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	134140	A. BUILDING _____ B. WING _____	12/22/2022

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MOMENTOUS HEALTH AT BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

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F0000 SS=	INITIAL COMMENTS Momentous Health at Battle Creek was surveyed for a Recertification survey on 12/22/22 . Intakes: MI00127738, MI00128361, MI00129672, MI00130337, MI00130365, MI00130932 Census= 53	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of	F0550	1. Resident #48, #40, and #21 were addressed by caregivers to increase their situation to reflect care with dignity on 12-23-2022. 2. All residents have the potential to be affected by this deficient practice. An audit was completed by Social Worker/ Designee on 1-24-2023 of all residents to find out if they are receiving care with dignity. No other concerns were noted. 3. The facility policy on Resident's Rights was reviewed by the QAPI Committee on 1-12-2023 and deemed appropriate. The facility policy on Resident's Rights was reviewed with all staff on 1-12-23 and 1-13-23 by the administrator/designee'. 4. An audit of 25% of residents was completed by the administrator/designee' weeklyx4 and monthly thereafter. Results were trended and brought to the QAPI Committee for trending and process improvement. 5. The Administrator is responsible for this plan of correction.	1/31/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/27/2023

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

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	interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00130932 Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and respect for three(R21, R40, and R48) of five residents reviewed for dignity, resulting in potential for feelings of diminished self-worth, sadness, and frustration. Findings include: Resident #21(R21) Review of the Face Sheet and Minimum Data Set (MDS) dated 10/24/22, reflected R21 was a 79 year old female admitted to the facility on 1/24/17, with diagnoses that included dementia, coronary heart disease, heart failure, peripheral vascular disease, seizure disorder, schizophrenia, and mantic depression. The MDS reflected R 21 had a BIM (assessment tool) score which indicated her ability to make daily decisions was severely impaired, and she required one person physical assist with bed mobility, transfers, locomotion on unit, dressing, eating, toileting, hygiene, and bathing.			

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	During an observation on 12/11/22 at 9:07 AM, R21 was laying on an air mattress positioned low with hospital gown on with head awkwardly positioned to the left with very strong smell of urine in room. R21 door was open with stop sign on door that read, "aerosol generate\ing procedure" that indicated required use of gloves, mask, gown, and eye protection, with no Personal Protective Equipment(PPE) observed outside door. R21 had an air mattress in place, appeared thin and frail, was awake with eyes open holding stuffed animal and rosary. R21 did not appear to be verbal and appeared calm with soft touch call light located out of reach under top of pillow. Folding chair was noted at bedside along with bedside table with 2 large Styrofoam cups with straws that appeared to be orange juice and water. During an observation on 12/11/22 at 3:45 p.m., R21 continued to lay in bed with gown on with neck turned to left in dark room. During an interview on 12/11/22 at 2:45 PM, Certified Nurse Aid (CNA) "MM" reported assisted R21 for breakfast and reported was not able to recall what R21 ate for breakfast but reported had either nectar or honey thick liquids from kitchen. CNA "MM" reported knows how to care for each resident by verbal report at shift change. CNA "MM" reported documents in Electronic Medical Record (EMR) at nurse station only because she does not have access to hall monitors			

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and reported unsure how to determine what each resident diets are including restrictions from EMR. CNA "M" joined interview in hall and verified no way for CNA staff to determine resident diet from EMR and reported aware of resident care including diets from verbal report at shift change and sign in main kitchen with resident liquid modification and consistency.

During an interview on 12/11/22 at 2:55 PM, CNA "M" reported had forgot that they have access to Kardex for each resident that had care and diet modifications including liquid consistencies. CNA "MM" also present for interview verified that was the first CNA "MM" had heard about the Kardex and was unsure how to even look at it.

During an observation on 12/14/22 at 9:20 AM, CNA "KK" and Administrator "A" observed in R21's room. R21 was noted positioned low in bed awkwardly leaning to left side. CNA "KK" then asked CNA "NN" for assist with boosting R21 up in bed because ADM "A" asked her to make R21 comfortable. At 9:27 AM R21's call light was observed and heard alarming with door closed and observed four staff pass R21's room with call light on as indicated by light illuminated over door. At 9:31 AM CNA "KK" exited R21 room with bag of soiled items and call light was turned off. At 9:34 AM this surveyor entered R21 room with CNA "KK" and observed CNA "NN" and CNA "KK" finish R21 morning care including linen. R21 was repositioned and

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	brief and hospital gown changed. Staff did not apply moisture barrier cream to R21. This surveyor observed television was on programmed to, "Two broke girls"(current television show). During an observation on 12/14/22 at 11:33 AM R21's meal tray was delivered to her room and placed on the bedside table next to the bed and staff exited the room. R21 was noted in bed and the meal tray was covered and untouched. Several staff noted on hall and smell of outside food noted one door down from R21 room with several staff noted eating lunch. This surveyor continued to observe outside R21's room and R21 call light turned on at 12:23 PM CNA "M" entered R21 room, turned off the call light, offered R21 something to eat and drink from the untouched meal tray and R21 accepted. At 12:37 PM, CNA "M" exited R21's room with the meal tray and reported R21 ate about 25% of meal including mandarin oranges mostly, did not want mashed potato's or pureed possible beef/broccoli or magic cup which was no longer cold to touch. CNA "M" reported R21 drank quite a bit. This surveyor verified dishes were not warm. CNA "M" reported trays were delivered to unit about 11:30 a.m. and was unsure who delivered R21 tray. Review of the Care Plans, revised 5/3/17, reflected, "I am incontinent of Bowel and Bladder			

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	potentially d/t progressive dementia. My guardian has elected I receive hospice services and a decline in my condition is expected. My skin will not become impaired r/t incontinence by next review. I will be free of odor while maintaining my dignity. Assist me with incontinence care post incontinent episodes. Clean and dry skin, inspect for skin irritation or compromise, and apply moisture barrier cream with each change of briefs or linens. Assist me to change my clothing as needed. I require extensive assistance for toileting. Check frequently and change as needed. Assist me with my meals and encourage me to be in my wheelchair while eating. Date Initiated: 01/29/2017 Revision on: 05/03/2017..." During an observation on 12/20/22 at 8:20 AM, R21 was laying on back in low bed, eyes closed, wearing a hospital gown, with 2 mugs on bedside table with straws. Observe R21 meal meal tray on hall cart with CNA "M" with 2 bowls of pureed items. One bowl was untouched and on with maybe one bite taken and empty glucerna on the tray. CNA "M" reported meals not posted but reported breakfast was biscuits and gravy and sausage. During an observation on 12/20/22 at 9:50 AM R21 was laying in low bed on back with eyes closed wearing hospital gown with lights off and no music. Continued to observed R21			

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room with no staff entering R21 room up through 10:45 a.m.

During an interview on 12/21/22 at 10:45 AM, CNA "M" reported residents are bored and complain of nothing to do. CNA "M" reported new owner took over and sold the facility bus and now residents complain that they used to be able to go out and now they can not. CNA "M" reported had never seen hospice spiritual care in for R21, only hospice CNA who provided baths usually 2 times weekly. CNA "M" reported was unsure of R21 religious preference. Licensed Practical Nurse (LPN) "OO" joined the interview and reported had cared for R21 for several years and use to enjoy regular trips out of the facility. LPN "OO" reported had not observed R21 out of bed in two weeks and does not like group events. LPN "OO" reported was unsure if R21 liked music and reported long history of using rosary and had always had cross necklace she was very attached to. LPN "OO" reported was unsure of R21's religious background and reported had never observed hospice spiritual services visiting R21. LPN "OO" and CNA "MM" both reported were unsure what services R21 was receiving from hospice and reported they only sign hospice tablet after visits for CNA and Nurse.

During an interview on 12/21/22 at 12:25 PM Hospice CNA "PP" reported provided R21 bathing services two times weekly on Wednesday and Friday and often comes during lunch to assist with meals. CNA "OO"

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reported facility had been short staffed and reported R21 was going to be discharged from Hospice services and skin started to breakdown related to incontinence located in brief area and facility moved R21 from north to south unit. Hospice CNA "OO" reported Hospice offered music and pet therapy but R21 did not receive and was unsure why. CNA "OO" reported was told yesterday that hospice binder would be located in front of building because difficult to locate staff for nurse to sign for visits.

Resident #40

According to the clinical record including the Minimum Data Set (MDS) dated 11/19/22 resident 40 (R40) was a 58 year old female, admitted to the facility with diagnosis that include severe intellectual disabilities, early onset Alzheimer's, Bi-polar disorder, anxiety, Down syndrome unspecified. R40 scored 00 (severe cognitive impairment) on the Brief Interview for Mental Status. Of note, further record review revealed R40 had a court appointed guardian, no contact with family, and had no visitors.

R40 was observed on 12/11/22 at approximately 12:00 pm, sitting alone at a table in the dining room, her hair had not been combed, she wore mismatched clothing and had a disheveled appearance. Unidentified staff delivered R40 her lunch and walked away to assist other residents. R40 was observed to eat with her fingers (there was a fork provided) no verbal or physical cueing was provided to assist R40 to use utensils, after several minutes passed, R40 was then observed to consume part of

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her meal by putting her face in the plate and proceeded to eat without fingers, hands or utensils, it was momentarily after this observation that staff acknowledged R40 and cued her to use utensils.

On 12/13/22 at 08:47 AM, R40 was observed to be walking with an unidentified Activity aide, R40 had a strong odor of feces, Licensed Practical Nurse (LPN) "N" was observed to walk passed R40 in the dining room where other residents and staff were present, and while waving her hand in front of her face, LPN "N" loudly questioned "Oh, who is stinky?!"

Resident #48 (R48)

Review of R48's electronic medical record (EMR) revealed R48 was admitted to the facility on 6/17/2022. Diagnoses included congestive heart failure (causes weakness and shortness of breath), Dementia, muscle weakness.

Record review of a "Minimum Data Set" (MDS) assessment, dated 7/1/2022, revealed R48 had a "Brief Interview for Mental Status" (BIMS) score of zero out of 15, which indicated R48 had severely impaired cognition. Further review of the MDS R48 required use of a wheelchair for maximum assistance with all personal care.

During the same observation Certified Nurse Aid (CNA) "U" was observed to grab R48's left forearm and pull him into the dining room from the hallway while he was in his

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	wheelchair. R48 did not have footrest on his wheelchair to be pushed or pulled, only self-propel.			
F0559 SS= D	Choose/Be Notified of Room/Roommate Change §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide advanced written notice prior to a room change for one resident (#20) reviewed for room changes which resulted in reported frustration with the potential for increased anxiety, misunderstanding of the reason for the room change, and the lack of opportunity for resident questions. Findings include: Resident # 20 (R20) initially admitted to facility 8/5/21 with most recent facility readmission 9/22/22 with diagnoses including cerebral infarction, type 2 diabetes	F0559	1. The need for a room move during facility renovations was discussed with resident #20 prior to her room move. She did agree to the room move verbally on the day of the move . Once the move was completed , the Social Worker asked the resident , who is her own decision-maker, to sign the facility's room move sheet on 12-12-2022. 2. The room move sheets for all moves completed within the last 30 days were audited to ensure timely signatures by the Social Worker/Designee on 1-23-2023.. Any signatures not obtained were reviewed with the resident/responsible party and then the form was completed on 1-23-2023. 3. The procedure for the room moves and necessary signatures was reviewed by the QA Committee on 1-12-2023, and deemed appropriate. All staff involved in the room change process were educated by the NHA /Designee on 1-12-2023 and 1-13-2023. 4. Room move sheets for all resident moves will be audited by the Social Worker/Designee' weekly x4 and monthly thereafter. Results will be presented to the QAPI Committee for process improvement until the issue is resolved. 5. The Administrator is responsible for this plan of correction.	1/31/2023

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mellitus, chronic pain, displaced fracture of left femur, and morbid obesity. Review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/13/22 revealed that R20 had highly impaired hearing but had clear speech and was understood and understands with a Brief Interview for Mental Status (BIMS) score of 6 (severe cognitive impairment). Section G of MDS revealed that R20 required two-person extensive assistance with bed mobility, two-person total dependence for transfers, one-person total dependence with dressing, independent with eating after set up assist, two- person total dependence with toilet use, and two-person extensive assistance with personal hygiene. Section P of MDS reflected that R20 used bed rails daily. Review of the Discharge MDS dated 9/21/22, revealed that R20 had an unplanned discharge to an acute care hospital and that her return to the facility was anticipated.

During an observation and interview on 12/11/22 at 12:54 PM, Resident #20 (R20) was observed laying in bed, on left side, dressed in facility gown. Oxygen noted to be in place at 3 liters per minute via nasal cannula. Bilateral quarter side rails and over the bed trapeze noted to be in place. R20 stated that last week, she believed it was on Thursday, a Certified Nurse Aide (CNA) or Housekeeper entered her room with a cart and begin removing items from her closet and placing them on the cart. R20 stated that

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	when she questioned the staff member, she was informed that she would be changing rooms. R20 denied being notified prior to the initiation of the room change and stated that she still did not understand the rationale for the room change. R20 stated that she was initially frustrated with the abrupt move but was now getting comfortable in the new room. In an interview on 12/12/2022 at 2:10 PM, Social Worker (SW) "D" stated that any pending room change would be discussed amongst the Interdisciplinary Team (IDT) daily in the AM or PM meeting. SW "D" stated that she would then follow up with the resident to review and have the resident sign the "Acknowledgement of Room Change" form. SW "D" further stated that a housekeeper may mention the room change to a resident and even initiate the room change prior to the form being reviewed as stated that the housekeeping staff were responsible for the completion of the room change. SW "D" confirmed that R20's room change had been complete and that R20 was already moved to Room 128 prior to the time that she reviewed the room change form with R20 on 12/9/22. Per SW "D", R20's main concern at the time the room change form was complete post room change had been that there would be a third person in the room but after she was reassured that was not the case, SW "D" stated that R20 denied additional concerns.			

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	Review of R20's medical record included no nurses notes or social work notes on the day of or the days following the room change which reflected the change or resident's reaction to the new room. Review of the facility policy titled "Room Changes" dated 5/2/2022, indicated that " ...2) Prior to changing a room or roommate assignment all parties involved in the change/assignment ...will be given a 24 hour/day advance notice of such changes ...4) Unless medically necessary or for the safety and well-being of the resident(s), a resident will be provided with an advance notice of the room change. Such notice will include the reason(s) why the move is recommended."			
F0565 SS= D	Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups	F0565	1. The Resident Council Concerns related to staffing, food temps, and environment were addressed as of 1/13/2023. 2. All residents have the potential to be affected by this deficient practice. An audit was completed on 1/13/2023 and all concerns were documented and addressed. 3. The process for conducting Resident Council Meetings and following up on concerns to resolution from the Resident Council Meeting. Logging Resident Council minutes to retain concern status for 36 months was also reviewed with the QAPI Committee and updated on 1-12-2023. The updated policy was reviewed with all staff by the NHA on 1-12-2023 and 1-13-2023. 4. A query of like residents was completed for 25% of the like residents weekly x4 and monthly thereafter. All results were brought to the QAPI committee for ongoing process improvement.	1/31/2023

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	concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that grievances were promptly documented, investigated, tracked and resolved for 9 of 9 members of the Resident Council resulting in unresolved complaints, anger and frustration. Findings Include: On 12/13/22 at 10:00 am, during the Resident Council meeting, 9 of 9 participants reported their complaints are frequently not addressed, responded to timely and/or go resolved without explanation. Members of the Resident Council reported they felt unheard, ignored and angry. Review of Resident Council Meeting Minutes dated 6/8/22 reflected concerns related to meal trays taking to long, dietary staff not reading tickets (resulting in food preference not being followed) , rooms not clean, lack of		5. The Administrator is responsible for this plan of correction.	

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	Nursing staff along with nursing staff being rude. Resolutions to the 6/08/22 Resident council meeting were to continue with tray audits, all staff to assist with passing trays, educate housekeeping staff and complete check off lists, and "Staffing- staffing to get more staff." The 7/6/22 Resident Council Minutes reflected in part, concerns related to housekeeping, dirty rooms "they stink", call light response time for call lights, and missing cloths. The facility response was to educate laundry on replacing labels for missing cloths, educate housekeeping staff on how to properly clean, and a call light audit that started and ended on 7/8/22. Resident Council Minutes dated 8/3/22 - listed complaints of dirty rooms, missing clothes, staffing, and cold food. Facility response was to continue education for laundry labels and complete check offs for housekeeping and ongoing review of rounds. Dietary was to continue to do food temperature audits. Resident Council Minutes dated 9/7/22 complained of rude staff, dirty rooms, not receiving scheduled showers showers.			

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	The facility response was to educate staff on dirty clothes going to right bin, educate staff on proper labeling, staff education on infection control and shower audits. Resident Council Minutes dated 10/12/22 reflected residents voiced concerns that pertained to not getting proper showers, missing clothes, facility dirty, night shift staff being too loud, and dietary not reading meal tickets. The facility Response was to do walking rounds to be done daily, a better process of labeling clothes and audit meal service 3 times a week. Education on noise reduction to be done in person. Resident Council Minutes dated 11/09/22 reflected residents voiced concerns that reflected rooms were dirty. The facility response was to do audits for cleaning rooms and educate staff about showers. During the 12/13/22 Resident Council meeting with the State Agency, one participant stated he complained about missing clothes on a monthly basis, the participant further reported nobody had assisted him in filling out a concern form and despite his ongoing complaint none of his items have been located or replace. This particular Resident Council participant was observed to be wearing pants with large			

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	holes in the material above the left knee, the participant reported that was one of his 2 remaining pair of pants, which he was embarrassed to wear but had no choice. The participants elaborated that staff attitudes are not addressed at all, and the ongoing facility cleanliness of the building just gets ignored. The participants elaborated that the facility always has a "Plan" in which they (the resident) is expected to sign, however the "Plan" never materializes. On 12/20/22 at 02:51 PM, during an interview with Activity Director "P" reported she had been the Activity Director for over 1 year and her duties included running the Resident Council Meetings. Activity Director "P" agreed that issues are brought forth month after month without being resolved. Activity Director "P" stated she had never filled out specific concern form for the missing items or resident specific issues, and elaborated that a recent Nursing Home Administrator (NHA) (there had been 3 Administrators in recent months) told her about one month ago this needed to be done and she will discuss issues with current NHA "A".			
F0577 SS= B	Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility;	F0577	1. Survey results were updated to include all survey results with the plan-of-correction by the NHA on 1-26-2023. 2. A query of interviewable residents was completed on 1-26 and 1-27 by the NHA and the activity director to ensure all residents are	1/31/2023

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	and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the Survey Book was consistently readily available, and that the book was maintained to include the facility plan of correction for identified deficiencies. Resulting in the potential for residents and visitors to be uninformed. Findings include: On 12/13/22 at 10:00 am, during the Resident Council meeting, 9 of 9 participants reported that they were aware of the location of the survey book was, however it frequently would be missing for extended periods of time. One group participant stated, they wished the facility had documented on how		aware of the required contents of the survey book posted outside the administrator's office. 3. The policy of the posted survey book contents was updated by the QAPI Committee on 1-12-2023. All staff were educated on the requirements and locations of survey posting by the administrator on 1-12-2023 and 1-12-2023. The Administrator reviewed the policy with the residents at resident Council Meeting on 1-30-2023. 4. Monthly queries of all interviewable residents will be completed by the administrator monthly x3 and quarterly thereafter. Results will be brought to the QAPI Committee for process improvement. 5. The Administrator is responsible for this plan of correction.	

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	they would correct the issues identified by the State Agency. On the afternoon of 12/13/22, the survey book was located across from the main dining room, review of the survey book reflected an abbreviated survey was conducted on 3/16/22 with two citations issued, one at harm level. The report in the survey book did not include the plan of correction, just as the Resident Council participant had described. On 12/20/22 at 02:51 PM, during an interview with Activity Director "P" reported she was not responsible for maintaining the survey book, and did not know who was. On 12/20/22 at 4:40 PM during an interview with Director of Nursing "B" she stated the current Nursing Home Administrator (NHA) "A" had been at the facility for approximately 1 month and the facility had not had a survey in that time. DON "B" stated she was not responsible for the survey book and was not aware of what had to be posted, and that the former NHA handled it.			
F0578 SS= D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F0578	1. The Advanced Directives for residents #27, #21, #17 were reviewed by the Social Worker/Designee with the resident, representative, physician, and witness all signing review on the same date. This was completed on 1-23-2023 2. An audit of all resident advanced directives for current residents of Momentous Battle Creek was completed by the Social Worker/Designee on 1-24-2023. Any	1/31/2023

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	inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure updated and accurate advance directive information was in place for three residents (Resident #7, #21, #27) of five reviewed for advance directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time), resulting in the potential		advanced directives with signatures that were not on a consistent date had their advanced directives reviewed with them, their responsible party, the physician, and a witness. Signatures will be obtained at the same time on the same date for all resident advanced directives. 3. The policy for Advanced Directives with emphasis on obtaining timely and consistent signatures for all residents was reviewed by the QAPI Committee and deemed appropriate on 1-12-2023. 1:1 Education was provided by the Licensed Nursing Home Administrator to the Social Worker, who signed off understanding of this process on 1-26-2023. 4. To ensure compliance an audit to ensure proper process for Advanced Directives will be completed for 25% of total residents weeklyx4 , and monthly thereafter. All results will be trended and brought to QAPI for ongoing process improvement. 5. The Administrator is responsible for this pla of correction.	

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	for a resident's preferences for medical care to not be followed by the facility, or other healthcare providers. Findings Include: Review of the MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT, Act 193 of 1996 (Revised 3-25-14), revealed that, "An order executed under this section shall be on a form described in section 4. The order shall be dated and executed voluntarily and signed by each of the following persons: (a) The declarant, the declarant's patient advocate, or another person who, at the time of the signing, is in the presence of the declarant and acting pursuant to the directions of the declarant. (b) The declarant's attending physician. (c) Two witnesses 18 years of age or older, at least 1 of whom is not the declarant's spouse, parent, child, grandchild, sibling, or presumptive heir. (3) The names of all signatories shall be printed or typed below the corresponding signatures. A witness shall not sign an order unless the declarant or the declarant's patient advocate appears to the witness to be of sound mind and under no duress, fraud, or undue influence.			

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	Further review of this Act revealed, "Sec. 4. A do-not-resuscitate order executed under section 3 or 3a shall include, but is not limited to, the following language, and shall be in substantially the following form: "DO-NOT-RESUSCITATE ORDER This do-not-resuscitate order is issued by _____, attending physician for _____. (Type or print declarant's or ward's name) Use the appropriate consent section below: A. DECLARANT CONSENT I have discussed my health status with my physician named above. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. This order will remain in effect until it is revoked as provided by law. Being of sound mind, I voluntarily execute this order, and I understand its full import. _____ _____ (Declarant's signature) (Date) _____ _____ (Signature of person who signed for declarant, if applicable) (Date)			

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_____

(Type or print full name)

B. PATIENT ADVOCATE CONSENT

I authorize that in the event the declarant's heart and breathing should stop, no person shall attempt to resuscitate the declarant. I understand the full import of this order and assume responsibility for its execution. This order will remain in effect until it is revoked as provided by law.

_____
_____

(Patient advocate's signature) (Date)

_____

(Type or print patient advocate's name)

C. GUARDIAN CONSENT

I authorize that in the event the ward's heart and breathing should stop, no person shall attempt to resuscitate the ward. I understand the full import of this order and assume responsibility for its execution. This order will remain in

effect until it is revoked as provided by law.

_____

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	_____ (Guardian's signature) (Date) _____ (Type or print guardian's name) _____ _____ (Physician's signature) (Date) _____ (Type or print physician's full name) ATTESTATION OF WITNESSES The individual who has executed this order appears to be of sound mind, and under no duress, fraud, or undue influence. Upon executing this order, the declarant has (has not) received an identification bracelet. _____ _____ (Witness signature) (Date) (Witness signature) (Date) _____ _____ (Type or print witness's name) (Type or print witness's name)			

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	THIS FORM WAS PREPARED PURSUANT TO, AND IS IN COMPLIANCE WITH, THE MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT." Resident #27 (R27) Review of the medical record revealed R27 was admitted to the facility on 8/12/22 with diagnoses that included chronic osteomyelitis, diabetes, anxiety, depression, and dementia. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/22 revealed R27 scored 00 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R27 had a legal guardian in place. On 12/20/22 at 9:55 AM, R27 was observed asleep in bed. Review of R27's Code Status/"Do Not Resuscitate" Directive revealed the form was signed by R27's guardian on 3/9/22, however the form was not signed by two witnesses until five days later, on 3/14/22. In an interview on 12/20/22 at 11:32 AM, Social Worker (SW) "D" reported witnesses should sign at the time the resident or responsible party signed the Do Not Resuscitate Directive. SW "D" could not explain why two witnesses signed the document five days after R27's guardian.			

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	Resident #7 According to the clinical record, including the Minimum Data Set (MDS) dated 11/10/22, Resident # 7 (R7) was a 78 year old female admitted to the facility with multiple medical/health issues including dementia. Further record review reflected R7 scored 5 out of 15 (severe cognitive impairment) on the Brief Interview Mental Status (BIMS) completed on 2/15/21. Review of R7's advanced directive forms, reflected R7 signed a Do Not Resuscitate (DNR) form on 2/17/21, the same form was signed by the Physician on 2/19/21, the same form had 2 witness signatures which were both dated 2/24/21. On 12/20/22 at 12:56 PM, during an interview with Social Worker (SW) "D" it was queried if residents with known severe cognitive impairment would not be evaluated by a physician for their degree of ability to participate in medical decisions. SW "D" stated she does request that evaluation routinely but could not account for why this was not done for R7. When queried about the DNR form, with witness signatures 5 days after R7's signature, SW "D" agreed it should be signed by the witness right after it was signed by R7. Resident #21(R21) Review of the Face Sheet and Minimum Data			

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	Set (MDS) dated 10/24/22, reflected R21 was a 79 year old female admitted to the facility on 1/24/17, with diagnoses that included dementia, coronary heart disease, heart failure, peripheral vascular disease, seizure disorder, schizophrenia, and mantic depression. The MDS reflected R 21 had a BIM (assessment tool) score which indicated her ability to make daily decisions was severely impaired, and she required one person physical assist with bed mobility, transfers, locomotion on unit, dressing, eating, toileting, hygiene, and bathing. During an observation on 12/11/22 at 9:07 AM, R21 was laying on an air mattress positioned low with hospital gown on with head awkwardly positioned to the left with strong smell of urine in room. R21 door was open with stop sign on door that read, "aerosol generate\ing procedure" that indicated required use of gloves, mask, gown, and eye protection, with no Personal Protective Equipment(PPE) observed outside door. R21 had an air mattress in place, appeared thin and frail, was awake with eyes open holding stuffed animal and rosary. R21 did not appear to be verbal and appeared calm with soft touch call light located out of reach under top of pillow. Folding chair was noted at bedside along with bedside table with 2 large Styrofoam cups with straws that appeared to be orange juice and water. Review of R21's Code Status/"Do not Resuscitate" Directive revealed the form was			

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	134140	A. BUILDING _____ B. WING _____	12/22/2022

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	signed by R21's guardian on 1/24/20, however the form was not signed by witnesses until 1/25/20. During an interview on 12/20/22 at 1:10 PM, Social Worker (SW) "D" reported would expect witnesses to sign at the time the resident or responsible party signed the Do Not Resuscitate Directive. SW "D" could not explain why witness signed the document a day after R21's guardian.			
F0600 SS= D	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure residents were free of physical and verbal involving 2 residents (#40 and 25), of 6 residents that were reviewed for abuse, resulting in Resident 40 being verbally and physically abused. Findings include: **Resident #25**	F0600	1. Resident #40 no longer resides in the facility. Resident #25 was seen by Social Work on 1-25-2023 and shows no lasting effects from the resident interaction. 2. All residents have the potential to be affected by this deficient practice. A query of all interviewable residents was completed by the NHA and the activity director on 1-26-2023 and 1-27-2023 to ensure there were no other incidents of abuse and no concerns were noted. 3. The facility's policy on abuse prevention was reviewed by the QAPI Committee and deemed appropriate on 1-12-2023. All staff were educated on the facility policy on abuse prevention 1-12-2023 and 1-13-2023 by the administrator. 4. To ensure compliance, 5 residents will be audited for freedom from abuse by the administrator/designee. Audits will be completed weeklyx4 and monthly thereafter. Results will be brought to the QAPI Compliance Committee for ongoing compliance and process improvement. 5. The Administrator is responsible for this plan of correction.	1/31/2023

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	According to the clinical record, including the Minimum Data Set (MDS) dated11/15/22 reflected Resident 25 (R25) was an 84 year old female admitted to the facility with diagnosis of dementia and bi-polar disorder. The MDS revealed R25 had long and short term memory impairment with severely impaired decision making skills. **Resident #40** **Review of Nursing progress notes dated 11/30/2022 reflected Certified Nursing Assistant (CNA) "CC"** **walked by R40's room at 12:30 am and observed R25 was slapping R40 and calling R40 names. Upon CNA "CC" trying to intervene, R25 then became verbally and physically aggressive with CNA "CC", at which time CNA "EE" entered and separated R25 and R40.** **Review of the facility Incident report dated 11/30/22 reflected R40 "received physical aggression."** An attempt to contact the Licensed Practical Nurse (LPN) "DD", who authored the progress note and was assigned to R25 and R40 on 11/30/22. LPN "DD" had multiple phone numbers on file none of which were in service and attempts to interview via emergency phone numbers listed in her personnel file were not valid phone numbers. Multiple attempts were made to contact CNA "CC" via voice mail and texts on 12/21 and 12/22 but none were returned.			

