STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION	(X3) D/ COMP	ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
NAME OF PRO	/IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STAT	E, ZIP CO	DE
MOMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CI EFERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
F0000 SS=	for a Recertification	h at Battle Creek was surveyed on survey on 12/22/22.	F0000				
F0550 SS= D	§483.10(a) Resid has a right to a c determination, and access to persor outside the facilit in this section. §- treat each reside and care for each in an environmer maintenance or quality of life, rec individuality. The promote the righ (2) The facility m quality care rega of condition, or p must establish a and practices reg and the provision plan for all reside source. §483.10 resident has the rights as a reside citizen or resident can without interferer or reprisal from t	Exercise of Rights dent Rights. The resident lignified existence, self- nd communication with and as and services inside and ty, including those specified 483.10(a)(1) A facility must ent with respect and dignity h resident in a manner and nt that promotes enhancement of his or her cognizing each resident's a facility must protect and ts of the resident. §483.10(a) ust provide equal access to rdless of diagnosis, severity ayment source. A facility nd maintain identical policies garding transfer, discharge, n of services under the State ents regardless of payment (b) Exercise of Rights. The right to exercise his or her ent of the facility and as a th of the United States. the facility must ensure that exercise his or her rights nce, coercion, discrimination, he facility. §483.10(b)(2) The right to be free of	F0550	address situatio 2022. 2. All re affectee was co on 1-22 are rec concern 3. The reviewe 2023 al policy c all staff adminis 4. An a comple weekly: were tr Commi improve 5. The	dent #48, #40, and #21 were sed by caregivers to increase the into reflect care with dignity on esidents have the potential to be d by this deficient practice. An a mpleted by Social Worker/ Des 4-2023 of all residents to find ou- eiving care with dignity. No othe ns were noted. facility policy on Resident's Rig ed by the QAPI Committee on 1 nd deemed appropriate. The fa on Resident's Rights was review i on 1-12-23 and 1-13-23 by the strator/designee'. Judit of 25% of residents was ted by the administrator/design x4 and monthly thereafter. Resi ended and brought to the QAPI (thee for trending and process ement. Administrator is responsible for correction.	12-23- e audit ignee it if they er hts was -12- cility ved with ee' ults	1/31/2023
LABORATORY	DIRECTOR'S OR PI	ROVIDER/SUPPLIER REPRESEN	TATIVE'S SIGNA	TURE	TITLE	(X6) DA	TE
Electronical	y 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.

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	PLE CON G	ISTRUCTION		ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MOMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	reprisal from the her rights and to in the exercise of under this subpa This REQUIREM evidenced by: This citation pert Based on observa review, the facility were treated with three(R21, R40, a reviewed for digr feelings of dimin and frustration. Findings include: Resident #21(R27 Review of the Fac Set (MDS) dated a 79 year old ferr on 1/24/17, with dementia, corona failure, periphera disorder, schizop depression. The N BIM (assessment her ability to mak severely impaired person physical a transfers, locomo	IENT is not met as ains to intake: MI00130932 ation, interview and record y failed to ensure residents in dignity and respect for and R48) of five residents nity, resulting in potential for ished self-worth, sadness,					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION UMBER: 134140		À. BUILDIN	IG	STRUCTION	ĊOMF	(X3) DATE SURVEY COMPLETED 12/22/2022	
AME OF PRO	R TTLE CREEK			STATE, ZIP CC	TATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE	
	AM, R21 was layi positioned low w head awkwardly very strong smel was open with st "aerosol generat indicated require and eye protectio Protective Equipe door. R21 had ar appeared thin ar open holding stu did not appear to calm with soft to reach under top noted at bedside with 2 large Styre appeared to be o During an observ p.m., R21 continu on with neck turn During an intervi Certified Nurse A assisted R21 for not able to recall but reported had liquids from kitch knows how to ca verbal report at s reported docume Record (EMR) at	vation on 12/11/22 at 9:07 ng on an air mattress with hospital gown on with positioned to the left with I of urine in room. R21 door op sign on door that read, eving procedure" that ed use of gloves, mask, gown, on, with no Personal ment(PPE) observed outside in air mattress in place, and frail, was awake with eyes of fed animal and rosary. R21 o be verbal and appeared uch call light located out of of pillow. Folding chair was e along with bedside table ofoam cups with straws that orange juice and water. vation on 12/11/22 at 3:45 ued to lay in bed with gown hed to left in dark room. ew on 12/11/22 at 2:45 PM, hid (CNA) "MM" reported breakfast and reported was what R21 ate for breakfast d either nectar or honey thick hen. CNA "MM" reported re for each resident by shift change. CNA "MM" ents in Electronic Medical nurse station only because <i>y</i> access to hall monitors						

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 134140		PLE CONSTRU		(X3) DATE SURVEY COMPLETED 12/22/2022		
AME OF PROVIDER OR SI			STREET ADDRESS, CITY, S			_	
IOMENTOUS HEALTH	BATTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 490				
PRÉFIX (EACH DE	STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY JLATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CORRECT	R'S PLAN OF CORRECTI FIVE ACTION SHOULD B ENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
each reside from EMR. and verifie determine reported a diets from sign in mai modificatio During an CNA "M" r access to k care and d consistenc interview v "MM" had unsure how During an AM, CNA " observed i positioned left side. C assist with ADM "A" a At 9:27 AM heard alarr observed f light on as door. At 9: with bag o turned off. R21 room "NN" and o	unsure how to determine what a diets are including restrictions NA "M" joined interview in hall no way for CNA staff to sident diet from EMR and re of resident care including rbal report at shift change and kitchen with resident liquid and consistency. erview on 12/11/22 at 2:55 PM, orted had forgot that they have dex for each resident that had modifications including liquid . CNA "MM" also present for fied that was the first CNA ard about the Kardex and was o even look at it. servation on 12/14/22 at 9:20 " and Administrator "A" k21's room. R21 was noted w in bed awkwardly leaning to . "KK" then asked CNA "NN" for posting R21 up in bed because ed her to make R21 comfortable. 21's call light was observed and ng with door closed and r staff pass R21's room with call dicated by light illuminated over AM CNA "KK" exited R21 room oiled items and call light was s 9:34 AM this surveyor entered th CNA "KK" and observed CNA A "KK" finish R21 morning care in. R21 was repositioned and						

