, Nurse "Y" indicated that the resident has one that should be utilized. Upon review of R42's sacrum, the same soiled dressing dated 10/11/22 with rolled edges was present. However, upon closer inspection, the dressing appeared to have caused an additional skin tear (flap of skin seen with bright red, wet tissue underneath) on the resident's right buttock that was not present when incontinence care was observed the previous day. When queried regarding the wound dressing, Nurse "Y" stated that the assigned nurses can change the dressing as needed (PRN). When informed that the same dressing was observed as not intact the previous day during incontinence			

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care, Nurse "Y" stated she would have expected the dressing to have been changed at that time. Nurse "Y" added, "That's why I put the PRN orders in."

When queried about offloading pressure and turning/repositioning R42, Nurse "Y" put a positioning wedge under the resident's right side and stated she expects the resident to be turned/repositioned every two hours and for pressure to be offloaded on the resident's wound/backside.

On 10/13/22 at 9:56 AM and 11:52 AM, R42 was observed lying in bed in the same position as was observed after wound care completion at 8:49 AM. R42's positioning wedge remained under the right side and the resident did not appear to have been moved in bed.

On 10/13/22 at 2:40 PM, the Director of Nursing (DON) was interviewed and asked what her expectation of nurses is if a wound dressing is not intact (has rolled up edges and/or soiled). The DON stated she expects nursing to change the dressing PRN if there is an order. The DON further indicated that dependent residents are expected to be turned/repositioned in bed at least every two hours, and she expects a positioning device to be in place to offload pressure if a resident has a skin concern.

A review of R42's care plan revealed:

-"The resident has bladder incontinence r/t (related to) Alzheimer's, Impaired Mobility Date Initiated: 06/29/2020."

-"BRIEF USE: The resident uses disposable briefs. Change often and prn (as needed). Date Initiated: 06/29/2020."

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	-"Clean peri-area with each incontinence episode. Date Initiated: 06/29/2020." -"Risk for Pressure Ulcer Formation related to: generalized debility and weakness as evidenced by: decreased mobility in bed and wheelchair, incontinence of bowel and bladder. Resident need staff assistance with incontinence care, turning and re positioning...Date Initiated: 08/08/2022." -"Frequent turning and repositioning. Date Initiated: 10/10/2022." -"Provide surface support and pressure redistribution, position changes, and off loading daily. Date Initiated: 10/10/2022." -"Provide wound care as ordered by physician and wound consult recommendations. Date Initiated: 10/10/2022." A review of the facility's policy/procedure titled, "Skin & Wound Policy," dated 04/2022, revealed, "...It is...our policy to follow the treatment plans for any wound / skin concerns as ordered by physicians...6. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change...8. Dressing changes may be provided outside the frequency parameters in certain situations: a. Feces has seeped underneath the dressing. b. The dressing has dislodged. c. The dressing is soiled otherwise, or is wet..."			
F0689 SS= G	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is	F0689	F689: Free of Accident and Hazzard/ supervision and Providing Safe Transfers Deficient Practice #1	11/8/2022

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	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Deficient Practice Statement #1 pertaining to intake MI00131282: Based on observation, interview, and record review, the facility failed to transfer a resident per the plan of care, affecting one (R129) of eight reviewed for accidents, resulting in a large, deep leg laceration that required a transfer to the hospital and 26 sutures. Findings include: A review of a complaint submitted to the State Agency revealed: "It was alleged that facility staff failed to properly transfer the resident, resulting in injury." A review of R129's Minimum Data Set (MDS) assessment dated 9/12/22 revealed that the resident was initially admitted into the facility on 3/9/20 and re-admitted on 2/24/22, is severely cognitively impaired, and requires extensive to total assistance from staff for activities of daily living (ADLs). R129's medical diagnoses include Subsequent Encounter For Fracture With Routine Healing, Vascular Dementia, Alzheimer's Disease, Type 2 Diabetes Mellitus Without Complications, Dysphagia, Moderate Protein-Calorie Malnutrition, Need For Assistance With Personal Care, Muscle Weakness, Difficulty In Walking, Syncope And Collapse, Anxiety, Edema, Pneumonia, Thrombosis, Respiratory Failure, Laceration Without Foreign Body, Right Lower Leg, Subsequent Encounter, and Sick Sinus Syndrome.		Element #1 Staff did not properly transfer a resident per plan of care which resulted in an injury. Resident # 129 has had chart review continues to be a 2 person assist for transfers with hoyer. Care plan updated as indicated. The resident has had no further incidents. Element #2 Residents residing in the facility who require assistance with hoyer transfers have the potential to be affected in a similar manner. Current residents were assessed for their transfer status, happy feet sign/Kardex updated to ensure accuracy. Hoyer lifts are functional and present on all units to assist with transfers. Element #3 Admin/DON reviewed Happy Feet Transfer Program and Fall Risk Injury prevention and deemed it appropriate. Nursing Staff were educated on the policy and procedure for proper transfers and injury prevention. Element #4 DON/designee will conduct random audits of up to 10 residents weekly x 4 then monthly x3 to ensure proper transfer status is written and implemented per plan of care. Findings will be addressed at time of audit with 1:1 education and return demonstration as indicated. Audit records will be reviewed by the Quality Assurance Committee for review and further recommendations. Deficient Practice #2 Staff did not properly supervise a resident at risk for elopement. Element #1 Residents # 23 chart has been reviewed,	

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	A review of R129's care plan revealed: -"Transfers: x2 with Hoyer, Date Initiated: 03/09/2020." -"Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface., Date Initiated: 03/10/2020." -"TRANSFER: The resident requires Mechanical Lift, Date Initiated: 12/29/2021." On 10/11/22 at 1:08 PM, Confidential Witness "C" was interviewed regarding R129's care at the facility. Witness "C" expressed concern regarding the resident being transferred in an unsafe manner and sustaining an injury to her leg that required a hospital visit and significant amount of sutures. On 10/11/22 at 1:15 PM, R129's right lower leg was observed to have a large "C"-shaped scar. On 10/11/22 at 1:49 PM, photos of R129's injury sustained in the facility on 11/25/21 were reviewed and revealed a large, bleeding, "C"-shaped wound with flap of skin on the resident's right lower leg that extended into the subcutaneous (fatty) tissue. A photo of the wound after closure was also reviewed and revealed that it required an extensive amount of sutures for closure. Bruising was also noted around the injury site. A review of R129's progress notes revealed the following: -"11/25/2021 21:43 (9:43 PM)...Writer notified by staff nurse that [R129] had obtained a laceration to...leg during a transfer into bed by CENA (Certified Nursing Assistant - CNA). Upon arrival to room, pt. (patient) was in bed		resident has appropriate assessments, interventions implemented, and plan of care updated. Appropriate assessments and monitoring are in place as needed. Element #2 Residents residing in the facility at risk for elopement have the potential to be affected in a similar manner. Residents at risk for wandering have been re-assessed, with appropriate interventions implemented, monitored and care plan updated. The wanderguard bracelets were checked for placement and function. All doors were checked for proper closure/locking, and elopement drills are current and up to date according to the schedule. Elopement risk binders which contain pictures of residents listed as elopement risks have been placed at every unit and the front desk and are updated as indicated. Element #3 Admin/DON reviewed Elopement Policy and deemed it appropriate. Facility staff have been educated on policy and regarding the requirement of staff to promptly respond to and effectively communicate observed behaviors related to exit seeking behavior, attempted elopement, wandering behaviors, and response to actual elopement. Residents identified at risk will have wanderguard placed, with appropriate interventions implemented, monitored and care plan updated. Element #4 DON/designee will review 24hr report and high risk progress notes Monday-Friday during morning for documentation indicating wandering behavior. DON/designee will	

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	lying on her left side with her right leg wrapped up in a bandage. Bandage pulled back and a deep laceration noted thru to the fatty tissue of about 1.5 inches long with bleeding noted. Pressure bandage in place. EMS (emergency medical service) notified to transport pt. to hospital for eval. (evaluation) and treatment. Nurse notified on call doctor and family. D.O.N (Director of Nursing) notified." -"11/25/2021 23:52 (11:52 PM)...late entry approximately 7 pm Cena called me to room found pt with a large skin tear on r (right) lower extremity. Cena said it happened during a transfer. family notified and family notified called [hospital]..." -"11/26/2021 01:48 (AM)...Resident returned from [hospital] via stretcher for treatment of laceration to RLE (right lower extremity) with 26 sutures..." A review of R129's hospital documentation dated 11/25/21 revealed: "Pt presents to the EC (emergency center) with c/o (complaint of) laceration resulting from transferring from a wheelchair. Pt denies fall. The laceration is on the R leg, lateral calf area. Bleeding is controlled at this time. Pt is from a nursing home with a language barrier so family member at bedside... ...Laceration repair. Date/Time: 11/25/2021 11:49 PM...Risks discussed: Infection, pain, poor cosmetic result, poor wound healing and need for additional repair...Laceration details:...Length (cm): 11.5...Number of sutures: 26..." The hospital documentation also noted that the patient received a tetanus shot.		conduct audits on 4 residents at high risk for elopement; that they have care plans and orders in place to ensure adequate supervision and monitoring weekly x 4 and then monthly x 3. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Deficient Practice #3 Nurse did not properly supervise resident during a nebulizer treatment. Element #1 Resident #576 continues to receive nebulizer treatments under supervision of a licensed nurse for diagnosis of asthma. DON/designee conducted an audit of residents receiving nebulizer treatments. Residents deemed appropriate to self-administer medications have an order and care plan interventions in place. Element #2 Residents in the facility who require nebulizer treatments have the potential to be affected in a similar manner. Residents receiving nebulizer treatments have been reviewed by RT to ensure each resident has an order and equipment at bedside. Care plans updated as indicated. Element #3 Admin/DON reviewed Nebulizer Treatment policy and deemed it appropriate. Licensed nursing staff have been educated on policy and process for Self-Administration of medication. Residents who require nebulizer treatments will have order, equipment at bedside. At time of medication administration, the nurse will	