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	According to the facility Policy titled "Abuse Prevention" dated 8/20/21 defined Abuse as "The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker of good or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled trough the use of technology, such as through the use of photographs and recording devices to demean or humiliate a resident. "			
F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey	F0609	1. Resident #40 no longer resides in the facility. Resident #25 was seen by Social Services on 1-25-2023 in relation to this incident . Resident #25 shows no lasting effects from this incident. 2. All residents have the ability to be affected by this deficient practice. A query of all residents was completed by the NHA and Activity Director on 1-26-2023 and 1-27-2023. 3. The policy for Abuse was reviewed and updated by the QAPI Committee on 1-12-2023. All staff were educated by the administrator on the updated policy. The NHA was educated by the CEO 1:1 on 1-24-2023 on the policy for resident-to-resident abuse reporting. 4. To ensure compliance, 5 residents will be	1/31/2023

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	Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report an allegation of abuse for two of 6 residents reviewed for abuse (#25 and 40). Resulting in allegations of abuse not being reported to the State Agency and the potential for additional allegations of abuse to go unreported. Resident #25 According to the clinical record, including the Minimum Data Set (MDS) dated 11/15/22 reflected Resident 25 (R25) was an 84 year old female admitted to the facility with diagnosis of dementia and bi-polar disorder. The MDS revealed R25 had long and short term memory impairment with severely impaired decision making skills. Resident #40 Review of Nursing progress notes dated		audited for abuse reporting by the administrator/designee. Audits will be completed weekly for 4 weeks and then monthly for 2 months. Results will be brought to the QAPI Committee for trending and process improvement. 5. The Administrator is responsible for this plan of correction.	

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11/30/2022 reflected Certified Nursing Assistant (CNA) "CC"

walked by R40's room at 12:30 am and observed R25 was slapping R40 and calling R40 names. Upon CNA "CC" trying to intervene, R25 then became verbally and physically aggressive with CNA "CC", at which time CNA "EE" entered and separated R25 and R40.

Review of the facility Incident report dated 11/30/22 reflected R40 "received physical aggression."

An attempt to contact the Licensed Practical Nurse (LPN) "DD", who authored the progress note and was assigned to R25 and R40 on 11/30/22. LPN "DD" had multiple phone numbers on file none of which were in service and attempts to interview via emergency phone numbers listed in her personnel file were not valid phone numbers. Multiple attempts were made to contact CNA "CC" via voice mail and texts on 12/21 and 12/22 but none were returned.

On 12/21/22 at 12:59 PM, during an interview with Nursing Home Administrator (NHA) "A" the incident was discussed and it was revealed that NHA "A" acknowledge the abuse but that she did not report it to the Stat Agency. NHA "A" elaborated, and initially stated she was new and did not have access on the computer system in order to report allegation of abuse to the State Agency, NHA

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	"A" then offered another explanation for the incident not being reported in which she stated the facility had a separate but reportable allegation of drug diversion which took precedence for reporting which was reported by the owner of the facility. According to the facility Policy titled "Abuse Prevention" dated 8/20/21 under initial reporting 1b. read in part "The Administrator or his/her designee will notify DOH (Department of Health) of all alleged violations involving abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of resident property and injuries of unknown Source as soon as possible, but in no event later than twenty-four (24) hours from the time the incident/allegation was made known to the staff member." Under the heading reporting #3. "State Department of Health, When possible DOH will be notified using the online reporting system. The facility will submit an online facility reported incident form in accordance with DOH's then current instructions. In the event of an Internet outage or similar failure, This facility will temporarily notify the DOH District Office of the allegation via alternative method (e.g. phone), and will submit the self reported incident online once service is restored. Only the Administrator or someone specifically designed by the Administrator is authorized to submit a Self-Reported incident to the DOH."			

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F0641 SS= D	Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessments for three (Resident #21, #27, #50) of 15 reviewed, resulting in inaccurate MDS assessments and the potential for unmet care needs. Findings include: Resident #27 (R27) Review of the medical record revealed R27 was admitted to the facility on 8/12/22 with diagnoses that included chronic osteomyelitis, diabetes, anxiety, depression, and dementia. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/22 revealed R27 scored 00 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool), had an indwelling catheter in place, was always incontinent of urine, had one or more unhealed pressure ulcers, yet none were documented under each stage of pressure ulcers. R27's MDS was also not coded for any venous or arterial ulcers. On 12/20/22 at 9:55 AM, R27 was observed asleep in bed. R27 had an indwelling catheter	F0641	1. Resident #21's assessment was reviewed for accuracy and corrected as needed by the DON/Designee on 1-16-2023.Resident #50's assessment was reviewed for accuracy by the DON/Designee' and corrected as needed. Resident #27's assessments was reviewed for accuracy and corrected as needed by the DON/Designee' on 1-16-2023. 2. All residents have the potential to be affected by this deficient practice. The DON/Designee' completed an audit of all resident assessments for accuracy of assessments on 1-26-2023. Any inaccuracies were addressed on 1-26-2023. 3. The QAPI Committee reviewed the policy for accuracy of assessments and deemed it appropriate on 1-12-2023. All staff were inserviced on the policy for accuracy of assessments by the NHA on 1-12-2023 and 1-13-2023. 4. The DON/Designee will complete an audit of 25% of all residents for accuracy of assessments weekly x4 and monthly thereafter. Results of these audits were trended and brought to QAPI for ongoing process improvement. 5. The Administrator is responsible for this plan of correction.	1/31/2023

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in place.

In an interview on 12/20/22 at 10:06 AM, Director of Nursing (DON) "B" reported she was also the facility's MDS nurse. DON "B" reported R27 did not have pressure ulcers, but instead had venous ulcers. DON "B" reported R27's MDS was coded incorrectly and should have been coded as not having any unhealed pressure ulcers. When asked about R27 being coded as having an indwelling catheter and always incontinent of urine, DON "B" reported R27's incontinence status should have been coded as "not rated" since she had an indwelling catheter.

Resident #50

According to the clinical record, including the Minimum Data Set (MDS) dated 7/10/22 and 10/10/22, Resident 50 (R50) was a 91 year old female admitted to the facility in July 2022 with diagnoses that included Alzheimer's disease.

On 12/11/22 at 02:17 PM, R50 was observed in her room, she did not respond to simple questions, but did smile when surveyor greeted her. On the wall next to R50's bed , was notebook paper taped to the wall observed with key words from Spanish to English i.e. hola-Hello, aqua-water etc...

Review of R50's medical record revealed R50 was born in Mexico and her primary language was Spanish, but at one point R 50 was bilingual.

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On 12/14/22 at 9:15 am, during an interview with R50's family member "FF", they verified R50's primary/preferred language was Spanish and her place of birth was Mexico. Per family member "FF" R50 no longer spoke English and they believed she had forgotten how to, which was why they made and posted the notebook paper on the wall in order to assist R50's needs be met.

Review of the 2 MDS's completed since R50's admission, dated 7/10 and 10/10/22 reflected R50 was not of Hispanic or Latino decent, nor did either assessment capture R50's preferred language.

On 12/13/22 at 11:11 AM, during an interview with Director of Nursing (DON) "B" who also serves as the MDS Nurse offered no explanation for the errors.

Resident #21(R21)

Review of the Face Sheet and Minimum Data Set (MDS) dated 10/24/22, reflected R21 was a 79 year old female admitted to the facility on 1/24/17, with diagnoses that included dementia, coronary heart disease, heart failure, peripheral vascular disease, seizure disorder, schizophrenia, and mantic depression. The MDS reflected R21had a BIM (assessment tool) score which indicated her ability to make daily decisions was severely impaired, and she required one person physical assist with bed mobility, transfers,

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locomotion on unit, dressing, eating, toileting, hygiene, and bathing.

During an observaton on 12/11/22 at 9:07 AM, R21 was laying on an air mattress positioned low with hospital gown on with head aukwardly positioned to the left with strong smell of urine in room. R21 door was open with stop sign on door that read, "aerolol generate\ing procedure" that indicated required use of gloves, mask, gown, and eye protection, with no Personal Pertective Equipment(PPE) observed outside door. R21 had an air mattress in place, appeared thin and frail, was awake with eyes open holding stuffed animal and rosery. R21 did not appear to be verbal and appeared calm with soft touch call light located out of reach under top of pillow. Folding chair was noted at bedside along with bedside table with 2 large styrofaom cups with straws that appeared to be orange juice and water.

Review of the facility Matrix, dated 12/11/22, reflected R21 was not receiving Hospice services.

Review of the MDS, dated 10/24/22, 7/24/22 and 1/21/22, reflected R21 was not receiving hospice services.

Review of the EMR on 12/12/22 reflected R21 did not have a physician order for hospice services.

Review of R21 Hospice Care Plans, dated

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	1/8/20 to current, reflected,"I have a terminal prognosis and elected to have Hospice...Work cooperatively with hospice team to ensure my spiritual, emotional, intellectual, physical and social needs are met..." During an interview on 12/20/22 at 1:35 PM, Director of Nursing (DON) "B" reported R21 had been a Hospice resident for several months and reported would expect R21 to have an order for hospice. DON "B" reported had been the MDS nurse prior to DON and reported R21's MDS should reflect hospice services and if it did not it was an error. During an interview on 12/21/22 at 12:25 PM Hospice CNA "PP" reported provided R21 bathing services two times weekly on Wednesday and Friday and often comes during lunch to assist with meals. CNA "OO" reported facility had been short staffed and reported R21 was going to be discharged from Hospice services and skin started to breakdown related to incontinants located in brief area and facility moved R21 from north to south unit. Hospice CNA "OO" reported Hospice offered music and pet therapy but R21 did not receive and was unsure why. CNA "OO" reported was told yesterday that hospice binder would be located in front of building because difficult to locate staff for nurse to sign for visits.			
F0656 SS= E	Develop/Implement Comprehensive Care Pla §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F0656	1. Personalized care plans were developed for residents #21, #18, #50, #14 by the IDT Team on 1-18-2023.	1/31/2023

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	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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.		2. An audit of all care plans was conducted by the interdisciplinary team on 1-26-2023. Any care plans in need of development were developed by the IDT Team. 3. The policy on Care Plan Development was reviewed and deemed appropriate by the QAPI Team on 1-12-2023. The Policy on Care Plan Development was reviewed with all staff , including the IDT Team , by the administrator on 1-12-2023 and 1-13-2023. 4. 25% of all resident care plans will audited for development weeklyx4 and monthly thereafter by the DON/Designee. Results were brought to QAPI Committee for ongoing compliance and process improvement. 5. The Administrator is responsible for this plan of correction.	

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	This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00130932 Based on observation, interview and record review the facility failed to develop and implement comprehensive care plans for 6 (Resident #'s 14, 18, 21, 27, 48 and 50) of 15 reviewed for comprehensive care planning, resulting in the potential for unmet care needs and services. Findings include: **Resident #50** **According to the clinical record, including the Minimum Data Set (MDS) dated 7/10/22 and 10/10/22, Resident 50 (R50) was a 91 year old female admitted to the facility in July 2022 with diagnoses that included Alzheimer's disease.** **On 12/11/22 at 02:17 PM, R50 was observed in her room, she did not respond to simple questions, but did smile when surveyor greeted her. On the wall next to R50's bed , was notebook paper taped to the wall observed with key words from Spanish to English i.e. hola-Hello, aqua-water etc...** **Review of R50's medical record revealed R50 was born in Mexico and her primary language was Spanish, but at one point R 50 was bilingual.** **On 12/14/22 at 9:15 am, during an interview with R50's family member "FF", they verified**			

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	R50's primary/preferred language was Spanish and her place of birth was Mexico. Per family member "FF" R50 no longer spoke English and they believed she had forgotten how to, which was why they made and posted the notebook paper on the wall in order to assist staff to meet R50's needs. **On 12/13/22 at 11:11 AM, during an interview with Director of Nursing (DON) "B" who also serves as the MDS Nurse, R50's care plans were reviewed and reflected R50's mood care plan, created on 6/29/22 stated R50 could speak English, but would refuse to do so if mad or irritated, the goal of the care plan was for R50 to be free of side effects related to antidepressant therapy, there was no goal and no interventions that pertained to language or communication. DON "B" agreed the mood care plan did not address R50's communication needs and further review of the medical record reflected there was no care plan at all in place to address R50's communication needs.** Resident #27 (R27) Review of the medical record revealed R27 was admitted to the facility on 8/12/22 with diagnoses that included chronic osteomyelitis, diabetes, anxiety, depression, and dementia. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/22 revealed R27 scored 00 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and required extensive assistance of one person for bed mobility.			

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	On 12/11/22 at 09:25 AM, R27 was observed asleep in bed with an alternating pressure mattress (APM) set to 2.5 normal pressure float. R27 had a dressing on her left stump, an incontinence pad rolled up and placed under her left stump, and a boot on her right foot. On 12/20/22 at 09:55 AM, R27 was observed asleep in bed. R27's left below the knee amputation site had one 4x4 gauze in place and the alternating pressure mattress was unplugged and not functioning. R27 had a dressing in place on her right foot, but did not have a pressure relieving boot in place or a blanket rolled up under her left stump. Review of the Physician's Order dated 6/6/22 revealed "APM mattress in place for wound management". Review of the Physician's Order dated 9/11/22 revealed an order for a left below the knee daily dressing change which included to cover with dry gauze and secure with border gauze. Review of R27's most recent Wound Clinic Notes dated 11/21/22 revealed "Z flex offloading boot at all times to right calcaneus" (heel) and "Keep a rolled up blanket behind left knee to keep her from rolling the stump behind the upper thigh". Review of R27's Potential/Actual Skin Impairment care plan, revealed an			

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	intervention of a pressure reducing mattress. R27's Potential/Actual Skin Impairment to Skin Integrity of the Sacrum care plan revealed an intervention of APM mattress. R27's care plans did not mention a boot to the right foot or a rolled-up blanket behind the left knee. In an interview on 12/20/22 at 09:58 AM, Licensed Practical Nurse (LPN) "K" reported R27 had skin impairments. When asked why the mattress was not functioning, LPN "K" entered R27's room and reported the mattress was not plugged in and she was unsure how long it had been unplugged. In an interview on 12/20/22 at 10:06 AM, Director of Nursing (DON) "B" reported R27 should have a dressing on her left below the knee amputation incision, a functioning alternation pressure mattress, and a boot to the right foot in place. During the interview, DON "B" left the room and then came back and reported the Physician was in the building and would complete R27's dressing to her left stump. On 12/21/22 at 08:53 AM, DON "B" reported R27 should have a boot to the right foot in place at all times. On 12/20/22 at 10:56 AM, R27's left stump dressing change was completed. R27's mattress was plugged in and she had a boot to the right foot in place. In an interview on 12/21/22 at 08:53 AM, DON "B" reported R27 should have a boot to			

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the right foot in place at all times.

Resident #18(R18)

Review of the Face Sheet and Minimum Data Set (MDS) dated 9/4/22 reflected R18 was a 70 year old male admitted to the facility on 9/1/20, with diagnoses that included hypertension, peripheral vascular disease, and mood disorder. The MDS reflected R18 had a BIM (assessment tool) score which indicated his ability to make daily decisions was cognitively intact.

During an observation and interview on 12/11/22 at 10:27 a.m., R18 was sitting in wheelchair in room. R18 reported not a lot of interest in captivities offered at facility. R18 reported likes to watch TV but not many activities of interest for men.

Review of the most recent Life Enrichment (Activities) Assessment, dated 9/3/20, reflected R18 preferred activities included playing cards, exercise, sports, reading, music, baking/cooking, trips/traveling, talking/coffee chats, watching TV, watching movies, parties/social events and keeping up with news.

Review of R18 Activity Care Plans on 12/20/22 at 11:15 AM, reflected, "My name Is [named R18] I Prefer to be called [named]. I am an Army Veteran for 3 years...I enjoyed traveling. I enjoyed riding motorcycles...I am religious Presbyterian. I played the drums...I

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am also into racing both NASCAR

and drag racing. I also enjoy smoking. I also enjoy therapeutic coloring and I prefer to use Crayons...

Revision on: 04/01/2021...Goals...I will maintain involvement in cognitive stimulation, social

activities as desired through review date...Interventions...I will attend/participate in

activities of my choice (3-5 times weekly) by next review date...Invite me to scheduled activities...Provide me with an activities calendar and notify me of any changes...Provide me with materials for individual activities as I desire...Staff will encourage me to wear a mask...Thank me for attending activity functions. The Activity Care Plans reflected no mention of R18 preferred activities.

Review of the Activity Task documentation, dated 11/1/22 through 12/19/22, reflected R18 only participated in social hour, TV/movie/music and bingo with no evidence of R18 other areas of interest.

Resident #21(R21)

Review of the Face Sheet and Minimum Data Set (MDS) dated 10/24/22, reflected R21 was a 79 year old female admitted to the facility

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	on 1/24/17, with diagnoses that included dementia, coronary heart disease, heart failure, peripheral vascular disease, seizure disorder, schizophrenia, and mantic depression. The MDS reflected R 21 had a BIM (assessment tool) score which indicated her ability to make daily decisions was severely impaired, and she required one person physical assist with bed mobility, transfers, locomotion on unit, dressing, eating, toileting, hygiene, and bathing. During an observation on 12/11/22 at 9:07 AM, R21 was laying on an air mattress positioned low with hospital gown on with head awkwardly positioned to the left with strong smell of urine in room. R21 door was open with stop sign on door that read, "aerosol generate\ing procedure" that indicated required use of gloves, mask, gown, and eye protection, with no Personal Protective Equipment(PPE) observed outside door. R21 had an air mattress in place, appeared thin and frail, was awake with eyes open holding stuffed animal and rosary. R21 did not appear to be verbal and appeared calm with soft touch call light located out of reach under top of pillow. Folding chair was noted at bedside along with bedside table with 2 large Styrofoam cups with straws that appeared to be orange juice and water. During an observation on 12/11/22 at 3:45 p.m., R21 continued to lay in bed with gown on with neck turned to left in dark room.			

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	During an interview on 12/11/22 at 2:45 PM, Certified Nurse Aid (CNA) "MM" reported assisted R21 for breakfast and reported was not able to recall what R21 ate for breakfast but reported had either nectar or honey thick liquids from kitchen. CNA "MM" reported knows how to care for each resident by verbal report at shift change. CNA "MM" reported unsure how to determine what each resident diets are including restrictions from EMR. CNA "MM" reported had noticed hospitality aid had placed two large Styrofoam cups with straws with water and orange juice after breakfast and CNA "MM" informed aid to use smaller cups. CNA "MM" reported R21 could have straws. CNA "M" joined interview in hall and verified no way for CNA staff to determine resident diet from EMR and reported aware of resident care including diets from verbal report at shift change and sign in main kitchen with resident liquid modification and consistency. During an interview on 12/11/22 at 2:55 PM, CNA "M" reported had forgot that they have access to Kardex for each resident that had care and diet modifications including liquid consistencies. CNA "MM" also present for interview verified that was the first CNA "MM" had heard about the Kardex and was unsure how to even look at it. During an observation on 12/14/22 at 9:20 AM, CNA "KK" and Administrator "A" observed in R21's room. R21 was noted positioned low in bed awkwardly leaning to			

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	left side. CNA "KK" then asked CNA "NN" for assist with boosting R21 up in bed because ADM "A" asked her to make R21 comfortable. At 9:27 AM R21's call light was observed and heard alarming with door closed and observed four staff pass R21's room with call light on as indicated by light illuminated over door. At 9:31 AM CNA "KK" exited R21 room with bag of soiled items and call light was turned off. At 9:34 AM this surveyor entered R21 room with CNA "KK" and observed CNA "NN" and CNA "KK" finish R21 morning care including linen. R21 was repositioned and brief and hospital gown changed. Staff did not apply moisture barrier cream to R21. This surveyor observed television was on programmed to, "Two broke girls"(current television show). During an observation on 12/14/22 at 11:33 AM R21's meal tray was delivered to her room and placed on the bedside table next to the bed and staff exited the room. R21 was noted in bed and the meal tray was covered and untouched. Several staff noted on hall and smell of outside food noted one door down from R21 room with several staff noted eating lunch. This surveyor continued to observe outside R21's room and R21 call light turned on at 12:23 PM. CNA "M" entered R21 room, turned off the call light, offered R21 something to eat and drink from the untouched meal tray and R21 accepted. At 12:37 PM, CNA "M" exited R21's room with the meal tray and reported R21 ate about 25% of meal including mandarin oranges			

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mostly, did not want mashed potato's or pureed possible beef/broccoli or magic cup which was no longer cold to touch. CNA "M" reported R21 drank quite a bit. This surveyor verified dishes were not warm. CNA "M" reported trays were delivered to unit about 11:30 a.m. and was unsure who delivered R21 tray.

Review of the, "Life Enrichment (Activities) Assessment, dated 1/27/21, reflected R21 indicated the following were either very important or somewhat important to her: choose clothing to wear, snacks between meals, choose type of bathing, bedtime, family involved in care, private calls, listen to music, be around animals/pets, groups of people, favorite activities, outdoors, and religious services. The assessment indicated R21 preferred activities were playing cards, crafts, music, spiritual religious activities, spending time outdoors, watching TV, listening to radio, watching movies and parties/social events. This surveyor had not observed R21 out of bed or offered any activities.

Review of the ADL documentation, dated 12/11/22 through 12/14/22, reflected R21 was walked in room, transferred, walked in corridor, and had locomotion on and off unit. Resident not observed out of bed and staff interviews indicated R21 had not been out of bed.

Review of the Life Enrichment assessment,

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	dated 1/26/2017, reflected R21 church affiliation and level of participation was catholic mass. Review of the Activity Task documentation, dated 12/1/22 through 12/14/22, reflected no documentation to reflect preferred actives for R21. Review of the R 21 Care Plans, dated 1/29/17 through 11/25/22, reflected, "I am incontinent of Bowel and Bladder potentially d/t progressive dementia. My guardian has elected I receive hospice services and a decline in my condition is expected...Goal...My skin will not become impaired r/t incontinence by next review...I will be free of odor while maintaining my dignity...Interventions...Assist me with incontinence care post incontinent episodes. Clean and dry skin, inspect for skin irritation or compromise, and apply moisture barrier cream with each change of briefs or linens. Assist me to change my clothing as needed...I require extensive assistance for toileting. Check frequently and change as needed... My name is [named R21]. I prefer to be in my bed most days. I do get up from time to time and enjoy looking out my window...Also like snacks(cheese puffs and ginger ale). I also enjoy bingo but need help placing the chip on the correct space. I like to have a pop but need it in a cup with handles...Revision on: 04/01/2021...Goal...I will maintain involvement in cognitive stimulation, social			

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	activities as desired through review date...Target Date: 01/03/2023...Interventions...Ensure that the activities I am attending are: Compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed(such as large print, holders if I lack hand strength, task segmentation), Compatible with my needs and abilities; and Age appropriate. Revision on: 02/07/2017...Establish and record my prior level of activity involvement and interests by talking with me, caregivers, and family on admission and as necessary. Revision on: 02/07/2017. I need 1:1 bedside/in-room visits 3x a week with LEAs. Date Initiated: 02/07/2017 Revision on: 09/08/2020...I prefer to socialize with: small groups, I am not very social. Date Initiated: 02/07/2017 Revision on: 02/07/2017...Introduce me to others with similar background, interests and encourage/facilitate my interaction. Date Initiated: 02/07/2017. Revision on: 02/07/2017...Invite me to scheduled activities. Date Initiated: 02/07/2017. Revision on: 02/07/2017...My preferred activities are: watching Cops, watching the news, talking, going outside when it is nice. Date Initiated: 02/07/2017 Revision on: 02/07/2017. Provide me a program of activities that interest and empower me by encouraging/allowing my choice, self-expression and responsibility. Date Initiated: 02/07/2017...Revision on: 02/07/2017. Provide me with an activities calendar and notify me of any changes. Date			

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	Initiated: 02/07/2017 Revision on: 02/07/2017...When I choose not to participate in organized activities, I prefer to watch TV, go outside, have pet visits, and chat 1:1 for social and sensory stimulation. Date Initiated: 02/07/2017 Revision on: 02/07/2017... I need assistance with my ADL's d/t weakness r/t dx of dementia, bipolar, schizophrenia, anemia, seizures, rheumatoid arthritis, osteoarthritis, and COPD. My guardian has elected I receive hospice services and a decline in my condition is expected. I also have a DX of CHF (7/23/18). Date Initiated: 01/31/2017 Revision on: 11/29/2021...Goal...I will achieve optimal hygiene and grooming with staff assistance, as I tolerate, through the review date. Revision on: 10/05/2022. Target Date: 01/03/2023...I prefer to use non-spill cups with handles of my choosing for my drinks. Revision on: 11/05/2018...No male caregivers for personal cares. Date Initiated: 05/29/2020...Resident is EXT - TOTAL with all areas of adl's...Revision on: 11/29/2021...BED MOBILITY: I require extensive assistance x1 for turning and repositioning when in bed. Please offer assistance with repositioning at least Q 2 hours while in bed...Revision on: 11/05/2018...EATING: I benefit from extensive to total assistance with feeding, as I am unable to hold utensils with my right hand...Revision on: 07/05/2019...			

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	I have impaired cognitive function/dementia or impaired thought processes r/t Difficulty making decisions, dx of schizophrenia, bipolar, anxiety...Engage me in activities that I enjoy to improve my focus and enhance my quality if life...Revision on: 11/29/2021... I am at nutritional risk r/t my chronic conditions. I have schizophrenia, malnutrition, COPD, dementia, GERD, anemia. I am edentulous and do not wear dentures. I require a mechanically altered diet with thickened liquids. My appetite is poor and I have low BMI. I have impaired skin requiring nutritional supplements. I require 1:1 assistance with meals. I have a food allergy. I receive diuretic therapy, fluid related weight changes are anticipated. I receive medications that may impact my appetite. I receive hospice services and a decline in my condition is expected. Date Initiated: 01/29/2017 Revision on: 11/09/2022...Goal...Minimize risk of aspiration as feasible...I will accept at least 50% of ordered supplements through next review date. Target dated 1/3/20223...Interventions...Assist me with my meals and encourage me to be in my wheelchair while eating. Date Initiated: 01/29/2017 Revision on: 05/03/2017...Offer me my preferred choices of food - I like ice cream, hot dogs, roast beef, grilled cheese, pork chops. Given my diet texture constraints some of my favorite foods are not			

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	permitted. Revision on: 05/09/2020... I have a swallowing problem r/t difficulty with eating and drinking thin liquids. I am on comfort care with Hospice. Revision on: 11/29/2021...Interventions...Alternate small bites and sips using a spoon for eating and do not allow me to have a straw. Date Initiated: 11/29/2021. Assist/encourage me to eat in an upright position, eat slowly, chew each bite thoroughly and taste my food. Date Initiated: 11/29/2021...I am to eat with extensive assistance... I am at risk for impaired skin integrity related to poor nutrition and recent weight loss. I also need assistance with adls Date Initiated: 02/21/2022...Interventions...Assist in repositioning me frequently in my bed or chair...Keep my urinal in reach since I use it independently(R21 is a famale). I am incontinent of bowels so check and change me when soiled. I use an incontinent pad when I am in bed-no brief. Date Initiated: 08/19/2022...Keep my skin clean and dry. Use lotion or A&D on dry skin...Turn and reposition me every two hours as tolerated to keep my off my back except during meals times... I have a rash of the under bilateral breast r/t reoccurrence yeast infection. Date Initiated: 11/01/2022...Interventions...Encourage me to get out of bed as tolerated...			

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I have a terminal prognosis and elected to have Hospice. Date Initiated: 01/08/2020...Interventions...Work cooperatively with hospice team to ensure my spiritual, emotional, intellectual, physical and social needs are met..." Care Plans reflected no mentions of what hospice services R21 received or what hospice company or frequency of services.

During an observation on 12/20/22 at 8:20 AM, R21 was laying on back in low bed, eyes closed, wearing a hospital gown, with 2 mugs on bedside table with straws. Observe R21 meal meal tray on hall cart with CNA "M" with 2 bowls of pureed items. One bowl was untouched and on with maybe one bite taken and empty glucerna on the tray. CNA "M" reported meals not posted but reported breakfast was biscuits and gravy and sausage. Continue to observe R21 in room with lights off and no music, no staff entered, no type of activities on hall until 10:45 a.m.

During an interview and record on 12/20/22 at 3:10 PM, Activity Director (AD) "P" reported had been in position since November 2021. AD "P" reported was responsible for completing annual and new admission activity assessments. AD "P" reported completed annual reviews when they pop up and residents should have an activity assessment at least once per year. AD "P" verified R21's most recent activity assessment had been completed 1/27/21 and

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reported was unsure who generates them. AD "P" reported R21 should of had one completed January 2022 and was unsure why. AD "P" reported was no aware she was responsible for maintaining Activity Care Plans until two months ago when current Director of Nursing(DON) "B" took over. AD "P" reported R21 should have daily 1:1 in room activity and would expect it to be documented in EMR, including refusals. AD "P" reported was unaware of R21's religious preferences and verified did have rosary when on north unit but was unsure of her denomination.

During an interview on 12/20/22 at 3:30 PM, DON "B" reported had a care conference with R21 Hospice that today and reported prior to that day no history of hospice involvement with care conferences. DON "B" reported plans to involve Hospice companies with residents Care Conferences now moving forward. DON "B" reported document in binder was signed today and should have been signed by staff receiving report from hospice staff and will be part of plan of correction moving forward. DON "B" reported R21's Care Plans should be personalized including Hospice services provided.

During an observation on 12/21/22 at 9:43 AM, first observed activities noted on south unit with two staff observed reading to residents in rooms. Activity staff observed in R21 room for less than three minutes.