TATEMENT OI ND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	Á. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
AME OF PROV	TTLE CREEK		STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 4901					
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	LIDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE	
	not apply moistu surveyor observe programmed to, television show). During an observe AM R21's meal to room and placed to the bed and sa and untouched. and smell of outs down from R21 mean eating lunch. Thi observe outside turned on at 12:2 room, turned off something to ea untouched meal 12:37 PM, CNA " the meal tray an 25% of meal incl mostly, did not v pureed possible which was no lor reported R21 drav verified dishes w reported trays w 11:30 a.m. and w tray.	al gown changed. Staff did the barrier cream to R21. This ed television was on "Two broke girls" (current "Two broke girls" (current "ation on 12/14/22 at 11:33 ray was delivered to her I on the bedside table next taff exited the room. R21 was d the meal tray was covered Several staff noted on hall side food noted one door room with several staff noted s surveyor continued to R21's room and R21 call light 23 PM CNA "M" entered R21 the call light, offered R21 the call light, offered R21 the call light, offered R21 the drink from the tray and R21 accepted. At M" exited R21's room with d reported R21 at about uding mandarin oranges want mashed potato's or beef/broccoli or magic cup nger cold to touch. CNA "M" ene delivered to unit about tas unsure who delivered R21 re Plans, revised 5/3/17,						
		ncontinent of Bowel and						

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING		ISTRUCTION	(X3) DA COMPI	ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
NAME OF PROVIDE	ER OR SUPPLIEI	R			STREET ADDRESS, CITY, STATE,	ZIP COI	DE
MOMENTOUS HE	EALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
PRÉFIX (E	EACH DEFICIEN	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
gui, ser exp r/t rev ma inc Cle or cre Ass rec Ch Ass to Init Rev Du AM clo on me wit un and rep bre Du AM	ardian has electronices and a deepected. My skir incontinence to view. I will be fr aintaining my d continence care ean and dry skir compromise, a eam with each of sist me to chan quire extensive neck frequently sist me with my be in my whee tiated: 01/29/20 vision on: 05/00 uring an observe A, R21 was layin posed, wearing a bedside table eal meal tray or th 2 bowls of pu- touched and ou d empty glucer ported meals no eakfast was biso uring an observe A R21 was layin es closed weari	ee of odor while ignity. Assist me with post incontinent episodes. n, inspect for skin irritation nd apply moisture barrier change of briefs or linens. ge my clothing as needed. I assistance for toileting. and change as needed. y meals and encourage me lchair while eating. Date 017					

TATEMENT OF DE ND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		(X3) DATE SURVEY COMPLETED	
		134140	B. WING			12/22/2022		
AME OF PROVIDE	ER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CC	DE	
IOMENTOUS HI	EALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49			
PRÉFIX (E	EACH DEFICIEN	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
	om with no sta rough 10:45 a.ı	ff entering R21 room up m.						
CN co rej fac the ca ho CN we rel (LF ha en "O be ev lik us ne rej ba ob R2 we fro ho Su ch ho CN we rel (LF ha en "O be ev lik us ne fac co CN we rel co co co co co co co co co co co co co	IA "M" reported mplain of noth ported new ow cility bus and n ey used to be a n not. CNA "M spice spiritual JA who provid- eekly. CNA "M" igious preferent N) "OO" joine d cared for R2 joy regular trip O" reported ha d in two weeks ents. LPN "OO ed music and r ing rosary and cklace she was ported was unsi- ckground and served hospice 1. LPN "OO" a ere unsure what om hospice and spice tablet af- tring an intervi- ospice CNA "PF thing services ednesday and	ew on 12/21/22 at 10:45 AM, ed residents are bored and hing to do. CNA "M" oner took over and sold the ow residents complain that able to go out and now they " reported had never seen care in for R21, only hospice ed baths usually 2 times " reported was unsure of R21 nce. Licensed Practical Nurse d the interview and reported 1 for several years and use to os out of the facility. LPN ad not observed R21 out of s and does not like group " reported long history of had always had cross s very attached to. LPN "OO" sure of R21's religious reported had never e spiritual services visiting nd CNA "MM" both reported t services R21 was receiving d reported they only sign ter visits for CNA and Nurse. ew on 12/21/22 at 12:25 PM " reported provided R21 two times weekly on Friday and often comes assist with meals. CNA "OO"						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDING	PLE CONSTRUCTION	_ COM	DATE SURVEY PLETED 2/2022	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY 675 WAGNER DR BATTLE CREEK, MI 4			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SHOUL REFERENCED TO THE APP DEFICIENCY)	D BE CROSS-	(X5) COMPLETIO DATE	
	reported R21 wa from Hospice set breakdown relati- brief area and fa to south unit. Ho Hospice offered R21 did not rece "OO" reported w hospice binder w building because nurse to sign for Resident #40 According to the Minimum Data S resident 40 (R40 admitted to the fa include severe in onset Alzheimer Down syndrome (severe cognitive Interview for Men record review ret appointed guard and had no visito R40 was observa approximately 12 table in the dinin been combed, sl and had a disher Unidentified staff and walked awa? R40 was observa (there was a fork physical cueing v	clinical record including the et (MDS) dated 11/19/22) was a 58 year old female, acility with diagnosis that tellectual disabilities, early s, Bi-polar disorder, anxiety, unspecified. R40 scored 00 a impairment) on the Brief ntal Status. Of note, further vealed R40 had a court ian, no contact with family,					

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		134140	B. WING _			12/22	/2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	TATE, ZIP CC	DE
MOMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 4901	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	proceeded to eat utensils, it was m observation that cued her to use u	ng her face in the plate and t without fingers, hands or nomentarily after this staff acknowledged R40 and utensils. 8:47 AM, R40 was observed					
	aide, R40 had a s Licensed Practic observed to walk room where othe present, and whi	h an unidentified Activity strong odor of feces, al Nurse (LPN) "N" was passed R40 in the dining r residents and staff were le waving her hand in front "N" loudly questioned "Oh,					
	(EMR) revealed R facility on 6/17/2 congestive heart	8) electronic medical record 48 was admitted to the 022. Diagnoses included failure (causes weakness breath), Dementia, muscle					
	(MDS) assessmer R48 had a "Brief (BIMS) score of z indicated R48 ha cognition. Further required use of a assistance with a During the same	a "Minimum Data Set" nt, dated 7/1/2022, revealed Interview for Mental Status" ero out of 15, which d severely impaired er review of the MDS R48 wheelchair for maximum Il personal care. observation Certified Nurse as observed to grab R48's left					
		him into the dining room while he was in his					