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	On 10/13/22 at 9:21 AM, Witness "C" alerted this surveyor to a new skin alteration to R129's left upper arm. Witness "C" stated they were called to be notified about the skin tear the day before yesterday, but no one could tell them how it happened. On 10/13/22 at 9:56 AM, Licensed Practical Nurse (LPN) "W", the facility's "Safety Nurse," was interviewed at R129's bedside and queried regarding the new skin tear to her left upper arm. LPN "W" stated that he was informed that the skin tear was not present two days ago and that the resident requires a Hoyer lift for transfer. LPN "W" indicated the skin tear could have been from a transfer, or a blood pressure cuff, and added, "But not sure...The resident can't tell us...[R129's] skin is very frail and has gotten a lot of injuries, even just boosting her up [in bed]." LPN "W" assessed the skin tear which was a large, dark, bruised area with the top layer of skin peeled back, revealing wet, red skin underneath. LPN "W" stated, "It's superficial but I'm sure it burns." LPN "W" was then queried regarding the injury R129 sustained to her left lower leg on 11/25/21. LPN "W" indicated he investigated the incident and determined that the resident's assigned CNA was putting the resident in bed by herself. LPN "W" explained that as the CNA was bringing R129's legs up to put them in bed, the resident's leg was caught on the bed's metal frame. LPN "W" showed this surveyor the resident's bed frame, which is metal with a hinge in the middle. The edge and hinge of the frame were noted to be quite hard and sharp. LPN "W" stated that the assigned CNA, CNA "DD," transferred R129 by herself even though the resident required two people for transfers at that time, and the CNA also did not use the Hoyer lift. LPN "W" stated that a facility-wide in-service was conducted after the injury and added, "[The laceration] looked bad...like a dog had attacked her."		supervise residents who have not been deemed appropriate to self-administer medication. Element #4 DON/designee will conduct random audits of up to 6 residents weekly x 4 then monthly x3 to ensure nebulizer treatments are given per order with proper supervision. Findings will be addressed at time of audit with 1:1 education up through progressive disciplinary actions. Ongoing audits will continue to maintain compliance. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	

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On 10/13/22 at 10:50 AM, CNA "DD," who was assigned to care for R129 on 11/25/21, was interviewed via phone. CNA "DD" was asked what happened with the resident on the date her leg was cut open. CNA "DD" would not provide any specific details about the incident. CNA "DD" stated, "The aging body is frail and just a touch can open up in the elderly people." CNA "DD" further stated that nothing that she does is "Consciously malicious." CNA "DD" explained that on the date of R129's injury, she was assigned to care for 20 residents, 9 of whom required a Hoyer lift for transfers (which requires two staff to operate). CNA "DD" stated, "I told them they were giving me too many people to take care of. I was exhausted." CNA "DD" stated she felt she was put in a difficult position and added, "By hurrying up, having too many people to take care of, you end up hurting someone, which you don't want."

On 10/13/22 at 1:30 PM, the Nursing Home Administrator (NHA) was interviewed during the Quality Assurance (QA) task review. When queried regarding the injury to R129's leg, the NHA was unable to provide specific details related to the incident since it happened before her arrival to the facility. The NHA did state that multiple in-services were given to staff regarding safe transfers and that there was a full fall monitoring action plan at that time. The NHA added that CNA "DD" would not fully discuss the incident and subsequently resigned from working at the facility during a disciplinary meeting.

On 10/13/22 at 2:40 PM, the DON was interviewed and queried regarding staff following the plan of care for activities of daily living (ADLs) including transfers. The DON stated that if a resident is a two-person assist, that, "I'm going to go get help and come back." The DON denied any current concerns related to residents

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not being transferred appropriately by staff.

A review of the facility's policy/procedure titled, "Happy Feet Transfer Program," dated 9/29/2017 revealed, "POLICY: All residents admitted to the facility shall be evaluated to determine the safest method of transfer. PROCEDURE:...3. The safest method of transfer (bed to wheelchair transfer and toileting transfer) shall be posted in the resident's room. (i.e. bed to wheelchair transfer is x one and toilet transfer is x one, the posting would be x one). (i.e. bed to wheelchair transfer is x one and toilet transfer is x two, the posting would be x one and BR x two)...6. The nurse manager/designee will document the method of transfer in the ADL book and on the care plan...

A review of the facility's policy/procedure titled, "Fall Risk/Injury Prevention Assessment," dated 10/1/22 revealed, "It is the policy of this facility to assess every resident for fall risk and provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents...The care plan will include interventions, including recommended assistance, consistent with a resident ' s needs, goals, and current standards of practice in order to reduce the risk of an accident..."

Deficient Practice Statement #2

This citation pertains to intake numbers MI00131431.

Based on interview and record review the facility failed to monitor one resident (R23), who was a known elopement risk, of eight residents reviewed for accidents, resulting in the resident exiting the building unbeknown

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	to staff and being located outside of the building, approximately thirty yards from a highly traffic congested road. Findings include: On 10/11/22 at 9:17 AM, an incident/accident report (I/A) was reviewed involving R23 and stated the following, "9/8/22 14:30 (2:30 PM): Nursing Description: Resident went outside facility by themselves through a door not connected to a wanderguard (device that triggers alarms and locks monitored doors). Description: Resident was immediately returned inside facility. Injuries Observed At Time of Incident: No injuries observed at time of incident." On 10/11/22 at 9:30 AM, a review of R23's electronic medical record (EMR) revealed multiple elopement assessments in R23's EMR which indicated that R23 was a "High Risk To Wander" resident. On 10/11/22 at 9:43 AM, a progress note located in R23's EMR revealed the following, "8/6/2022 18:59 (6:59 PM) Nursing-Progress Note Text: The writer observed resident wandering on 900, [R23] was near the exit door attempting to open the door, the nurse on 300 was paged and the writer redirected the resident back to their appropriate unit...the resident does have a wander bracelet on their right ankle." On 10/11/23 at 9:52 AM, further review of R23's EMR revealed that R23 was originally			

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	admitted to the facility on 7/11/22 with diagnoses that included Cerebral infraction (Stroke) and Dementia. R23's most recent minimum data set assessment (MDS) dated 8/3/22 revealed that R23 had a severely impaired cognition and required extensive assistance for all activities of daily living (ADLs) other than eating. On 10/12/22 at 10:10 AM, Certified Nursing Assistatnt (CNA) "N" was interviewed regarding the incident involving R23 on 9/8/22. CNA "N" indicated that they observed [R23] outside the building in the north parking lot at approximately 2:40 PM, when returning from a scheduled break. CNA "N" stated, "I brought [R23] back inside." The exact location where CNA "N" indicated that they had found R23 was approximately thirty yards from a highly traffic congested road. On 10/12/22 at 10:30 AM, Nurse "P" was interviewed regarding the incident involving R23 on 9/8/22. Nurse "P" indicated that they last saw R23 on the unit at approximately 1:30 PM. Nurse "P" was unable to provide any other information regarding the incident involving R23. On 10/12/22 at 10:39 AM, Nurse "Q" was interviewed regarding the incident involving R23 on 9/8/22 and indicated that R23 "Frequently propels themselves around the building. I redirect them back to their unit. [R23] is busy." Nurse "Q" had no specific information related to the incident on 9/8/22.			

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On 10/12/22 at 11:15 AM, Nurse "W" was interviewed regarding the incident involving R23 on 9/8/23. Nurse "W" stated, "I last saw [R23] sitting in their wheelchair at 2:20 PM, we had a code blue (patient in need of immediate medical attention) on another unit and all the nurses went to help out. [R23] must have gotten out then." Nurse "W" had no further information regarding the incident.

On 10/12/22 at 3:30 PM, the Assistant Director of Nursing (ADON) was interviewed regarding the incident involving R23 on 9/8/23. The ADON indicated that based upon an internal investigation of the incident involving [R23], it is speculated that [R23] exited an deactivated alarmed door on the east side of the building during the time that a code blue was occurring in the building. The ADON further indicated that speculation was that [R23] wheeled themself down a sidewalk on the east side of the building into the east parking lot area where they were found by CNA "N" who was returning from a break. The ADON stated, "Based upon our investigation we believe [R23] was out of the building for approximately twenty minutes."

On 10/12/22 at 3:39 PM, the facility reported incident (FRI) and the facility's investigation of the incident was reviewed with the Director of Nursing (DON) and the Administrator (NHA). They were asked what the facility expectation was for monitoring residents and preventing facility elopement.

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They indicated, that all staff are responsible for monitoring residents. The DON stated, "It takes a village."