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	During an interview on 12/21/22 at 10:45 AM, CNA "M" reported residents are bored and complain of nothing to do. CNA "M" reported new owner took over and sold the facility bus and now residents complain that they used to be able to go out and now they can not. CNA "M" reported had never seen hospice spiritual care in for R21, only hospice CNA who provided baths usually 2 times weekly. CNA "M" reported was unsure of R21 religious preference. Licensed Practical Nurse (LPN) "OO" joined the interview and reported had cared for R21 for several years and use to enjoy regular trips out of the facility. LPN "OO" reported had not observed R21 out of bed in two weeks and does not like group events. LPN "OO" reported was unsure if R21 liked music and reported long history of using rosary and had always had cross necklace she was very attached to. LPN "OO" reported was unsure of R21's religious background and reported had never observed hospice spiritual services visiting R21. LPN "OO" and CNA "MM" both reported were unsure what services R21 was receiving from hospice and reported they only sign hospice tablet after visits for CNA and Nurse. During an interview on 12/21/22 at 12:25 PM Hospice CNA "PP" reported provided R21 bathing services two times weekly on Wednesday and Friday and often comes during lunch to assist with meals. CNA "OO" reported facility had been short staffed and reported R21 was going to be discharged			

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from Hospice services and skin started to breakdown related to incontinence located in brief area and facility moved R21 from north to south unit. Hospice CNA "OO" reported Hospice offered music and pet therapy but R21 did not receive and was unsure why. CNA "OO" reported was told yesterday that hospice binder would be located in front of building because difficult to locate staff for nurse to sign for visits.

Resident #48 (R48)

Review of R48's electronic medical record (EMR) upon R48 was admitted to the facility on 6/17/2022 hospice services were already in place. Diagnoses included congestive heart failure (causes weakness and shortness of breath), Dementia, muscle weakness.

Record review of a "Minimum Data Set" (MDS) assessment, dated 7/1/2022, revealed R48 had a "Brief Interview for Mental Status" (BIMS) score of zero out of 15, which indicated R48 had severely impaired cognition. Further review of the MDS R48 required use of a wheelchair for maximum assistance with all personal care.

During an interview on 12/12/22 at 03:20 PM with Licensed Practical Nurse (LPN) "N" regarding care coordination with hospice. LPN "N" stated when hospice would come in to see R48 she had no idea what they did. LPN "N" stated there was a binder up in a cupboard at the nurse's station.

Record review of hospice binder revealed hospice Certified Nurse Aide (CNA) had documented R48 had received showers on 12/12/22, 12/08/22, 12/06/22, 12/05/22, 12/01/22, 11/28/22,

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11/21/22, 11/18/22, 11/14/22 and 11/07/22. Further reveal hospice binder revealed no hospice care plan in place.

In an interview on 12/13/22 at 08:23 AM, CNA "U" stated hospice provided showers on the facility scheduled shower days. Writer inquired if R48 ever gets two showers a day.

During an interview on 12/21/22 at 09:05 AM, Director of Nursing (DON) "B" stated she thought hospice CNAs provided all showers on facility scheduled shower day, instead of the facility CNAs. DON "B" further stated the facility CNAs only gave showers if the hospice CNA did not show up.

Record review of R48's hospice binder did not contain a care plan, Kardex (CNAs direction of care), physician orders, schedule of hospice visits, nor nurses' notes were in the binder. Review of R48's care plan, no comprehensive care plan was ever put in place regarding R48 hospice services he was receiving and therefor no interventions were in place for coordination of care such to what services hospice was providing.

Resident #14

Resident #14 (R14) admitted to facility 10/1/19 with diagnoses including end stage renal disease, asthma, anemia, chronic obstructive pulmonary disease, acute lymphoblastic leukemia, and congestive heart failure. Review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/20/22 revealed R14 to have a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). Section G of MDS revealed that R14 was independent with bed

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	mobility after set up, independent with eating and toilet use, and required one person limited assistance with transfers and dressing. During an observation and interview on 12/11/22 at 9:47 AM, R14 was observed sitting in a wheelchair at bedside with oxygen in place at 3 liters per minute via nasal cannula. R14 stated that her kidneys were weak and that she had started hemodialysis in October of 2022 and held up her right arm and pointed at the fistula that could be seen in her right upper arm. Per R14, she left the facility at approximately 6:30 AM every Monday, Wednesday, and Friday for dialysis and returned at approximately 12:00 PM. Review of R14's Care Plan Focus created 10/13/2022 stated, "I am receiving Dialysis r/t (related to) my renal failure M-W-F at [name and location of dialysis center]". Care Plan Goal stated, "I will have immediate intervention should any signs and symptoms of complications from dialysis occur" with 10/13/2022 created date and 11/15/2022 revision date. Care Plan Intervention stated, "Observe for signs and symptoms of fluid overload i.e. (such as) shortness of breath, fatigue, lower extremity swelling. Monitor me for signs and symptoms of pain" with 10/13/2002 initiated date. No additional interventions noted to reflect resident centered interventions i.e. R14's routine dialysis times, transportation to/from dialysis center, dialysis access site, potential complications that could arise from dialysis			

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	treatment, or dialysis center contact information. In an interview on 12/20/22 at 2:46 PM, DON "B" stated that a dialysis care plan should be formulated when a resident begins dialysis treatment and that the care plan should include dialysis location and contact information, individualized dialysis schedule and times, specific resident centered instructions from dialysis (i.e. snacks that should be sent with resident), dialysis access site location and monitoring, and potential complications that could arise post dialysis treatment. Review of facility policy titled "Dialysis" dated 5/1/2022, indicated that " ...2) Risk factors related to potential for bleeding, alteration in fluid volume, potential for infection, alteration in nutrition, alteration in skin integrity, risks for adverse medication effects and psychosocial needs should be identified, assessed, and interventions to manage addressed in the individualized care plan ...5) An individual care plan should be developed and followed in coordination with the comprehensive assessment ...8) Emergency protocols should be identified and incorporated into the individual care plan."			
F0657 SS= E	Care Plan Timing and Revisio §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii)	F0657	1. The care plans of residents #1, #48, #14, #40,#51, #21were revised by the IDT team on 1-24-2023. 2. An audit of all resident care plans for necessary revisions was conducted by the	1/31/2023

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	Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise care plans for 4 (Residents #1, #14, #40, #21) of 15 reviewed for care plans resulting in the potential for inadequate/inappropriate care plan interventions and unmet resident needs. Findings include: Resident #1 Resident #1 (R1) initially admitted to facility 4/8/2016 with diagnoses including multiple sclerosis, anemia, right ankle contracture, left ankle contracture, osteoporosis,		interdisciplinary team on 1-18-2023. Any care plans in need of revision were updated by the interdisciplinary team on 1-18-2023. 3. The policy for care plan revision was reviewed and updated by the QAPI Team on 1-12-2023. The updated policy was reviewed with all staff by the Administrator on 1-12-2023 and 1-13-2023. 4. The DON/Designee will complete an audit of 5 resident care plans weekly x4 and monthly thereafter to ensure appropriate revision. Audit results will be trended and brought to the QAPI Committee for process improvement. 5. The Administrator is responsible for this plan of correction.	

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	polyneuropathy, and urge incontinence. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/6/22 revealed that R1 had a Brief Interview for Mental Status (BIMS) score of 6 (severe cognitive impairment). Section G of MDS revealed that R1 required one-person extensive assistance with bed mobility, dressing, eating, and personal hygiene; one-person total dependence with toilet use; and two-person total dependence with transfer. Section H of MDS reflected that R1 was always incontinent of bowel and bladder. Section M of MDS indicated that R1 was at risk of developing pressure injuries and had two Stage 1 pressure injuries. The MDS dated 8/6/22 revealed that R1 was at risk for developing pressure injuries but was not indicated to have any at time of assessment. On 12/11/22 at 11:50 AM, R1 was observed laying in bed, in facility gown, positioned on back with head of bed elevated to approximately seventy-five degrees. Staff member noted to be sitting at bedside and feeding resident with staff name tag indicating "Hospitality Aide". Hospitality Aide (HA) "E" stated that resident required extensive assist at meals and that when she intermittently assisted her to eat, R1 would consume 50 to 75% of meal. On 12/13/22 at 3:01 PM, Licensed Practical Nurse (LPN) "C" confirmed that R1 had an order for oral care and that she would either provide the oral care or verify with the			

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assigned aide that the care had been completed. LPN "C" stated that R1 required extensive to complete assistance with oral care as R1 had limited dexterity in arms and hands to assist with completion of task.

In an interview on 12/13/22 at 3:06 PM, Certified Nurse Aide (CNA) "M" stated that R1 required "full/total assist" with oral care. CNA "M" stated that R1 sometimes refused assist with care including oral care but that she tried to complete daily.

During the same interview, CNA "M" stated that a CNA that was unfamiliar with a resident would look at the Kardex to determine the assistance level that a resident required. CNA "M" proceeded to review R1's kardex which stated, "I need limited assistance from you with personal hygiene and oral care". CNA "M" stated that according to the kardex, it appeared that R1 could basically complete oral care on her own with only verbal cues and minimal assist from staff. CNA "M" confirmed that this was inaccurate and stated again that R1 needed total assist with oral care.

Review of R1's Care Plan Focus created 4/11/2016 and last revised on 11/25/2022 stated, "I need assistance with ADL's (Activities of Daily Living) d/t (due to) weakness and difficulty in walking from ...." Care Plan Goal stated, "I will maintain my current level of functioning through the review date" with 3/10/2020 created and

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	11/25/2022 revision date. Care Plan Intervention stated, "PERSONAL HYGIENE: I need limited assistance from you with personal hygiene and oral care" with 3/10/2020 initiated and revision date. Review of R1's Kardex included under "Hygiene/Oral Care" that for "PERSONAL HYGIENE: I need limited assistance from you with personal hygiene and oral care. However, the MDS and staff that were familiar with resident's current status indicated that R1 required extensive to total assist with oral hygiene. Resident #14 Resident #14 (R14) admitted to facility 10/1/19 with diagnoses including end stage renal disease, asthma, anemia, chronic obstructive pulmonary disease, acute lymphoblastic leukemia, and congestive heart failure. Review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/20/22 revealed R14 to have a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). Section G of MDS revealed that R14 was independent with bed mobility after set up, independent with eating and toilet use, and required one-person limited assistance with transfers and dressing. In an interview on 12/21/22 at 11:12 AM, CNA "M" confirmed that she was familiar with R14 and worked with her frequently.			

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	CNA "M" stated that R14 was "really independent" including with transfers and with dressing and that she only assisted her with showers. In an interview on 12/21/22 at 11:20 AM, CNA "KK" stated that she was new to facility but had worked with R14 and was assigned to her that date. CNA "KK" stated that she referenced the Kardex for resident care needs and that R14 required set up assist for dressing and meals but that she was otherwise independent with transfers and toileting. Review of R14's Care Plan Focus created 10/28/2019 with no indicated revision date stated, "I require supervision and assistance with ADL's ..." Care Plan Goal stated, "I will remain in the facility for my long-term care needs". Care Plan Intervention stated, "Resident requires limited with all areas of ADL performance" with 7/21/2021 initiated and revision date. Review of R14's Care Plan Focus created 1/5/2020 and revised 11/26/2021 stated, "I am at risk for falls r/t (related to) gait/balance problems ..." Care Plan Goal stated, "I hope to be free from falls without a serious injury by next review" with 1/5/2020 created date and 11/15/2022 revision date. Care Plan Interventions stated, "Do not leave me alone in the bathroom" with 1/5/20220 initiated date with no revision date noted.			

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	Review of R14's Care Plan Focus created 5/6/5022 stated, "MY TRANSFER STATUS". Care Plan Goal stated, "I will transfer safely" with 5/6/2022 created date and 11/15/2022 revision date. Care Plan Interventions stated, "transfers independently" with 5/6/2022 initiated and revision date. Review of R14's Care Plan Focus created 10/9/2019 and revised 10/24/2019 stated, "I need assistance with my ADL's ..." Care Plan Goal stated, "I will maintain my current level of functioning through the review date" with 10/9/2019 created date and 11/15/2022 revision date. Care Plan Interventions included, "TOILET USE: I am able to toilet myself" with 10/24/2019 initiated and revision date, and "DRESSING: I dress myself with supervision. Assistance by staff PRN to help set up ..." with 11/26/2021 initiated and revision date. Review of R14's Kardex reflected the Care Plan Interventions which included that resident "transfers independently", "Dressing: I dress myself with supervision, assistance by staff PRN [as needed] to help set up", and "Do not leave me alone in the bathroom". In an interview on 12/21/22 at 12:17 PM, DON "B" stated that R14 was independent with bed mobility and personal hygiene after set up, required up to limited assist with transfers and dressing since starting dialysis, and remained independent with toileting.			

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	DON "B" confirmed that the MDS dated 10/20/22 accurately reflected resident status and that the care plan focus, goals, and interventions needed to be reviewed and revised to reflect R14's current status and level of care which included limited assist with transfers and dressing. Review of facility policy titled "Resident Care Plans" dated 5/1/2022, indicated that " ...2)The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment ...13) Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change ...14) The Interdisciplinary Team must review and update the care plan ...d. At least quarterly, in conjunction with the required quarterly MDS assessment ..." Resident #40 According to the clinical record including the Minimum Data Set (MDS) dated 11/19/22 resident 40 (R40) was a 58 year old female, admitted to the facility with diagnosis that include severe intellectual disabilities, early onset Alzheimer's, Bi-polar disorder, anxiety, Down syndrome unspecified. Review of the MDS dated 11/19/22 reflected R40 was always incontinent of bowel and bladder, required extensive assistance with toilteintg, hygiene extensive assistance and required 1 person physical assistance with dressing and hygiene. The Brief Interview for			

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	Mental Status reflected a score of 00, severe cognitive impairment. Of note, R40 resided on the facility's locked dementia unit. On 12/11/22 at 09:03 AM, R40 was observed wandering around the unit, she was barefoot, had mis matched clothing clothing on, her hair was messy, R40 was observed to have form fitting yoga type pants on her brief was observed to be overly saturated and hung to one side to the back of R40's knee, there was a very pungent urine odor. At 9:30am the same observation of R40 was made, observations of R40 walk by Licensed Practical Nurse (LPN) "R", Certified Nursing Assistant "Q" and GG, Hospitality Aide "HH" and an unidentified Activity staff person. None of the identified staff were observed to have noticed R40's disheveled appearance and need for incontinent care. On 12/12/22 at 08:05 AM, Resident # 40 observed walking in hall wearing tight fitting light gray sweat pants, the back of the pants were observed discolored/ (wet), a large sagging bulge was observed on the back of the brief that hung just above R40's knees. On 12/12/22 10:28 AM R40 was observed wandering in and out of other residents rooms, R40 was observed to be wearing the pants from the day before (yoga type pants, navy blue with large roses on them) her brief remained soiled/saturated and hung to the right side, there was a strong odor of urine. On 12/13/22 at 08:47 AM, R40 was observed to be walking with an unidentified Activity aide, R40 had a strong odor of feces, Licensed Practical Nurse (LPN) "N" was observed to walk passed R40 in the dining room where other residents and staff were			

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present while verbalizing someone was "Stinky." In which no staff present were observed to investigate or attempt to correct LPN's "N""s concern, and R40 continued to wander.

Observation of R40 on 12/14/22 at 09:34 AM, revealed R40 had been wearing the same pants for 3 consecutive days. R40's closet was observed to have ample clothing hanging in it.

Review of R40's care plan for bowel and bladdar with a revision date of 4/26/21 reflected in part "Check me at least every 2 hours during the day and change my brief if needed." The goal was to be free of odor and maintain dignity. Review of the Activity Daily Living Care plan with a most recent revision date of 4/26/21 reflected "I need assistance with my ADLs. I at times choose to sleep in my roomate's bed." the goal was to maintain current level of function, and interventions included check and change resident every 2 hours, set up with meals, limited assistance with bed mobility, transfers, toileting, hygeine, dressing, bathing, and eating. The Activity care plan with a most dated 12/10/20 reflected R40 enjoyed puzzles and coloring and picture books.

On 12/20/22 03:07 PM, during an interview with Activity Director "P" stated she had been the Activity Director for over a year, but did not know until 2 to 3 months ago that she was responsible for updating care plans and reassessments.

During a follow up interview with Activity Director "P" on 12/21/22 12:44 PM, she reported R40 no longer colors, does not like painting or exercising. Activity Director "P"

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elaborated that R40 doesnt do anything except wander in and out of other resident rooms and continuously takes other residents belongings which makes other residents on the unit angry.

Resident #21(R21)

Review of the Face Sheet and Minimum Data Set (MDS) dated 10/24/22, reflected R21 was a 79 year old female admitted to the facility on 1/24/17, with diagnoses that included dementia, coronary heart disease, heart failure, peripheral vascular disease, seizure disorder, schizophrenia, and mantic depression. The MDS reflected R 21 had a BIM (assessment tool) score which indicated her ability to make daily decisions was severely impaired, and she required one person physical assist with bed mobility, transfers, locomotion on unit, dressing, eating, toileting, hygiene, and bathing.

During an observation on 12/11/22 at 9:07 AM, R21 was laying on an air mattress positioned low with hospital gown on with head awkwardly positioned to the left with strong smell of urine in room. R21 door was open with stop sign on door that read, "aerosol generate\ing procedure" that indicated required use of gloves, mask, gown, and eye protection, with no Personal Protective Equipment(PPE) observed outside door. R21 had an air mattress in place, appeared thin and frail, was awake with eyes open holding stuffed animal and rosary. R21 did not appear to be verbal and appeared

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calm with soft touch call light located out of reach under top of pillow. Folding chair was noted at bedside along with bedside table with 2 large styrofaom cups with straws that appeared to be orange juice and water.

During an observation on 12/11/22 at 3:45 p.m., R21 continued to lay in bed with gown on with neck turned to left in dark room.

During an observation on 12/14/22 at 9:34 AM this surveyor entered R21 room with CNA "KK" and observed CNA "NN" and CNA "KK" finish R21 morning care including linen. R21 was repositioned and brief and hospital gown changed. Staff did not apply moisture barrier cream to R21. This surveyor observed television was on programmed to, "Two broke girls"(current television show).

Review of the, "Life Enrichment (Activities) Assessment, dated 1/27/21, reflected R21 indicated the following were either very important or somewhat important to her: choose clothing to wear, snacks between meals, choose type of bathing, bedtime, family involved in care, private calls, listen to music, be around animals/pets, groups of people, favorite activities, outdoors, and religious services. The assessment indicated R21 preferred activities were playing cards, crafts, music, spiritual religious activities, spending time outdoors, watching TV, listening to radio, watching movies and parties/social events. This surveyor had not observed R21 out of bed or offered any

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	activities. Review of the ADL documentation, dated 12/11/22 through 12/14/22, reflected R21 was walked in room, transferred, walked in corridor, and had locomotion on and off unit. Resident not observed out of bed and staff interviews indicated R21 had not been out of bed. Review of the Life Enrichment assessment, dated 1/26/2017, reflected R21 church affiliation and level of participation was catholic mass. Review of the Activity Task documentation, dated 12/1/22 through 12/14/22, reflected no documenting to reflect preferred actives for R21. Review of the R 21 Care Plans, dated 1/29/17 through 11/25/22, reflected, "My name is [named R21]. I prefer to be in my bed most days. I do get up from time to time and enjoy looking out my window...Also like snacks (cheese puffs and ginger ale). I also enjoy bingo but need help placing the chip on the correct space. I like to have a pop but need it in a cup with handles...Revision on: 04/01/2021...Goal...I will maintain involvement in cognitive stimulation, social activities as desired through review date...Target Date: 01/03/2023...Interventions...Ensure that the activities I am attending are: Compatible with physical and mental capabilities; Compatible			

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	with known interests and preferences; Adapted as needed(such as large print, holders if I lack hand strength, task segmentation), Compatible with my needs and abilities; and Age appropriate. Revision on: 02/07/2017...Establish and record my prior level of activity involvement and interests by talking with me, caregivers, and family on admission and as necessary. Revision on: 02/07/2017. I need 1:1 bedside/in-room visits 3x a week with LEAs. Date Initiated: 02/07/2017 Revision on: 09/08/2020...I prefer to socialize with: small groups, I am not very social. Date Initiated: 02/07/2017 Revision on: 02/07/2017...Introduce me to others with similar background, interests and encourage/facilitate my interaction. Date Initiated: 02/07/2017. Revision on: 02/07/2017...Invite me to scheduled activities. Date Initiated: 02/07/2017. Revision on: 02/07/2017...My preferred activities are: watching Cops, watching the news, talking, going outside when it is nice. Date Initiated: 02/07/2017 Revision on: 02/07/2017. Provide me a program of activities that interest and empower me by encouraging/allowing my choice, self-expression and responsibility. Date Initiated: 02/07/2017...Revision on: 02/07/2017. Provide me with an activities calendar and notify me of any changes. Date Initiated: 02/07/2017 Revision on: 02/07/2017...When I choose not to participate in organized activities, I prefer to watch TV, go outside, have pet visits, and chat 1:1 for social and sensory stimulation.			

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	Date Initiated: 02/07/2017 Revision on: 02/07/2017..." During an observation on 12/20/22 at 8:20 AM, R21 was laying on back in low bed, eyes closed, wearing a hospital gown, with 2 mugs on bedside table with straws. Continue to observe R21 in room with lights off and no music, no staff entered, no type of activities on hall until 10:45 a.m. During an interview and record on 12/20/22 at 3:10 PM, Activity Director (AD) "P" reported had been in position since November 2021. AD "P" reported was responsible for completing annual and new admission activity assessments. AD "P" reported completed annual reviews when they pop up and residents should have an activity assessment at least once per year. AD "P" verified R21's most recent activity assessment had been completed 1/27/21 and reported was unsure who generates them. AD "P" reported R21 should of had one completed January 2022 and was unsure why. AD "P" reported was no aware she was responsible for maintaining Activity Care Plans until two months ago when current Director of Nursing(DON) "B" took over. AD "P" reported R21 should have daily 1:1 in room activity and would expect it to be documented in EMR, including refusals. AD "P" reported was unaware of R21's religious preferences and verified did have rosary when on north unit but was unsure of her denomination.			

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	During an observation on 12/21/22 at 9:43 AM, first observed activities noted on south unit with two staff observed reading to residents in rooms. Activity staff observed in R21 room for less than three minutes. During an interview on 12/21/22 at 10:45 AM, CNA "M" reported residents are bored and complain of nothing to do. CNA "M" reported new owner took over and sold the facility bus and now residents complain that they used to be able to go out and now they can not. CNA "M" reported had never seen hospice spiritual care in for R21, only hospice CNA who provided baths usually 2 times weekly. CNA "M" reported was unsure of R21 religious preference. Licensed Practical Nurse (LPN) "OO" joined the interview and reported had cared for R21 for several years and use to enjoy regular trips out of the facility. LPN "OO" reported had not observed R21 out of bed in two weeks and does not like group events. LPN "OO" reported was unsure if R21 liked music and reported long history of using rosary and had always had cross necklace she was very attached to. LPN "OO" reported was unsure of R21's religious background and reported had never observed hospice spiritual services visiting R21.			
F0677 SS= E	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	F0677	1. Resident #40 no longer resides at the facility. Residents #28, #51, #21 had their care plans reviewed by the IDT Team and updated on 1-20-2023. POC Kardex were also updated	1/31/2023

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	nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: This citation pertains to intake M100130932 Based on observation, interview and record review, the facility failed to ensure two residents of eight residents (R21and R40) receive the necessary care and services for activities of daily living resulting in potential unmet care needs. Findings Include: Resident #21(R21) Review of the Face Sheet and Minimum Data Set (MDS) dated 10/24/22, reflected R21 was a 79 year old female admitted to the facility on 1/24/17, with diagnoses that included dementia, coronary heart disease, heart failure, peripheral vascular disease, seizure disorder, schizophrenia, and mantic depression. The MDS reflected R21had a BIM (assessment tool) score which indicated her ability to make daily decisions was severely impaired, and she required one person physical assist with bed mobility, transfers, locomotion on unit, dressing, eating, toileting, hygiene, and bathing. During an observation on 12/11/22 at 9:07 AM, R21 was laying on an air mattress positioned low with hospital gown on with		for residents #48, #51, and #21 on 1-20-2023. The DON verified the updated ADL needs were being met for residents #48,#51, and #21 on 1-26-2023. 2. All residents have the potential to be affected by the deficient practice. An audit was done by the DON/Designee 1-25-2023 to ensure that there were no residents with unmet ADL care needs. 3. The policy for ADL care was reviewed and deemed appropriate by the QAPI Committee on 1-12-2023. All staff were educated on the facility Policy for ADL Care by the administrator on 1-12-2023 and 1-13-2023. 4. To ensure compliance, 25% of all residents will be audited for ensuring proper ADL care was performed. This audit will be be performed by the DON/Designee. Audits will be completed 2x a month for 3 months and then as QAPI recommendations. 5. The Administrator is responsible for this plan of correction.	

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	head awkwardly positioned to the left with strong smell of urine in room. R21 door was open with stop sign on door that read, "aerosol generate\ing procedure" that indicated required use of gloves, mask, gown, and eye protection, with no Personal Protective Equipment(PPE) observed outside door. R21 had an air mattress in place, appeared thin and frail, was awake with eyes open holding stuffed animal and rosary. R21 did not appear to be verbal and appeared calm with soft touch call light located out of reach under top of pillow. Folding chair was noted at bedside along with bedside table with 2 large styrofaom cups with straws that appeared to be orange juice and water. During an observation on 12/11/22 at 3:45 p.m., R21 continued to lay in bed with gown on with neck turned to left in dark room. During an interview on 12/11/22 at 2:45 PM, Certified Nurse Aid (CNA) "MM" reported assisted R21 for breakfast and reported was not able to recall what R21 ate for breakfast but reported had either nectar or honey thick liquids from kitchen. CNA "MM" reported knows how to care for each resident by verbal report at shift change. CNA "MM" reported documents in Electronic Medical Record (EMR) at nurse station only because she does not have access to hall monitors and reported unsure how to determine what each resident diets are including restrictions from EMR. CNA "M" joined interview in hall and verified no way for CNA staff to			

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determine resident diet from EMR and reported aware of resident care including diets from verbal report at shift change and sign in main kitchen with resident liquid modification and consistency.

During an interview on 12/11/22 at 2:55 PM, CNA "M" reported had forgot that they have access to Kardex for each resident that had care and diet modifications including liquid consistencies. CNA "MM" also present for interview verified that was the first CNA "MM" had heard about the Kardex and was unsure how to even look at it.

During an observation on 12/14/22 at 9:20 AM, CNA "KK" and Administrator "A" observed in R21's room. R21 was noted positioned low in bed awkwardly leaning to left side. CNA "KK" then asked CNA "NN" for assist with boosting R21 up in bed because ADM "A" asked her to make R21 comfortable. At 9:27 AM R21's call light was observed and heard alarming with door closed and observed four staff pass R21's room with call light on as indicated by light illuminated over door. At 9:31 AM CNA "KK" exited R21 room with bag of soiled items and call light was turned off. At 9:34 AM this surveyor entered R21 room with CNA "KK" and observed CNA "NN" and CNA "KK" finish R21 morning care including linen. R21 was repositioned and brief and hospital gown changed. Staff did not apply moisture barrier cream to R21. This surveyor observed television was on programmed to, "Two broke girls"(current

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television show).

During an observation on 12/14/22 at 11:33 AM R21's meal tray was delivered to her room and placed on the bedside table next to the bed and staff exited the room. R21 was noted in bed and the meal tray was covered and untouched. Several staff noted on hall and smell of outside food noted one door down from R21 room with several staff noted eating lunch. This surveyor continued to observe outside R21's room and R21 call light turned on at 12:23 PM. CNA "M" entered R21 room, turned off the call light, offered R21 something to eat and drink from the untouched meal tray and R21 accepted. At 12:37 PM, CNA "M" exited R21's room with the meal tray and reported R21 ate about 25% of meal including mandarin oranges mostly, did not want mashed potato's or pureed possible beef/broccoli or magic cup which was no longer cold to touch. CNA "M" reported R21 drank quite a bit. This surveyor verified dishes were not warm. CNA "M" reported trays were delivered to unit about 11:30 a.m. and was unsure who delivered R21 tray.