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:			ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		134140	B. WING			12/22	/2022
NAME OF PRO	VIDER OR SUPPLIE	ĒR			STREET ADDRESS, CITY, STA	TE, ZIP CO	DE
MOMENTOU	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPR DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
	wheelchair.						
		e footrest on his wheelchair pulled, only self-propel.					
F0559 SS= D	Change §483.10 room with his or residents live in t spouses consen §483.10(e)(5) Th his or her roomm practicable, whe same facility and the arrangement receive written n for the change, b roommate in the This REQUIREM evidenced by: Based on observ review, the facilit written notice pr resident (#20) re which resulted in the potential for misunderstandin change, and the resident question Findings includes Resident # 20 (R facility 8/5/21 wi readmission 9/22		F0559	renova prior to room m Once th Worken decisio move s 2. The comple audited Social ' signatu the res form w 3. The necess Commi approp change /Design 4. Roon will be weekly be press process resolve 5. The	need for a room move during tions was discussed with resic her room move. She did agre tove verbally on the day of the asked the resident , who is h n-maker, to sign the facility's i heet on 12-12-2022. room move sheets for all mov ted within the last 30 days we to ensure timely signatures b Worker/Designee on 1-23-202 res not obtained were review ident/responsible party and th as completed on 1-23-2023. procedure for the room move: ary signatures was reviewed ttee on 1-12-2023, and deem riate. All staff involved in the r process were educated by th seen to the QAPI Committee simprovement until the issue d. Administrator is responsible for correction.	lent #20 e to the move. Social er own oom es re y the 3 Any ed with en the 3 Any ed with en the 3 Any ed with en the 3 Any ed with en the 23 May ed by the QA ed oom e NHA 23 moves Designee' soults will for is	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140		Á. BUILDIN	IG	STRUCTION	ĊOMF	(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLIE S HEALTH AT BA		STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 4901					
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	left femur, and m Minimum Data S Assessment Refe 11/13/22 revealed impaired hearing was understood Interview for Me (severe cognitive MDS revealed th extensive assista person total dep independent wit two- person total dep independent wit two- person total dep independent wit two- person total dep independent wit two- person total and two-person personal hygien that R20 used be Discharge MDS R20 had an unpl care hospital and facility was antice During an obser 12/11/22 at 12:5 was observed lay dressed in facilit in place at 3 liter cannula. Bilatera the bed trapeze stated that last w Thursday, a Cert Housekeeper en and begin remov	pain, displaced fracture of norbid obesity. Review of Set (MDS) with an erence Date (ARD) of ed that R20 had highly g but had clear speech and and understands with a Brief ntal Status (BIMS) score of 6 e impairment). Section G of nat R20 required two-person nce with bed mobility, two- endence for transfers, one- endence with dressing, h eating after set up assist, al dependence with toilet use, extensive assistance with e. Section P of MDS reflected ed rails daily. Review of the dated 9/21/22, revealed that anned discharge to an acute d that her return to the ipated. vation and interview on 4 PM, Resident #20 (R20) ying in bed, on left side, y gown. Oxygen noted to be rs per minute via nasal I quarter side rails and over noted to be in place. R20 veek, she believed it was on ified Nurse Aide (CNA) or tered her room with a cart ving items from her closet n on the cart. R20 stated that						

ND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		(X3) DATE SURVEY COMPLETED	
		134140	B. WING				12/22/2022	
IAME OF PROVID	DER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CC	DE	
IOMENTOUS H	TTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 490					
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE	
v rri s t t ir v rr l S S p p a d s s rr t t f c s s rr c c a t t R c v t t r r n n n n n n n n n n n n n n n n	vas informed tha ooms. R20 denie nitiation of the r he still did not u he room change nitially frustrated vas now getting oom. In an interview o focial Worker (St bending room ch imongst the Inte laily in the AM of tated that she w esident to review he "Acknowledg orm. SW "D" fur nousekeeper ma o a resident and thange prior to t tated that the h esponsible for ti thange. SW "D" change had beer ilready moved to hat she reviewed 20 on 12/9/22. concern at the til vas complete po hat there would oom but after sl	oned the staff member, she at she would be changing ed being notified prior to the room change and stated that understand the rationale for e. R20 stated that she was d with the abrupt move but comfortable in the new n 12/12/2022 at 2:10 PM, W) "D" stated that any nange would be discussed erdisciplinary Team (IDT) or PM meeting. SW "D" vould then follow up with the w and have the resident sign gement of Room Change" ther stated that a y mention the room change I even initiate the room the form being reviewed as ousekeeping staff were he completion of the room confirmed that R20's room n complete and that R20 was o Room 128 prior to the time d the room change form with Per SW "D", R20's main me the room change form ost room change had been be a third person in the he was reassured that R20 denied rns.						

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NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STAT 675 WAGNER DR BATTLE CREEK, MI 49017			E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE (FERENCED TO THE APPROPR DEFICIENCY)	CROSS-	(X5) COMPLETION DATE	
F0565 SS= D	nurses notes or s of or the days for which reflected t reaction to the m Review of the far Changes" dated 2) Prior to char assignment all p change/assignm hour/day advand Unless medically and well-being of will be provided the room changer reason(s) why th Resident/Family §483.10(f)(5) Th organize and pa the facility. (i) Th resident or famil private space; al with the approva- residents and fa upcoming meetin Staff, visitors, or resident group o at the respective facility must prov- person who is a family group and responsible for p responding to w from group meeting consider the view group and act pr	medical record included no social work notes on the day llowing the room change the change or resident's new room. cility policy titled "Room 5/2/2022, indicated that " nging a room or roommate arties involved in the entwill be given a 24 ce notice of such changes4) r necessary or for the safety of the resident(s), a resident with an advance notice of e. Such notice will include the e move is recommended." Group and Response e resident has a right to rticipate in resident groups in the facility must provide a y group, if one exists, with nd take reasonable steps, al of the group, to make milly members aware of ngs in a timely manner. (ii) other guests may attend r family group meetings only group's invitation. (iii) The ride a designated staff oproved by the resident or a the facility and who is providing assistance and ritten requests that result tings. (iv) The facility must ws of a resident or family oomptly upon the grievances ations of such groups	F0565	staffing address 2. All re affecter was co were du 3. The Counci concern Counci minutes was als and up policy v on 1-12 4. A qu 25% of monthly	Resident Council Concerns re , food temps, and environmer sed as of 1/13/2023. seidents have the potential to d by this deficient practice. An mpleted on 1/13/2023 and all ocumented and addressed. process for conducting Resident I Meetings and following up on s to resolution from the Resid I Meeting. Logging Resident C is to retain concern status for 3 so reviewed with the QAPI Co dated on 1-12-2023. The upda vas reviewed with all staff by the 2-2023 and 1-13-2023. ery of like residents weak comp the like residents weekly x4 a y thereafter. All results were b PI committee for ongoing pro- ement.	nt were be audit concerns ent dent Council 36 months mmittee ated he NHA bleted for and rought to	1/31/2023	