On 10/13/22 at 2:30 PM, a facility policy titled "Accident and Incident Report Date Approved: 06/20/2022" was reviewed and stated the following, "The purpose of this policy is...(f) to prevent re-occurrence of a similar incident; (g) to provide timely follow-up of corrective measures..."

Deficient Practice Statement #3

Based on observation, interview and record review, the facility failed to supervise a resident during medication administration for one sampled resident (R576) of one resident reviewed for med administration resulting in, medication being taken by the resident without proper supervision. Findings include:

On 10/11/22 at 11:21 AM, R576 was observed sitting in their wheelchair, nebulizer mask observed on their table, nebulizer machine on and running. There was no nurse present inside or outside of the room. R576 was asked where the nurse went and stated, "They always say they will come back but never do." R576 was asked if the nurse remains in the room during their nebulizer treatments, and they stated, "Sometimes they do, and sometimes they don't.

A review of R576's medical record revealed that they were admitted into the facility on 9/30/22 with diagnoses that included Viral Pneumonia, Health Failure and Respiratory Failure. Further review of R576's medical record revealed a Minimum Data Set assessment dated 10/2/22 revealing a Brief Interview for Mental Status

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score of 10/15 indicating a moderately impaired cognition, and required extensive assistance for Activities of Daily Living.

Further review of R576's medical record revealed the following physician's order dated 10/6/22, "Ipratropium-Albuterol Solution 0.5-2.5 (3) MG (milligrams)/3ML (milliliters). 3 ml inhale orally four times a day for Asthma SOB (shortness of breath)."

Further review of R576's medical record did not reveal an assessment indicating that they could self-administer their own medications.

On 10/12/22 at 1:05 PM, R576 was observed sitting up in bed with their nebulizer mask covering their mouth. There was no nurse present inside or outside of the resident's room.

On 10/13/22 at 2:36 PM, the Director of Nursing was asked whether a nurse should be present during the administration of a nebulizer treatment, and she explained that staff should stay with the resident until their treatment is complete, unless the resident has an assessment indicating that they can self-administer medications on their own.

A review of the facility's "Nebulizer Treatment" policy revealed the following, "o) If the patient is deemed appropriate to self-administer medication the nurse will setup the patient with the medication ready for administration. The medication will continue to remain in the medication cart until at which time the patient needs the medication. The nurse does not need to be present in the room for the entire time of administration. (this should be documented with the order or on the plan of care that the patient may self-administer) See self-administration of drug policy #2070 p) At the completion of the

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	treatment, the medication cup is cleaned with water and allowed to air dry. q) Take apart nebulizer. Wash all parts except tubing and finger valve with soap and water. Rinse with water, dry & store..."			
F0692 SS= D	Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00131282. Based on observation, interview, and record review, the facility failed ensure the consistent provision of fresh water to dependent residents, affecting two (R42 and R129) of three reviewed for hydration, resulting in the potential for dehydration or fluid imbalance. Findings include: Resident #129 (R129)	F0692	F692: Nutrition /Hydration requirements (Resident 129 for sure, Element #1 CENA did not provide fresh water to resident # 42 and 129. Resident # 42 continues to reside at facility and is provided fresh water every shift and prn. No evidence of fluid depletion. Resident # 129 continues to reside at facility and is provided fresh water every shift and prn. No evidence of fluid depletion. DON/designee conducted house audit at bedside to ensure residents who were not NPO had fresh water at bedside. Element #2 Residents residing in the facility whom are not NPO have the potential to be affected in a similar manner. DON/designee conducted a facility wide audit to ensure each resident had fresh water at bedside. Areas of concern will be addressed at time of findings with 1:1 education up through progressive disciplinary actions. Ongoing audits will continue to maintain compliance. Element #3 Admin/DON reviewed Hydration Policy and Activities of Daily Living and deemed it appropriate. DON/designee educated the nursing staff on the polices, with focus on the areas of providing proper hydration. Residents are provided fresh water per shift and as requested in line with dietary orders.	11/8/2022

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	A review of an intake submitted to the State Agency revealed the following: "...[R129] was dehydrated...from [R129] not having anything to drink at the facility..." A review of R129's Minimum Data Set (MDS) assessment dated 9/12/22 revealed that the resident was initially admitted into the facility on 3/9/20 and re-admitted on 2/24/22, is severely cognitively impaired, and requires extensive to total assistance from staff for activities of daily living (ADLs). R129's medical diagnoses include Subsequent Encounter For Fracture With Routine Healing, Vascular Dementia, Alzheimer's Disease, Type 2 Diabetes Mellitus Without Complications, Dysphagia, Moderate Protein-Calorie Malnutrition, Need For Assistance With Personal Care, Muscle Weakness, Difficulty In Walking, Syncope And Collapse, Anxiety, Edema, Pneumonia, Thrombosis, Respiratory Failure, Laceration Without Foreign Body, Right Lower Leg, Subsequent Encounter, and Sick Sinus Syndrome. A review of R129's emergency room visit documentation from 2/20/22 revealed that the resident was sent to an acute care facility due to altered mental status. The document noted the following: "...[Family] at bedside...concerned patient is not eating, hydrating well or truly receiving medications at nursing facility. States patient had similar episode of unresponsive in the past that improved with hospitalization and hydration...AKI (acute kidney injury) noted in metabolic work-up. Pt (patient) started on IV (intravenous) hydration...Unclear etiology of mental status change..." On 10/11/22 at 11:44 AM, Confidential Witness "B" was interviewed via phone regarding R129's		Resident council who meets monthly will review status of frequency and satisfaction with water pass and report findings to the Administrator for follow up. Concerns will be addressed through concern/grievance process. Element #4 DON/designee will conduct random audit of 20 residents per week x 6 weeks to ensure fresh water is passed and at beside. Ongoing audits will continue to maintain compliance. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	

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	care at the facility. Witness "B" mentioned that the resident had been in the hospital months ago, and was found to be dehydrated and required IV fluids. On 10/11/22 at 12:16 PM, R129 was observed sleeping in their bed, tilted toward their left side. R129's right arm was elevated and in a supportive brace. R129's feet and legs were noted to be bare and appeared slightly edematous. R129's only hydration/water cup available at the bedside was noted to be dated, "10/10 11-7 (11 PM - 7 AM shift)." The water cup was observed to be a 16 ounce white Styrofoam cup, and was noted to be almost completely full. On 10/12/22 at 11:56 AM, R129 was observed sleeping in their bed with their right arm elevated and in a supportive brace. R129's only hydration/water cup available was noted to be dated, "10/10 11-7 (11 PM - 7 AM shift)," and was not within the resident's reach. The water cup was now noted to be half full. On 10/12/22 at 2:16 PM, R129 was observed sleeping in their bed with their right arm elevated and in a supportive brace. R129's only hydration/water cup available was noted to be dated, "10/10 11-7 (11 PM - 7 AM shift)," and was still not within the resident's reach. The water cup was still noted to be half full. On 10/12/22 at 4:17 PM, R129 was observed sitting up in a wheelchair in their room. A fresh water cup from afternoon shift was noted to be present, however, the cup was full. On 10/13/22 at 9:02 AM, Wound Care Nurse "Y" was observed conducting a skin assessment on R129. At this time, R129's only hydration/water cup available at the bedside was noted to be dated, "10/12 3-11 PM." The cup was full.			

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	On 10/13/22 at 11:51 AM, R129 was observed sleeping in bed. R129's only hydration/water cup available at the bedside was noted to still be dated, "10/12 3-11 PM." The cup was still full. A review of R129's care plan revealed that the resident was identified as being at risk for dehydration. Resident #42 (R42) A review of 42's Minimum Data Set (MDS) assessment dated 8/4/22 revealed that the resident was admitted into the facility on 6/23/2020, is severely cognitively impaired, and has medical diagnoses including Fracture of Lumbar Vertebra (history of), Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Anxiety Disorder, Depression, Pulmonary Hypertension, Osteoarthritis, Alzheimer's Disease, Dementia, Dysphagia, Heart Failure, Muscle Weakness, Glaucoma, Muscle Weakness, and Need For Assistance With Personal Care. On 10/12/22 at 11:56 AM, R42 was observed moaning/calling out upon entry into their room. The resident's blanket was pushed off, exposing their incontinence brief. R42 motioned to this surveyor to come closer. R42 was making crying/moaning sounds but was unable at this time to verbalize what was wrong. R42's only hydration/water cup available at the bedside was noted to be dated, "10/10 11-7 (11 PM - 7 AM shift)." Only half of the thickened water in the cup was noted to be gone. On 10/12/22 at 2:16 PM, R42 was observed lying in bed and appeared to be asleep. R42's only hydration/water cup available at the bedside was noted to be dated, "10/10 11-7 (11 PM - 7 AM shift)." Only half of the thickened water in the cup was noted to be gone. The cup was not within			