Review of the Care Plans, revised 5/3/17, reflected, "I am incontinent of Bowel and Bladder

potentially d/t progressive dementia. My guardian has elected I receive hospice services and a decline in my condition is expected. My skin will not become impaired

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	r/t incontinence by next review. I will be free of odor while maintaining my dignity. Assist me with incontinence care post incontinent episodes. Clean and dry skin, inspect for skin irritation or compromise, and apply moisture barrier cream with each change of briefs or linens. Assist me to change my clothing as needed. I require extensive assistance for toileting. Check frequently and change as needed. Assist me with my meals and encourage me to be in my wheelchair while eating. Date Initiated: 01/29/2017 Revision on: 05/03/2017...I need assistance with my ADL's d/t weakness r/t dx of dementia, bipolar, schizophrenia, anemia, seizures, rheumatoid arthritis, osteoarthritis, and COPD. My guardian has elected I receive hospice services and a decline in my condition is expected. I also have a DX of CHF (7/23/18). Date Initiated: 01/31/2017 Revision on: 11/29/2021...Goal...I will achieve optimal hygiene and grooming with staff assistance, as I tolerate, through the review date. Revision on: 10/05/2022. Target Date: 01/03/2023...I prefer to use non-spill cups with handles of my choosing for my drinks. Revision on: 11/05/2018...No male caregivers for personal cares. Date Initiated: 05/29/2020...Resident is EXT - TOTAL with all areas of adl's...Revision on: 11/29/2021...BED MOBILITY: I require extensive assistance x1 for turning and repositioning when in bed. Please offer assistance with repositioning at			

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	least Q 2 hours while in bed...Revision on: 11/05/2018...EATING: I benefit from extensive to total assistance with feeding, as I am unable to hold utensils with my right hand...Revision on: 07/05/2019...I have impaired cognitive function/dementia or impaired thought processes r/t Difficulty making decisions, dx of schizophrenia, bipolar, anxiety...Engage me in activities that I enjoy to improve my focus and enhance my quality if life...Revision on: 11/29/2021..." During an observation on 12/20/22 at 8:20 AM, R21 was laying on back in low bed, eyes closed, wearing a hospital gown, with 2 mugs on bedside table with straws. Observe R21 meal meal tray on hall cart with CNA "M" with 2 bowls of pureed items. One bowl was untouched and on with maybe one bite taken and empty glucerna on the tray. CNA "M" reported meals not posted but reported breakfast was biscuits and gravy and sausage. During an observation on 12/20/22 at 9:50 AM R21 was laying in low bed on back with eyes closed wearing hospital gown with lights off and no music. Continued to observed R21 room with no staff entering R21 room up through 10:45 a.m. During an interview on 12/21/22 at 10:45 AM, CNA "M" reported residents are bored and complain of nothing to do. CNA "M" reported new owner took over and sold the facility bus and now residents complain that they used to be able to go out and now they			

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	can not. CNA "M" reported had never seen hospice spiritual care in for R21, only hospice CNA who provided baths usually 2 times weekly. CNA "M" reported was unsure of R21 religious preference. Licensed Practical Nurse (LPN) "OO" joined the interview and reported had cared for R21 for several years and use to enjoy regular trips out of the facility. LPN "OO" reported had not observed R21 out of bed in two weeks and does not like group events. LPN "OO" reported was unsure if R21 liked music and reported long history of using rosary and had always had cross necklace she was very attached to. LPN "OO" reported was unsure of R21's religious background and reported had never observed hospice spiritual services visiting R21. LPN "OO" and CNA "MM" both reported were unsure what services R21 was receiving from hospice and reported they only sign hospice tablet after visits for CNA and Nurse. During an interview on 12/21/22 at 12:25 PM Hospice CNA "PP" reported provided R21 bathing services two times weekly on Wednesday and Friday and often comes during lunch to assist with meals. CNA "OO" reported facility had been short staffed and reported R21 was going to be discharged from Hospice services and skin started to breakdown related to incontinence located in brief area and facility moved R21 from north to south unit. Hospice CNA "OO" reported Hospice offered music and pet therapy but R21 did not receive and was unsure why. CNA "OO" reported was told yesterday that			

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hospice binder would be located in front of building because difficult to locate staff for nurse to sign for visits.

Resident #40

According to the clinical record including the Minimum Data Set (MDS) dated 11/19/22 resident 40 (R40) was a 58 year old female, admitted to the facility with diagnosis that include severe intellectual disabilities, early onset Alzheimer's, Bi-polar disorder, anxiety, Down syndrome unspecified.

Review of the MDS dated 11/19/22 reflected R40 was always incontinent of bowel and bladder, required extensive assistance with toilteintg, hygiene extensive assistance and required 1 person physical assistance with dressing and hygiene. The Brief Interview for Mental Status reflected a score of 00, severe cognitive impairment. Of note, R40 resided on the facility's locked dementia unit.

On 12/11/22 at 09:03 AM, R40 was observed wandering around the unit, she was barefoot, had mis matched clothing clothing on, her hair was messy, R40 was observed to have form fitting yoga type pants on her brief was observed to be overly saturated and hung to one side to the back of R40's knee, there was a very pungent urine odor. At 9:30am the same observation of R40 was made, observations of R40 walk by Licensed Practical Nurse (LPN) "R", Certified Nursing Assistant "Q" and GG, Hospitality Aide "HH"

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and an unidentified Activity staff person. None of the identified staff were observed to have noticed R40's disheveled appearance and need for incontinent care.

On 12/12/22 at 08:05 AM, Resident # 40 observed walking in hall wearing tight fitting light gray sweat pants, the back of the pants were observed discolored/ (wet), a large sagging bulge was observed on the back of the brief that hung just above R40's knees.

On 12/12/22 10:28 AM R40 was observed wandering in and out of other residents rooms, R40 was observed to be wearing the pants from the day before (yoga type pants, navy blue with large roses on them) her brief remained soiled/saturated and hung to the right side, there was a strong odor of urine.

On 12/13/22 at 08:47 AM, R40 was observed to be walking with an unidentified Activity aide, R40 had a strong odor of feces, Licensed Practical Nurse (LPN) "N" was observed to walk passed R40 in the dining room where other residents and staff were present while verbalizing someone was "Stinky." In which no staff present were observed to investigate or attempt to correct LPN's "N"'s concern, and R40 continued to wander.

Observation of R40 on 12/14/22 at 09:34 AM, revealed R40 had been wearing the same pants for 3 consecutive days. R40's closet was observed to have ample clothing hanging in

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	it. On 12/21/22 at 9:05am during an interview with Director of Nursing (DON) "B" verbalized Residents were to be checked and changed every 2 hours and as needed, DON "B" and offered no explanation for R40's care.			
F0679 SS= E	Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00130932 Based on observation, interview and record review, the facility failed to provide meaningful activities for three Resident (R18, R21and R40) of seven residents reviewed for meaningful activities. This deficient practice resulted in the potential for boredom and decreased quality of life. Findings include: Resident #18(R18)	F0679	1. Resident #40 no longer resides at the facility. Resident #51 ‘s care plan was updated to include 1:1 in room activities appropriate for her dx of dementia on 1-17-2023 by the Director of Activities.. Resident #21 ‘s care plan was updated to include activities appropriate to her diagnosis on 1-17-2023 by the activity director. Resident #18’s care plan was updated for current appropriate activities for his age and diagnoses on 1-17-2023 by the activity director. 2. All residents have the potential to be affected by this deficient practice. An audit of Activity Care Plans and resident activity preferences was completed by the Activity Director and the administrator on 1/26/2023 or 1/27/2023. Any care plans needing update were promptly updated by the Activity Director/Designee’. 3. The facility policy for Activities and Activity Care Plans was reviewed by the QAPI Committee on 1-12-2023 and deemed appropriate. All staff were inserviced on the policy for Activities and Activity Care Plans by the Administrator on 1-12-2023 and 1-13-2023. 4. The Audit of 25% Activity Care Plans and Resident Activity preferences will be completed monthly by the NHA/Designee and brought to QAPI to ensure compliance with federal and state regulations, as well as process improvement.	1/31/2023

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	Review of the Face Sheet and Minimum Data Set (MDS) dated 9/4/22 reflected R18 was a 70 year old male admitted to the facility on 9/1/20, with diagnoses that included hypertension, peripheral vascular disease, and mood disorder. The MDS reflected R18 had a BIM (assessment tool) score which indicated his ability to make daily decisions was cognitively intact. During an observation and interview on 12/11/22 at 10:27 a.m., R18 was sitting in wheelchair in room. R18 reported not a lot of interest in captivities offered at facility. R18 reported likes to watch TV but not many activities of interest for men. Review of the most recent Life Enrichment (Activities) Assessment, dated 9/3/20, reflected R18 preferred activities included playing cards, exercise, sports, reading, music, baking/cooking, trips/traveling, talking/coffee chats, watching TV, watching movies, parties/social events and keeping up with news. Review of R18 Activity Care Plans on 12/20/22 at 11:15 AM, reflected, "My name Is [named R18] I Prefer to be called [named]. I am an Army Veteran for 3 years...I enjoyed traveling. I enjoyed riding motorcycles...I am religious Presbyterian. I played the drums...I am also into racing both NASCAR and drag racing. I also enjoy smoking. I also		5. The Administrator is responsible for this plan of correction.	

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	enjoy therapeutic coloring and I prefer to use Crayons... Revision on: 04/01/2021...Goals...I will maintain involvement in cognitive stimulation, social activities as desired through review date...Interventions...I will attend/participate in activities of my choice (3-5 times weekly) by next review date...Invite me to scheduled activities...Provide me with an activities calendar and notify me of any changes...Provide me with materials for individual activities as I desire...Staff will encourage me to wear a mask...Thank me for attending activity functions. The Activity Care Plans reflected no mention of R18 preferred activities. Review of the Activity Task documentation, dated 11/1/22 through 12/19/22, reflected R18 only participated in social hour, TV/movie/music and bingo with no evidence of R18 other areas of interest. Resident #21(R21) Review of the Face Sheet and Minimum Data Set (MDS) dated 10/24/22, reflected R21 was a 79 year old female admitted to the facility on 1/24/17, with diagnoses that included dementia, coronary heart disease, heart failure, peripheral vascular disease, seizure			

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	disorder, schizophrenia, and mantic depression. The MDS reflected R 21 had a BIM (assessment tool) score which indicated her ability to make daily decisions was severely impaired, and she required one person physical assist with bed mobility, transfers, locomotion on unit, dressing, eating, toileting, hygiene, and bathing. During an observation on 12/11/22 at 9:07 AM, R21 was laying on an air mattress positioned low with hospital gown on with head awkwardly positioned to the left with strong smell of urine in room. R21 door was open with stop sign on door that read, "aerosol generate\ing procedure" that indicated required use of gloves, mask, gown, and eye protection, with no Personal Protective Equipment(PPE) observed outside door. R21 had an air mattress in place, appeared thin and frail, was awake with eyes open holding stuffed animal and rosary. R21 did not appear to be verbal and appeared calm with soft touch call light located out of reach under top of pillow. Folding chair was noted at bedside along with bedside table with 2 large styrofaom cups with straws that appeared to be orange juice and water. During an observation on 12/11/22 at 3:45 p.m., R21 continued to lay in bed with gown on with neck turned to left in dark room. During an observation on 12/14/22 at 9:34 AM this surveyor entered R21 room with CNA "KK" and observed CNA "NN" and CNA "KK"			

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	finish R21 morning care including linen. R21 was repositioned and brief and hospital gown changed. Staff did not apply moiture barrier cream to R21. This surveyor observed television was on programmed to, "Two broke girls"(current television show). Review of the, "Life Enrichment (Activities) Assessment, dated 1/27/21, reflected R21 indicated the following were either very important or somewhat important to her: choose clothing to wear, snacks between meals, choose type of bathing, bedtime, family involved in care, private calls, listen to music, be around animals/pets, groups of people, favorite activities, outdoors, and religious services. The assessment indicated R21 preferred activities were playing cards, crafts, music, spiritual religious activities, spending time outdoors, watching TV, listening to radio, watching movies and parties/social events. This surveyor had not observed R21 out of bed or offered any activities. Review of the ADL documentation, dated 12/11/22 through 12/14/22, reflected R21 was walked in room, transferred, walked in corridor, and had locomotion on and off unit. Resident not observed out of bed and staff interviews indicated R21 had not been out of bed. Review of the Life Enrichment assessment, dated 1/26/2017, reflected R21 church affiliation and level of participation was			

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	catholic mass. Review of the Activity Task documentation, dated 12/1/22 through 12/14/22, reflected no documenting to reflect preferred actives for R21. Review of the R 21 Care Plans, dated 1/29/17 through 11/25/22, reflected, "My name is [named R21]. I prefer to be in my bed most days. I do get up from time to time and enjoy looking out my window...Also like snacks (cheese puffs and ginger ale). I also enjoy bingo but need help placing the chip on the correct space. I like to have a pop but need it in a cup with handles...Revision on: 04/01/2021...Goal...I will maintain involvement in cognitive stimulation, social activities as desired through review date...Target Date: 01/03/2023...Interventions...Ensure that the activities I am attending are: Compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed(such as large print, holders if I lack hand strength, task segmentation), Compatible with my needs and abilities; and Age appropriate. Revision on: 02/07/2017...Establish and record my prior level of activity involvement and interests by talking with me, caregivers, and family on admission and as necessary. Revision on: 02/07/2017. I need 1:1 bedside/in-room visits 3x a week with LEAs. Date Initiated: 02/07/2017 Revision on: 09/08/2020...I prefer to socialize with: small			

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	groups, I am not very social. Date Initiated: 02/07/2017 Revision on: 02/07/2017...Introduce me to others with similar background, interests and encourage/facilitate my interaction. Date Initiated: 02/07/2017. Revision on: 02/07/2017...Invite me to scheduled activities. Date Initiated: 02/07/2017. Revision on: 02/07/2017...My preferred activities are: watching Cops, watching the news, talking, going outside when it is nice. Date Initiated: 02/07/2017 Revision on: 02/07/2017. Provide me a program of activities that interest and empower me by encouraging/allowing my choice, self-expression and responsibility. Date Initiated: 02/07/2017...Revision on: 02/07/2017. Provide me with an activities calendar and notify me of any changes. Date Initiated: 02/07/2017 Revision on: 02/07/2017...When I choose not to participate in organized activities, I prefer to watch TV, go outside, have pet visits, and chat 1:1 for social and sensory stimulation. Date Initiated: 02/07/2017 Revision on: 02/07/2017..." During a confidential interview on 12/12/22 at 3:05 PM, Confidential Resident "QQ" reported facility did not offer activities of interest to men. Resident reported had gone on what activity staff call fishing trip to local pond and given kid character pole to fish with, occasional bowling is ok, "something to do." Resident reported otherwise they watch TV all day and stated, "this place to me is where people come to die and I'm not ready			

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for that yet." Resident reported they do offer video games occasionally.

During an observation on 12/20/22 at 8:20 AM, R21 was laying on back in low bed, eyes closed, wearing a hospital gown, with 2 mugs on bedside table with straws. Observe R21 meal meal tray on hall cart with CNA "M" with 2 bowls of pureed items. One bowl was untouched and on with maybe one bite taken and empty glucerna on the tray. CNA "M" reported meals not posted but reported breakfast was biscuits and gravy and sausage. Continue to observe R21 in room with lights off and no music, no staff entered, no type of activities on hall until 10:45 a.m.

During an interview and record on 12/20/22 at 3:10 PM, Activity Director (AD) "P" reported had been in position since November 2021. AD "P" reported was responsible for completing annual and new admission activity assessments. AD "P" reported completed annual reviews when they pop up and residents should have an activity assessment at least once per year. AD "P" verified R21's most recent activity assessment had been completed 1/27/21 and reported was unsure who generates them. AD "P" reported R21 should of had one completed January 2022 and was unsure why. AD "P" reported was no aware she was responsible for maintaining Activity Care Plans until two months ago when current Director of Nursing(DON) "B" took over. AD "P" reported R21 should have daily 1:1 in

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room activity and would expect it to be documented in EMR, including refusals. AD "P" reported was unaware of R21's religious preferences and verified did have rosary when on north unit but was unsure of her denomination.

During an observation on 12/21/22 at 9:43 AM, first observed activities noted on south unit with two staff observed reading to residents in rooms. Activity staff observed in R21 room for less than three minutes.

During an interview on 12/21/22 at 10:45 AM, CNA "M" reported residents are bored and complain of nothing to do. CNA "M" reported new owner took over and sold the facility bus and now residents complain that they used to be able to go out and now they can not. CNA "M" reported had never seen hospice spiritual care in for R21, only hospice CNA who provided baths usually 2 times weekly. CNA "M" reported was unsure of R21 religious preferance. Licensed Practical Nurse (LPN) "OO" joined the interview and reported had cared for R21 for several years and use to enjoy regular trips out of the facility. LPN "OO" reported had not observed R21 out of bed in two weeks and does not like group events. LPN "OO" reported was unsure if R21 liked music and reported long history of using rosary and had always had cross necklace she was very attached to. LPN "OO" reported was unsure of R21's religious background and reported had never observed hospice spiritual services visiting

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	R21. LPN "OO" and CNA "MM" both reported were unsure what services R21 was receiving from hospice and reported they only sign hospice tablet after visits for CNA and Nurse. During an interview on 12/21/22 at 12:25 PM Hospice CNA "PP" reported provided R21 bathing services two times weekly on Wednesday and Friday and often comes during lunch to assist with meals. CNA "OO" reported facility had been short staffed and reported R21 was going to be discharged from Hospice services and skin started to breakdown related to incontinence located in brief area and facility moved R21 from north to south unit. Hospice CNA "OO" reported Hospice offered music and pet therapy but R21 did not receive and was unsure why. Resident #40 According to the clinical record including the Minimum Data Set (MDS) dated 11/19/22 resident 40 (R40) was a 58 year old female, admitted to the facility with diagnosis that include severe intellectual disabilities, early onset Alzheimer's, Bi-polar disorder, anxiety, Down syndrome unspecified. Review of the MDS dated 11/19/22 reflected R40 was always incontinent of bowel and bladder, required extensive assistance with toilteintg, hygiene extensive assistance and required 1 person physical assistance with dressing and hygiene. The Brief Interview for Mental Status reflected a score of 00, severe			

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	cognitive impairment. Of note, R40 resided on the facility's locked dementia unit. Review of R40's last Activity progress note was dated 12/15/21 and reflected R40 liked coloring, small groups and 1:1 visits. Throughout the survey of 12/11 through 12/22/22 R40 was not observed to have been involved in any small group activity or coloring. There was observations of Activity Aide following R40, attempt to interact or converse with R40- strictly followed R40 in and out of other residents rooms. There was no current care plan in place that identified R40's likes and interests. On 12/20/22 03:07 PM, during an interview with Activity Director "P" stated she had been the Activity Director for over a year, but did not know until 2 to 3 months ago that she was responsible for updating care plans and reassessments. During a follow up interview with Activity Director "P" on 12/21/22 12:44 PM, she reported R40 no longer enjoys coloring, does not like painting or exercising. Activity Director "P" elaborated that R40 didn't do anything except wander in and out of other resident rooms and continuously takes other residents belongings which makes other residents on the unit angry.			
F0684 SS= E	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that	F0684	1. Resident #20 was assessed for pain while waiting on the ambulance to pick her up. She	1/31/2023

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	applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation has 2 Deficient Practice Statements: (A) & (B) (A) Based on observation, interview, and record review, the facility failed to complete routine post fall assessments and ensure timely completion of a stat x-ray order for 1 (Resident #20) of 15 residents reviewed for quality of care, resulting in delayed identification and treatment of a fracture, and increased pain. Findings include: Resident # 20 (R20) initially admitted to facility 8/5/21 with most recent facility readmission 9/22/22 with diagnoses including cerebral infarction, type 2 diabetes mellitus, chronic pain, displaced fracture of left femur, and morbid obesity. Review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/13/22 revealed that R20 had highly impaired hearing but had clear speech and		is Ax0x4, and was able to state she is not in pain. A new assessment was completed by the DON/Designee during survey to ensure her pain is been appropriately managed. Resident #21 , #48, and #32 were evaluated by the facility IDT Team and their hospice teams and an interdisciplinary note completed and care plans updated to ensure quality of care on 1-23-2023. 2. All residents have the ability to be affected by this deficient practice. An audit was done on 1-26-2023 by the DON/Designee to ensure that there were no residents whose care needs were not being met. No other concerns were noted. 3. The Policy for Resident Care and Hospice was reviewed by the QAPI Team on 1-12-2023 and deemed appropriate. All nursing staff were inserviced on the Policy for Resident Care on by the NHA/DON on 1-12-2023 and 1-13-2023. 4. To ensure compliance, 5 residents will be audited for ensuring proper care was delivered by the DON /Designee. Audits will be reviewed and reported to the QAPI Compliance Committee by the DON/Designee. Audits will be completed monthly for 3 months, and then as recommended by the QAPI Committee. 5. The Administrator is responsible for this plan of correction.	

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	was understood and understands with a Brief Interview for Mental Status (BIMS) score of 6 (severe cognitive impairment). Section G of MDS revealed that R20 required two-person extensive assistance with bed mobility, two-person total dependence for transfers, one-person total dependence with dressing, independent with eating after set up assist, two- person total dependence with toilet use, and two-person extensive assistance with personal hygiene. Section P of MDS reflected that R20 used bed rails daily. Review of the Discharge MDS dated 9/21/22, revealed that R20 had an unplanned discharge to an acute care hospital and that her return to the facility was anticipated. During an observation and interview on 12/11/22 at 12:54 PM, Resident #20 (R20) was observed lying in bed, on left side, dressed in facility gown. Oxygen noted to be in place at 3 liters per minute via nasal cannula. Bilateral quarter side rails and over the bed trapeze noted to be in place. R20 stated that she rolled out of bed approximately three to four weeks ago and broke her left leg. Per R20, as she moved her legs to reposition herself, her legs started to slide off the edge of the bed causing her to roll out of bed and onto the floor. R20 stated that she put on her call light but before staff could arrive to assist with repositioning, she slid to the floor. R20 stated that after she was on the floor, she yelled out and "staff came running". Per R20, facility staff called Emergency Medical Services (EMS) to assist			

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staff with lifting her back into bed.

Incident Report dated 9/16/22, provided by Nursing Home Administrator (NHA) "A", indicated "Person Preparing Report" to be Assistant Director of Nursing (ADON) "L" with "Incident Location" indicated to be "Resident's Room". Within "Incident Description" the "Nursing Description" indicated that "Resident observed laying on floor in bedroom on left side, assessment completed, vitals obtained WNL (within normal limits), skin tear to right elbow" and the "Resident Description" indicated "Resident stated she was attempting to use equipment to reposition self in bed." Section titled "Immediate Action Taken", indicated that EMS was contacted to assist with post fall care, stat x-ray ordered of left knee and femur, and that R20 was not taken to the hospital. Within same report, R20's mental status both at time of incident and post incident was indicated as oriented to person, place, situation, and time and that she was able to communicate with EMS/Staff. Within report, pain level was indicated as "3" at time of incident and as "2" post incident. Section within report titled "Injuries Report Post Incident" indicated "No injuries observed post incident."

Review of R20's medical record complete with the following findings noted:

Nurses note dated 9/16/22 at 7:11 PM, indicated "At approximately 1730 (5:30 PM)

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....observed resident laying on right side parallel to and facing bed ...resident stated ...."My legs started going, and the rest of me just followed." ...Called Lifecare for lift assist ...Assessed for injuries ...MD (Medical Doctor) notified, orders received to obtain X-Rays."

Pain Tool assessment dated 9/16/2022 at 5:49 PM, indicated "Left knee (front)" within section titled "Location". "Current Pain Level" via Numerical Pain Scale indicated as an "8" with indication that "PRN (as needed) pain meds (medications)" makes the pain better. Numerical Pain Scale score indicated as a "2" when pain was at its least. Within section titled "What Makes the Pain Worse?", "Movement" was indicated with the Numerical Pain Scale noted to indicate a score of "8" when pain is at its worst. Within section titled "Effects of Pain on ADLS (Activities of Daily Living)", Physical activity and mobility are indicated to be affected. Within "Comments" section of the same form, there was indication that "X-Rays ordered related to pain after fall".

Nurses note dated 9/17/2022 at 5:29 AM, indicated "Resting in bed comfortable, pain meds given at 4:30 AM with good effective for right leg pain, X-ray tech unable to obtain X-ray image, manager notify, no acute distress noted ...neuro (neurological) check WNL ..."

Order dated 9/17/22 at 11:09 AM, stated "Obtain X-Rays of pelvis, left hip, left femur,

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left knee, LLE (left lower extremity), and left ankle".

Order dated 9/18/22 at 11:12 AM, indicated discontinuation of "Norco Tablet 5-325 MG Give 1 tablet by mouth every 12 hours as needed" and new order with same date and time stated, "Norco Tablet 5-325 MG (HYDROcodone-Acetaminophen) *Controlled Drug* Give 1 tablet by mouth every 8 hours as needed for pain".

Order dated 9/18/22 at 11:13 AM, stated "Voltaren Gel 1 % (Diclofenac Sodium). Apply to affected areas topically every 8 hours as needed for pain. 2 grams to affected areas."

Interdisciplinary (IDT) Notes dated 9/19/22 at 10:14 AM, indicated that "IDT met to discuss resident's fall that occurred on 09/16/2022 at 1730 (5:30 PM). Fall was unwitnessed. Resident was observed laying on the floor after falling from her bed. Resident reported that she was moving in the bed and her body rolled out of the bed. Lifecare came to assist getting resident back into her bed. At last care conference, resident and family requested for the strap to help resident move around in her bed. P.A.C.E (Program of All-Inclusive Care for the Elderly) will be asked to reevaluate interventions put in place by them. Neuros started, pain assessment completed, pain medication given and effective post fall, and vitals taken. P.A.C.E. doctor and DON (Director of Nursing) notified, and X-Rays obtained. Care plan reviewed and updated."

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Nurses Note dated 9/21/2022 at 6:48 PM, indicated " ...informed by PACE that the results of her x-ray was FX (fracture) of the femur and that they were sending EMTS (Emergency Medical Technicians) for her to be sent to Hospital ...called the south unit manager she called the administrator and the DON".

Nurse Note dated 9/23/2022 at 9:47 AM, indicated "LATE ENTRY-PACE provider in for care conference in reference to recent fall post new bed mobility equipment including positioning strap. New interventions for safety to include new evaluation of use of bed mobility equipment by pace PT/OT. X-ray ordered for resident. Removal of positioning strap until new evaluation of use. No other new orders received."

Neurological Assessment beginning 9/16/22 at 5:30 PM and noted to continue through 9/20/22 included routine vital sign monitoring, pupil response, eye response, level of consciousness and motor response but provided no indication of extremity range of motion or additional physical assessment.

Review of R20's Hospital After Visit Summary dated 9/21/22-9/22/22, included left femur x-ray results with indication of "acute mildly displaced supracondylar fracture of the distal femur".

Further review of R20's medical record,

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reflected no additional nurses notes or resident assessments during the period from the date/time of fall (9/16/22 at 5:30 PM) to the date/time R20 was transferred to the hospital (9/21/22). No comprehensive physical nursing assessment was noted to be complete on 9/17/22 after the 5:29 AM Nurses Note entry nor was a comprehensive physical nursing assessment noted to be complete on 9/18/22, 9/19/22, 9/20/22, or on 9/21/22 prior to or at the time of R20's transfer to the hospital. Additionally, no Physician Progress Note was noted to be complete during this time.

In an interview on 12/21/22 at 4:20 PM, DON "B" stated that an "Accident and Incident/Fall Episode Checklist" was used by the facility nursing staff for guidance in the completion of resident assessments post fall. Per DON "B", post fall assessment should include a risk management report, a head-to-toe physical assessment including range of motion, and neurological checks, and that this assessment would guide the nursing staff on the need to provide in facility treatment versus hospital transfer. DON "B" stated that the checklist does not indicate the frequency or duration of a resident assessment post fall and stated that she was not aware of a facility policy that indicated this information nor was she able to verbalize this information.

During the same interview, DON "B" stated that she was not informed that R20's ordered x-ray was not complete and confirmed that

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	there was no indication in the medical record that the primary physician was notified. Upon further review of R20's medical record, DON "B" stated that she would expect to see routine nursing assessments and documentation within a progress note regarding resident status from the time of the fall to the time of the hospital transfer. DON "B" reviewed and acknowledged R20's 9/18/22 orders for pain medication increase and that the expectation would be to complete nursing documentation and pain assessments to reflect the rationale for the order changes that warranted an increase in pain medication. Additionally, upon further review of R20's medical record, DON "B" confirmed that there was no noted documentation regarding the primary physician's assessment of R20's status post fall within the medical record with no additional assessment documentation provided prior to survey exit. In an interview on 12/22/22 at 9:03 AM, ADON "L" stated that she was not R20's assigned nurse on the date of the fall but that she was in DON "B's" office when she was notified that R20 "rolled out of bed". ADON "L" Stated that when she entered R20's room, resident was noted to be laying on her right side to the left of the bed. ADON "L" stated that she did not assess resident as assigned nurse that was also present in the room had completed assessment. Per ADON "L", EMS was contacted to assist with transfer and aided facility staff in a 6 person transfer			

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	off the floor using a lift sheet. ADON "L" stated that the assigned nurse notified R20's physician following the fall and that an x-ray order was obtained. ADON "L" stated that although she recalled that resident denied pain at time of fall, an x-ray order was obtained as a precautionary measure as assessment was difficult due to resident size. However, a Pain Tool assessment in R20's medical record dated 9/16/22 at 5:49 PM indicated left knee pain at an "8" at time of fall with "movement" making the pain worse. During the same interview, ADON "L" stated that the expectation would be for a post fall assessment to be completed and documented every shift for 72 hours with the assessment including a comprehensive physical assessment, pain assessment and vital signs. ADON "L" confirmed that although neurological monitoring was completed, no comprehensive physical assessment was completed from 9/17/22 at 5:29 AM through the time R20 was transferred to the hospital on 9/21/22. ADON "L" also confirmed that the expectation would be for a nurses note to be completed with any new or changed orders, acknowledging that although orders received on 9/17/22 regarding increase and addition in R20's pain medication, that no corresponding nurses note was present to indicate these order changes or rationale for the changes. During the same interview, ADON "L" stated			

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	that she was at home when she was contacted by R20's assigned nurse in the early AM (morning) of 9/17/22 and notified that R20's x-rays were unable to be completed by the mobile x-ray company. ADON "L" stated that she notified DON "B" and the NHA at that time but had no additional involvement in R20's plan of care on 9/17/22 and did not know if the physician was notified. Upon review of R20's medical record, ADON "L" confirmed that there was no documentation regarding physician notification of inability to obtain ordered x-rays and proceeded to state "if something is not documented, then it wasn't done." During same interview, ADON "L" stated that an interdisciplinary team meeting was completed on 9/19/22 and that sometime between 9/19/22 and 9/21/22, PACE facilitated and sent own mobile x-ray unit for completion of R20's ordered x-rays. ADON "L" stated that she could not confirm whether physician assessment of R20 was completed post fall but upon review of medical record, confirmed that no physician notes were available to reflect and provided no additional assessment documentation prior to survey exit. ADON "L" also stated that although the completed x-ray reports had been requested, that they had never been received. Review of the facilities "Accident and Incident/Fall Episode Checklist" included the guidance "If resident is injured obtain order			

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for x-ray, or any other testing that can be done STAT (immediately) within the facility or send to ER (Emergency Room)".