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		DATE SURVEY PLETED	
		134140	B. WING	12/22	12/22/2022		
	VIDER OR SUPPLIE S HEALTH AT BA			STREET ADDRESS, CITY, 675 WAGNER DR BATTLE CREEK, MI 49			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHOULD REFERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
	the facility. (A) T demonstrate the such response. (construed to me- implement as re- the resident or fa The resident has family groups. §4 a right to have fa resident represe with the families of other resident This REQUIREM evidenced by: Based on observ review the facility grievances were investigated, trace members of the unresolved comp Findings Include On 12/13/22 at 1 Resident Council reported their co addressed, response resolved without the Resident Council reported their co addressed (response)	MENT is not met as ation, interview and record y failed to ensure that promptly documented, cked and resolved for 9 of 9 Resident Council resulting in olaints, anger and frustration. : 10:00 am, during the I meeting, 9 of 9 participants omplaints are frequently not onded to timely and/or go : explanation. Members of uncil reported they felt		5. The Administrator is responsil plan of correction.	ble for this		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			À. BUILDING	G	STRUCTION	(X3) DATE SURVEY COMPLETED	
		134140	B. WING _			12/22/	/2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MOMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	Nursing staff alor rude.	ng with nursing staff being					
	meeting were to staff to assist with housekeeping sta	e 6/08/22 Resident council continue with tray audits, all passing trays, educate ff and complete check off g- staffing to get more staff."					
	reflected in part, housekeeping, di	ent Council Minutes concerns related to rty rooms "they stink", call ne for call lights, and missing					
		nse was to educate laundry Is for missing cloths,					
		eping staff on how to nd a call light audit that d on 7/8/22.					
		Minutes dated 8/3/22 - of dirty rooms, missing and cold food.					
	for laundry labels housekeeping an	was to continue education and complete check offs for d ongoing review of rounds. ntinue to do food ts.					
	complained of ru	Minutes dated 9/7/22 de staff, dirty rooms, not ed showers showers.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTIF A. BUILDING	PLE CONSTRUCTION		DATE SURVEY PLETED
	134140	B. WING _			2/2022
NAME OF PROVIDER OR SUPPLIE	R		STREET ADDR	ESS, CITY, STATE, ZIP C	ODE
MOMENTOUS HEALTH AT BA		675 WAGNER BATTLE CRE	R DR EEK, MI 49017		
PRÉFIX (EACH DEFICIEN TAG FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	CORRECTIVE ACTIC REFERENCED TO	OF CORRECTION (EACH IN SHOULD BE CROSS- THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
dirty clothes goir on proper labelin infection control Resident Council reflected resident pertained to not missing clothes, f being too loud, a tickets. The facility Response rounds to be dor labeling clothes and audit meal se Education on noi person. Resident Council reflected resident reflected resident reflected rooms w response was to of and educate staff During the 12/13 meeting with the participant stated missing clothes of participant furthe assisted him in fil despite his ongoi items have been particular Resident	nse was to educate staff on ig to right bin, educate staff g, staff education on and shower audits. Minutes dated 10/12/22 is voiced concerns that getting proper showers, acility dirty, night shift staff ind dietary not reading meal onse was to do walking the daily, a better process of ervice 3 times a week. se reduction to be done in Minutes dated 11/09/22 is voiced concerns that vere dirty. The facility do audits for cleaning rooms about showers. /22 Resident Council State Agency, one I he complained about in a monthly basis, the or reported nobody had ling out a concern form and ng complaint none of his located or replace. This int Council participant was rearing pants with large				

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140		À. BUILDIN	G	cc	(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLIE S HEALTH AT BA				STREET ADDRESS, CITY, STATE, ZIP 675 WAGNER DR BATTLE CREEK, MI 49017	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (EACH RECTIVE ACTION SHOULD BE CROSS FERENCED TO THE APPROPRIATE DEFICIENCY)		
	participant repor remaining pair of embarrassed to w participants elabe are not addresse facility cleanlines ignored. The part facility always ha resident) is expec "Plan" never mat On 12/20/22 at 0 with Activity Dire been the Activity her duties includ Council Meetings agreed that issue after month with Activity Director filled out specific missing items or elaborated that a Administrators in about one month	erial above the left knee, the ted that was one of his 2 i pants, which he was vear but had no choice. The brated that staff attitudes d at all, and the ongoing s of the building just gets ticipants elaborated that the s a "Plan" in which they (the ted to sign, however the erializes. 2:51 PM, during an interview ctor "P" reported she had Director for over 1 year and ed running the Resident s. Activity Director "P" s are brought forth month out being resolved. "P" stated she had never concern form for the resident specific issues, and recent Nursing Home HA) (there had been 3 recent months) told her n ago this needed to be I discuss issues with current					
F0577 SS= B	Info §483.10(g)(1 right to- (i) Exam recent survey of Federal or State	Results/Advocate Agency (0) The resident has the ine the results of the most the facility conducted by surveyors and any plan of ct with respect to the facility;	F0577	survey the NH 2. A qu comple	ey results were updated to include a results with the plan-of-correction by A on 1-26-2023. ery of interviewable residents was ted on 1-26 and 1-27 by the NHA an vity director to ensure all residents a	d	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUF IND PLAN OF CORRECTION IDENTIFICATION NU 134140		À. BUILDIN	NG	STRUCTION	(X3) D/ COMP 12/22/	
(X4) ID		TTLE CREEK	ID		STREET ADDRESS, CITY, ST 675 WAGNER DR BATTLE CREEK, MI 4901 'IDER'S PLAN OF CORRECTION	7 DN (EACH	(X5)
PREFIX TAG	FULL REGULAT and (ii) Receive a acting as client a the opportunity to §483.10(g)(11) T a place readily a family members residents, the reis survey of the faci respect to any su complaint investi facility during the plan of correction facility, available upon request; ar availability of suc facility that are p the public. (iv) TI available identify complainants or This REQUIREM evidenced by: Based on observ review, the facilit Book was consist that the book wa facility plan of co deficiencies. Rest residents and vis Findings include: On 12/13/22 at 1 Resident Council reported that the of the survey boo would be missing time. One group	IENT is not met as ation, interview and record y failed to ensure the Survey tently readily available, and is maintained to include the prrection for identified ulting in the potential for itors to be uninformed.	PREFIX TAG	aware of book po 3. The j content on 1-12 required by the a 2023. T with the on 1-30 4. Mont residen adminis thereaft Commi 5. The j	RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY) of the required contents of the posted outside the administration policy of the posted survey is was updated by the QAPI -2023. All staff were educated ments and locations of survey are residents at resident Count -2023. hly queries of all interviewant the administrator reviewed by the strator monthly X3 and quart ter. Results will be brought the ter or process improvement Administrator is responsible correction.	he survey ator's office. book Committee ted on the ey posting and 1-12- the policy cil Meeting ble terly to the QAPI nt.	