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	the resident's reach. On 10/12/22 at 4:17 PM, a fresh water cup from afternoon shift was noted to be present for R42, however, the cup was full. On 10/13/22 at 8:49 AM, a wound care observation for R42 was conducted with Wound Care Nurse (WCN) "Y" and Certified Nursing Assistant (CNA) "Z". R42's water cup was noted to be completely full of thickened water, and was dated, "10/12 3-11 PM." When queried regarding the observation, both WCN "Y" and CNA "Z" indicated that it did not appear that R42 had received any water whatsoever. CNA "Z" indicated that he would get fresh water for the resident after completion of care. On 10/13/22 at 2:40 PM, the Director of Nursing (DON) was interviewed and asked when residents should be receiving fresh water. The DON replied. "Should be every shift." When asked how often water should be offered to dependent residents, the DON stated, "As frequently as staff is in the room. We are in and out often." A review of the facility's policy/procedure titled, "Hydration," dated 9/29/17, revealed, "It is the policy of this Facility to provide ample fluids to all residents. Dietary will provide a minimum of 22 ounces (660 cc) of fluid per day on resident trays. Nursing will provide a minimum of 48 ounces (1440 cc) of water per day at bedside (unless contraindicated). It is the policy of this Facility to monitor our residents for signs and symptoms of dehydration and fluid and electrolyte imbalance and to use clinical observation as well as laboratory data as indicators of hydration status...1. Nursing will ensure access to a minimum of 48 ounces (1440cc) of fluid per day. Once per shift, the resident will be provided with 16 ounces of water			

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	left at bedside. 2. Staff will provide assistance to residents not capable of self-accessing fluids..."			
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain an nebulizer rebreather mask in a sanitary manner, for one Resident (R85), resulting in the likelihood for infection. Findings include: On 10/11/22 at 12:37 PM, R85 was observed in their room sitting in the wheelchair. R85 was asked about their stay at the facility and stated, "They take too long at night. I'm usually in pain or have to urinate." Observed on the night stand was R85's nebulizer with the rebreather mask laying directly on top of the night stand. On 10/12/22 at 12:52 PM, R85's nebulizer and rebreather mask were observed in the same condition as above. On 10/13/22 at 11:58 AM, the Respiratory Therapist was asked how the nebulizer rebreather mask are to be stored and explained, they are to be cleaned and placed into a bag.	F0695	F695: Respiratory/Tracheostomy Care and Suctioning Element #1 The nurse did not properly store resident # 85 nebulizer at bedside after use. Resident #85 nebulizer was discarded and replaced with a new nebulizer set up. The nurse involved received 1:1 education regarding not properly storing the nebulizer when not in use. Element #2 Residents who use nebulized medications have the potential to be affected in a similar manner. DON/designee conducted an audit of current residents who are prescribed nebulized medications to ensure equipment, was properly stored when not in use. Element #3 Admin/DON reviewed Nebulizer treatments policy and deemed it appropriate. Licensed nurses were educated on the policy. Respiratory therapist will audit the residents requiring respiratory treatments to ensure oxygen masks/nebulizer are placed on a barrier or in a bag when not in use. Areas of concern will be addressed at time of findings and reported to DON for follow up as indicated. Element #4 DON/designee will audit at least 6 residents with nebulizer treatments weekly to ensure compliance with storage of components within the resident□s room. This will be completed	11/8/2022

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	A review of R85's medical record revealed, R85 was admitted to the facility on 10/4/22 with diagnosis of Non-Surgical Orthopedic/Musculoskeletal. A review of R85's MDS assessment noted R85 with an intact cognition and required extensive assistance with ADLs. A review of R85's care plan noted, "Focus: The resident has Emphysema, COPD (Chronic obstructive pulmonary disease) Date Initiated: 10/14/2022. Goal: The resident will display optimal breathing patterns daily through review date. Date Initiated: 10/14/2022. Intervention: Give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. Date Initiated: 10/14/2022." A review of the facility's policy titled, "Nebulizer Treatments" dated, 4/20 noted, "POLICY: To facilitate medication into the lungs as written in a physicians order... p) At the completion of the treatment, the medication cup is cleaned with water and allowed to air dry... q)Take apart nebulizer. Wash all parts except tubing and finger valve with soap and water. Rinse with water, dry & store."		weekly x 4 weeks and then monthly x 3 months thereafter. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	
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	F0725	F725: Sufficient Nursing Staff Element #1 The facility did not ensure sufficient number of staff were available to respond timely to residents requesting assistance. Resident # 34, #54, #59, have had plan of care reviewed and updated to ensure interventions are up to date and in place to provide quality of care. Resident # 85, #325 and #327 no longer reside in the facility. DON/designee conducted an audit to ensure that call lights are within reach and resident	11/8/2022

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	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 in part to intakes MI00130665, MI00130704, MI00131091, MI00131282, MI00131416, and MI00131735. Based on observation, interview, and record review, the facility failed to ensure sufficient staff were available to respond timely and provide quality care to residents requesting assistance, affecting six residents (R34, R54, R59, R85, R325, and R327) reviewed for staffing, also affecting multiple residents wishing to remain anonymous, and potentially affecting all residents residing in the facility, resulting in resident frustration, feelings of disrespect, unmet care needs, and the potential for psychosocial harm. Findings include: On 10/11/22 at 9:57 AM, a staff member wishing to remain anonymous expressed concern related to the lack of continuity of care at the facility due to the utilization of so many agency staff (nurse aides and nurses). The staff member also stated that for the residents with memory impairments, seeing familiar faces generally resulted in more cooperation during care. The staff member added, "Today, we have a 'Shower Team.' We never have the staff for that."		needs are met per plan of care. Element #2 Residents residing in the facility have the potential to be affected in a similar manner. NHA/designee conducted an audit of Staffing patterns and levels to ensure resident needs can be met. NHA/designee reviewed resident concern forms to ensure any concerns regarding staffing, care have been addressed. Element #3 Staffing Coordinator has been in-serviced on staffing requirements. Staffing Coordinator will meet 3x week with DON/NHA to review staffing schedule, open positions, challenges, call offs and attempts made to replace. Staffing levels will be monitored utilizing State Guidelines as required. Resident council will meet monthly and services such as timely call light response and assistance with ADL□s will be reviewed. Resident concerns will be addressed through the Resident concern/grievance process. Element #4 NHA/designee will audit/interview 10 residents weekly x 4 weeks and then monthly x 3 months thereafter to ensure needs are being met and to identify any concerns related to staffing. Resident concern form will be completed to address any new concerns. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	

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	On 10/11/22 at 10:03 AM, R34's call light was observed to be on. Upon entering the room, R34 was observed sitting in their room in their wheelchair. R34 had regular black pants on, with a hospital-type gown on top. R34 stated, "They didn't dress me." R34 indicated that their brief was wet, and has been wet for an hour. R34 added, "Always pushing my call light, and they do not come." When queried, R34 indicated that they are continent most of the time, if they have help to get to the bathroom. Two agency Certified Nursing Assistants (CNAs) "J" and "L" entered the resident's room and assisted them to the bathroom. R34's brief was observed to be visibly wet with urine. R34 requested to still be placed onto the toilet and was assisted to do so by the staff. A review of R34's Minimum Data Set (MDS) assessment dated 7/22/22 revealed that the resident is cognitively intact, is frequently incontinent of urine and occasionally incontinent of bowel, and requires extensive assistance from one staff for dressing and extensive assistance from two staff for toileting. On 10/11/22 at 11:44 AM, Confidential Witness "B" was interviewed via phone regarding their loved one's care at the facility. Witness "B" indicated their biggest concerns were that, "Staff doesn't communicate with each other...Sometimes there is only one nurse to 30 patients...[And] aides barely have a chance to change briefs." On 10/11/22 at 3:25 PM, R59's call light was observed to be activated. Upon entering the room and inquiring why their call light was on, R59 responded, "I told the aide at 2:30 PM that I needed to be changed. She said, 'Give me a minute, I'm changing the other lady.'" R59 indicated that the aide never came back, and that they also did not know the aide's name because			

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she didn't tell him what it was. CNA "AA" then entered the room and was asked why R59 had been waiting almost an hour to be changed. CNA "AA" explained that she is an afternoon shift worker and just got here. CNA "AA" further stated, "It was probably agency (day shift aide)." CNA "AA" stated that the aides do not give report at the end of their shift and she did not see the day shift aide she was coming in to relieve. CNA "AA" stated that the aide still had until 3 PM (end of the day shift) to change R59 and would expect it to have been done. CNA "AA" added, "But agency doesn't care...Even if it were near the end of my shift I would just finish the job."

CNA "AA" then provided incontinence care to R59, whose incontinence brief was noted to be wet with urine. This observation was confirmed by CNA "AA". CNA "AA" provided incontinence care, and helped turn the resident side to side in bed, by herself. No grab bars were noted to be present on the bed, and the resident held the bed frame while teetering on the edge of the mattress when turned on their side. The bed was elevated to CNA "AA"'s hip level while providing care. R59's "Happy Feet," communication form on the wall indicated that the resident was "x 2" (two person assist) for bed mobility. When queried about this, CNA "AA" stated she felt comfortable changing the resident by herself and was familiar with R59.

A review of R59's Minimum Data Set (MDS) assessment dated 8/9/22 revealed that the resident is cognitively intact, is incontinent of urine and bowel, and requires extensive assistance from two staff for toileting and bed mobility.