Review of the facility policy titled "Falls & Incident Investigation" dated 10/28/2021, indicated that "The following procedure is to be initiated whenever a fall or incident occurs ....3) DON/Designee: a. Reassess resident, and document findings in medical record ...d. Review documentation by Licensed Nurse, assess need for any additional monitoring ...4) The resident will be followed up on the 24-hour report and progress notes for 72 hours (3 days) post-accident/incident".

"B"

Based on observation, interview and record review the facility failed to ensure the necessary care and services was provided to two out of 15 residents (R48 and R21) to maintain the highest practical level of wellbeing, resulting in potential for care needs not being met.

Findings include:

Resident #48 (R48)

Review of R48's electronic medical record (EMR) upon R48 was admitted to the facility on 6/17/2022 hospice services were already in place. Diagnoses included varicose veins of left lower extremity with ulcer in other part of lower leg.

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Record review of a "Minimum Data Set" (MDS) assessment, dated 7/1/2022, revealed R48 had a one venous ulcer (ulcer that develops due to poor circulation).

Record review of the care plan in place revealed a focus of venous ulcers dated 09/12/22 related in impaired vascular status. Review of the interventions in place dated 09/12/22 revealed to complete dressing changes as ordered by the physician. Observe dressing daily for cleanliness, drainage and compression. Follow skin management program and report any abnormalities to physician.

Record review of R48's weekly skin/wound assessments revealed R48 had vascular impairment on the back of the left calf, right shin and right ankle.

Weekly skin/wound assessments revealed on 09/12/22, 09/19/22, 09/26/22, 10/04/22 and 11/11/22, were the only skin/wound assessments documented over a two-month period. There were no assessments documented after 11/11/22 through 12/21/22.

During an interview on 12/21/22 at 09:05 AM, DON "B" regarding R48's weekly wound care assessments not being completed, DON "B" stated, R48 vascular wounds had healed up so that may be the reason for no weekly assessment. No

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documentation to reflect wound healing/healed or worsened.

Observation on 12/21/22 at 10:00 AM revealed R48's had an open wound on his right shine, ankle and calf of the left leg that were not healed.

Facility had not followed orders to complete weekly assessment, measuring and monitoring.

Resident #21(R21)

Review of the Face Sheet and Minimum Data Set (MDS) dated 10/24/22, reflected R21 was a 79 year old female admitted to the facility on 1/24/17, with diagnoses that included dementia, coronary heart disease, heart failure, peripheral vascular disease, seizure disorder, schizophrenia, and mantic depression. The MDS reflected R21had a BIM (assessment tool) score which indicated her ability to make daily decisions was severely impaired, and she required one person physical assist with bed mobility, transfers, locomotion on unit, dressing, eating, toileting, hygiene, and bathing.

During an observaton on 12/11/22 at 9:07 AM, R21 was laying on an air mattress positioned low with hospital gown on with head aukwardly positioned to the left with strong smell of urine in room. R21 door was open with stop sign on door that read, "aerolol generate\ing procedure" that indicated required use of gloves, mask, gown, and eye protection, with no Personal Pertective Equipment(PPE) observed outside door. R21 had an air mattress in place,

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	appeared thin and frail, was awake with eyes open holding stuffed animal and rosery. R21 did not appear to be verbal and appeared calm with soft touch call light located out of reach under top of pillow. Folding chair was noted at bedside along with bedside table with 2 large styrofaom cups with straws that appeared to be orange juice and water. Review of the facility Matrix, dated 12/11/22, reflected R21 was not receiving Hospice services. Review of the MDS, dated 10/24/22, 7/24/22 and 1/21/22, reflected R21 was not receiving hospice services. Review of the EMR on 12/12/22 reflected R21 did not have a physician order for hospice services. During an interview on 12/20/22 at 1:35 PM, Director of Nursing (DON) "B" reported R21 had been a Hospice resident for several months and reported would expect R21 to have an order for hospice. DON "B" reported had been the MDS nurse prior to DON and reported R21's MDS should reflect hospice services and if it did not it was an error. Review of the R21Care Plans, dated 1/29/17 through 11/25/22, reflected, "I have a terminal prognosis and elected to have Hospice. Date Initiated: 01/08/2020...Interventions...Work cooperatively with hospice team to ensure my spiritual, emotional, intellectual, physical and social needs are met..." Care Plans reflected no mentions of what hospice services R21 received or what hospice company or fequency of services.			

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	During an interview on 12/20/22 at 3:30 PM, DON "B" reported had a care conference with R21 Hospice that today and reported prior to that day no history of hospice involvement with care conferences. DON "B" reported plans to involve Hospice companies with residents Care Conferences now moving forward. DON "B" reported document in binder was signed today and should have been signed by staff receiving report from hospice staff and will be part of plan of correction moving forward. DON "B" reported R21's Care Plans should be personalized including Hospice services provided. During an interview on 12/21/22 at 10:45 AM, CNA "M" reported had never seen hospice spiritual care in for R21, only hospice CNA who provided baths usually 2 times weekly. Licensed Practical Nurse (LPN) "OO" joined the interview and reported had cared for R21 for several years and use to enjoy regular trips out of the facility. LPN "OO" reported had not observed R21 out of bed in two weeks and does not like group events. LPN "OO" reportd was unsure if R21 liked music and reported long history of using rosery and had always had cross necklace she was very attached to. LPN "OO" reported was unsure of R21's religious background and reported had never observed hospice spiritual services visiting R21. LPN "OO" and CNA "MM" both reported were unsure what services R21 was receiving from hospice and reported they only sign hospice tablet after visits for CNA and Nurse. During an interview on 12/21/22 at 12:25 PM Hospice CNA "PP" reported provided R21 bathing services two times weekly on Wednesday and Friday and often comes during lunch to assist with meals. CNA "OO"			

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	reported facility had been short staffed and reported R21 was going to be discharged from Hospice services and skin started to breakdown related to incontinants located in brief area and facility moved R21 from north to south unit. Hospice CNA "OO" reported Hospice offered music and pet therapy but R21 did not receive and was unsure why. CNA "OO" reported was told yesterday that hospice binder would be located in front of building because difficult to locate staff for nurse to sign for visits.			
F0686 SS= D	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: This citation pertains to M100130932. Based on observation, interview, and record review, the facility failed to assess pressure injury risk, and failed to accurately and routinely assess and document pressure injury presentation in one of five residents	F0686	1. Resident #1 was assessed by nursing and her physician and a plan of care was put in place for all of her pressure ulcers on 12/23/2022. 2. All residents have the ability to be affected by this deficient practice. An audit was done on 1/16/2023 by the DON/Designee to ensure there were no residents who had unaddressed pressure ulcers. No other concerns were noted. 3. The policy for wound care was reviewed by QAPI Committee and updated on 1-12-2023 All nursing staff were educated on 1-12-2023 and 1-13-2023 by the DON/Designee on the new policy. In addition, the ADON was assigned to directly oversee all wound care and accompany the wound care NP on regular rounds on 1-13-2023 by the DON. 4. To ensure compliance, 5 residents will be audited to ensure proper wound care. Is in place by the Administrator/Designee. Audits will be reviewed and reported to the QAPI compliance committee. Audits will be completed monthly for 3 months and then as QAPI committee recommendations indicate. 5. The Administrator is responsible for this plan of correction.	1/31/2023

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	(Resident #1) reviewed for pressure injuries resulting in the potential for delayed healing, wound deterioration, and the formation of additional pressure injuries. Findings include: Resident #1 (R1) initially admitted to facility 4/8/2016 with diagnoses including multiple sclerosis, anemia, right ankle contracture, left ankle contracture, osteoporosis, polyneuropathy, and urge incontinence. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/6/22 revealed that R1 had a Brief Interview for Mental Status (BIMS) score of 6 (severe cognitive impairment). Section G of MDS revealed that R1 required one-person extensive assistance with bed mobility, dressing, eating, and personal hygiene; one-person total dependence with toilet use; and two-person total dependence with transfer. Section H of MDS reflected that R1 was always incontinent of bowel and bladder. Section M of MDS indicated that R1 was at risk of developing pressure injuries and had two Stage 1 pressure injuries. The MDS dated 8/6/22 revealed that R1 was at risk for developing pressure injuries but was not indicated to have any at time of assessment. On 12/11/22 at 11:50 AM, R1 was observed lying in bed, in facility gown, positioned on back with head of bed elevated to approximately seventy-five degrees. Purple foam heel protector was noted at right heel			

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with visible gauze dressing beneath.

In an interview on 12/13/22 at 1:29 PM, Assistant Director of Nursing (ADON) "L" stated that R1 had a wound on her bottom related to incontinence, a left ear scab from pressure, and a right heel wound from pressure. ADON "L" denied additional knowledge regarding wound formation and presentation as stated that Director of Nursing (DON) "B" completed weekly wound assessments.

On 12/13/22 at 1:33 PM, observed completion of R1's wound care by Licensed Practical Nurse (LPN) "C" and Certified Nurse Aide (CNA) "M". CNA "M" unfastened brief and completed peri care using personal cleansing wipes as R1 noted to be incontinent of soft brown stool. No dressing was noted to be present to sacrum. Sacrum noted to present with small open wound with thin layer of adherent yellow tissue at central aspect of wound base and thin line of dark pink tissue surrounding and extending to wound borders. Surrounding tissue with intact pink epithelial tissue. LPN "C" washed hands, placed gloves, cleansed sacral wound with normal saline and 4 by 4 gauze, patted area dry with 4 by 4 gauze, and applied bordered foam dressing. LPN stated that wound presented similar as in previous week and commented, "It hasn't gotten any worse or better."

LPN "C" removed gloves, washed, and dried

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	hands, applied new gloves, and removed heel protector and gauze wrap from R1's right heel. Right lateral heel noted to present with dime size area of adherent dry, black tissue with intact pink tissue surrounding. Left ear presented with intact pink tissue. No open areas noted. Review of R1's medical record complete with the following findings noted: 8/24/2022 Weekly Wound Healing-Wound Care Nurse form reflected sacral alteration acquired in house on 8/17/2022. Wound was indicated as Moisture Associated Stasis Dermatitis (MASD) and staged as a Suspected Deep Tissue Injury (SDTI). Wound was indicated to measure 2.5centimeters (cm) by 1.2cm by 0.1cm and to present with epithelial tissue in wound base, scant serous drainage, and intact peri-wound. Box within "Treatment" section noted to state "Order for dry dressing". 8/31/2022 Weekly Wound Healing Record-Wound Care Nurse form reflected sacral alteration to be an "other" type of alteration with entry blank under prompt to "Specify Other". Under "Pressure Ulcer Stage", wound indicated as a SDTI. Wound was indicated to measure 2.3cm by 1.2cm by 0.1cm and to present with epithelial tissue in wound base, scant serous drainage, and intact peri-wound. Box within "Treatment" section noted to state "Xeroform".			

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9/8/2022 Weekly Wound Healing Record-Wound Care Nurse form indicated sacral alteration as MASD and staged as SDTI. Wound was indicated to measure 2.5cm by 1.2cm by 0.1cm and to present with dry epithelial tissue in wound base, scant serous drainage, and intact peri-wound. Box within "Treatment" section noted to state "Continue with dry dressing".

9/13/2022 Weekly Wound Healing Record-Wound Care Nurse form reflected sacral alteration to be an "other" type of alteration with entry blank under prompt to "Specify Other". Under "Pressure Ulcer Stage", wound indicated as SDTI. Wound was indicated to measure 2.5cm by 1.2cm by 0.1cm with dry wound base, scant serous drainage, and intact peri-wound. No tissue type was noted to be selected. Inflammation and slight redness indicated to be present with box under "Treatment" noted to state "Add medihoney to order".

9/20/2022 Weekly Wound Healing Record-Wound Care Nurse form reflected sacral alteration to be MASD. Wound was indicated to measure 2.5cm by 1.5cm by 0.1cm and to present with granulation tissue in wound base and scant serous drainage. Peri-wound was indicated to be "Normal for resident". Box within "Treatment" section noted to state "Continue medihoney".

9/27/2022 Weekly Wound Healing Record-

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	Wound Care Nurse form indicated sacral alteration as MASD. Wound was indicated to measure 2.7cm by 1.4cm by 0.1cm with dry wound base and scant serous drainage. No tissue type was noted to be selected. Peri-wound was indicated to be "Normal for resident". Box within "Treatment" section stated, "No changes, continue light softening of wound bed to increase epithelial production". 10/4/2022 Weekly Wound Healing Record-Wound Care Nurse form reflected sacral alteration to be an "other" type of alteration with entry under prompt to "Specify Other" noted to state "sacral". Wound was indicated to measure 2.6cm by 1.4cm by 0.1cm and to present with granulation tissue in wound base and scant serous drainage. Peri-wound was indicated to be "Normal for resident". Box within "Treatment" section stated, "No changes this week as wound is healing, more granulation tissue present". 10/11/2022 Weekly Wound Healing Record-Wound Care Nurse form indicated sacral alteration to be a Stage 2 Pressure Injury. Wound was noted to measure 2.5cm by 1.5cm by 0.1cm and to present with granulation tissue in wound base and small amount serous drainage. Peri-wound was indicated to be "Normal for resident". Box within "Treatment" section stated, "Medihoney". 10/18/2022 Weekly Wound Healing Record-			

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	Wound Care Nurse form indicated sacral alteration to be a Stage 2 Pressure Injury. Wound was noted to measure 2.8cm by 3.0cm by 0.2cm and to present with granulation tissue in wound base and scant serous drainage. Peri-wound was indicated to be "Intact normal color for resident". Box within "Treatment" section stated, "Continue Medihoney". 12/8/2022 Weekly Wound Healing Record-Wound Care Nurse form indicated sacral alteration to be a Stage 2 Pressure Injury. Wound was noted to measure 3.5cm by 5.0cm with no noted depth. Wound base was indicated to present with epithelial tissue with intact peri-wound. Box within "Treatment" section stated, "Cleanse with Normal Saline ...Cover with Optifoam". Review of R1's Sacral treatment orders and Treatment Administration Record from August 2022 through December 19, 2022, reflected the following: Treatment Order dated 8/23/2022, indicated to "Cleanse sacrum with Normal Saline ...Pat dry ...Cover with Xeroform and Optifoam dressing ...everyday". Although 8/24/2022 Weekly Wound Healing-Wound Care Nurse form reflected that sacral alteration was acquired in house on 8/17/2022, no treatment order noted until 8/23/2022. Treatment Order dated 9/2/2022, indicated to "Cleanse sacrum with Normal Saline ...Pat			

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dry ...Cover with Optifoam ...Change every three days ..."

Treatment Order dated 9/13/2022, indicated to "Cleanse sacrum with Normal Saline ...Pat dry ...Cover with Medihoney and Optifoam ...Everyday ..."

Treatment Order dated 11/25/2022, indicated to "Cleanse sacrum with Normal Saline ...Pat dry ...Cover with Optifoam ...Everyday ..."

9/27/2022 Weekly Wound Healing-Wound Care Nurse form reflected a Stage 2 left ear pressure injury acquired in house on 9/21/2022. Wound was indicated to measure 0.3centimeters (cm) by 2.0cm by 0.1cm and to present with dry, necrotic tissue (brown, black, leather, scab-like). Peri-wound indicated to be "normal for resident". Box within "Treatment" section stated, "Dry dressing to protect, reduce infection ...add xeroform".

10/4/2022 Weekly Wound Healing-Wound Care Nurse form reflected a Stage 2 left ear pressure injury. Wound was indicated to measure 0.3cm by 1.8cm by 0.1cm. No indication of wound base presentation noted as all areas within "Visible Tissue" section blank. Peri-wound indicated to be intact. Box within "Treatment" section stated, "No changes ...Continue same treatment of medihoney".

10/11/2022 Weekly Wound Healing-Wound

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	134140	A. BUILDING _____ B. WING _____	12/22/2022

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MOMENTOUS HEALTH AT BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

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	Care Nurse form reflected a Stage 1 left ear pressure injury. Wound was indicated to measure 0.2cm by 0.1cm by 0.1cm with no indication of wound base presentation noted as all areas within "Visible Tissue" section blank. Peri-wound indicated to be intact. Box within "Treatment" section stated, "Staff to continue to encourage resident to not lean to left ...keep pillow in place ...Xeroform". 10/18/2022 Weekly Wound Healing-Wound Care Nurse form reflected a Stage 2 left ear pressure injury. Wound was indicated to measure 0.3cm by 0.5cm by 0.1cm with no indication of wound base presentation noted as all areas within "Visible Tissue" section blank. Peri-wound indicated to be intact. Box within "Treatment" section stated, "Continue treatment of Xeroform ..." Review of R1's left ear treatment orders from September 2022 through December 20, 2022 reflected the following: Treatment order dated 9/20/2022, indicated to "Clean left ear with Normal Saline (NS), cover with gauze and tape ...at bedtime ..." Treatment order dated 9/27/2022, indicated to "Clean left ear with NS ...cover with Xeroform ...cover with dry gauze and secure with tape ...everyday ..." Treatment order dated 11/25/2022, indicated to "Clean left ear with NS ...cover with dry gauze and secure with tape ...everyday ..."			

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Review of R1's medical record reflected that no Weekly Wound Healing-Wound Care Nurse form was completed to reflect R1's right heel wound from wound presentation to current date of 12/20/22.

Review of R1's right heel treatment orders from October 2022 through December 20, 2022 reflected the following:

Treatment order dated 10/24/2022 indicated "Right Heel Treatment: apply skin prep to right heel area every night shift ...for prevention".

Treatment order dated 12/13/2022 indicated "Right Heel Treatment: apply skin prep to right heel area every night shift, cover with kerlix for comfort ...for prevention".

Review of Weekly Head-To-Toe Assessment form complete from August 2022 through December 20, 2022 with the following noted:

Form dated 8/11/2022 indicated "No new skin issues" but otherwise blank.

Form dated 8/18/2022 indicated "No new skin issues noted" but otherwise blank although 8/24/2022 Weekly Wound Healing-Wound Care Nurse form reflected sacral alteration acquired in house on 8/17/2022.

Form dated 8/25/2022 indicated a sacral alteration measuring 5.0cm by 3.0cm. with

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	wound type indicated as "incontinence derm [dermatitis]" and indicated to be a "Stage 2". Notes on same form stated, "noted to have open area on sacrum ...treatment in place". Form dated 9/2/2022 indicated "Skin intact" but otherwise blank. Form dated 9/8/2022 indicated "No new skin issues noted" but otherwise blank. Form dated 9/15/22 indicated "No new skin issues noted...treatment in place for incontinence derm" but otherwise blank. Form dated 9/22/2022 indicated "No new skin issues noted" but otherwise blank although 9/27/2022 Weekly Wound Healing-Wound Care Nurse form reflected a Stage 2 left ear pressure injury acquired in house on 9/21/2022. Form dated 9/29/22 indicated "No new skin issues noted" but otherwise blank. Form dated 10/6/2022 indicated "No new skin issues noted" but otherwise blank. Form dated 10/13/2022 indicated a Stage 2 Pressure Injury at Coccyx and a Left Ear Pressure Injury with no additional details noted. Form dated 10/20/2022 indicated "No new skin issues noted" but otherwise blank.			

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	Form dated 10/27/2022 indicated "No new skin issues noted" but otherwise blank. Form dated 11/3/2022 indicated "No new skin issues noted" but otherwise blank. Form dated 11/17/22 indicated " ...has treatment in place, no new areas of concern" but otherwise blank. Form dated 12/1/2022 indicated a Stage 2 Pressure Injury at Right Heel and a Stage 2 Pressure Injury at Coccyx with no additional details noted. Notes on same form stated, "Resident with previous right heel ulcer and coccyx ulcer ...Treatments continue ...Other skin areas intact". Form dated 12/8/2022 indicated "Resident with previous right heel ulcer and coccyx ulcer ...Treatments continue ...Other skin areas intact". Form dated 12/15/2022 indicated "Noted area on sacrum ...treatment in place". Review of R1's Progress Notes from August 2022 through December 20, 2022 reflected the following: A Skin/Wound Note dated 8/30/2022, indicated "Nurse in to assess wound on sacrum ...Epidermis intact, redness, and blanchable". A Skin/Wound Note dated 9/13/2022,			

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	indicated " .... interventions for sacral wound that appears to be MASD ...obtained order to add medihoney ..." An eInteract SBAR note dated 9/20/2022, indicated " ...skin wound or ulcer ...Recommendations: clean and put dressing on it. Order is on the TAR (Treatment Administration Record)". No additional information noted within note regarding wound location or presentation. A Skin/Wound Note dated 9/27/2022, indicated " ...has wound on buttocks that presents as MASD ...left ear that presents as stage 2 pressure ..." A Skin/Wound Note dated 10/4/2022, indicated " ...wound on ear appears to be healing as it is smaller in size and has new growth of epithelial tissue ...sacral wound is healing ..." A Skin/Wound Note dated 10/24/2022, indicated " ...she is currently receiving treatment for her left ear, right heel and sacral area ..." No additional assessment information contained within note indicating wound measurements or wound presentation. A Nurses Note dated 11/9/2022, indicated " ...continues to receive wound care on her heel, ear, and sacrum ...wounds are healing as evidence by new epithelial tissue growth on sacrum and ear, heel is soft ..." No additional			

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assessment information contained within note indicating wound measurements or wound presentation.

A Nurses Note dated 11/25/2022, indicated " ...wound on her ear is 0.2 by 0.1 by 0.1 and has a scab ...Right heel is soft ...has delicate skin on sacrum and is incontinent ..." No additional assessment information contained within note indicating wound measurements or wound presentation.

A Skin/Wound Note dated 11/30/2022, indicated " ...has wound on left ear, sacrum, and right heel ..." No additional assessment information contained within note indicating wound measurements or wound presentation.

Review of Physician Progress Notes dated 9/8/2022, 10/4/2022, 11/3/2022 and 12/9/2022 complete with no indication of skin alterations noted.

Review of R1's Assessments revealed no completion of a Braden Scale (an assessment tool used to assess risk for developing a pressure injury) since 7/7/2021.

In an interview on 12/20/22 at 11:52 AM, Director of Nursing (DON) "B" stated that she had been completing and was currently still responsible for the completion of R1's wound assessments and documentation but that she was in the process of transitioning the wound nurse role to ADON "L". DON "B" stated that

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	the expectation was to assess and document on R1's wounds each week and that each assessment should include wound measurements and presentation, review of orders, review of interventions and coordination with physician as warranted. DON "B" stated that the weekly wound assessments should be documented within R1's medical record using the "Weekly Wound Healing Record-Wound Care" form. DON "B" confirmed that R1 currently had active left ear, sacrum, and right heel pressure injuries. Upon review of R1's medical record, DON "B" confirmed that the last weekly documented assessment for the left ear and sacrum was complete on 10/18/2022 and that weekly assessments had never been initiated for R1's right heel wound. DON "B" stated that the last time she visualized R1's wounds was on 12/8/2022 and stated that at that time the right heel wound was closed and presented with dry necrotic tissue in wound base and both the sacrum and left ear presented with superficial open areas with scant drainage. DON "B" stated that documentation was not complete for the assessments that she completed on 12/8/2022 but that the ordered treatments all remained appropriate. DON "B" stated that although weekly assessments had not been completed since 10/18/2022, which she stated was approximately the time that she transitioned to the facilities Director of Nursing, assessments, and documentation within the "Weekly Wound Healing Record-Wound Care" should still have been			

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completed on a weekly basis. DON "B" further confirmed that a Braden Scale for Predicting Pressure Ulcer Risk should be completed quarterly but upon review of R1's medical record, DON confirmed that the last one that was complete was dated 7/7/2021 and was unable to provide a more recent assessment.

In a follow-up interview on 12/22/22 at 9:03 AM, ADON "L" stated that she was in the process of assuming the wound nurse role. ADON "L" confirmed that on 12/8/2022 that she assessed and documented on R1's sacral wound for the first time but denied assessing the right heel or left ear wounds or completing any of the wound assessments since.

A review of the facility policy titled "Wound Care" dated 5/1/2022, indicated that "The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores ...In addition, the nurse shall describe and document ...Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue ...pain assessment ...mobility status ...current treatments, including support surfaces."

The National Pressure Injury Advisory Panel (2016) updated staging system defines a Stage 1, Stage 2, Stage 3, Stage 4, Unstageable Pressure Injury, and Suspected

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	Deep Tissue Injury as follows: "Stage 1 Pressure Injury-nonblanchable erythema. Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching. Stage 2 Pressure Injury Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining			

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	and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear." Additionally, the NPUAP provides the following information regarding Pressure Ulcer Assessment: "Assess the pressure ulcer initially and re-assess it at least weekly ...Document the results of all wound assessments ...Assess and document physical characteristics including location, category/stage, size, tissue type(s), color, peri-wound condition, wound edges, sinus tracts, undermining, tunneling, exudate, and odor ..."			

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	(http:www.npuap.org/wp-content/uploads/2014/08/Quick-Reference-Guide-DIGITAL-NPUAP-EPUAP-PPPIA-Jan2016.pdf)			
F0698 SS= D	Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the completion of routine post dialysis monitoring, assessments, and documentation for one resident (Resident #14) of one reviewed for dialysis, resulting in the potential for unidentified change in condition and complications post dialysis treatment. Findings include: Resident #14 (R14) admitted to facility 10/1/19 with diagnoses including end stage renal disease, asthma, anemia, chronic obstructive pulmonary disease, acute lymphoblastic leukemia, and congestive heart failure. Review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/20/22 revealed R14 to have a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). Further review of the medical record revealed that R14 received	F0698	1. Resident #14's dialysis sheets were audited by the NHA/Designee for 30 days to ensure she had no more missing dialysis sheets on 1-14-2023. No sheets were found to be missing. 2. All residents on dialysis have the potential to be affected. An audit was completed by the Administrator/Designee' on 1-27-2023 of the communication sheets of all residents on dialysis. Any missing communications resulted in a call from the DON/Designee to the dialysis clinic to ensure a communication sheet was generated after each dialysis visit and sent back to the facility. 3. The procedure for Dialysis Patient Communication was reviewed by the QAPI Committee and updated on 1-12-2023. All licensed nurses were educated on the updated procedure for Dialysis Patient Communication on 1-12-2023 and 1-13-2023 by the Administrator/designee'. 4. An audit will be completed by the Administrator/Designee' of the communication sheets of all residents on dialysis weeklyx4 and monthly thereafter. All results were trended and brought to QAPI Meeting for trending and ongoing process improvement. 5. The Administrator is responsible for this plan of correction.	1/31/2023

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	dialysis treatment, at an outpatient dialysis center, on Mondays, Wednesdays, and Fridays. During an observation and interview on 12/11/22 at 9:47 AM, R14 was observed sitting in a wheelchair at bedside with oxygen in place at 3 liters per minute via nasal cannula. R14 stated that her kidneys were weak and that she had started hemodialysis in October of 2022 and held up her right arm and pointed at the fistula that could be seen in her right upper arm. Per R14, she left the facility at approximately 6:30 AM every Monday, Wednesday, and Friday for dialysis and returned at approximately 12:00 PM. Review of R14's medical record included a "Dialysis Communication Form" which was noted to include three sections: Top: Facility Pre-Dialysis Information including date/time, resident name, medications administered prior to dialysis, meal/snack sent, shunt location/status, additional information since last visit, vital signs, and nurse signature. Middle: Dialysis Center Information including pre and post weight, fluid removed, meal/snack intake, shunt location/status, additional information (changes in condition, medications administered, labs drawn, lab results), new MD (Medical Doctor) orders/recommendations, vital signs, and nurse signature.			

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Bottom: Facility Post-Dialysis Information including date/time, bruit/thrill present, bleeding, general condition of resident, vital signs, and nurse signature.

Review of R14's Dialysis Communication Forms located within the medical record complete with the following findings noted:

Bottom section of the Dialysis Communication Form titled "Facility Post-Dialysis Information" which included date/time, assessment of bruit/thrill, bleeding, general condition of resident, vital signs, and nurse signature noted to be blank on 10/31/2022, 11/4/2022, 11/11/2022, 11/14/2022, 11/18/2022, 11/20/2022, 11/25/2022, 11/30/2022, 12/2/2022, and 12/9/2022.

No Dialysis Communication Forms noted within R14's medical record for the dialysis treatment that resident was scheduled to receive on 10/24/2022, 10/26/2022, 10/28/2022, 11/7/2022, 11/28/2022, 12/5/2022, and 12/14/2022.