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 134140		Á. BUILDI	NG	Č	(X3) DATE SURVEY COMPLETED 12/22/2022	
	OVIDER OR SUPPLIE		STREET ADDRESS, CITY, ST 675 WAGNER DR BATTLE CREEK, MI 4901				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I VIDER'S PLAN OF CORRECTION (EAU RECTIVE ACTION SHOULD BE CROS EFERENCED TO THE APPROPRIATE DEFICIENCY)		
	the State Agency On the afternoor book was located dining room, rev reflected an abbi- conducted on 3/ issued, one at ha survey book did correction, just a participant had co On 12/20/22 at 0 with Activity Dire not responsible f book, and did no 12/20/22 at 4:40 Director of Nursi Nursing Home A been at the facili month and the fa- in that time. DOI responsible for t	n of 12/13/22, the survey d across from the main iew of the survey book reviated survey was 16/22 with two citations irm level. The report in the not include the plan of s the Resident Council described. D2:51 PM, during an interview ector "P" reported she was for maintaining the survey ot know who was. On PM during an interview with ng "B" she stated the current dministrator (NHA) "A" had ty for approximately 1 acility had not had a survey N "B" stated she was not he survey book and was not ad to be posted, and that the					
F0578 SS= D	Adv Dir §483.10 refuse, and/or di participate in or experimental res advance directiv this paragraph si right of the resid of medical treatm	/Dscntnue Trmnt;FormIte (c)(6) The right to request, scontinue treatment, to refuse to participate in tearch, and to formulate an e. §483.10(c)(8) Nothing in hould be construed as the ent to receive the provision ment or medical services ly unnecessary or	F0578	#21, #1 Worker represe signing comple 2. An a for curr Creek	Advanced Directives for residents 7 were reviewed by the Social 7/Designee with the resident, entative, physician, and witness all review on the same date. This wa ted on 1-23-2023 udit of all resident advanced direct ent residents of Momentous Battle was completed by the Social 7/Designee on 1-24-2023. Any	s	

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	IG	ISTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 12/22/2022	
		134140	B. WING			_ 12/22/	2022	
JAME OF PRC	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DE	
IOMENTOU	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	17		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I /IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E :FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETIOI DATE	
	must comply with in 42 CFR part 4 Directives). (i) Th provisions to infor- information to all the right to acce- surgical treatment option, formulate This includes a with facility's policies directives and ag Facilities are per- entities to furnish legally responsite requirements of adult individual is admission and is information or ar she has execute facility may give information to th representative in (v) The facility is to provide this in once he or she is information. Foll- place to provide individual directh This REQUIREN- evidenced by: Based on observ review, the faciliti and accurate adw was in place for #21, #27) of five directives (legal person to identif	A83.10(g)(12) The facility In the requirements specified A89, subpart I (Advance hese requirements include form and provide written I adult residents concerning pt or refuse medical or nt and, at the resident's e an advance directive. (ii) written description of the to implement advance oplicable State law. (iii) mitted to contract with other in this information but are still ole for ensuring that the this section are met. (iv) If an s incapacitated at the time of a uable to receive ticulate whether or not he or d an advance directive, the advance directive e individual's resident n accordance with State law. not relieved of its obligation formation to the individual s able to receive such ow-up procedures must be in the information to the y at the appropriate time. IENT is not met as ation, interview, and record ty failed to ensure updated vance directive information three residents (Resident #7, reviewed for advance documents that allow a ty decisions about end-of-life ne), resulting in the potential		not on a directiv response witness same ti advance 3. The emphas signatu the QA on 1-12 the Lice the Soci undersi 4. To e proper be com weekly: will be to ongoing	ed directives with signature a consistent date had their es reviewed with them, the sible party, the physician, a Signatures will be obtain me on the same date for a ed directives. policy for Advanced Directi sis on obtaining timely and res for all residents was re PI Committee and deemed 2-2023. 1:1 Education was ensed Nursing Home Admi cial Worker, who signed off anding of this process on nsure compliance an audit process for Advanced Directi pleted for 25% of total resi k4, and monthly thereafter trended and brought to QA g process improvement. Administrator is responsible action.	advanced bir and a ed at the ill resident ives with consistent viewed by appropriate provided by nistrator to 1-26-2023. to ensure ectives will dents . All results PI for		