On 10/11/22 at 3:37 PM, R54 was observed in their room, sitting next to their bed which was stripped of the linen. When queried regarding care received at the facility, R54 stated,

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	"Sometimes I get mad...They are short of staff. I want to get back in my bed. That bothers me...They took my sheet off this morning. As you can see now it's not made, and probably won't get made until 9-10 o'clock tonight. And it takes a long time for them to answer the call light. Sometimes I feel like I'd be better off at home than being here." When queried as to why the sheets had been stripped from their bed, R54 stated, "Well, 'cause they were wet. I take a water pill. I can't get up out of bed by myself...Can't move fast enough...And I can't hold it." R54 stated that staff also did not sanitize/wipe off their mattress after stripping the soiled linen. An obvious urine odor was noted to be coming from R54's mattress upon inspection. A review of R59's Minimum Data Set (MDS) assessment dated 8/8/22 revealed that the resident is cognitively intact, is occasionally incontinent of urine and always continent of bowel, and requires limited to extensive assistance from one staff for activities of daily living (ADLs). On 10/13/22 at 2:40 PM, the Director of Nursing (DON) was interviewed. The DON was queried regarding her expectation of staff response to resident requests and specifically the situation observed involving R59. The DON indicated she expected staff to respond to requests, or come back to help a resident, within a reasonable amount of time. The DON stated that the day shift aide still had until 3 PM to change R59. The DON added that an aide is expected to go find help before providing care to a resident identified as a two-person assist. When queried regarding linen changes and the procedure for cleaning soiled mattresses, the DON stated, "When [linen is] soiled, [staff is to] remove the soiled linen, clean the mattress, let it dry, and put on new ones."			

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	On 10/11/22 at 9:22 AM, Nurse "A" was asked about staffing and reported that they were "agency" and it was their first day working at the facility. Nurse "A" was then asked about any orientation provided prior to start of their day and reported they had been oriented to the med room and provided access to electronic medical record. Nurse "A" indicated they felt they could handle things that came up but was "slightly" behind. On 10/11/22 at 9:36 AM, Nurse "K" was asked about staffing and reported that if they are short staffed they will move faster and get things done. On 10/11/22 at 9:54 AM, R325 reported on Sunday 10/09/22 on the midnight shift they had put their call light on four to five times to get help with incontinence care. R325 reported that staff either did not answer or came in and turned off the call light but did not return to change them. R325 reported they were not changed until the day shift came in and at that time they were wet up onto their back and onto the bedding. A review of the facility assignment sheets documented two staff were on for the night shift. On 10/11/22 at 10:47 AM, the call lights for rooms 402 and 400 were observed to be activated and four staff walked by, one with a supply cart, one in gray scrubs and two in green scrubs. At 10:50 AM the nurse aide entered 400 and exited then a nurse entered and exited 402. On 10/11/22 at 11:26 AM, staff was observed to exit the room of Anonymous Resident "O". Resident "O" was observed to be in bed, dressed and with a lift sling under them. The pad type call light was on the over bed table which was away from the side of the bed about a foot. The resident had limited range of motion of the extremities and on attempt could not reach the call light. Resident "O" was asked about the care at the facility and			

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	reported along with their spouse that there was never enough help at the facility. The couple commented that the resident was to be out of bed per Therapy and staff say have to go find Hoyer lift and are then gone for an hour and a half. The spouse further noted that most of the staff are pretty good though some are "snotty" and staff can change every day. It was also reported that the resident had not had a bath or shower in two weeks. Resident "O" commented that the night staff can be loud at times and it takes a while to answer the call light so sometimes it "feels like they are ignoring you." At 01:00 PM the Hoyer lift was observed outside the resident's room and at 1:08 PM the resident was out of bed and seated in a wheelchair next to the bed. A review of the shower documentation indicated Resident "O" had refused showers on 10/01/22, 10/06/22 and 10/08/22. On query of the resident, the resident denied refusal of showers/baths. On 10/11/22 at 1:43 PM, observations were made on the 700 unit. Certified Nurse Assistant (CNA) "M" was observed to exit the room of a resident with a meal tray. The meal had not been eaten and the resident was observed to have slept through lunch while up in their wheelchair at the bed side. CNA "M" had asked the resident if they were done and the resident indicated they were and wanted to go back to bed. CNA "M" reported they were "agency staff and it was the first time they were assisting the residents on the 700 unit. On 10/11/22 at 3:14 PM, an anonymous Resident "R" on the low 900 unit reported they had to stop a nurse from administering albuterol (inhaled medication to open lung passages) to them. Resident "R" reported the nurse acknowledged they were in the wrong room. Resident "R" had noted this was and agency nurse. On 10/11/22 at 3:39 PM, R327 reported on query			

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that the nursing care was "sub par" but therapy had been good. R327 indicated that for nursing staff there was no consistency and they were always short staffed. R327 reported once they went without getting pain medication for 24 and half hours and their pain was an eight out of ten. On this day (10/11/22) they were supposed to get their (scheduled) medications at nine in the morning and did not receive them until almost 12:30 PM. R327 was due for pain medications and antibiotics. R327 further commented that there are staff brought in from agency and only one nurse to care for the whole unit. R327 also reported they "have to stay on them" about changing the dressing to their leg and went three days without it being changed.

On 10/11/22 at 4:01 PM, Anonymous Resident "S" reported the only problem was that the facility was understaffed and the nurses were not in a hurry to get their morning medications passed. Resident "S reported they had back surgery and the healing process was not going well as their pain limited what they could do in therapy especially when their morning/9:00 AM medications were late (around 12:30) as they were "today." Resident "S reported their dose and schedule (as needed rather than scheduled) for pain medications was not correct and a nurse once did not have the medications available and they had to be ordered. Resident "S" also reported their morning medication were late the day before and was waiting for them out in the hall at 11:30 AM.

On 10/12/22 at 8:42 AM, a resident on isolation precautions, Anonymous Resident "T" reported some staff are better than others and reported they had one day been left up in their wheelchair from breakfast until after 10 at night and had to take themselves to the bathroom. Resident "T" also commented they are supposed to have their compression wraps put on and off three times a day for an hour and it had not been consistently

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	done. Resident "T" also noted they required assistance to wash up as they could not reach their back due to a torn rotator cuff. A review of the resident Minimum Data Set (MDS) assessment dated 07/21/22 indicated intact cognition with 15/15 Brief Interview for Mental Status (BIMS) score and the need for extensive assistance of one or two persons for activities of daily living. On 10/13/22 at 8:42 AM, two nurses were observed on the 900 unit along with two others at the desk on the low side. Nurse "U" was observed to have started their medication pass on the 900 unit. At 9:09 AM, Nurse "U" was checking blood sugar levels on residents. The breakfast trays were on the floor. Nurse "U" then went to a resident room to complete a discharge. On 10/13/22 at 10:35 AM, Nurse "U" was observed to continue their assigned medication pass. Six residents were observed to be highlighted in red on the computer screen. Nurse "U" reported on query this was because the medications were past due the scheduled administration time. Medication pass was observed for a resident in room 915 and upon completion of the observation Resident "S" was observed standing in the doorway of their room and said not to interrupt Nurse "U" as they were still waiting on their morning medications. Nurse "U" was asked about the delay in the administration of medications to residents and reported it was related to only having one nurse. Nurse "U" also reported it had been a "rough" morning. Nurse "U" was asked about the second nurse seated at the nurse station and reported that nurse was assigned to the (two) COVID patients and therefore could not assist the non isolated residents. On 10/13/22 at 10:40 AM, Anonymous Resident			

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	"T" reported they waited five and a half hours to get changed the night before. On 10/13/22 at 12:57 PM, the Director of Nursing (DON) reported on query that the standard for medications administration is up to one hour before and up to one hour after the scheduled time. The DON also reported the nurse should report to the unit manager when they need assistance and the unit manager should help to complete tasks timely. The DON was asked about call light response time and reported ideally staff should respond within 15 minutes. The DON was also asked about the use of agency staff and reported that regular staff are scheduled and then agency are place to fill in and the challenges include late call ins and no shows. On 10/13/22 at 1:12 PM, Unit Manager Nurse "X" was asked about the concern for the late medication pass and reported they were not aware of any resident complaints about late medications nor that the nurse was late on their medication pass the day before and today. Nurse "X" did report they were available to help out with the nurse's assigned tasks, but had not been asked. On 10/13/22 at 1:30 PM, the Administrator was asked about staffing challenges and reported thos has been part of the Quality Assurance and Perfomance Improvement for the last three months and that late medication passes come with the staffing challenges. The Administrator further reported their scheduler left over the last weekend without notice and the new person does not know the staff like the old one. On 10/11/22 at 12:37 PM, R85 was observed in their room sitting in the wheelchair. R85 was asked about their stay at the facility and stated, "They take too long at night. I'm usually in pain or have to urinate."			