Further review of R14's medical record complete with the following findings noted:

Nurses Note dated 10/26/2022 at 9:02 AM, stated "received phone call from dialysis stating that vein had infiltrated when attempting to start dialysis. Give instructions to put ice on area every 20 minutes, off for 20

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	minutes today until goes to bed tonight. Stated to expect bruising. Assessed fistula right arm when returned. No bruising observed, but some swelling observed above fistula." Nurses Note dated 10/28/2022 at 1:49 PM, stated "Doctor in bedside to evaluate fistula and surrounding skin. No new orders at this time." Physician Progress Notes dated 11/3/2022 2:00 PM, stated " ...Right arm discomfort ...pain scale 0 out of 10 with pain in the arm 2 out of 10 ..." However, no assessment or documentation of right upper extremity or fistula noted. Physician H & P (History and Physical) dated 12/8/2022 12:46 PM, stated " ...Fistula site appears to be well-healed." However, no further assessment or documentation information regarding fistula and extremity presentation noted. Review of nurse's notes from 10/1/2022 through 12/20/2022 complete with no further notes identified to include resident post dialysis assessment information, and review of vital sign section for this same time period included no routine documentation to reflect post dialysis vital signs. On 12/20/22 at 2:36 PM, Nursing Home Administrator (NHA) "A" was requested to provide R14's Dialysis Communication Forms			

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	dated 10/24/2022, 10/26/2022, 10/28/2022, 11/7/2022, 11/28/2022, 12/5/2022, and 12/14/2022 that could not be located within the medical record. In an interview on 12/21/22 at 8:56 AM, Director of Nursing (DON) "B" stated that the nurse assigned to the resident should initiate a Dialysis Communication Form and complete the Facility Pre-Dialysis Information section prior to a resident leaving the facility on each scheduled dialysis treatment day. DON "B" stated that the form would then be sent with the resident to the dialysis center and that the resident should return with the same form with the section titled "Dialysis Center Information" complete by the dialysis center. Per DON "B", the expectation would be that upon resident return to the facility post dialysis, the assigned nurse completed a comprehensive assessment which included vital signs and site assessment and documented the information on the same Dialysis Communication Form within the "Facility Post-Dialysis Information" section. DON "B" stated that the facility had a difficult time getting the return paperwork from the dialysis center and acknowledged that several dialysis forms were missing from R14's medical record. DON "B" denied knowledge of any other location in R14's medical record where post dialysis assessments would be complete if not complete on the Dialysis Communication Form or any other location that the completed Dialysis Communication Forms would be kept.			

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	On 12/21/22 at 10:50 AM, a follow-up request was made to NHA "A" for R14's Dialysis Communication Forms dated 10/24/2022, 10/26/2022, 10/28/2022, 11/7/2022, 11/28/2022, 12/5/2022, and 12/14/2022 that could not be located within the medical record. On 12/21/11 at 11:48 AM, NHA "A" confirmed that after checking with both Medical Records and the Unit Manager, that the requested Dialysis Communication Forms for R14 were unable to be located with no additional information provided prior to the end of the survey. A Review of the facility policy titled "Dialysis" dated 5/1/2022, included "Purpose: To adequately assess resident needs and provide care goals which achieve the highest practicable level of care to residents with end stage renal disease receiving hemodialysis ...Procedure: ... 2) Risk factors related to potential for bleeding, alteration in fluid volume, potential for infection, alteration in nutrition, alteration in skin integrity, risk for adverse medication effects and psychosocial needs should be identified, assessed, and interventions to manage addressed ..."			
F0725 SS= E	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	F0725	1. No specific residents were listed in this citation. 2. All residents of Momentous Battle Creek have the potential to be affected by this deficient practice. An audit was done of the	1/31/2023

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	or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: This Citation Pertains To Intakes: MI00128361, MI00130337, MI00130932, MI00129672, Based on observation, interview, and record review the facility failed to ensure sufficient nursing staff for 8 of 9 resident council members, resulting in the potential for all 54 residents who resided at the facility to not attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: Review of the facility's CMS-672 Resident		past two weeks comparing the staffing level to the census/ acuity level by the NHA/ Designee on 1-23-2023.No new concerns noted. 3. The facility policy on Adequate Staffing was reviewed by the QAPI Committee and deemed appropriate. The schedule for 4 weeks ahead is now being posted by the scheduler/designee and updated following a daily census and staffing review at a.m. meeting. This was updated as of 1-15-2023. 4. To ensure compliance two week staffing audits will be completed weekly x4 and monthly thereafter by the NHA/Designee'. Results will be brought to QAPI Committee for Process Improvement. 5. The Administrator is responsible for this plan of correction.	

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	Census and Conditions of Residents dated 12/11/22 revealed the facility's census was 54, of which 48 required assistance of one or two staff for bathing, 52 required assistance of one or two staff for dressing, 38 required assistance of one or two staff for transferring, 38 required assistance of one or two staff for toilet use, and 21 required assistance of one or two staff for eating. The CMS-672 also revealed 6 residents were dependent on staff for bathing, 0 were dependent on staff for dressing, 7 were depending on staff for transferring, 9 were dependent on staff for toilet use, and 2 were dependent on staff for eating. Review of the PBJ report, dated 4/1/22 through 6/30/22, reflected facility was triggered for failing to have Licensed Nursing coverage 24 Hours/Day for four or more days within the quarter. During an interview and record review on 12/21/22 at 3:40 PM, Requested staffing from Scheduler "GG" for following dates: 5/8/22 (Sunday), 5/21/22 (Saturday), 5/22/22 (Sunday), 5/30/22 (Monday), 6/4/22 (Saturday), 6/5/22 (Sunday), 6/19/22 (Sunday). Scheduler "GG" reported started as scheduler mid June 2022 and reported does not submit data for PBJ reports. Scheduler "GG" reported creates schedules according to census per direction of Facility Owner "LL". Scheduler "GG" reported had been the owner since 7/1/21. Scheduler "GG" reported attempts to schedule Registered Nurses in			

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each 24 hours but agency staff are Licensed Practical Nurses and not always an option and reported they only have two RN staff and one works night shift and one was per-diem day shift. Scheduler "GG" reported provides Facility Owner "LL" with census and he provides staff to resident ratio according to census and provided example of tool used to determine required staff. Scheduler "GG" reported no knowledge of requirement for staffing RN staff apposed to LPN staff. Scheduler "GG" verified on Saturday May 21, 2022 the facility was staffed with LPN nurses only from 6am to 6am on 5/22/22.

Review of provided staffing tool, labeled, "[facility name] Par Calculator", reflected staffing was as follows:

Optimal

7am to 7pm(days)=1 CNA/9 Residents(1:9); 1 Nurse/20 Residents(1:20).

7pm to 7am(nights)=1:14; 1:28

Acceptable

7am to 7pm=1:12; 1:25. Plus one unit manager weekdays.

7pm to 7am=1:16; 1:30.

Minimal

7am to 7pm=1:14; 1:30. Plus one unit

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	manager weekdays. 7pm to 7am=1:20; 1:36. Continued review of the staffing tool reflected 1 supervisor on weekends and nights and 1 restorative aid on weekdays. Continued review reflected no mention of resident acuity. On 12/13/22 at 10:00 am, during the Resident Council meeting, 8 of 9 participants reported they had concerns with sufficient staff and the call light response time. One of the participants reported it was not unusual to wait for an hour or more to receive assistance. Review of Resident Council Meeting minutes reflected they had voiced these concerns on 6/8, 7/6, 8/3, and 9/7. Six of the Nine participants reported they do not receive showers twice weekly as scheduled due to lack of sufficient nursing staff. On 12/14/22 at 11:41 AM, during an interview with Director of Nursing (DON) "B" she reported she had had the position since October 2022 and offered no explanation for the concerns brought forth by Resident Council.			
F0726 SS= E	Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and	F0726	1. All nursing staff received competency checkoff by the DON 0n 1-25, 1-26, and 1-27-2023. 2. All residents have the ability to be affected by the deficient practice. An audit was conducted by the HR Coordinator of personnel files on 1-23 and 1-24 to identify	1/31/2023

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	psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure three Licensed Practical Nurses (LPN C, N, II) had specific competencies and skills necessary to meet resident needs, failed ensure two Certified Nursing Assistants (CNA "GG" and "JJ") of two CNA's reviewed for nursing competencies had their required annual competency evaluation in skills and techniques necessary to care for residents, resulting in the potential for nursing staff to lack the necessary qualifications and training to adequately care for the needs of the		any nursing staff in need of competency checkoff. 3. The facility policy on Nursing Staff Competencies was reviewed by the QAPI committee and updated on 1-12-2023. The facility updated their system for staff education and competency training on 1-12-2023. All staff who were not tested within the last year will be tested by the D.O.N./Designee by 1-27-2023 4. An audit of 25% of nursing department competencies will be completed by the DON/Designee weekly x 4 and then monthly thereafter. All results will be brought to the QAPI Committee for trending and process improvement. 5. The Administrator is responsible for this plan of correction.	

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	residents, and failed to ensure one Hospitality Aide ("E") ie. non-certified/ trained staff provide services within their scope of practice. Findings include: On 12/21/22 at 4:45PM, during a review of Personnel records, it was discovered LPN "C" with a hire date of 12/14/21, LPN "N" with a hire date of 3/19/14 and LPN "II" with a hire date of 5/19/20 did not have any nurse competencies and or performance reviews. Review of CNA personnel records for CNA "GG" hired 4/8/15 and CNA "JJ" with a hire date of 11/02/21 had no annual competency evaluation in skills and techniques necessary to care for residents. On 12/21/22 at 5:05PM, during an interview with Human Resource Director (HR) "S" and Director of Nursing (DON) "B" both reported they were new to their role and offered no explanation as to why personal files, required nursing staff competencies and skills check lists were not completed. Resident #1 Resident #1 (R1) initially admitted to facility 4/8/2016 with diagnoses including multiple sclerosis, anemia, right ankle contracture, left ankle contracture, osteoporosis, polyneuropathy, and urge incontinence. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of			

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	11/6/22 revealed that R1 had a Brief Interview for Mental Status (BIMS) score of 6 (severe cognitive impairment). Section G of MDS revealed that R1 required one-person extensive assistance with bed mobility, dressing, eating, and personal hygiene; one-person total dependence with toilet use; and two-person total dependence with transfer On 12/11/22 at 11:50 AM, R1 was observed laying in bed, in facility gown, positioned on back with head of bed elevated to approximately seventy-five degrees. Staff member noted to be sitting at bedside and feeding resident with staff name tag indicating "Hospitality Aide". Hospitality Aide (HA) "E" stated that R1 required extensive assist at meals and that when she intermittently assisted her to eat, R1 would consume 50 to 75% of meal. R1 was observed to take small bites of food as provided by HA "E". R1's tray ticket stated mechanical soft diet, nectar thick liquids, and mugs with lid and straw. In an interview on 12/13/22 at 10:42 AM, Director of Nursing (DON) "B" stated that a Hospitality Aide's job description included tidying/housekeeping tasks and stated that they could not do any hands-on skilled care such as transferring. DON "B" stated that the Speech Therapist provided feeding education for a few of the Hospitality Aides regarding diets and textures and that these trained HA's could feed a resident.			

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	In an interview on 12/13/22 at 11:51 AM, Nursing Home Administrator "A" stated that the HA job description included the ability to deliver meal trays to a resident but that they had not went through the training required to feed residents and therefore could not assist a resident with feeding. NHA "A" confirmed that some of the HA's had been provided feeding training by the Speech Therapist but that these HA's still could not feed a resident. In a follow-up interview on 12/13/22 at 12:13 PM, DON "B" stated she had been mistaken and that the Speech Therapist had not provided feeding training to the Hospitality Aides and confirmed that the Hospitality Aides should not be feeding residents. On 12/21/22 at 2:05 PM, Human Resources (HR) "S" confirmed that HA "E" was a Hospitality Aide with a 10/24/22 date of hire. Review of education record, provided by HR "S", included no education regarding feeding. Review of the facility document titled Job Description for the Hospitality Aide dated 5/1/22, indicated " ...Essential Functions ...Can do tasks including ...Deliver water and snacks to residents not on a mechanically altered diet ...Deliver meals to residents not receiving a mechanically altered diet during mealtime ..." The job description provides no indication that the Hospitality Aide can feed a resident on a regular or mechanically altered diet.			

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F0727 SS= D	RN 8 Hrs/7 days/Wk, Full Time DO §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure that a Registered Nurse was on duty for 8 consecutive hours a day for seven days a week, resulting in the likelihood of inadequate coordination of emergency or routine care with negative clinical outcomes affecting all 53 residents residing in the facility. Findings include Review of the PBJ report, dated 4/1/22 through 6/30/22, reflected facility was triggered for failing to have Licensed Nursing coverage 24 Hours/Day for four or more days within the quarter. During an interview and record review on 12/21/22 at 3:40 PM, Requested staffing from Scheduler "GG" for following dates: 5/8/22	F0727	1. The facility updated its schedule to include RN coverage 7 days per week for 1 month out. The schedule was communicated to all staff and on-call personnel on 1-12-2023. 2. All residents have the ability to be affected by the deficient practice. An audit of the last 2 weeks of schedules was conducted by the staffer on 1-13-2023. No issues with RN coverage were found. 3. The facility policy on RN Staffing 7 days per week was reviewed by the QAPI committee and updated on 1-12-2023. The facility updated the staff schedule to include RN coverage daily and the on-call coverage on 1-13-2023. 4. An audit of the nursing department schedule will be completed by the NHA/Designee weekly x 4 and then monthly thereafter. All results will be brought to the QAPI Committee for trending and process improvement. 5. The Administrator is responsible for this plan of correction.	1/31/2023

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	(Sunday), 5/21/22 (Saturday), 5/22/22 (Sunday), 5/30/22 (Monday), 6/4/22 (Saturday), 6/5/22 (Sunday), 6/19/22 (Sunday). Scheduler "GG" reported started as scheduler mid June 2022 and reported does not submit data for PBJ reports. Scheduler "GG" reported creates schedules according to census per direction of Facility Owner "LL". Scheduler "GG" reported had been the owner since 7/1/21. Scheduler "GG" reported attempts to schedule Registered Nurses in each 24 hours but agency staff are Licensed Practical Nurses and not always an option and reported they only have two RN staff and one works night shift and one was per-diem day shift. Scheduler "GG" reported provides Facility Owner "LL" with census and he provides staff to resident ratio according to census and provided example of tool used to determine required staff. Scheduler "GG" reported no knowledge of requirement for staffing RN staff apposed to LPN staff. Scheduler "GG" verified on Saturday May 21, 2022 the facility was staffed with LPN nurses only from 6am to 6am on 5/22/22. Review of provided staffing tool, labeled, "[facility name] Par Calculator", reflected staffing was as follows: Optimal 7am to 7pm(days)=1 CNA/9 Residents(1:9); 1 Nurse/20 Residents(1:20). 7pm to 7am(nights)=1:14; 1:28			

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	Acceptable 7am to 7pm=1:12; 1:25. Plus one unit manager weekdays. 7pm to 7am=1:16; 1:30. Minimal 7am to 7pm=1:14; 1:30. Plus one unit manager weekdays. 7pm to 7am=1:20; 1:36. Continued review of the staffing tool reflected 1 supervisor on weekends and nights and 1 restorative aid on weekdays. Continued review reflected no mention of resident acuity.			
F0730 SS= D	Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that two Certified Nurse Aides (CNA "GG" and "JJ") whose in-service training files were reviewed, had the	F0730	1. No residents were identified in this citation. 2. All residents have the ability to be affected by this deficient process. The Human Resources Coordinator audited all C.N.A. personnel files for up-to-date C.N.A. evaluations on 1-25-2023, and then gave the DON the list of C.N.A. staff that need performance review 1-25-2023. 3. The policy for C.N.A. Performance Review was reviewed by the QAPI Team and updated on 1-12-2023. The policy for C.N.A. Performance Review was reviewed with all staff on 1-12-2023 by the administrator/designee. 4. The Human Resources Coordinator will review 5 personnel files weeklyx4 and monthly thereafter. Results were brought to QAPI Committee for review and process	1/31/2023

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	required 12 hours of in-service training, resulting in the potential for unmet educational needs and missed opportunity for improved quality of care and services provided to the residents. Findings include: Review of CNA personnel records for CNA "GG" hired 4/8/15 and CNA "JJ" with a hire date of 11/02/21 revealed there was not 12 hours of training, education and or in-service. On 12/21/22 at 2:05 pm, during an interview with Director of Nursing (DON) "B" and Human Resources (HR) "S" they reported they had a recent mandatory training in early December, HR "S" stated the training was approximately 2 hours in length and that was the only documented education, in-service training she had for any of the CNA's over the last 12 months. When queried why the requirement was not met, DON "B" reported the facility did not have time to train provide in-services upon orientation therefore the facility did not have time to do it on an annual basis. DON "B" stated she was aware this was an issue and planned to take it to quality assurance meeting.		improvement. 5. The Administrator is responsible for this plan of correction.	
F0744 SS= E	Treatment/Service for Dementia §483.40(b) (3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.	F0744	1. The care plans for residents #48, #40, #49 were reviewed by the IDT team on 1-20-2023 and updated as needed to ensure appropriate dementia services are delivered by the IDT Team 2. All residents have the ability to be affected	1/31/2023

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	This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure staff were educated in behavioral care training for two of three residents (R40 and R49) reviewed for behavioral care resulting in the potential all 24 residents residing in the Dementia unit to receive adequate behavioral care. Findings Include; Resident #49 (R49) Review of the medical record reflected R49 was originally admitted to the facility 06/15/2022 with a diagnosis of Alzheimer's Disease. Record review on 07/29/2022 reflected behavior notes on R49 who continues 15-minute checks because other residents were wondering in his room. In an interview on 12/21/22 at 11:02 AM, Social Worker (SW) "D" stated the facility does not have a behavioral program. SW "D" was provided documentation showing 15-minute checks being performed on R49. SW "D" was asked why R49 was placed on 15-minute checks. SW "D" stated I am not sure why we put him on 15 mins checks. During an interview and record review on 12/21/22 at 02:05 PM, Human Resources (HR)		by this deficient practice. An audit of care plans for all residents with a dementia or dementia-related diagnosis was completed by the Director of Recreational Services on 1-27-2023_ to ensure appropriate plans of care for dementia are in place and updated as needed. 3. The policy for Dementia Care and Services and the Scope of Care for the Dementia Unit were reviewed for accuracy and updated as needed by the QAPI Committee on 1/12/2023. The policy for Dementia Care and Services and the Scope of Care for the Dementia Unit were reviewed with all staff and managers, including those involved in the admission process on 1-12-2023 by the DON/Designee. 4. The Director of Recreational Services/Designee' will review the care plans of 5 residents with a dementia or dementia-related diagnosis weekly x4 and monthly thereafter 1-31-2023. Results will be trended and brought to QAPI Committee for trending and process improvement. 5. The Administrator is responsible for this plan of correction.	

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"S" stated competencies had not been completed. She did not have any documentation on staff behavioral training.

Resident #40

According to the clinical record including the Minimum Data Set (MDS) dated 11/19/22 resident 40 (R40) was a 58 year old female, admitted to the facility with diagnosis that include severe intellectual disabilities, early onset Alzheimer's, Bi-polar disorder, anxiety, Down syndrome unspecified.

Review of the MDS dated 11/19/22 reflected R40 was always incontinent of bowel and bladder, required extensive assistance with toilteintg, hygiene extensive assistance and required 1 person physical assistance with dressing and hygiene. The Brief Interview for Mental Status reflected a score of 00, severe cognitive impairment. Of note, R40 resided on the facility's locked dementia unit.

On 12/11/22 at 09:03 AM, R40 was observed wandering around the unit, she was barefoot, had mis matched clothing clothing on, her hair was messy, R40 was observed to have form fitting yoga type pants on her brief was observed to be overly saturated and hung to one side to the back of R40's knee At 9:30am the same observation of R40 was made, observations of R40 walk by Licensed Practical Nurse (LPN) "R", Certified Nursing Assistant "Q" and GG, Hospitality Aide "HH" and an unidentified Activity staff person. None of the identified staff were observed to have noticed R40's disheveled appearance and need for incontinent care, or attempted to engage with her. R40 was continued to be observed to wander in and out of other

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	residents rooms. On 12/12/22 at 08:05 AM, Resident # 40 observed wandering the unit, entering other resident rooms. On 12/12/22 10:28 AM R40 was observed wandering in and out of other residents rooms, including room 117 where R40 took a tube of lotion. On 12/13/2022 at 8:14am several staff were overheard that R40 will be a 1:1, Licensed Practical Nurse (LPN) "N" it was queried why R40 would have a 1:1 assigned to her. LPN "N" stated she was not completely certain, but thought it was due to her continuous wandering in and out of other resident rooms and taking their belongings. When LPN "N" was further if R40 behavior was the same on 12/11 and 12/12, LPN "N" stated yes it was,and offered no explanation. On 12/13/22 at 8:19am R40 was observed unsupervised in room 103 (not R40's room). On 12/13/22 at 08:47 AM, R40 was observed to be walking with an unidentified Activity aide. R40 proceeded to enter rooms with Activity Aide following her. On 12/14/22 at 09:36 AM observed Resident # 40 observed wandering unit, including behind the nurses station, staff observed to follow but do not attempt engage or redirect. 12/20/22 R40 was observed wandering throughout the unit and in and out of other resident rooms. Review of R40's clinical record, including			

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behavior tracking tool from 12/01 -12/20/22 reflected 1 episode of wandering (12/20). Further review of the clinical record reflected R40 was put on "close supervision" which was a check off form, R40 was on close supervision from 12/1-12/9, 12/11, 12/15, 12/16, and 12/17. There was no corresponding behavior log, progress note to identify the reason for the "Close supervision."

On 12/21/22 09:17 AM, during an interview with Director of Nursing (DON) "B" it was queried why R40 was on closer supervision and or 15 checks. DON "B" stated they were the same thing, and would have implemented due to R40's behavior. DON "B"further stated staff should have correlating notes for behaviors and risk management as to why closer supervision was implemented. The December dates were reviewed and DON "B" made aware no documented reasons were located in the medical record.

On 12/21/22 at 11:02 AM, during an interview with Social Worker (SW) "D" she reported R40 wanders in and out of other resident rooms on a daily basis and that if she is not involved with something R40 will just walk. SW "D" stated she has 1:1 with activities they walk with her, and R40 enjoyed coloring. SW "D" stated the facility had no behavioral management program in place but do discuss issues as they arise. SW "D" offered no explanation for the "closer supervision." When queried about Dementia

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	Care, SW "D" stated the Activity department was to occupy R40. During an interview with Activity Director "P" on 12/21/22 12:44 PM, she reported R40 no longer enjoys coloring, does not like painting or exercising. Activity Director "P" elaborated that R40 didn't do anything except wander in and out of other resident rooms and continuously takes other residents belongings which makes other residents on the unit angry. On 12/21/22 at 2:05 pm, during an interview with Director of Nursing (DON) "B" and Human Resources (HR) "S" they reported they had a recent mandatory training in early December, HR "S" stated the training was approximately 2 hours in length and did include dementia care. When queried if the facility provided education on behavioral health care, HR "S" reported that was not offered.			
F0756 SS= E	Drug Regimen Review, Report Irregular, Act O §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an	F0756	1. Residents # 27 & #49 drug regimens were reviewed by the DON and physicians and completed regimens are up to date as of 1-26-2023. 2. All residents have the ability to be affected by this deficient practice. An audit was done on 1-23-2023 to ensure there were no residents who had drug Regimen Review not being done. No other concerns were noted. 3. The policy for Drug Regimen Review was reviewed and updated by the QA Committee on 1-12-2023 . All Nursing Staff were educated on by the Administrator/Designee' on the updated policy on 1-12-2023 and 1-13-	1/31/2023

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	unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the physician reviewed and acted upon identified medication regimen irregularities for three (Resident #22, #27, and #49) of five reviewed, resulting in the potential for unnecessary medications and adverse reactions. Findings include: Resident 27 (R27) Review of the medical record revealed R27 was admitted to the facility on 8/12/22 with		2023. 4. To ensure compliance, 5 residents will be audited for Completed Drug Regiman Review and Facility Response. will be performed by the Administrator/Designee. Audits will be reviewed and reported to the QAPI compliance committee. Audits will be completed monthly for 3 months and then as the QAPI committee recommends. 5. The Administrator is responsible for this plan of correction.	

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diagnoses that included chronic osteomyelitis, diabetes, anxiety, depression, and dementia. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/22 revealed R27 scored 00 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).

On 12/20/22 at 09:55 AM, R27 was observed asleep in bed.

In an email on 12/22/22 at 08:27 AM, Director of Nursing (DON) "B" sent R27's pharmacy medication regimen reviews for September, October, and November 2022 that had been previously requested three times. DON "B" reported the physician did not want to decrease R27's Plavix due to her vascular status and medical history.

Review of pharmacy reviews dated 9/13/22, 10/18/22, 11/15/22 revealed "The patient currently receives both Clopidogrel [Plavix] 75 mg [milligrams] QD [every day] and Aspirin 81 mg QD. Current recommendation notes dual antiplatelet therapy, namely ASA [Aspirin] plus Plavix, is only indicated for 30 days (for carotid artery stenting) or 90 days (for intracranial large artery atherosclerosis). After the initial treatment period, only ONE antiplatelet should be administered." The physician did not sign or document any of the pharmacy reviews.

Review of the physician's orders revealed R27

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was still prescribed Plavix 75 mg daily and Aspirin 81 mg daily.

In an interview on 12/22/22 at 09:18 AM, DON "B" reported the physician was in the facility last week and signed R27's October and November pharmacy reviews, but she was unable to locate the signed documents. Physician documentation was requested regarding R27's pharmacy reviews and not provided prior to the survey exit.

Resident #22

According to the clinical record, including the Minimum Data Set (MDS) dated 11/18/22 revealed Resident 22 was admitted to the facility on 8/12/21, (R22) scored 00 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).

Review of R22's monthly pharmacy reviews and recommendations reflected the January 27, 2021 pharmacy recommendation read "Evaluated the patient immunological history in the chart and noticed this patient may be a candidate for pneumococcal vaccination." There was no written response from the Physician, and no signed consent or refusal from R22's legal guardian. It was requested that a signed physician copy of the pharmacy recommendation be provided on 12/20/22

On 12/14/22 at 11:41 AM, during an interview with Director of Nursing (DON) "B" she reported being new to her role and did not have an insight or knowledge how Pharmacy services work, along with the

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process and protocols. R22's signed pharmacy recommendation for January 2021 was requested at that time.

DON "B" reported on 12/20/22 10:10 am, that she had located a very large binder with Pharmacy recommendations and would attempt to locate the Physician signed document, at this time a 2nd request was made for R22's January 2021 pharmacy recommendation signed by the Physician.

Physician documentation was requested regarding R22's pharmacy reviews and not provided prior to the survey exit.

Resident #49 (R49)

Review of the medical record reflected R49 was originally admitted to the facility 06/15/2022 with a diagnosis of Alzheimer's Disease, Depression and Anxiety.

During a record review of a Monthly Medication Review (MMR) on 12/12/22, revealed R49 was ordered to receive Galantamine Hydrobromide 4 MG Tablet. Give 1 tablet by mouth twice a day, Zoloft Tablet 100 MG 1 tablet by mouth one time a day for paranoid personality disorder.

During an interview on 12/14/22 at 11:41 AM, DON "B" stated, she did not know the MMR process.

Record review on 12/16/22 of R48 pharmacy

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	recommendations in the electronic medication record (EMR), revealed there were no MMR performed from July 2022 through December 2022 On 12/20/22 at 0800 AM, Admin "A" and DON "B" was requested last 6 months of MMR. On 12/21/22 at 0910 AM, Admin "A" and DON "B" was requested last 6 months of MMR again. As of 12/22/22 at approximately 12:00 PM, time of exit, the last six months of MMR's were not provided.			
F0759 SS= D	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent when five medication errors were observed from a total of twenty-nine opportunities for two residents (Resident # 30 and # 8) of five reviewed for medication administration, resulting in a medication error rate of 17.24% and the potential for reduced efficacy of medications and increased risk of adverse reactions/side effects.	F0759	1. Residents # 30 and #8 were reviewed and found to be unaffected by medication errors on 1-5-2023 by the DON/Designee. 2. All residents have the ability to be affected by this deficient practice. An audit was done on 1-26-2023 and 1-27-2023 by the DON/Designee' to ensure the medication pass competency of all nursing staff 3. The policy for Medication Administration was reviewed by the QAPI Committee and deemed appropriate on 1-12-2023. All nursing staff were educated on 1-12-2023 and 1-13-2023 on the policy for Medication Administration by the DON/Designee. 4. To ensure compliance, 5 nurses will be audited to ensure proper medication administration monthlyX3 by the DON/Designee'. Audits will be reviewed and reported to the QAPI Compliance Committee for trending and process improvement. 5. The Administrator is responsible for this plan of correction.	1/31/2023

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Findings include:

Resident #30

On 12/13/22 at 8:33 AM, Licensed Practical Nurse (LPN) "C" was observed preparing multiple medications for Resident #30 (R30) including one Aspirin 325milligram (mg) enteric coated tablet and one Docusate Sodium 100mg tablet. After preparing the medications, LPN "C" was observed to administer the medications to R30 and then proceeded to document the medications as given in the electronic medical record.

On 12/13/22, a review of R30's medical record was complete. During the review, a physician's order dated 12/24/2020 read, "Aspirin Tablet 325mg. Give 1 tablet by mouth one time a day ..." and a physician's order dated 12/15/2020 read, "Colace Capsule 100mg (Docusate Sodium). Give 1 capsule by mouth one time a day ..."

The orders were specifically for an Aspirin tablet and a Colace capsule. R30 was administered an Aspirin enteric coated tablet and a colace tablet.

Resident #8

On 12/13/22 at 8:47 AM, LPN "C" was observed preparing multiple oral medications for Resident #8 (R8) including one Aspirin 81mg chewable tablet and one Multi Vitamin

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tablet (without minerals). LPN "C" was also observed to prepare R8's Basaglar Insulin pen for injection. LPN "C" was observed to clean the insulin pen hub with an alcohol swab, attach the disposable needle to the pen, and then dial the pen to 30 units. LPN "C" then entered R8's room, sanitized hands, placed gloves, cleaned R8's left abdominal region with an alcohol swab, verified that the pen was dialed to 30 units, and then administered the insulin injection to R8. At no time prior to the insulin administration was LPN "C" observed to prime (remove the air from the pen vial) the insulin pen. LPN "C" was then observed to administer the oral medications to R8 and then proceeded to document the medications as given in the electronic medical record.