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTIF A. BUILDING	PLE CON G	ISTRUCTION		ATE SURVEY LETED
		134140	B. WING _			12/22	/2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STAT	E, ZIP CO	DE
MOMENTOUS HEALTH AT BATTLE CREEK					675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
		references for medical care d by the facility, or other lers.					
	Findings Include:						
	RESUSCITATE PR 1996 (Revised 3-2 order executed u a form described be dated and exe by each of the fo (a) The declarant, advocate, or anot of the signing, is declarant and act directions of the	the declarant's patient ther person who, at the time in the presence of the ting pursuant to the declarant.					
	(c) Two witnesses	's attending physician. 5 18 years of age or older, at 5 not the declarant's spouse,					
	grandchild, siblin	g, or presumptive heir.					
	printed or typed signatures. A witr unless the declara	all signatories shall be below the corresponding ness shall not sign an order ant or the declarant's patient s to the witness to be of					
	sound mind and undue influence.	under no duress, fraud, or					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					STRUCTION	(X3) D/ COMP	ATE SURVEY LETED	
		134140		B. WING _			12/22/2022	
NAME OF PROVIDER OR S	UPPLIE	R		•		STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MOMENTOUS HEALTH	AT BA	TTLE CREEK				675 WAGNER DR BATTLE CREEK, MI 49017		
PRÉFIX (EACH DI	EFICIEN EGULA1	TEMENT OF DEFICIENC ICY MUST BE PRECEDE FORY OR LSC IDENTIFY NFORMATION)	D BY	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
do-not-re section 3 limited to be in subs "DO-NOT This do-no- attending or print do Use the ap A. DECLAI I have diss physician event my no persor This order revoked a mind, I vo understar	suscita or 3a sl , the fo stantiall -RESUS ot-resu physic eclaran ppropri RANT C cussed named heart a n shall a r will re is provi- uluntaril nd its fu t's signa t's signa	t's or ward's name) ate consent section be CONSENT my health status with r above. I request that i nd breathing should st ttempt to resuscitate r main in effect until it is ded by law. Being of sc y execute this order, ar Il import. ature) (Date) son who signed for (Date)	er shall by (Type dow: how: my n the top, me. sound nd I					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140			À. BUILDIN	PLE CONSTRUCTION	COMPLET	(X3) DATE SURVEY COMPLETED 12/22/2022	
NAME OF PRO	VIDER OR SUPPLIE	R		STREET ADDRESS, CITY, S	STATE, ZIP CODE		
MOMENTOUS HEALTH AT BATTLE CREEK				675 WAGNER DR BATTLE CREEK, MI 490)17		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD REFERENCED TO THE APPRO DEFICIENCY)	BE CROSS- C	(X5) COMPLETION DATE	
	(Type or print ful	l name)					
	B. PATIENT ADVO	DCATE 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	e's signature) (Date)					
		tient advocate's name)					
	C. GUARDIAN CC	DNSENT					
	and breathing sh attempt to resuse the full import of	n the event the ward's heart ould stop, no person shall citate the ward. I understand this order and assume its execution. This order will					
	effect until it is re	evoked as provided by law.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIF A. BUILDING	PLE CON	ISTRUCTION	(X3) DATE SURVEY COMPLETED		
		134140		B. WING _			12/22/2022	
NAME OF PROV	VIDER OR SUPPLIE	R				STREET ADDRESS, CITY, STATE,	ZIP CO	DE
MOMENTOUS HEALTH AT BATTLE CREEK						675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIE ICY MUST BE PRECEDED FORY OR LSC IDENTIFYIN NFORMATION)	BY	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	(Guardian's signa	ature) (Date)						
	(Type or print gu	ardian's name)						
	(Physician's signa	ature) (Date)						
	(Type or print ph	ysician's full name)						
	ATTESTATION O	F WITNESSES						
	appears to be of duress, fraud, or executing this or	no has executed this ord sound mind, and under undue influence. Upon der, the declarant has (h identification bracelet.	no					
	(Witness signatu (Date)	re) (Date) (Witness signa	ture)					
	(Type or print witwitness's name)	tness's name) (Type or p	rint					

STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) MULT A. BUILDIN	PLE CONST	TRUCTION	(X3) DATE SURVEY COMPLETED	
		134140	B. WING			12/22/	2022
NAME OF PROVI	DER OR SUPPLIE	R		S	TREET ADDRESS, CITY, STATE,	ZIP CO	DE
MOMENTOUS	HEALTH AT BA	TTLE CREEK			75 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	CORRE	DER'S PLAN OF CORRECTION (E ECTIVE ACTION SHOULD BE CR ERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	AND IS IN COMP MICHIGAN DO-N PROCEDURE ACT Resident #27 (R2' Review of the me was admitted to to diagnoses that in osteomyelitis, dia and dementia. Th with an Assessme 11/18/22 revealed (severe cognitive Interview for Mer screening tool). R place. On 12/20/22 at 9 asleep in bed. Review of R27's C Resuscitate" Direc signed by R27's g the form was not until five days late In an interview or Social Worker (SV should sign at the responsible party Resuscitate Direc explain why two v	7) dical record revealed R27 the facility on 8/12/22 with cluded chronic betes, anxiety, depression, e Minimum Data Set (MDS) ent Reference Date (ARD) of d R27 scored 00 out of 15 impairment) on the Brief atal Status (BIMS-a cognitive 27 had a legal guardian in 55 AM, R27 was observed Code Status/"Do Not ctive revealed the form was juardian on 3/9/22, however signed by two witnesses					

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SI COMPLETED	
		134140	B. WING _		12/22/2022	
NAME OF PRO	VIDER OR SUPPLIE	R		STREET ADDRESS, CITY, S	TATE, ZIP CODE	
MOMENTOU	S HEALTH AT BA	TTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 490	17	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPRO DEFICIENCY)	E CROSS- CON	(X5) IPLETION DATE
	Resident #7					
	Minimum Data S Resident # 7 (R7) admitted to the f medical/health is Further record re out of 15 (severe the Brief Interview completed on 2/ Review of R7's ac reflected R7 sign- (DNR) form on 2/ signed by the Physical States of the second signed by the Physical States of the second	Ivanced directive forms, ed a Do Not Resuscitate /17/21, the same form was ysician on 2/19/21, the same ss signatures which were				
	On 12/20/22 at 1 with Social Work residents with kn impairment woul physician for thei participate in me stated she does r routinely but cou was not done for DNR form, with v after R7's signatu be signed by the signed by R7. Resident #21(R21	2:56 PM, during an interview er (SW) "D" it was queried if own severe cognitive d not be evaluated by a r degree of ability to dical decisions. SW "D" equest that evaluation Id not account for why this R7. When queried about the vitness signatures 5 days Ire, SW "D" agreed it should witness right after it was				

ATEMENT OF DEFIC D PLAN OF CORRE	(X3) DATE SURVEY COMPLETED 12/22/2022	
	12/22/2022	
ME OF PROVIDER (, ZIP CODE	
DMENTOUS HEAI		
(X4) ID SUI PREFIX (EAC TAG FUI	EACH (X5) ROSS- COMPLETIC TE DATE	
Set (N a 79 y on 1// deme failure disord depre BIM (a her al severe perso transf eating Durin AM, R positi head strong open "aero: indica and e Protec door. appea open did no calmo		
indica and e Protec door. appea open did no		

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		134140	B. WING _		12/22/	/2022	
NAME OF PRO	VIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STAT	E, ZIP CO	DE	
MOMENTOU	S HEALTH AT BA	TTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 49017			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE C REFERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETION DATE	
F0600 SS= D	however the form witnesses until 1/ During an intervis Social Worker (SV expect witnesses resident or respo Not Resuscitate II explain why with day after R21's gu Free from Abuse Freedom from At Exploitation The free from abuse, resident property in this subpart. Th limited to freedor involuntary seclu chemical restrain resident's medica The facility must- verbal, mental, so corporal punishm seclusion; This REQUIREM evidenced by: Based on intervise facility failed to e physical and verb and 25), of 6 resid abuse, resulting i	ew on 12/20/22 at 1:10 PM, W) "D" reported would to sign at the time the nsible party signed the Do Directive. SW "D" could not ess signed the document a	F0600	 Resident #40 no longer resides in 1 facility. Resident #25 was seen by Sc Work on 1-25-2023 and shows no las effects from the resident interaction. All residents have the potential to b affected by this deficient practice. A c all interviewable residents was compl the NHA and the activity director on 1 and 1-27-2023 to ensure there were incidents of abuse and no concerns v noted. The facility's policy on abuse preve was reviewed by the QAPI Committed deemed appropriate on 1-12-2023. A were educated on the facility policy o prevention 1-12-2023 and 1-13-2023 administrator. To ensure compliance, 5 residents audited for freedom from abuse by th administrator/designee. Audits will be completed weeklyx4 and monthly the Results will be brought to the QAPI Compliance Committee for ongoing compliance and process improvement 5. The Administrator is responsible for plan of correction. 	cial ting we uery of eted by -26-2023 no other vere ntion e and I staff n abuse by the will be e reafter.	1/31/2023	
	and 25), of 6 resid abuse, resulting i and physically ab	dents that were reviewed for n Resident 40 being verbally		Results will be brought to the QAPI Compliance Committee for ongoing compliance and process improvemen 5. The Administrator is responsible for	t.		