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	On 10/13/22 at 9:32 AM, R85 was asked how their night was and stated, "It was bad. I waited over an hour for help." A review of R85's medical record revealed, R85 was admitted to the facility on 10/4/22 with diagnosis of Non-Surgical Orthopedic/Musculoskeletal. A review of R85's MDS assessment noted R85 with an intact cognition and required extensive assistance with ADLs. A review of R85's care plan noted, "Focus: Resident has an ADL self-care performance deficit Date Initiated: 10/13/2022. Goal: Resident will participate in ADLs within functional limitations Date Initiated: 10/13/2022. Intervention: Locomotion: Wheelchair Date Initiated: 10/13/2022. BED MOBILITY: 2 person assist Date Initiated: 10/13/2022. TOILET USE: 2 person assist Date Initiated: 10/13/2022. TRANSFER: 2 Person assist Date Initiated: 10/13/2022. A review of the facility's policy/procedure titled, "Staffing Policy," dated 4/1/22, revealed, "It is the policy of this facility to have proper staffing to meet the residents needs for Activities of Daily Living as well as the health, wellbeing and safety of all in the facility."			
F0740 SS= D	Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-	F0740	F740: Behavioral Health Services Element #1 Resident #146 was not referred to psych services following behaviors. Resident # 146 did receive a psych consult and was evaluated by Psychiatric services on 10/25/22. Last GDR and AIMs completed on 10/25/22. Resident continues to be seen by psychologist for supportive counseling as	11/8/2022

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	being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to coordinate psychiatric services for one resident (R146) of two reviewed for mood/behaviors, resulting in the potential for inappropriate medication use and/or management, continued unstable mood/behaviors, and impaired psychosocial well-being. Findings include: A review of R146's Minimum Data Set (MDS) assessment dated 9/14/22 revealed that the resident was initially admitted into the facility on 6/9/22 and most recently re-admitted on 7/2/22. R146's medical diagnoses included Cerebral Infarction (stroke), Anemia, Myocardial Infarction (heart attack), End Stage Renal Disease, Dependence on Renal Dialysis, Contractures and Muscle Weakness, Falls, Barrett's Esophagus, Depression, and Anxiety Disorder. Further review of the MDS revealed that the resident is severely cognitively impaired and requires limited to extensive assistance from staff for activities of daily living (ADLs). On 10/11/22 at 1:33 PM, R146 was observed sitting in her wheelchair in her room. The resident was mumbling to herself with her head down and unable to appropriately answer interview questions currently. On 10/12/22 at 9:33 AM, Confidential Witness "EE" was interviewed regarding R146's care at the facility. Witness "EE" expressed concern regarding R146's recent mood/behaviors. Witness "EE" explained that the resident has been having		needed. DON/designee conducted an audit of residents with behaviors to ensure psychiatric services have been referred appropriately. Element #2 Residents who require psychiatric services or take psychiatric meds (on admission or prescribed while admitted to the facility) have the potential to be affected by this citation. SW/designee conducted an audit of resident□s taking psychiatric medications to ensure each are receiving or offered psychiatric services with proper documentation. Element #3 Admin/DON reviewed Psychoactive Medication Prescribing and Behavior Management Policy and Psychiatric Referral Process and deemed it appropriate. Admin/designee educated the Social work Director and department on the policies. Element #4 DON/designee will review 24hr report and high risk progress notes Monday-Friday during morning for documentation indicating behaviors to ensure psychiatric services are initiated as indicated. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	

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	504014	A. BUILDING _____ B. WING _____	10/13/2022

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difficulty finishing her dialysis treatments (outside of the facility on Tuesdays, Thursdays, and Saturdays) due to, "Holler[ing] and scream [ing]." Witness "EE" denied that the resident had difficulty making it to her dialysis appointments, but indicated she was now having trouble with her, "Medication wearing off before the dialysis is finished." When queried if R146 was receiving psychiatric services and visits while in the facility, Witness "EE" stated they did not believe so.

A review of R146's record revealed the following progress notes:

-"9/11/2022 02:59 (AM): ...resident kept yelling out loud "help me!!! help me!!! but when attended resident, resident will say "oh nothing" reoriented resident and explain to resident try not to yell out if she needs nothing with good understanding, resident currently in bed with eyes closed and call light within easy reach, will continue to monitor ..."

-"9/30/2022 23:36 (11:36 PM): ...Res (resident) alert; pt (patient) screams for "Help" throughout the shift ..."

-"10/4/2022 02:02 (AM): ...Resident yelling all night ,keeping room mate awake Unit manager made aware. Suggest maybe she be moved ..."

-"10/9/2022 16:04 (4:04 PM): Resident sitting at Nurses station crying stating " Can I get out of here, please help me". Tried re-directing multiple times. Author: [Director of Nursing (DON)]."

-"10/9/2022 16:20 (4:20 PM): Phone to [physician] regarding crying out and increase anxiety, new orders for xanax 0.25mg (milligrams) every 8hrs (hours) PRN (as needed). x's 14 days. Author: [DON]."

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A review of R146's physician orders revealed: "Consult Psychiatry ...Active 08/17/2022."

Continued review of R146's record did not reveal any progress notes from a psychiatric service provider.

A review of R146's care plan revealed: -"Psych eval (evaluation) for psychosocial, cognitive changes and medication review. Date Initiated: 09/19/2022."

Upon request for psychiatric service notes/consents for R146, the facility provided a consent form for R146 to receive psychiatric services that was filled out by the Social Service Director (SSD) and dated 10/12/22. The reasons for referral were marked as, "Psychotropics - Resident currently on or has past history of psychotropic medication use (medication management); Mental Status (sadness, anxiousness circled); and Adjustment Difficulties to current living environment."

On 10/13/22 at 10:33 AM, the SSD was interviewed. When queried regarding who is responsible for coordinating psychiatric services after a consult is ordered, the SSD stated, "Typically, nursing will notify social work if a consult has been put in and we will fax over consent." The SSD did acknowledge that despite the consult being ordered months ago, the consent for R146 to received psychiatric services was signed just yesterday. During discussion of R146's mood/behavior difficulties, the SSD indicated that R146 has been "Having a hard time," and that the resident has been requiring PRN Xanax (anti-anxiety medication) and would benefit from psych services. The SSD also acknowledged that the resident's anti-depressant medication (sertraline) had been ordered and discontinued multiple times and was unsure why.

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	The SSD stated that R146 was slated to be seen by psych services in the facility on Monday (10/17/22). On 10/13/22 at 2:40 PM, the DON was interviewed. The DON was asked if she was familiar with the behavioral needs of R146. The DON responded, "I know that I came in Sunday (10/9/22), after church, and the resident was crying in the hall. Her [family member] usually comes every day, but [has not been able to] ...She was crying out, saying she needed help and wanted to go home. She cries. [R146's family member] says at dialysis, [R146] starts crying ..." When queried about receiving psych services in the facility, the DON indicated that she would have expected R146 to have been seen prior to now. A review of the facility's policy/procedure titled, "Behavior Management Program," dated 12/1/2016, revealed, " ...3. Recognizing that all problematic behaviors do not require medication, the Social Worker, Recreational therapy, Nursing, outside psychology &/or Physician will work together to develop a person-centered plan of care. This plan will provide direction of services to residents to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. 4. Each resident will receive the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders ..."			
F0761 SS= E	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals	F0761	F761: Medication Labeling and Storage	11/8/2022

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	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: This citation has two deficient practices. Deficient practice number one: Based on observation, interview and record review the facility failed to ensure insulins, eyedrops and or inhalers were labeled with resident name and or dated when opened in four of four medication carts reviewed, resulting in the potential for decreased efficacy of the medications. Findings include: On 10/12/22 at 1:02 PM, the 600 high medication cart was reviewed with Nurse "K".		Deficient Practice #1 Element #1 No cited residents Licensed Nurses did not label, and date insulin pens, inhalers and eye drop upon opening. Element #2 Residents who reside in the facility have the potential to be affected in a similar manner. DON/designee conducted an audit of medication/treatment carts to ensure pens, vials, inhalers and eye drops were labeled and dated appropriately. Areas of concern were addressed at time of findings with 1:1 education given and documented. Element #3 Admin/DON reviewed Policy for medication storage and deemed it appropriate. DON/designee educated the nursing department on the policy with concentration to the fact that multi-use vials of insulin should be dated upon opening and discarded 28 days; inhalers/eye drops should be dated when opened for use. Element #4 DON/designee will conduct a weekly audit of medication carts as well as treatment carts. Carts will be checked for the dating of all medications required by policy. This will be completed weekly x 4 weeks and then monthly x 3 months thereafter. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Deficient Practice # 2 Licensed Nurses did not lock	

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	Five insulin pens and one Lispro insulin vial were opened and not dated with a use by date. There were four Semglee (Glargine-yfgn) pens and one Lantus (glargine) insulin pen. It was observed that there were mulitple insulin pens of the same insulin for the same residents and insulins pens for residents who had discharged. Nurse "K" confirmed insulins should be dated when opened. On 10/12/22 at 2:25 PM, a review of the Hudson one low medication cart with Nurse "FF" revealed: A Semglee insulin pen, three Lispro insulin pens and a Lantus insulin pen without a date when opened. Two Lispro insulin pens, a Lantus insulin pen and two Novolog insulin pens were observed with no resident name and no date when opened. An Incruse inhaler was not dated when opened. Two latanoprost eye droppers were not dated when opened. Nurse "FF" reported on query that the items observed should have the resident name and date opened. On 10/12/22 at 2:47 PM, a review of the 900 low medication care with Nurse "GG" revealed a Lispro insulin pen, and a latanoprost eye dropper were not dated when opened. A review of the manufacturer's insert at 'dailymed.nlm.nih.gov' for the Semglee pens indicated the pens were good for 28 days at room temperature opened or unopened. The Lantus (glargine) pen manufacturer's insert at 'products.sanofi.us" indicated. "Only use your		Medication/Treatment carts when left unattended. Element #1 No cited residents Element #2 Residents who reside in the facility have the potential to be affected in a similar manner. DON/designee conducted an audit of medication/treatment carts to ensure they were locked when not attended. Areas of concern were addressed at time of findings with 1:1 education through progressive disciplinary actions. Element #3 Admin/DON reviewed Policy for medication storage and deemed it appropriate. DON/designee educated the nursing department on the policy including that all medication and treatment carts must be locked whenever unattended by nursing personal. Element #4 DON/designee will conduct daily random checks of up to 10 medication/treatment carts will be checked for locked status when unattended. This will continue 5 days a week x4 weeks, then weekly x4 weeks. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	