On 12/13/22, a review of R8's medical record was complete. During the review, a physician's order dated 3/15/2022 read, "Aspirin EC (enteric coated) tablet Delayed Release 81mg. Give 1 tablet by mouth one time a day ..." and a physician's order dated 10/2/2022 read, "Multivital Tablet (Multiple Vitamins-Minerals). Give 1 tablet by mouth one time a day ..."

The orders were specifically for an Aspirin enteric coated tablet and a Multiple Vitamins-Minerals tablet. R8 was administered an Aspirin chewable tablet and a Multi Vitamin tablet (without minerals).

In an interview on 12/13/22 at 10:42 AM,

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	Director of Nursing (DON) "B" stated that prior to the administration of an oral medication, the right medication, right dosage, and right route should be verified. Additionally, DON "B" stated that the manufacturer's instructions for insulin administration via a pen should be followed including cleaning the insulin pen hub with an alcohol swab, placing a needle, dialing pen to ordered units, cleaning resident injection site with an alcohol swab, and then administering the insulin. DON did not mention the step to prime the insulin pen prior to dialing and administering the ordered insulin dosage. Review of the facility policy titled "Medication Administration" and dated 5/1/2022 indicated, "Procedure ....7) The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication ....14) Insulin pens will be clearly labeled with the resident's name or other identifying information ...Prior to administering insulin with an insulin pen, the Nurse will verify that the correct pen is used for that resident ..." No additional information noted within the policy regarding the procedure for insulin pen preparation or insulin administration via a pen. Instructions on Basaglar Kwikpen at https://dailymed.nlm.nih.gov/basaglarkwikpe			

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	134140	A. BUILDING _____ B. WING _____	12/22/2022

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	n within section titled "Instructions for Use" under "Priming you Pen" included "Prime before each injection ...Priming means removing the air from the Needle and Cartridge that may collect during normal use. It is important to prime your Pen before each injection so that it will work correctly ...If you do not prime before each injection, you may get too much or too little insulin ...To prime your Pen, turn the Dose Knob to select 2 units ...Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top ...Continue holding your Pen with the Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window ...You should see insulin at the tip of the Needle ..."			
F0761 SS= D	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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,	F0761	1. No residents are listed in this citation. The citation states that expired meds were found on both nursing units, North and South. The Medication Rooms and Medication Carts were audited by the administrator/Designee and cleaned out of expired or mislabelled medication on 12-23-2022. 2. All residents have the ability to be affected by the deficient practice. An audit was done on by the NHA/Designee. to ensure there were no expired or mislabelled or inappropriately stored medications on any of the medication carts on 12-23-2022. 3. The Policy for Expired Medications was reviewed by the QAPI Team and updated on 1 -12-2023. All nursing staff were educated on the Policy for Expired Medications by the administrator/designee on 1-12-2023 and 1-13 -2023. 4. An audit of 25% of all medication carts and	1/31/2023

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	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: Based on observation and interview the facility failed to ensure nutritional supplements and over the counter medications were not expired and discarded. Resulting in the potential for altered potency and efficacy for the 53 residents receiving nutritional supplements and over the counter medications out of the medication room. During an observation and interview on 12/13/22 at 08:30 AM with LPN "N" regarding the number of medications. LPN "N" stated we have 2 med rooms, one on north and one on south. Med room- north-(Dementia unit) 3 bottles of Zinc 50mg expired on 08/22. On 12/13/22 at 08:45 A.M., A common area environmental tour was continued with Environmental Service Director "F". The following item was noted: North Unit: Medical Supply Room: Two full cases of "Glucerna" Rich Chocolate nutritional supplement were observed with an expiration date that read May 1, 2022. One full case of "Glucerna" Creamy Strawberry nutritional supplement was also observed with an expiration date that read June 1, 2022. Environmental Services Director "F" indicated		medication rooms will completed by the administrator/designee weekly x4 and monthly thereafter. Results will be trended and taken to the QAPI Meeting for process improvement. 5. The Administrator is responsible for this plan of correction.	

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	she would have staff discard the expired nutritional supplements as soon as possible.			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment effecting 53 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, decreased interior food service equipment illumination, and plumbing water leaks. Findings include: On 12/11/22 at 09:20 A.M., An initial tour of the food service was conducted with Food Service Director "H". The following items	F0812	1. The vent- and hood cleaning was completed on 1-5-2023 by our outside vendor. The floors, sinks, and drains were cleaned by the dietary staff. All pots and pans that had coating on them were disposed of by the dietary staff by 1-23-2023.Light bulbs were replaced and the hand sink hot water valve stem were repaired by maintenance by 1-23-2023. 2. This deficient practice has the ability to affect all residents of the facility. An audit of the kitchen for required cleanliness levels was completed by the Food Service Director on 1-15-2023 and all open areas were addressed. 3. The policy for kitchen sanitation was reviewed by the QAPI Committee and updated on 1-12-2023. The FSD and NHA have implemented a new sanitation checklist for the FSD and administrator to complete and carryover any unfinished items to completion. All staff were educated on the policy for kitchen sanitation on 1-12-2023 and 1-13-2023 by the administrator. 4. The facility FSD/Designee will complete the sanitation checklist weekly x4 and then monthly thereafter. Results will be trended and brought to QAPI meeting for process improvement. 5. The Administrator is responsible for this plan of correction.	1/31/2023

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	were noted: On 12/11/22 at 09:23 A.M., An interview was conducted with Food Service Director "H" regarding rodent activity within the food production kitchen. Food Service Director "H" stated: " One rodent was caught in a snap trap approximately one month ago." The "True" one-door reach-in freezer was observed missing the interior light bulb. One of two "Garland" convection oven interior light assemblies were observed non-functional. The "2017 FDA Model Food Code" section 6-303.11 states: "The light intensity shall be: (A) At least 108 lux (10 foot candles) at a distance of 75 cm (30 inches) above the floor, in walk-in refrigeration units and dry FOOD storage areas and in other areas and rooms during periods of cleaning; (B) At least 215 lux (20 foot candles): (1) At a surface where FOOD is provided for CONSUMER self-service such as buffets and salad bars or where fresh produce or PACKAGED FOODS are sold or offered for consumption, (2) Inside EQUIPMENT such as reach-in and under-counter refrigerators; and (3) At a distance of 75 cm (30 inches) above the floor in areas used for handwashing, WAREWASHING, and EQUIPMENT and UTENSIL storage, and in toilet rooms; and (C) At least 540 lux (50 foot candles) at a surface where a FOOD			

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	EMPLOYEE is working with FOOD or working with UTENSILS or EQUIPMENT such as knives, slicers, grinders, or saws where EMPLOYEE safety is a factor." The hand sink hot water valve stem was observed faulty allowing the valve to not completely close, creating a water leak. Food Service Director "H" indicated she would contact maintenance for necessary repairs as soon as possible. The "2017 FDA Model Food Code" section 5-205.15 states: "A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; and (B) Maintained in good repair." The hand sink basin was observed soiled with accumulated dirt and grime. The "South Bend" stove/oven exterior surfaces (door fronts, door handles, etc.) were observed soiled with accumulated and encrusted food residue. The Coffee Machine interior surfaces were observed with accumulated food residue/splash. The Coffee Machine (backsplash, under splash, and spout assemblies) were also observed soiled with accumulated food residue/splash. The interior surfaces of the Coffee Urns were observed soiled and stained with accumulated and encrusted food residue.			

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	Dry Storage (Basement): "Magnum" freezer was observed (1/4) obstructed with ice dams. The Walk-In Cooler condenser fan grill plate was observed soiled with accumulated dust and dirt deposits. The "2017 FDA Model Food Code" section 4-601.11 states: "(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." The Walk-In Cooler flooring surface was observed (cracked, chipped, missing). Food Service Director "H" indicated she would contact maintenance for necessary repairs as soon as possible. The "2017 FDA Model Food Code" section 6-201.11 states: "Except as specified under § 6-201.14 and except for antislip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are SMOOTH and EASILY CLEANABLE." Main Dining Room: 4 of 11 blue tablecloths			

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	were observed soiled with accumulated food residue/splash. The "2017 FDA Model Food Code" section 4-801.11 states: "Clean LINENS shall be free from FOOD residues and other soiling matter." On 12/12/22 at 08:00 A.M., Record review of the Policy/Procedure entitled: "Cleaning Equipment and Utensils" dated (no date) revealed under Policy: "Equipment and utensils will be properly cleaned, sanitized, and stored to prevent contamination." Record review of the Policy/Procedure entitled: "Cleaning Equipment and Utensils" dated (no date) further revealed under Procedure: "(4) All culinary staff will be in-serviced on cleaning and sanitizing equipment." On 12/12/22 at 08:15 A.M., Record review of the Policy/Procedure entitled: "Maintenance and Repairs of Equipment" dated (no date) revealed under Policy: "It is the policy of this facility that all malfunctions and need for repairs are reported to the Maintenance Department and the Administrator in a timely manner." Record review of the Policy/Procedure entitled: "Maintenance and Repairs of Equipment" dated (no date) further revealed under Procedure: "(4) Preventative maintenance will be provided for major equipment at regular intervals. The Culinary Manager and Maintenance Department will be responsible to coordinate			

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	these check-ups and in-putting into the TELS system."			
F0839 SS= D	Staff Qualifications §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a Certified Activities Director was employed at the facility, resulting in potential for all 53 residents to not be provided with meaningful activities. In an interview on 12/14/22 at 07:59 AM Activity Director certification. AD "P" stated she was not a certified as an activity director, but stated the facility set her up for an online program. however, the AD "P" had not started the program yet. Admin "A" sent an email that revealed that AD "P" was to start her training on 12/14/22 at 08:50 AM. On 12/14/22 at 09:58 AM and email was emailed was received from Admin "A" that	F0839	1. The Activity Director started her certification class in December of 2022. 2. All residents have the potential to be affected by this deficient practice. 3. The requirement for Certified Activity Professionals for SNF activity directors was reviewed by the QAPI team and deemed appropriate on 1-12-2023. The system for monitoring the activity director's classroom progress was updated to include be a monthly update email from the instructor tacked and logged Unit completion by the NHA. This process was updated by the NHA on 1-20-2023 and reviewed with the activity director on 1-27-2023. 4. An audit of completed units will be completed by the NHA monthly X12 until coursework and certification is completed. Results will be brought to QAPI for ongoing compliance and process improvement. 5. The Administrator is responsible for this plan of correction.	1/31/2023

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	AD "P" had not been signed up, until 12/14/22 Writer received second email from training site dated 12/14/22 at 09:58 AM reflecting AD "P" had been signed up for this online program at this date and time. In a continued interview with AD "P" on 12/14/22 at 07:59 AM, AD "P" stated she had been in her active role of AD for one year without training prior to this registration for the online certification program on 12/14/22.			
F0849 SS= D	Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an	F0849	1. Resident #21 , #48, and #32 were evaluated by the facility IDT Team and their hospice teams and an interdisciplinary note completed and care plans updated to ensure quality of care on 1-23-2023. 2. All Residents on Hospice have the potential to be affected. An audit was completed on all Hospice residents on 1/26/2023 and no other concerns were noted. 3.The Policy for Hospice was reviewed by the QAPI Team on 1-12-2023 and deemed appropriate. All nursing staff were inserviced on the Policy for Hospice on by the NHA/DON on 1-12-2023 and 1-13-2023 4. To ensure compliance, 5 residents on hospice will be audited for ensuring proper care was delivered by the DON /Designee. Audits will be reviewed and reported to the QAPI Compliance Committee by the DON/Designee. Audits will be completed monthly for 3 months, and then as recommended by the QAPI Committee. 5. The Administrator is responsible for this plan of correction.	1/31/2023

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	authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for			

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	the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and			

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	coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-			

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	being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure proper communication/documentation of the services that Hospice had provided to two of two residents (R48 and R21) reviewed for Hospice services, resulting in a lack of coordination of care between the facility and Hospice. Findings include: Resident #48 (R48) Review of R48's electronic medical record (EMR) upon R48 was admitted to the facility on 6/17/2022 hospice services were already in place. Diagnoses included congestive heart failure (causes weakness and shortness of breath), Dementia, muscle weakness. Record review of a "Minimum Data Set" (MDS) assessment, dated 7/1/2022, revealed R48 had a "Brief Interview for Mental Status" (BIMS) score of zero out of 15, which indicated R48 had severely impaired cognition. Further review of the MDS R48 required use of a wheelchair for maximum assistance with all personal care. During an interview on 12/12/22 at 03:20 PM with Licensed Practical Nurse (LPN) "N" regarding care coordination with hospice.			

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	LPN "N" stated when hospice would come in to see R48 she had no idea what they did. LPN "N" stated there was a binder up in a cupboard at the nurse's station. Record review of hospice binder revealed hospice Certified Nurse Aide (CNA) had documented R48 had received showers on 12/12/22, 12/08/22, 12/06/22, 12/05/22, 12/01/22, 11/28/22, 11/21/22, 11/18/22, 11/14/22 and 11/07/22. Further reveal hospice binder revealed no hospice care plan in place. In an interview on 12/13/22 at 08:23 AM, CNA "U" stated hospice provided showers on the facility scheduled shower days. Writer inquired if R48 ever gets two showers a day. During an interview on 12/21/22 at 09:05 AM, Director of Nursing (DON) "B" stated she thought hospice CNAs provided all showers on facility scheduled shower day, instead of the facility CNAs. DON "B" further stated the facility CNAs only gave showers if the hospice CNA did not show up. Record review of R48's hospice binder did not contain a care plan, Kardex (CNAs direction of care), physician orders, schedule of hospice visits, nor nurses' notes were in the binder. Review of R48's care plan, no comprehensive care plan was ever put in place regarding R48 hospice services he was receiving and			

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	therefor no interventions were in place for coordination of care such to what services hospice was providing. Resident #21(R21) Review of the Face Sheet and Minimum Data Set (MDS) dated 10/24/22, reflected R21 was a 79 year old female admitted to the facility on 1/24/17, with diagnoses that included dementia, coronary heart disease, heart failure, peripheral vascular disease, seizure disorder, schizophrenia, and mantic depression. The MDS reflected R 21 had a BIM (assessment tool) score which indicated her ability to make daily decisions was severely impaired, and she required one person physical assist with bed mobility, transfers, locomotion on unit, dressing, eating, toileting, hygiene, and bathing. During an observation on 12/11/22 at 9:07 AM, R21 was laying on an air mattress positioned low with hospital gown on with head awkwardly positioned to the left with strong smell of urine in room. R21 door was open with stop sign on door that read, "aerosol generate\ing procedure" that indicated required use of gloves, mask, gown, and eye protection, with no Personal Protective Equipment(PPE) observed outside door. R21 had an air mattress in place, appeared thin and frail, was awake with eyes open holding stuffed animal and rosary. R21 did not appear to be verbal and appeared calm with soft touch call light located out of			

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	reach under top of pillow. Folding chair was noted at bedside along with bedside table with 2 large Styrofoam cups with straws that appeared to be orange juice and water. Review of the facility Matrix, dated 12/11/22, reflected R21 was not receiving Hospice services. Review of the MDS, dated 10/24/22, 7/24/22 and 1/21/22, reflected R21 was not receiving hospice services. Review of the EMR on 12/12/22 reflected R21 did not have a physician order for hospice services. During an interview on 12/20/22 at 1:35 PM, Director of Nursing (DON) "B" reported R21 had been a Hospice resident for several months and reported would expect R21 to have an order for hospice. DON "B" reported had been the MDS nurse prior to DON and reported R21's MDS should reflect hospice services and if it did not it was an error. Review of the R 21 Care Plans, dated 1/29/17 through 11/25/22, reflected, "I have a terminal prognosis and elected to have Hospice. Date Initiated: 01/08/2020...Interventions...Work cooperatively with hospice team to ensure my spiritual, emotional, intellectual, physical and social needs are met..." Care Plans reflected no mentions of what hospice services R21 received or what hospice			

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	company or frequency of services. During an interview on 12/20/22 at 3:30 PM, DON "B" reported had a care conference with R21 Hospice that today and reported prior to that day no history of hospice involvement with care conferences. DON "B" reported plans to involve Hospice companies with residents Care Conferences now moving forward. DON "B" reported document in binder was signed today and should have been signed by staff receiving report from hospice staff and will be part of plan of correction moving forward. DON "B" reported R21's Care Plans should be personalized including Hospice services provided. During an interview on 12/21/22 at 10:45 AM, CNA "M" reported had never seen hospice spiritual care in for R21, only hospice CNA who provided baths usually 2 times weekly. Licensed Practical Nurse (LPN) "OO" joined the interview and reported had cared for R21 for several years and use to enjoy regular trips out of the facility. LPN "OO" reported had not observed R21 out of bed in two weeks and does not like group events. LPN "OO" reported was unsure if R21 liked music and reported long history of using rosary and had always had cross necklace she was very attached to. LPN "OO" reported was unsure of R21's religious background and reported had never observed hospice spiritual services visiting R21. LPN "OO" and CNA "MM" both reported were unsure what services R21 was			

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	receiving from hospice and reported they only sign hospice tablet after visits for CNA and Nurse. During an interview on 12/21/22 at 12:25 PM Hospice CNA "PP" reported provided R21 bathing services two times weekly on Wednesday and Friday and often comes during lunch to assist with meals. CNA "OO" reported facility had been short staffed and reported R21 was going to be discharged from Hospice services and skin started to breakdown related to incontinence located in brief area and facility moved R21 from north to south unit. Hospice CNA "OO" reported Hospice offered music and pet therapy but R21 did not receive and was unsure why. CNA "OO" reported was told yesterday that hospice binder would be located in front of building because difficult to locate staff for nurse to sign for visits.			
F0880 SS= E	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and	F0880	The facility Quality Assurance Team completed on 1-27-2023 that a Root Cause Analysis (RCA) to identify the concerns with the two areas of facility failure on Tag F880-Infection Control . The facility identified the following root causes (RCA): Issue A: RCA -The root cause for the facility's failure to annually review and approve updated Infection Control Policy was determined to be the change in administration (DNS A). Based on this the facility implemented the following: QAPI Meeting -was held on 1-12-2023 to ensure Infection Control Subcommittee review all Infection Control Policies and sign off their review. The NHA also reviewed the necessity	1/31/2023

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	other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:		of annual Infection Control Policy by the QAPI Committee. Policy Update: The QA Committee Agenda was updated for annual Infection Control Subcommittee infection control policy review on 1-12-2023 by the NHA. Issue B RCA-The root cause of the facility's failure to maintain appropriate infection control procedures during medication administration and nebulizer treatments (DNS B) is the need for staff retraining on the specifics on medication pass and infection control and the need for supplies and clearer postings and communication for residents on nebulizer treatments. Training: All Staff were retrained on the Infection Control and specifically on: 1. Standard Infection Control Practice 2. Infection Control During Medication Pass. 3. Infection Control during nebulizer treatments. Competency: Staff were tested on the proper procedure for Infection Control, Medication Pass and Nebulizer Treatments on 1-26-2023 and 1-27-2023. Staff who did not pass were reeducated and retested. Policies: The facility policies for Infection Control and Nebulizer Treatments were updated and reviewed with all staff on 1-26-23 and 1-27-23 by the DON. Staff not at the trainings will be educated prior to their next shift. QAPI Meeting : was held on 1-12-2023 with all members of the QAPI Committee to review the Infection Control Policies. Auditing: As part of the ongoing auditing to ensure compliance , 3 residents on Nebulizer Treatments will be audited to ensure compliance. Medication Pass will be audited 3x per weex4 weeks and then 5x per month by the Director of Nursing/Designee to ensure	

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	This citation includes two Deficiet Practice Statements A and B. **DPS A** **Based on observation, interview, and record review the facility failed to review Infection Control Policies and Program annually resulting in the potential of not following the most current Infection Control Standards of Practice and resulting in the potential for the spread of infection for all 53 Residents that reside at the facility.** **Findings Included:** **During record review of the provided facility policies regarding Infection Control no documents listed a date that the policies were implemented and no date that the policies had been reviewed annually.** **In an interview on 12/21/22 08:43 a.m. Nursing Home Administrator "A" explained that the facility Infection Control Policies are reviewed annually in a QA (Quality Assurance) Committee meeting. When asked to provide documentation demonstrating that review of the facility Infection Control Policies had been completed annually, NHA "A" explained that she would have to locate that information and would provide it would be provided.** **In an interview on 12/21/22 12:59 p.m. Nursing Home Administrator (NHA) explained that she had reviewed all the QA (Quality Assurance) Committee meetings and could not find that facility Infection Control Policies had been reviewed annually. NHA "A" explained that the facility could not**		Infection Control Standards are maintained for med pass, nebulizer treatments, and wound care.	

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	provide any documentation that the facility Infection Control Policies had been reviewed annually. DPS B Based on observation, interview, and record review the facility failed to follow infection control process for three Residents (Resident #7, #8 #30) out of all 53 Residents that reside at the facility was followed for prevention and/or transmission of infections during medication administration and catheter care resulting in potential for spread of infection for all 53 Residents that reside at the facility. Resident #7 According to the clinical record, Resident 7 (R7) was admitted to the facility on 02/09/21 and transferred to the hospital on 12/15/22, R7 had diagnosis that include dementia and urinary retention that required a urinary catheter. Multiple observations were made of R7's catheter bag and tubing resting on the floor in the dining/activity area, these observations were made on 12/11 at 9:20am this observation included no dignity bag , 12/11 during the noon meal, 12/13 at 8:44 am and 12/14/22 throughout the day. During an interview with Director of Nursing (DON) "B" she on 12/21/22 at 11:50 am, she reported the expectation was the tubing and catheter bag not be on the ground.			

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Resident #30

On 12/13/22 at 8:33 AM, Licensed Practical Nurse (LPN) "C" was observed preparing multiple medications for Resident #30 (R30). During medication preparation of Tramadol 50 milligrams, 1 tablet was observed to drop directly on top of the medication cart after LPN "C" popped the tablet out of the blister pack. LPN "C" was then noted to pick up the tablet with her bare fingers and place it into the medication cup with the remainder of the prepared medications. After preparing the medications, LPN "C" was observed to administer the medications to R30.

Resident # 8

On 12/13/22 at 8:47 AM, LPN "C" was observed preparing multiple medications for Resident #8 (R8). During medication preparation of Potassium Chloride 10 milliequivalents, 1 tablet was observed to drop directly on top of the medication cart after LPN "C" popped the tablet out of the blister pack. LPN "C" was then noted to pick up the tablet with her bare fingers and place it into the mediation cup with the remainder of the prepared medications. After preparing the medication, LPN "C" was observed to administer the medications to R8.

In an interview on 12/13/22 at 10:42 AM, Director of Nursing (DON) "B", stated that the steps in preparing oral medications for administration would include verifying

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ordered medication, dose, and route and to not physically touch the pill when the medication was popped out of the blister pack. DON "B" stated that the expectation would be to dispose of a medication that fell on top of the medication cart during medication preparation and for a new medication to be dispensed.

Review of facility policy titled "Medication Administration" dated 5/1/2022, included " ...22) Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves ....) for the administration of medications ..."

During medication pass observation on 12/14/22 at 12:24 PM, a sign on the closed door of Room 132 indicated, "Aerosol Generating Procedure Sign". The sign was noted to be blank except for the handwritten date of "12/14/22" after the statement "An Aerosol Generating Procedure was performed in this room on". LPN "C" stated that upon completion of the nebulizer treatment (an aerosol generating procedure), the form would be updated to indicate the time of the procedure and the duration of time staff and visitors must enter the room with an N95 respirator mask post administration. LPN "C" stated that an N95 mask must be worn when entering the room for the duration of the precautionary period post nebulizer administration. The sign indicated that the precautionary period was based on "air changes per hour in this room"

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	with the line that indicated the specific air changes in that room noted to be blank. LPN "C" stated that she was uncertain as to how to figure out the duration of the precautionary period post nebulizer administration. LPN "C" stated that she knew that there was a certain time frame but could not state what it was and needed time to follow-up before proceeding with nebulizer treatment administration. On 12/14/22 at 12:48 PM, LPN "C" returned to unit with a new sign indicating a "4" in the space provided to indicate the air changes per hour in the room and stated that precautionary measures will continue for 104 minutes post nebulizer administration based on the 4-air changes per hour in the room. Per LPN "C", she had never completed the form prior and had never received education regarding the completion of the form. In an interview on 12/14/22 at 1:20 PM, LPN "K" stated "I'm going to be real with you" and then proceeded to state that she was an agency nurse and did not know what the facility policy was for nebulizer administration. LPN "K" confirmed that she was assigned to the resident in Room 129-2 and had administered a nebulizer treatment earlier that shift. LPN "K" proceeded to Room 129 with a blank "Aerosol Generating Procedure Sign" noted to be hanging on the open door. LPN "K" stated that the sign on the door was just to indicate that a resident was on a nebulizer treatment, nothing more,			

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and nothing additional needed to be done. No personal protective equipment (PPE) was noted outside of Room 129 with LPN "K" denying knowledge as to the location of the PPE. LPN "K" stated that at the facility, the only additional PPE that she wore when administering a nebulizer treatment was gloves as already had N95 and safety glasses on. LPN "K" denied wearing a gown when administering nebulizer treatments at the facility.

In an interview on 12/20/22 at 11:35 AM, DON "B" stated that the expectation would be for staff to follow the facility policy during the completion of an aerosol generating procedure. Per DON "B", there are isolation signs posted outside of the designated rooms to notify staff that an individual was receiving an aerosol generating procedure and that PPE precautions should be adhered to including the usage of N95, goggles, gown, and gloves.

During the same interview, DON "B" confirmed that an "Aerosol Generating Procedure Sign" was placed on the outside of each room where an aerosol generating procedure was administered and this would include nebulizer treatments. Per DON "B", the room air changes per hour in a room was a calculation completed by environmental staff and a prior nurse consultant and that anyone entering the room needed to wear an N95 mask for the period of time handwritten on the form each time an aerosol generating

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	procedure was complete. DON "B" was unable to explain how the "4" air changes per hour was obtained on 12/14/22, for Room 132, or the duration of time an N95 must be worn when entering a room post aerosol generating procedure as the time frame was based on the room air changes per hour and was uncertain as to how or where this information could be found. In a follow up interview on 12/21/22 8:56 AM, DON "B" stated that had discussed with environmental services staff and that the "air changes per hour" calculation was based on the ventilation system but was going to follow-up with outside resources on how to proceed and had no additional information to provide at that time. In a follow up interview in the afternoon of 12/21/22, DON "B" stated that "I took the sign down and threw it away" in reference to the sign posted on Room 132 indicating that "There are 4 air changes per hour in this room". DON "B" stated, "I would say 30 minutes, but I just don't know" in reference to the period of time an N95 respirator should be worn when entering a room post administration of an aerosol generating procedure. Review of the facility policy titled "Aerosol Generating Procedures (AGP)" dated 5/1/2022, indicated "Procedure ...3) Proper signage should be on the door to indicate that AGP's are being done in this room. This			

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	should include the procedure being done and when it will be safe again to enter the room. 4) Full Personal Protective Equipment (PPE) including N95 mask, gowns and gloves must be put on prior to the procedure being done ..."			
F0883 SS= E	Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii)	F0883	1. Residents #22, #29, #6, #356, #357 were assessed and found to have no ill effects from absence of vaccination follow-up on 1-15-2023 by the DON/Designee. All residents were offered all vaccines and signed off their preferences. 2. All residents have the ability to be affected by the deficient practice. An audit was done on 1-25-2023 by the DON/Designee to ensure there were no residents who had concerns with immunizations. No other concerns were noted. 3. The policy for resident immunization was reviewed and updated on 1-12-2023 by the QAPI Team. All Nursing Staff were educated on 1-12-2023 and 1-13-2023 by the Administrator on the updated policy. 4. To ensure compliance, 5 residents will be audited to ensure appropriate proper immunization tracking weekly x4 and monthly thereafter. Audits will be performed by the administrator/designee. Audits will be reviewed and reported to the QAPI Compliance Committee for process improvement and to ensure ongoing compliance. 5. The Administrator is responsible for this plan of correction.	1/31/2023

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	Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to offer pneumococcal and influenza immunization for three Residents (Residents #22, #356, and #357) out of 6 reviewed and failed to provide written declination of those immunizations refused for two Residents (Residents #6 and #29) out of six Residents resulting in the potential for increased risk of acquiring, transmitting, or experiencing complications of pneumococcal or influenza disease and the potential for miscommunication and misunderstanding of Residents immunization preferences. Findings Included: Resident #6 (R6)			

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	Review of the medical record revealed R6 was admitted to the facility 05/22/2017 with diagnoses that included type two diabetes mellitus, paranoid schizophrenia, vascular dementia with behavioral disturbances, dysphagia (difficulty swallowing), chronic kidney disease, hypertension, atherosclerotic heart disease (buildup of cholesterol plaque on the walls of arteries), depression, kidney failure, hypermagnesemia (high magnesium levels in the blood), and first-degree heart block (slow conduction of the atrioventricular node of the heart). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/11/2022, revealed R6 had Brief Interview for Mental Status (BIMS) of 00 (severely impaired cognition and could not repeat words correctly) out of 15. Review of R6 medical record revealed that the Pneumovax Dose 1 Immunization (pneumococcal immunization) had been refused, which was evident on the R6 Immunization Record. No declination for refusal was found in the medical record and no date of the refusal was present on the R6 Immunization Record. No documentation was found in R6's medical record that demonstrated receipt of education regarding benefits and that side effects of the immunization had been provided to R6's representative. No declination or education for the pneumococcal immunization was provided by time of survey exit.			