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDING	PLE CON G	STRUCTION		(3) DATE SURVEY OMPLETED	
		134140	B. WING _			12/22/2022		
IAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE	
IOMENTOU	S HEALTH AT BA	ATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017					
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE	
	Minimum Data S reflected Resider old female admi diagnosis of den The MDS reveale term memory in impaired decisio Resident #40 Review of Nursin 11/30/2022 refle Assistant (CNA) walked by R40's observed R25 w R40 names. Upo intervene, R25 th physically aggre which time CNA R25 and R40. Review of the fa 11/30/22 reflects aggression." An attempt to co Nurse (LPN) "DD progress note ar R40 on 11/30/22 phone numbers service and atter emergency phor personnel file we Multiple attempt	ng progress notes dated cted Certified Nursing "CC" room at 12:30 am and as slapping R40 and calling on CNA "CC" trying to hen became verbally and ssive with CNA "CC", at "EE" entered and separated cility Incident report dated ad R40 "received physical ontact the Licensed Practical ", who authored the d was assigned to R25 and 2. LPN "DD" had multiple on file none of which were in mpts to interview via he numbers listed in her ere not valid phone numbers. ts were made to contact CNA ail and texts on 12/21 and						

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER: 134140		À. BUILDI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLIE			STREET ADDRESS, CITY, STAT 675 WAGNER DR BATTLE CREEK, MI 49017			FE, ZIP CODE	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIEI FULL REGULA	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPF DEFICIENCY)	CROSS- COMPLETIO			
F0609 SS= D	Prevention" date "The willful inflic confinement, int with resulting ph anguish. Abuse a by an individual, good or services or maintain phys well-being. Insta irrespective of al condition, cause mental anguish. sexual abuse, ph abuse including trough the use of through the use of the allegation of the administrator of	e facility Policy titled "Abuse d 8/20/21 defined Abuse as tion of injury, unreasonable imidation or punishment hysical harm, pain or mental also includes the deprivation including a caretaker of that are necessary to attain sical, mental and psychosocial nces of abuse of all residents, ny mental or physical physical harm, pain or It includes verbal abuse, ysical abuse and mental abuse facilitated or enabled if technology, such as of photographs and ts to demean or humiliate a egged Violations §483.12(c) In gations of abuse, neglect, nistreatment, the facility)(1) Ensure that all alleged ng abuse, neglect, istreatment, including wn source and of resident property, are ately, but not later than 2 llegation is made, if the e the allegation involve n serious bodily injury, or not urs if the events that cause on tinvolve abuse and do obus bodily injury, to the the facility and to other ig to the State Survey	F0609	facility. Service inciden effects 2. All re by this residen Activity 3. The update 2023. A adminis was ed on the reportir	dent #40 no longer resides in Resident #25 was seen by S so on 1-25-2023 in relation to t. Resident #25 shows no las from this incident. esidents have the ability to be deficient practice. A query of ts was completed by the NH/ Director on 1-26-2023 and 1 policy for Abuse was reviewed d by the QAPI Committee on III staff were educated by the strator on the updated policy. ucated by the CEO 1:1 on 1- policy for resident-to-resident g. nsure compliance, 5 resident	accial this sting affected all A and -27-2023. ad and 1-12- The NHA 24-2023 abuse	1/31/2023	

AND PLAN OF	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING I34140 B. WING B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST MOMENTOUS HEALTH AT BATTLE CREEK 675 WAGNER DR					со́мр _ 12/22 /	
MOMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	17	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	state law provide care facilities) in through establish (4) Report the re- the administrator representative ar accordance with State Survey Age of the incident, al verified appropria taken. This REQUIREM evidenced by: Based on intervie facility failed to re- for two of 6 resid (#25 and 40). Res abuse not being Agency and the p allegations of abu Resident #25 According to the Minimum Data S reflected Residen old female admit diagnosis of dem The MDS reveale term memory im impaired decision Resident #40	t protective services where es for jurisdiction in long-term accordance with State law hed procedures. §483.12(c) sults of all investigations to or his or her designated nd to other officials in State law, including to the ency, within 5 working days nd if the alleged violation is ate corrective action must be IENT is not met as ew and record review the eport an allegation of abuse lents reviewed for abuse sulting in allegations of reported to the State potential for additional use to go unreported. clinical record, including the et (MDS) dated 11/15/22 tt 25 (R25) was an 84 year ted to the facility with mentia and bi-polar disorder. d R25 had long and short pairment with severely in making skills. g progress notes dated		adminis comple monthly to the C process 5. The	for abuse reporting by the strator/designee. Audits wil ted weekly for 4 weeks and / for 2 months. Results will DAPI Committee for trendin s improvement. Administrator is responsible correction.	l be d then be brought ig and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	À. BUILDIN	G	ISTRUCTION	. COMF	(X3) DATE SURVEY COMPLETED	
		134140	B. WING _			12/22	2/2022	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE	
MOMENTOU	S HEALTH AT BA	ATTLE CREEK			017			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
	11/30/2022 refle Assistant (CNA)	cted Certified Nursing 'CC"						
	observed R25 wa R40 names. Upo intervene, R25 th physically aggres time CNA "EE" e and R40. Review of the fac 11/30/22 reflectu aggression." An attempt to co Nurse (LPN) "DD progress note ar R40 on 11/30/22 phone numbers service and atter emergency phor personnel file we Multiple attemp? "CC" via voice m 12/22 but none							
	with Nursing Ho the incident was revealed that NH abuse but that s Stat Agency. NH stated she was n on the computer	12:59 PM, during an interview me Administrator (NHA) "A" discussed and it was IA "A" acknowledge the he did not report it to the A "A" elaborated, and initially ew and did not have access r system in order to report use to the State Agency, NHA						