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	pen for up to 28 days after its first use. Throw away the Lantus SoloStar pen you are using after 28 days, even if it still has insulin left in it." A review of the package inserts at Drugs.com indicated: For Latanoprost eyedrops: "Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks." For Lispro insulin: Insulin Lispro Injection prefilled pens should be stored at room temperature, below 86°F (30°C) and must be used within 28 days or be discarded, even if they still contain Insulin Lispro Injection. Protect from direct heat and light. For the Incruse Brand inhaler: "Incruse Ellipta should be stored inside the unopened moisture-protective foil tray and only removed from the tray immediately before initial use. Discard Incruse Ellipta 6 weeks after opening the foil tray or when the counter reads "0" (after all blisters have been used), whichever comes first." Deficient Practice Statement #2 Based on observation, interview, and record review, the facility failed to maintain locked medication and treatment carts, resulting in an unsupervised medication and sharps to facility staff, visitors and facility residents. Findings include:			

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	On 10/11/22 at 11:09 AM, a treatment cart located on the high 200 hallway was observed as unlocked. Wound care items were in the treatment cart which also contained wound care supplies with facility residents' names on them. On 10/11/22 at 11:40 AM and 11:56 AM, the medication cart on the low 300 hallway was observed as unlocked. An unidentified resident was observed sitting in the hallway in front of the medication cart. On 10/11/22 at 1:13 PM, the treatment cart located on the high 200 hallway was observed as still unlocked. On 10/12/22 at 12:12 PM, the treatment cart on the low 300 hallway was observed as unlocked. On 10/12/22 at 3:53 PM, the medication cart on the low 400 hallway was observed as unlocked, and the medical record of a resident was observed as visible on the computer screen. On 10/13/22 at 9:27 AM and 11:12 AM, the treatment card on the high 200 hallway was observed as unlocked. On 10/13/22 at 2:36 PM, it was brought to the attention of the Director of Nursing (DON) that there were unlocked treatment and medication carts observed throughout the survey. The DON explained that her expectation is that treatment and medications carts should be locked if not in use. A review of the facility's "Medication and Treatment Cart" Policy revealed the following, "1.General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts,			

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	cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments (see attached listing). c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. d. Non-biologics for treatments will be stored in medication rooms and in treatment carts. Individual supplies specific for resident may be kept bedside..."			
F0773 SS= D	Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain lab results for one of one resident (R577) reviewed for lab results resulting in the potential for a delay in treatment. Findings include:	F0773	F773 Lab Services The Licensed Nurse did not obtain lab results resulting in potential delay of treatment. Element #1 Resident # 577 has had a chart review. Labs have been collected, resulted and reviewed by the physician. No changes were made at this time. DON/designee has conducted an audit on lab orders to ensure results have been obtained and carried through. Element #2 Residents who with orders for laboratory services have the ability to be affected by this citation. An audit of current with orders for laboratory services since the beginning of October 2022 was completed. All orders were checked against actual draws with results, refusals for draws and/or resident discharge previous to draw being completed.	11/8/2022

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	On 10/11/22 at 11:14 AM, R577 was observed sitting up in bed. Attempts to interview the resident were unsuccessful as they were pleasantly confused. A review of R577's medical record revealed that the resident was admitted into the facility on 8/10/22 with diagnoses that included Depression, Diabetes and Hypertension. Further review revealed a Minimum Data Set assessment dated for 9/28/22 revealing that the resident had a Brief Interview for Mental Status score of 13/15 indicating an intact cognition, and required limited to extensive assistance for Activities of Daily Living. Further review of R577's medical record revealed that the resident had a physician's order for the following dated for 9/19/22, "Metformin HCl (Anti-diabetic) Tablet 500 MG (milligrams). Give 1 tablet by mouth two times a day for Prophylaxis ... Further review of R577's medical record revealed that the resident did not have a diabetes care plan initiated until 10/12/22. Further review of R577's medical record revealed the following progress notes: "10/1/2022 18:05 Type: Nursing - Orders - Administration Note Metformin HCl Tablet 500 MG. Give 1 tablet by mouth two times a day for Prophylaxis. Resident refused medication and requested medication be discontinued." "10/5/2022 15:07 (3:07pm) Type: Physician Team - Progress Note: Encounter Date: 10-04-2022. Chief Complaint: Increased confusion DC (discontinue) metformin per daughter. HPI (History of Present Illness)...Patient is seen today for acute increased confusion reported by staff.		Element #3 Admin/DON reviewed Consulting Physician/Practitioner Orders and deemed it appropriate. DON/designee educated the nurses on the policy to ensure lab results are obtained and carried through. Element #4 DON/designee will audit at least 10 residents with lab orders weekly to ensure compliance with full process or order, obtain and report to physician. This will be completed weekly x 4 weeks and then monthly x 3 months thereafter. This will continue 5 days a week x4 weeks, then weekly x4 weeks. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	

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	Patient's daughter reports [R577] was not on metformin-needs to DC. No A1c (blood test measuring blood glucose) in chart or blood sugar readings for review. ...Assessments/Plans: Confusion Urine dip to rule out UTI (urinary tract infection) ...Confusion may be related to hypoglycemia (low blood sugar). Follow Accu-Cheks. CMP (complete metabolic panel). Diabetes type 2 with neuropathy A1c check now. discontinue metformin per daughter request-consider after checking kidney function and A1c result ..." "10/7/2022 14:24 (2:24pm) Type: Physician Team - Progress Note: Encounter Date: 10-07-2022 Chief Complaint: Confusion. loose stool Labs- DM2 (diabetes mellitus, type 2) ...Patient is seen today for routine f/u (follow-up). No labs available for review ... Per nurses note, Patient's daughter reports Pt was not on metformin-needs to DC. No A1c on chart or blood sugar readings for review. Will not dc until those results are obtained and considered. Recent UA (urinalysis) negative. Last labs 9/17/22. Confusion Urine dip to rule out UTI was negative. Confusion may be related to hypoglycemia. Follow Accu-Cheks ACHS x 3 days. No BS readings available for review. CMP not drawn. Last labs 9/17/22. Reorder. Diabetes type 2 with neuropathy A1c check now - no results available. reorder discontinue metformin per daughter request-consider after checking kidney function and A1c result ..." Further review of R577's medical record revealed two physician orders as follows: "A1c, CMP draw on 10/4/22." Order dated for 10/4/22. "A1c, CMP draw on 10/8/22." Order dated for 10/7/22.			

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	On 10/13/22 at 12:56 PM, a request for all R577's lab results were made however, they were not received by the end of the survey. On 10/13/22 at 2:36 PM, the Director of Nursing (DON) was asked about lab services in the facility. She explained that the lab services have improved and confirmed that lab orders should be followed once ordered. A review of the facility's "Lab Values, reporting of" did not reveal information relating to lab orders being carried through, or receiving lab results timely.			
F0804 SS= D	Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake: MI00131091. Based on observation, interview and record review the facility failed to consistently ensure meals were served at a preferred temperature and preferences honored for three residents (R33, R325, R327) reviewed for food related concerns, resulting in and the potential for dissatisfaction with the meal service. Findings include: On 10/11/22 at 9:54 AM R325 reported their	F0804	F804 Nutritive Value/Appear, Palatable/Prefer temp Element #1 It is the practice of the facility to ensure that food is being given to the resident at a palatable temperature, prepared by methods that conserve nutritive value, flavor and appearance. R325, R 33, R 327 were affected. R325, R327 are no longer residents. R33 did not receive food preferences updates and felt that the food was not hot enough. Element #2 Residents who reside at the facility have the potential to be affected by this citation and the components listed above. Audits for the following were completed: " Dining service manager/designee audited meal trays as they were taken to residents□ rooms, for meal preference satisfaction and palatable temperature. " Residents were reviewed for appropriateness to use select menu option. Element #3	11/8/2022

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	food preferences had not been checked and scrambled eggs and oatmeal are served every single day. A review of the menu for the week of the survey documented eggs on three of seven days and oatmeal daily. On 10/11/22 at 12:45 PM, a resident on the 700 unit reported the meals are served not always hot. On 10/11/22 at 1:13 PM, the lunch tray cart was observed to have been delivered to the 700 unit. There was a nurse on the unit and a nurse aide was observed to exit room 706 and walk away from the unit and did not return. At 1:25 PM the first tray was removed from the cart. The last tray was passed at 1:35 PM. The temperature of the the ham, carrots and potatoes were tested and found to be not hot and not cold but lukewarm in the mouth. A review of the tray cart delivery times documented the cart delivery time was 12:30 PM or 12:40 PM. On 10/11/22 at 1:52 PM the tray cart on the 900 unit was observed to be open with one tray left on the cart. Staff were not observed passing trays. The documented tray delivery time for the unit was 1:00 PM. On 10/11/22 at 3:39 PM, R327 reported they only receive double portions for a third of the meals delivered and liquid items are not always served in a cup they can drink out of without spilling.		Admin/DON reviewed Trayline Food Temperatures Policy and deemed it appropriate. Dietary staff will be educated on the importance of serving trays at a safe a palatable temperature. They were also educated on importance of providing choices to all residents. All parties educated acknowledged an understanding. Element #4 Dining service coordinator/designee will audit at least 20 resident trays weekly for the temperature that the food is when delivered to the room. Those same residents will be queried on their overall perception of their meal temperature related. This will be recorded on the audit and addressed as needed. This will be completed weekly x 4 weeks and then monthly x 3 months thereafter. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	