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During observation on 12/21/2022 at 01:23 p.m. R6 was observed lying in bed and appeared to be sleeping.

Resident #29 (R29)

Review of the medical record revealed R29 was admitted to the facility 05/15/2019 with diagnoses that included depression, alcohol dependence, cocaine dependence, left sided hemiplegia and hemiparesis (paralysis), bipolar disorder, epilepsy (nerve activity in the brain is disrupted causing seizures), traumatic brain injury, attention deficit disorder, anxiety, hyperlipidemia (high fat in the blood), hypertension, chronic obstructive pulmonary disease (COPD), and gastro-esophageal reflux. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 011/17/2022, revealed R29 had Brief Interview for Mental Status (BIMS) of 01 (severely impaired cognition) out of 15.

Review of R29 medical record revealed that Influenza Vaccination had be refused three times, Previnar 13 (pneumococcal immunization) refused one time, Previnar 20 (pneumococcal immunization) refused one time, which was evident by R29's Immunization Record. No declination for refusal was found in the medical record and no date of the refusal was present on R29's Immunization Record. No documentation was located in R29's medical record that

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demonstrated receipt of education regarding benefits and side effects of the immunization had been provided to R29's representative. No declination or education for the influenza immunization or the pneumococcal immunization was provided by time of survey exit.

During observation and interview on 12/21/2022 at 01:26 p.m. R29 was observed setting up in bed. He explained that things were going well at the facility but was unable to answer any questions about his vaccination status.

Resident #356 (R356)

Review of the medical record revealed R356 was admitted to the facility 12/09/2022 with diagnoses that included fracture of the right femur, depression, hypertension, hallucinations, and homelessness. R356 Admission Minimum Data Set (MDS) was not completed as of this survey. R356 "Nursing Admission Assessment", dated 12/10/2022, revealed that he was orientated to person, place, and time.

Review of R356 medical record revealed that his Immunization Record contained no information on the status of a pneumococcal immunization or an influenza immunization. No declination for pneumococcal immunization or influenza immunization was found in the medical record and none was provided by time of survey exit.

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During observation and interview on 12/21/2022 at 01:20 p.m. R356 was observed sitting up in a wheelchair. R356 explained that someone from the facility had just come into his room and offered him the COVID-19 Immunizations but could not recall if a pneumococcal immunization or influenza vaccination had been offered.

Resident #357 (R357)

Review of the medical record revealed R357 was admitted to the facility 12/07/2022 with diagnoses that included cellulitis (bacterial skin infection) right and left lower limb, chronic pain, type 2 diabetes, peripheral vascular disease, edema, morbid obesity, emphysema (lung condition causes shortness of breath), depression, hypertension, hyperlipidemia (high fat in the blood), and gastro-esophageal reflux. R357 Admission Minimum Data Set (MDS) was not completed as of this survey. R356 "Nursing Admission Assessment", dated 12/8/2022, revealed that she was orientated to person, place, and time.

Review of R357 medical record revealed that her Immunization Record contained no information on the status of a pneumococcal immunization or an influenza immunization. No declination for pneumococcal immunization or influenza immunization was found in the medical record and none was provided by time of survey exit.

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	During observation on 12/21/2022 at 01:19 p.m. R357 was observed lying in bed and appeared to be sleeping. In an interview on 12/21/2022 at 10:25 a.m. Director of Nursing (DON) "B" explained that the process for providing immunizations to residents would consist of asking the resident, explaining the risk and benefits, sign a consent form, then the vaccination was given to the resident, and the consent was to be upload into the computerized medical record. DON "B" explained that if a Resident refused the same process would be followed expect that immunization would not be given. In an interview on 12/21/2022 at 12:30 p.m. Director of Nursing (DON) "B" explained that it was her expectation that immunizations are offered within 72 hours our admission. DON "B" could not explain why a declination for pneumococcal immunization were not present for R6 in the medical record. DON "B" could not explain why a declination for influenza immunizations and pneumococcal immunizations were not present for R29 in the medical record. DON "B" explained that R356 and R357 should have had data in their immunization record and a declination for both in the medical record. She could not explain why immunizations had not been offered to R356 and R357. Resident #22			

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	According to the clinical record, including the Minimum Data Set (MDS) dated 11/18/22 revealed Resident 22 was admitted to the facility on 8/12/21, (R22) scored 00 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of R22's monthly pharmacy reviews and recommendations reflected the January 27, 2021 pharmacy recommendation read "Evaluated the patient immunological history in the chart and noticed this patient may be a candidate for pneumococcal vaccination." Review of R22's Nursing progress notes dated 2/25/22 that a message was left for R22's guardian at the time inquiring about the pnumococcal vaccine. There was no documentation that a return or follow up call had occurred. There was no documentation that R22's guardian at that time had been provided written education that pertained to the pneumococcal vaccine. Further review of the clinical record reflected R22 was appointed a new guardian on 8/2/22, there was no evidence that the current guardian had been educated and offered the pneumococcal vaccine on behalf of R22. On 12/20/22 at 2:32 PM, Director of Nursing (DON) "B" reported R22's former guardian was hard to contact and could not account for why there was no further attempt to reach			

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	R22's original guardian. DON "B" stated she was not aware if R22's current guardian had been informed, educated and or offered the pneumococcal vaccine, DON "B" stated she did not believe that had been done. Review of the facility policy titled "Pneumococcal Vaccine" dated 5/01/22 reflected all residents will be offered Pneumococcal vaccines to aid in the prevention of pneumonia. 1. "Prior to or upon admission, residents will be assessed for eligibility for to receive the Pneumococcal vaccine series, and when indicated, will be offered the vaccine series within 30 days of the admission to the facility unless medically contraindicated or the resident had already received the vaccinated." 5. "Residents/Representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the Pneumococcal vaccination."			
F0887 SS= E	COVID-19 Immunizatio §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects	F0887	1. Residents #6, #29, #, #25, #356, #357 were assessed and found to have no ill effects from absence of COVID Vaccine follow-up. All residents were offered the COVID 19 vaccine by the DON/Designee and signed off their preferences by 1-27-2023. 2. All residents have the ability to be affected by the deficient practice. An audit was done by the DON/Designee on 1-25-2023 to ensure there were no residents who had concerns with COVID Vaccine Tracking and administration. No other concerns were noted. 3. The policy for resident Covid 19	1/31/2023

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	associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Preventio's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as		Vaccinations was reviewed and updated on 1-12-2023 by the QAPI Team. All Nursing Staff were educated on 1-12-2023 and 1-13-2023 by the Administrator on the updated policy. 4. To ensure compliance, 5 residents will be audited to ensure appropriate proper COVID tracking and follow-up weekly x4 and monthly thereafter. . Audits will be performed by the administratoi/designee. Audits will be reviewed and reported to the QAPI Compliance Committee for process improvement and to ensure ongoing compliance. 5. The Administrator is responsible for this plan of correction.	

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	evidenced by: Based on observation, interview and record review the facility failed to offer COVID-19 Immunization, obtain complete declination for COVID-19 Immunization, provide COVID-19 Immunization education for five resident representatives or residents (residents #6,#29, #35, #356, and #357) out of five residents reviewed for COVID-19 Immunization resulting in the potential for miscommunication and misunderstanding of Resident COVI-19 Immunization preferences. Findings included: Resident #6 (R6) Review of the medical record revealed R6 was admitted to the facility 05/22/2017 with diagnoses that included type two diabetes mellitus, paranoid schizophrenia, vascular dementia with behavioral disturbances, dysphagia (difficulty swallowing), chronic kidney disease, hypertension, atherosclerotic heart disease (buildup of cholesterol plaque on the walls of arteries), depression, kidney failure, hypermagnesemia (high magnesium levels in the blood), and first-degree heart block (slow conduction of the atrioventricular node of the heart). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/11/2022, revealed R6 had Brief Interview for Mental Status (BIMS) of 00 (severely impaired			

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cognition and could not repeat words correctly) out of 15.

Review of R6 medical record revealed a "Public Health Department" document that a COVID-19 Immunization was offered at the facility on 11/22/2021. The document revealed a handwritten statement "refused 11/22/21". The document contained no signature of R6 representative and did not contain any documentation that the risk and benefits for the COVID-19 Immunization had been provided or discussed.

During observation on 12/21/2022 at 01:23 p.m. R6 was observed lying in bed and appeared to be sleeping.

Resident #29 (R29)

Review of the medical record revealed R29 was admitted to the facility 05/15/2019 with diagnoses that included depression, alcohol dependence, cocaine dependence, left sided hemiplegia and hemiparesis (paralysis), bipolar disorder, epilepsy (nerve activity in the brain is disrupted causing seizures), traumatic brain injury, attention deficit disorder, anxiety, hyperlipidemia (high fat in the blood), hypertension, chronic obstructive pulmonary disease (COPD), and gastro-esophageal reflux. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 011/17/2022, revealed R29 had Brief Interview for Mental Status (BIMS) of 01 (severely impaired

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cognition) out of 15.

Review of R29 medical record revealed a "Public Health Department" document that a COVID-19 Immunization was offered at the facility on 11/22/2021. The document revealed a handwritten statement "Declined". The document contained no signature of R29 representative and did not contain any documentation that the risk and benefits for the COVID-19 Immunization had been provided or discussed.

During observation and interview on 12/21/2022 at 01:26 p.m. R29 was observed setting up in bed. He explained that things were going well at the facility but was unable to answer any questions about his vaccination status.

Resident #35 (R35)

Review of the medical record revealed R35 was admitted to the facility 07/21/2020 with diagnoses that included insomnia, depression, neuromuscular dysfunction of the bladder, constipation, dysphagia (difficulty swallowing), anxiety, restless leg syndrome, dementia, cognitive communication deficit, and vision loss. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/28/2022, revealed R35 had Brief Interview for Mental Status (BIMS) of 00 (severely impaired cognition and could not repeat words correctly) out of 15.

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Review of R35 medical record revealed a "Public Health Department" document that a COVID-19 Immunization was offered at the facility on 11/22/2021. The document revealed a handwritten statement "NO". The document contained no signature of R35 representative and did not contain any documentation that the risk and benefits for the COVID-19 Immunization had been provided or discussed.

During observation on 12/21/2022 at 01:30 p.m. R35 was observed laying down in bed and appeared to be sleeping.

Resident #356 (R356)

Review of the medical record revealed R356 was admitted to the facility 12/09/2022 with diagnoses that included fracture of the right femur, depression, hypertension, hallucinations, and homelessness. R356 Admission Minimum Data Set (MDS) was not completed as of this survey. R356 "Nursing Admission Assessment", dated 12/10/2022, revealed that he was orientated to person, place, and time.

Review of R356 medical record revealed no documentation for consent or refusal of COVID-19 Immunization.

During observation and interview on 12/21/2022 at 01:20 p.m. R356 was observed sitting up in a wheelchair. R356 explained

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that someone from the facility had just come into his room and offered him the COVID-19 Immunizations and he had refused. He explained that he was explained the risk and benefits of the COVID-19 Immunizations.

Resident #357 (R357)

Review of the medical record revealed R357 was admitted to the facility 12/07/2022 with diagnoses that included cellulitis (bacterial skin infection) right and left lower limb, chronic pain, type 2 diabetes, peripheral vascular disease, edema, morbid obesity, emphysema (lung condition causes shortness of breath), depression, hypertension, hyperlipidemia (high fat in the blood), and gastro-esophageal reflux. R357 Admission Minimum Data Set (MDS) was not completed as of this survey. R356 "Nursing Admission Assessment", dated 12/8/2022, revealed that she was orientated to person, place, and time.

Review of R357 medical record revealed no documentation for consent or refusal of COVID-19 Immunization.

During observation on 12/21/2022 at 01:19 p.m. R357 was observed lying in bed and appeared to be sleeping.

In an interview on 12/21/2022 at 10:25 a.m. Director of Nursing (DON) "B" explained that the process for providing immunizations to residents would consist of asking the

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	resident, explaining the risk and benefits, sign a consent form, then the vaccination was given to the resident, and the consent was to be upload into the computerized medical record. DON "B" explained that if a Resident refused the same process would be followed and expect that immunization would not be given. In an interview on 12/21/2022 at 12:30 p.m. Director of Nursing (DON) "B" explained that is the was her expectation that immunizations are offered within 72 hours our admission. DON "B" confirmed that R356 and R357 had been offered COVID-19 Immunizations and she had been told they refused. DON "B" could not locate any documentation of immunizations in the medical records. DON "B" reviewed consents for R6, R29, and R35. DON "B" explained that what was in the medical record was not and accurate facility consent which should have included that education had been provided and contained a signature of the resident' representative. DON "B" could not explain why the consents were not accurate.			
F0921 SS= E	Safe/Functional/Sanitary/Comfortable Enviro §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record	F0921	1. No residents were listed in this citation. , All room and fire door floor transitions were cleaned, each resident room reviewed for clutter and decluttered. All common areas have had floor and surfaces thoroughly cleaned by the housekeeping and maintenance staff by 1-31-2023. The door length gaps between the metal doors in room 124, 125, 142 , emergency room exit by room 107, room 149 were addressed by	1/31/2023

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	reviews, the facility failed to effectively clean and maintain the physical plant effecting 53 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, decreased illumination, and plumbing leaks. Findings include: On 12/12/22 at 08:35 A.M., The drywall surface was observed bowed out between resident rooms 121 and 122. The damaged drywall surface alignment was observed to bow approximately 6-inches away from the remaining non-damaged symmetrical corridor drywall surfaces. On 12/12/22 at 08:40 A.M., The flooring surface was observed separated from the metal door frame, within Resident Room 124. The distance observed between the flooring surface and metal door frame was approximately 1.5 - 2.0 inches. On 12/12/22 at 08:45 A.M., The metal double door frame between Resident Room 124 and Resident Room 125 was observed separated from the flooring surface on the right-hand side. The distance observed between the flooring surface and metal double door frame was approximately 2.0 - 3.5 inches. On 12/12/22 at 08:55 A.M., The exterior upper metal door frame surface was observed separated from the drywall surface approximately 2.0 inches, within Resident Room 142. The drywall surface was also		maintenance and multiple repair estimates obtained by 1-3-2023. 2. Ayers Contracting has been engaged to correct the deficient areas for repairs of all walls and sinking floors in the facility by 1-31-2023 for long-term correction of these structural issues by the NHA/Director of Environmental Services. Quality Concrete has been engaged for repairs in the smoking area cracked concrete by 1-31-2023 by the NHA/Director of Environmental Services. These repairs will commence with appropriate weather conditions. All other listed repairs were corrected by maintenance by 1-31-2023. To ensure no safety concerns due to having to wait for the weather to improve to do the required work, 3x a week audits of the affected areas will be completed by NHA/Director of Environmental Services to ensure and maintain safety for residents and staff. 2. All residents have the potential to be affected by this deficient practice. A comprehensive Environmental Audit of all resident rooms, walls, doors, windows, and floors was completed by the Director of Environmental Services on 1-15-2023. 3.All residents have the potential to be affected by this deficient practice. A comprehensive Environmental Audit of all resident rooms, walls, doors, windows, and floors was completed by the Director of Environmental Services on 1-15-2023. 4. To ensure compliance, the NHA/Designee will audit 5 rooms/corridors to ensure they meet the required standards. Audits will be reviewed and reported to the QAPI Compliance Committee. Audits will be completed weekly x4 and then monthly thereafter. 5. The Administrator is responsible for this plan of correction.	

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	observed cracked and chipped, adjacent to the metal door frame surface. On 12/12/22 at 09:01 A.M., The return air exhaust ventilation grill was observed soiled with accumulated dust and dirt deposits, within Harmony Hall. On 12/12/22 at 09:06 A.M., The flooring surface was observed cracked and sinking, adjacent to Resident Room 121 and Resident Room 150. The cracked and sinking area measured approximately 12-feet-long by 8-feet-wide. On 12/12/22 at 09:10 A.M., The flooring surface was observed cracked and sinking, adjacent to Resident Room 101 and Resident Room 120. The cracked and sinking area measured approximately 12-feet-long by 8-feet-wide. On 12/12/22 at 09:15 A.M., A gap, measuring approximately 1.0 - 1.5 inches wide, was observed between the metal emergency exit door surface and the metal weather stripping. The metal emergency exit door was located adjacent to Resident Room 107 (Central Supply). On 12/12/22 at 09:21 A.M., The drywall surface was observed bowed out between Resident Room 117 and Resident Room 118. The damaged drywall surface alignment was observed to bow approximately 6-inches from the remaining non-damaged			

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	symmetrical corridor drywall surfaces. On 12/12/22 at 09:26 A.M., The drywall surface was observed bowed out between Resident Room 119 and Resident Room 120. The damaged drywall surface alignment was observed to bow approximately 4-inches from the remaining non-damaged symmetrical corridor drywall surfaces. On 12/12/22 at 10:05 A.M., The exterior metal entrance door was observed separated from the metal door frame jamb on the left-hand side, within Resident Room 149. The distance between the metal entrance door and metal door frame jamb was approximately 0.5 - 2.0 inches-wide. On 12/12/22 at 02:42 P.M., An expansion crack was observed directly above and adjacent to the upper exterior metal entrance door frame, within Resident Room 117. The drywall expansion crack measured approximately 24-inches long by .25 - .50 inches-wide. On 12/12/22 at 03:20 P.M., A common area environmental tour was conducted with Environmental Service Director "F". The following items were noted: Resident Smoking Area: The concrete surface was observed (cracked, chipped, and missing). The damaged concrete area measured approximately 15-feet wide by 30-feet long (450 square feet).			

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Service Hall: The south cement block wall surface was observed (raised, bubbled, particulate) from previous moisture exposure. One of two exterior window frame laminate surfaces were also observed loose-to-mount.

Staff Break Room: The microwave oven interior surface (floor, walls, ceiling) was observed soiled with accumulated food residue and splash.

South Unit:

Shower Room: 12 of 20 overhead 48-inch-long fluorescent light bulbs were observed non-functional. The return air exhaust ventilation grill was also observed soiled with accumulated dust and dirt deposits.

On 12/13/22 at 08:45 A.M., A common area environmental tour was continued with Environmental Service Director "F". The following items were noted:

South Unit:

South Emergency Exit Door: The weather stripping was observed (worn, torn, missing), adjacent to the Laundry Service. The damaged weather stripping created a gap that measured approximately 1.5 inches-wide by 1.5 inches-long.

Janitor Closet: The mop sink basin was observed heavily soiled with accumulated dirt

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	and grime deposits. The flooring surface and wall/floor junctures were also observed soiled with accumulated and encrusted dirt deposits. The vinyl coving base was further observed missing, throughout the room perimeter. Staff Restroom: The hot water valve stem was observed leaking at the hand sink faucet, upon actuation. Laundry Exit Door: The metal weather stripping was observed (worn, torn, missing), creating an opening to the exterior grounds. The gap measured approximately 2-inches-wide by 2-inches-long. The metal threshold plate was also observed missing, creating an opening to the exterior grounds. Laundry: 6 of 10 overhead 48-inch-long fluorescent light bulbs were observed non-functional. North Unit: Dining Room: 2 of 9 overhead light assemblies were observed non-functional. One stained 24-inch-wide by 48-inch-long acoustical ceiling tile was also observed stained from a previous moisture leak. Oxygen Storage Room: The return air exhaust ventilation grill was observed soiled with dust and dirt deposits. Main Parking Lot Emergency Exit Door: The			

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	metal exit door was observed bent, creating a gap between the door surface and metal weather stripping. The opening measured approximately 2-inches-wide by 24-inches-long. Journey Room: The restroom commode base caulking was observed (cracked, loose, missing). The Activity Director's chair was also observed (worn, torn, etched), exposing the inner Styrofoam padding. Environmental Services Director "F" stated: "I have a new chair in the basement. I will replace the chair today." Janitor Closet: The flooring surface was observed (worn, etched, severely soiled), exposing the concrete sub-surface. The mop sink basin was also observed soiled with accumulated and encrusted dirt/grime deposits. Shower Room: 4 of 6 overhead light assemblies were observed non-functional. The commode base caulking was also observed (cracked, worn, torn, missing). The caulking bead was additionally observed green in color for approximately 4-6 inches. On 12/13/22 at 01:35 P.M., An environmental tour of sampled resident rooms was conducted with Maintenance Supervisor "G". The following items were noted: 102: The commode support was observed loose-to-mount. The commode support			

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	could be moved from side to side approximately 4-6 inches. The restroom call light system pull cord was also observed frayed and threadbare. 105: The Bed 1 bedside table surface was observed (etched, scored, bubbled). 116: The restroom commode support was observed loose-to-mount. The commode support could be moved from side to side approximately 4-6 inches. The hand sink was also observed draining slowly. The restroom door latch strike plate and door jamb were additionally observed with a gap, allowing the door to not close completely. The distance between the door jamb and latch strike plate assembly measured approximately .25 - .50 inches. 125: The flooring surface was observed very unlevel. The restroom commode base caulking was also observed (chipped, cracked, particulate). The flooring surface was additionally observed separating from the wall/floor vinyl base coving, adjacent to the wooden wardrobe closet. 126: 1 of 2 exterior glass windowpanes (30-inches-wide by 48-inches-high) were observed cracked. The damaged glass measured approximately 14-inches-long. The restroom commode was also observed running water continuously, within the bowl basin. Maintenance Supervisor "G" stated: "The handle is stiff, and needs replaced."			

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	128: The Bed 2 window shade was observed soiled with food splash. 3 of 4 overbed light assembly upper 48-inch-long fluorescent light bulbs were also observed non-functional. The restroom commode support was further observed loose-to-mount. The commode support could be moved from side to side approximately 4-6 inches. 129: The restroom flooring surface was observed soiled and stained, adjacent to the commode base. The commode base caulking was also observed (cracked, chipped, missing). 130: The Bed 1 and Bed 2 wall surfaces were observed (etched, scored, particulate). The Bed 1 overbed light assembly upper 48-inch-long fluorescent light bulb was also observed non-functional. The restroom commode base caulking was further observed (etched, scored, stained, particulate). 136: The Bed 2 overbed light assembly upper 48-inch-long fluorescent light bulb was observed non-functional. 141: The restroom flooring surface was observed (stained, soiled, worn), adjacent to the commode base. The commode base caulking was also observed (cracked, chipped, missing). Restroom interior door surfaces were further observed (etched, scored, particulate).			

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	146: The restroom flooring surface was observed separated from the wall/floor vinyl coving base. The separation gap measured approximately 1-2 inches along the restroom perimeter wall. The commode support was also observed loose-to-mount. The commode support could be moved from side to side approximately 4-6 inches. 149: The restroom commode base caulking was observed (cracked, chipped, missing). The restroom entrance door metal frame was also observed separated from the flooring surface. The gap between the metal door frame and the flooring surface measured approximately 2-3 inches. On 12/13/22 at 03:40 P.M., Record review of the "Direct Supply TELS Work Orders" for the last 90 days revealed no specific entries related to the aforementioned maintenance concerns. On 12/13/22 at 04:15 P.M., Record review of the Policy/Procedure entitled: "Homelike Environment" dated 10/27/21 revealed under Policy: "Residents are provided with a safe, clean, comfortable, homelike environment and encouraged to use their belongings to the extent possible."			
F0925 SS= E	Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as	F0925	1. Residents #18 and Resident #41 ‘s rooms were checked to ensure they are free of any type of pests, insects or mice by the Director of Environmental Services on 1-25-2023 2. All residents have the potential to be	1/31/2023

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	evidenced by: Based on observations, interviews, record reviews, and 6 of 9 from the confidential group meeting, the facility failed to provide effective pest control services effecting 53 residents, resulting in the increased likelihood for insect and rodent infestations. Findings include: On 12/11/22 at 09:23 A.M., An interview was conducted with Food Service Director "H" regarding rodent activity within the food production kitchen. Food Service Director "H" stated: "One rodent was caught in a snap trap approximately one month ago." On 12/12/22 at 09:15 A.M., A gap, measuring approximately 1.0 - 1.5 inches wide, was observed between the metal emergency exit door surface and the metal weather stripping panel. The metal emergency exit door was located adjacent to Resident Room 107 (Central Supply). On 12/12/22 at 10:42 A.M., An interview was conducted with Environmental Services Director "F" regarding the facility Pest Control Program. Environmental Services Director "F" stated: "Our pest control contract is with (Pest Control Contractual Firm Name)." Environmental Services Director "F" was queried: "Have you had any pest activity within the last three months?" Environmental		affected by this deficient practice. An audit of all resident rooms and common areas was completed by the Director of Maintenance/Designee to ensure that all rooms have been effectively treated for control of pests on 1-25-2023. 3. The facility policy for pest control and prevention was reviewed by the facility management team and updated on 1-12-2023. All staff were educated on the policy and procedure for pest control and prevention by the NHA on 1-12-2023 and 1-13-2023.. The TELS System was updated to include ongoing audits to ensure no pests or evidence of pests were present on 1-30-2023. 4. The audit for Pest Control in resident rooms and facility common areas will be conducted weeklyx4 and then monthly thereafter. Results were brought to the QAPI Meeting for trending and process improvement. The Administrator is responsible for this plan of correction.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

Services Director "F" stated: "Yes" Environmental Services Director "F" also stated: "We have had Bees in the Therapy Room above the suspended ceiling tiles." Environmental Services Director "F" additionally stated: "((Pest Control Contractual Firm Name) was notified and removed the Bees nest." Environmental Services Director "F" further stated: "We have also caught three mice (2 in room 121) and (1 in room 122)."

On 12/13/22 at 08:45 A.M., A common area environmental tour was continued with Environmental Service Director "F". The following items were noted:

South Unit:

The South Emergency Exit Door: The weather stripping was observed (worn, torn, missing), adjacent to the Laundry Service. The damaged weather stripping was also observed to create a gap approximately 1.5 inches wide by 1.5 inches long, allowing potential pests (rodents) to enter the building. The South Emergency Exit Door metal threshold plate was additionally observed ill fitting, creating a gap between the metal threshold plate and the bottom of the metal door surface. Daylight could be seen through the gap that measured approximately 1.0 - 2.0 inches wide by 36-inches long.

Laundry Exit Door: The metal weather

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	134140	A. BUILDING _____ B. WING _____	12/22/2022

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	stripping was observed (worn, torn, missing), creating an opening to the exterior grounds. The gap measured approximately 2-inches-wide by 2-inches-long. The metal threshold plate was also observed ill fitting, creating an opening between the metal threshold plate and the bottom of the metal door surface. Daylight could be seen through the gap that measured approximately 1.0 - 2.0 inches wide by 36-inches long. Lift Room: One "Victor" snap trap was observed triggered with peanut butter residue attached to the yellow plastic actuator plate. Incontinent brief remnants were also observed within the storage closet, adjacent to the "Victor" snap trap. Harmony Hall: One dead "Stink Bug" carcass was observed resting within a base cabinet interior drawer. North Unit: Main Parking Lot Emergency Exit Door: The metal exit door was observed bent, creating a gap between the door surface and metal weather stripping. The opening measured approximately 2-inches-wide by 24-inches-long. Lift Room: One "Victor" snap trap was observed triggered without any evidence of bait residue or deceased rodent carcass. On 12/13/22 at 01:35 P.M., An environmental			

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	tour of sampled resident rooms was conducted with Maintenance Supervisor "G". The following items were noted: 117: Ants were observed foraging along the east restroom wall/floor vinyl base coving strip. Food residue and food debris were also observed, adjacent to the east restroom wall surface. 131: One gnat was observed flying directly in front of the entrance door. 141: Four gnats were observed flying, within and adjacent to the resident room hand sink basin. On 12/13/22 at 03:12 P.M., Resident #18 was interviewed regarding current pest (rodent) activity. Resident #18 was queried: "Have you seen any mice?" Resident #18 stated: "Oh my god, lots of them." Resident #18 also stated: "Usually at night." Resident #18 was also queried: "Have you seen any mice lately?" Resident #18 stated: "Sure. Last Night." Resident #18 further stated: "I usually see the mice when it gets dark outside." On 12/13/22 at 03:22 P.M., Resident #41 was interviewed regarding current pest (rodent) activity. Resident #41 was queried: "Have you seen any mice?" Resident #41 stated: "I have seen one." Resident #41 further stated: "He travels around and next to the room walls." On 12/13/22 at 03:45 P.M., Record review of			

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	the (Contractual Firm Name) Pest Elimination Services Agreement revealed no effective start date within the narrative of the contractual document. On 12/13/22 at 04:00 P.M., Record review of the (Contractual Firm Name) Pest Elimination Customer Service Report dated 11/30/2022 revealed under Target Pest: "Bedbugs". Record review of the (Contractual Firm Name) Pest Elimination Customer Service Report dated 11/30/2022 further revealed under Conditions Found/Actions Taken: "Inspected and treated selected areas. South Hallway Nurses Station and Shower Room inspected and treated. Facility team reported a potential bedbug was found on shoulder area of an office chair. Bug was flushed before being identified. Three office chairs that were inside of nurse's station were moved to the shower room for safe storage and for treatment." On 12/13/22 at 04:15 P.M., Record review of the Policy/Procedure entitled: "Homelike Environment" dated 10/27/21 revealed under Policy: "Residents are provided with a safe, clean, comfortable, homelike environment and encouraged to use their belongings to the extent possible." On 12/13/22 at 10:00 am, during the Resident Council meeting, 6 of 9 participants reported they regularly see mice throughout the building and this had been an ongoing issue. One participant reported they			

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	shake/jiggle their night stand in order to scare to mice away and hope to fall asleep before they return. Another participant reported mice were observed running around everywhere and maintenance staff were regularly setting traps, but its an ongoing problem.			