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	On 10/12/22 at 12:55 PM, the door to the 700 meal tray cart was left open by staff as the delivered a meal tray to room 702. On 10/12/22 at 1:26 PM, R33 commented that they had seen cream of wheat served and thought that it would be a nice change to the oatmeal. R33 reported they were a "picky eater." On 10/13/22 at 1:21 PM, the Dietary Manager was asked about measures used to keep the food warm once it leaves the kitchen and reported a heated plate and bottom are used along with an insulated top. The Dietary Manager further reported that optimally the trays should be distributed within 15 minutes of delivery to the floor and the temperature as close as possible to the temperature the food left the kitchen at. On 10/13/22 at 9:11 AM, the 500 unit meal tray cart was observed to be left open during tray distribution. Staff was observed to remove a tray and head toward the higher numbered rooms. Four food trays remained on the cart. A review of the "Trayline Food Temperatures" policy with issue date of 06/03/2005 documented, "....It is the policy of this facility to serve food at acceptable temperatures that deter bacterial growth..." A review of the "Dining Room Meal Service" policy with an issue date of 01/01/2020			

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	documented, "...Meal items will be served to the resident based on their selection from options available to the prescribed diet..."			
F0809 SS= E	Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure consistent offering of bedtime snacks for six confidential group residents. Findings include: On 10/12/22 at 2:02 PM, during a confidential group meeting 6 out of 8 residents explained that they did not receive snacks at bedtime. Two residents explained that they received snacks last night and had never received them before. Another resident	F0809	F809 Frequency of Meals/Snacks at Bedtime Element #1 It is the facility practice to ensure that all residents are served three meals per day, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests and plan of care. It is the facility practice that there is no more than 14 hours between dinner and breakfast, except when a nourishing snack is served at bedtime. No specific residents were affected by these practices. Element #2 Residents who reside at the facility have the potential to be affected by this citation and the components listed above. " All residents will be offered a snack from the dietary representative each evening. The resident will be allowed to choose from a variety of snacks. The dietary representative will document accept or refuse on the diet roster. Element #3 Admin/DON reviewed HS Snack Policy and deemed it appropriate. Dining and nursing staff will be educated on the importance of bedtime snacks for residents with diabetes and preferences of having a snack for all. All parties educated acknowledged an understanding. Element #4 The RD or designee will audit 10 residents per	11/8/2022

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	explained that they were unaware that snacks were available at bedtime. On 10/13/22 at 2:36 PM, the Director of Nursing (DON) was asked about residents not receiving snacks at bedtime, and reported that, "Residents should receive bedtime snacks." A review of the facility's "Snack Cart" policy revealed the following, "It is the policy of this facility to offer a nutritious HS (nighttime) snack to every resident. Snacks available will meet the restrictions for each individual resident's physician ordered diet. If a resident requests a snack that does not fall within their diet restrictions, their request will be met as long as there is no safety issue with chewing and swallowing involved..."		week regarding the offering of the HS snack x 4 weeks then weekly thereafter. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	
F0812 SS= D	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F0812	F812 Food Procurement, Store/Prepare/Serve Sanitary Element #1 It is the practice of the facility properly monitor and manage personal refrigerators within residents□ rooms. Residents 10 and 38 reside in the facility. Refrigerators were cleaned out and any outdated food was discarded of. Residents and families were reminded of the 3-day protocol. Element #2 Residents with personal refrigerators have the potential to be affected in a similar manner. Housekeeping conducted a house audit and outdated food was discarded and residents and families reminded of 3 day protocol and	11/8/2022

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	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the failed to monitor food items and temperatures in a personal refrigerator for residents R10, R38, R132 and R152 resulting in the potential of food borne illness. Findings include: On 10/11/22 at 11:38 AM, R10's room was observed to have a personal refrigerator. The contents of the refrigerator were observed to be full of containers with food from the outside of the facility. The containers were not labeled with open date or when the food items would be discarded. There were also multiple boxes of milk with expiration date of 10/6/22. The freezer was observed to have a buildup of ice on and around the freezer. R38 (spouse of R10) was observed in R10's room and in R10's refrigerator and was asked if there was a thermometer located inside of the refrigerator and was unable to locate one. A review of R10's medical record revealed, R10 was admitted to the facility on 6/26/2019 and readmitted on 4/29/2021 with diagnosis of Progressive Neurological Conditions. A review of R10's Minimum Data Set (MDS) assessment, R10 has an impaired cognition and requires total assistance with activities of daily living (ADLs). On 10/11/22 at 11:30AM, R38's room was observed to have a personal refrigerator. The contents of the refrigerator were observed to be full of containers with food from the outside of the facility. The containers were not labeled with open date or when the food items would be discarded. Inside the freezer a container of ice cream was observed with frozen ice cream on the outside of the container. The Ice cream was also		dating. Element #3 Admin/DON reviewed Outside food policy and deemed it appropriate. DON/designee educated the nursing dept, dietary and housekeeping on the policies. Housekeeping audits fridges during routine room cleaning and expired foods or meals > 3 days are discarded. Element #4 Admin/designee will audit at least 10 personal refrigerators weekly to ensure compliance with storage of food items and proper temperature checks. This will be completed weekly x 4 weeks and then monthly x 3 months thereafter. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	

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	frozen on the surface of the freezer. There were also multiple boxes of milk with expiration date of 10/6/22. A thermometer was not located inside of the refrigerator. exp milk in fridge no A review of R38's medical record revealed, R38 was admitted to the facility on 1/13/2022 with diagnosis of Stroke. A review of R38's MDS assessment, R10 has an intact cognition and requires limited assistance with ADLs. A review of the facility's policy titled, "Shelby Health & Rehabilitation Center" dated, 3/8/2021, noted, "POLICY: When families bring in food for our residents, the facility will provide safe storage as defined by the US Food Code. All food items provided by families will be labeled and dated, stored properly, and used within an acceptable timeframe... Cold Food Storage in Resident Room - Individual Refrigerator. 1. No raw food will be stored. 2. Leftover food will be stored in covered containers or wrapped carefully and securely. 3. Each item will be clearly labeled with the current date before being refrigerated. 4. Once weekly, Housekeeping is responsible for cleaning of the individual room refrigerators and for review of dated items stored in the refrigerator. 5. During weekly cleaning, leftovers older than 72 hours will be discarded." On 10/12/22 at 12:15 PM, the personal refrigerator for Resident #152 was observed with an undated sandwich, and no interior thermometer. On 10/12/22 at 12:20 PM, the personal refrigerator for Resident #132 was observed with an internal thermometer reading of 50 degrees Fahrenheit.			

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	According to the 2013 FDA Food Code section 3-501.16 Potentially Hazardous Food (Time/Temperature Control for Safety Food), Hot and Cold Holding, "1. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be maintained: (1) At 57ºC (135ºF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54ºC (130ºF) or above; or (2) At 5ºC (41ºF) or less."			
F0814 SS= F	Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the exterior trash refuse area in a sanitary manner. This deficient practice had the potential to affect all residents in the facility. Findings include: On 10/11/22 at 9:30 AM, the exterior dumpster area was observed with Dietary Staff "CC". The ground surrounding the 3 dumpsters was littered with flattened cardboard boxes, trash bags, disposable gloves, leaves and debris. In addition, the side door on the first dumpster was left open, and both lids on the top of the center dumpster	F0814	F 814 Dispose Garbage and Refuse Properly The maintenance/housekeeping staff did not maintain the exterior trash refuse area in a sanitary manner. Element #1 No cited residents. Element #2 Residents residing in the facility have the potential to be affected in a similar manner. Admin/designee conducted an audit of the exterior trash refuse and concerns were addressed at the time. Element #3 Admin/DON reviewed Environmental Services Inspection and deemed it appropriate. Admin/designee educated the Maintenance and Housekeeping staff on the policy. Housekeeping removes trash from all areas of facility at scheduled times during the day and places refuse in the dumpster. The dumpster	11/8/2022

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	were left open. Dietary Staff "CC" was queried regarding who was responsible for maintaining the exterior dumpster area and stated that Maintenance is responsible for keeping the dumpster area clean. On 10/11/22 at 10:30 AM, Maintenance Staff "BB" was queried regarding the maintenance and cleaning of the exterior dumpster area and stated, "We try to check it every morning." Review of the facility's policy "Environmental Services Inspection" dated 08/2022 noted: "1. The Director of Environmental Services will perform random and/or routine inspections inside the building and on the grounds outside the building. 2. All opportunities will be corrected immediately by environmental services personnel."		is to be closed and area around dumpster is to be kept clean. Element #4 Admin/designee will randomly audit the grounds outside 4 times a week x 4 weeks then weekly thereafter. All opportunities will be corrected immediately. Audits will be submitted to QAPI. This plan of correction will be monitored at the monthly Quality Assurance [QAPI] meeting until such time consistent substantial compliance has been met. Element #5 The NHA/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/8/22 and for sustained compliance thereafter.	