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140		Á. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022 E, ZIP CODE	
	VIDER OR SUPPLIE S HEALTH AT BA		STREET ADDRESS, CITY, STATE, 675 WAGNER DR BATTLE CREEK, MI 49017					
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA I	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION) another explanation for the	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE	
	incident not beir stated the facility reportable allega took precedence reported by the According to the Prevention" date reporting 1b. rea or his/her design (Department of I violations involvi Exploitation, Mis Misappropriation injuries of unkno possible, but in r four (24) hours f incident/allegati staff member." L #3. "State Depar possible DOH wi online reporting submit an online form in accordar instructions. In th outage or simila temporarily notif the allegation via phone), and will incident online of the Administrato designed by the	and other explanation for the ang reported in which she y had a separate but ation of drug diversion which e for reporting which was owner of the facility. e facility Policy titled "Abuse ed 8/20/21 under initial ad in part "The Administrator nee will notify DOH Health) of all alleged ing abuse, Neglect, treatment of a resident, or n of resident property and own Source as soon as no event later than twenty- rom the time the on was made known to the Under the heading reporting tment of Health, When ill be notified using the system. The facility will e facility reported incident nee with DOH's then current the event of an Internet r failure, This facility will fy the DOH District Office of a alternative method (e.g. submit the self reported once service is restored. Only or or someone specifically Administrator is authorized Reported incident to the						

	ITEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140 134140		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
	OVIDER OR SUPPLIE				TATE, ZIP CO	ATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE
F0641 SS= D	Accuracy of Assemust accurately This REQUIREM evidenced by: Based on observ review the facility accuracy of Mini- assessments for #50) of 15 review MDS assessment unmet care need Findings include: Resident #27 (R2 Review of the me was admitted to diagnoses that ir osteomyelitis, dia and dementia. The with an Assessment 11/18/22 revealed (severe cognitive Interview for Me screening tool), he place, was always one or more unho none were docur pressure ulcers. Fi coded for any ver-	7) edical record revealed R27 the facility on 8/12/22 with	F0641	for accu DON/D assess DON/D Residen accurad DON/D 2. All re affected DON/D residen assess were ac 3. The 0 for accu approp inservic assess 13-2023 4. The 1 of 25% assess thereaft trended process 5. The 0	dent #21's assessment was iracy and corrected as need esignee on 1-16-2023.Resi ment was reviewed for accu- esignee' and corrected as r t #27's assessments was r ey and corrected as needed esignee' on 1-16-2023. sidents have the potential t d by this deficient practice. esignee' completed an audit t assessments for accuracy ments on 1-26-2023. Any in ddressed on 1-26-2023. Any in ddressed on 1-26-2023. Any in dates on 1-26-2023. Any in date on 1-12-2023. All staff ed on the policy for accuracy ments by the NHA on 1-12- 3. DON/Designee will complet of all residents for accuracy ments weekly x4 and month er. Results of these audits and brought to QAPI for or simprovement. Administrator is responsible correction.	ded by the dent #50's uracy by the needed. reviewed for by the o be The it of all o of naccuracies the policy deemed it were cy of 2023 and 1- e an audit y of nly were ngoing	1/31/2023

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 134140	IA	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
				D. WING _			12/22/	
NAME OF PROVIDER OR \$	SUPPLIE	R				STREET ADDRESS, CITY, STATE	, ZIP COI	DE
MOMENTOUS HEALTH	AT BA	TTLE CREEK				675 WAGNER DR BATTLE CREEK, MI 49017		
PRÉFIX (EACH D	EFICIEN EGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)		ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
in place.								
Director of was also reported but instea reported and shou any unhe about R2 indwelline urine, DC status sho since she Resident According Minimum 10/10/22, old femal 2022 with Alzheime On 12/11 in her roo questions greeted h was note observed English i.e	of Nursi the facil R27 did ad had w R27's M Id have aled pre 7 being g cather w "B" ro ould have had an #50 g to the Data S Reside e admit diagno r's dise: /22 at C om, she s, but di her. On the book pa with ke e, hola-l f R50's r in Mexi was Sp	n 12/20/22 at 10:06 AM, ng (DON) "B" reported she ity's MDS nurse. DON "B" not have pressure ulcers, venous ulcers. DON "B" IDS was coded incorrectly been coded as not having essure ulcers. When asked coded as having an ter and always incontinent of eported R27's incontinence ve been coded as "not rated" indwelling catheter. clinical record, including the et (MDS) dated 7/10/22 and et (MDS) dated 7/10/22 and et to the facility in July uses that included ase. 22:17 PM, R50 was observed did not respond to simple d smile when surveyor the wall next to R50's bed , uper taped to the wall y words from Spanish to Hello, aqua-water etc medical record revealed R50 co and her primary anish, but at one point R 50						

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 134140		À. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLIE S HEALTH AT BA				TATE, ZIP CC	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROI DEFICIENCY)	E CROSS-	(X5) COMPLETIC DATE	
	with R50's family R50's primary/pri Spanish and her Per family memb English and they how to, which wa posted the noted order to assist R5 Review of the 2 M admission, dated R50 was not of H did either assess language. On 12/13/22 at 1 interview with Di who also serves a explanation for th Resident #21(R2 ⁻¹ Review of the Fac Set (MDS) dated a 79 year old ferr on 1/24/17, with dementia, corora failure, periphera disorder, schizop depression. The M (assessment tool ability to make d impaired, and sho							
STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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		134140	B. WING _		12/22/2022			
NAME OF PRO	VIDER OR SUPPLIE	R		STREET ADDRESS, CITY, S	STATE, ZIP CODE			
MOMENTOU	S HEALTH AT BA	TTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 490	017			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD REFERENCED TO THE APPRO DEFICIENCY)	BE CROSS- COMPLÉTION			
	locomotion on un toileting, hygiene	nit, dressing, eating, e, and bathing.						
	AM, R21 was layi positioned low w head aukwardly p strong smell of u open with stop si "aerolol generate indicated require and eye protectic Pertective Equipr door. R21 had an appeared thin an open holding stu did not appear to calm with soft too reach under top of noted at bedside with 2 large styrc appeared to be of Review of the fac reflected R21 was services. Review of the MD and 1/21/22, refle hospice services. Review of the EM did not have a ph services.	vaton on 12/11/22 at 9:07 ng on an air mattress with hospital gown on with positioned to the left with rine in room. R21 door was ign on door that read, exing procedure" that d use of gloves, mask, gown, on, with no Personal ment(PPE) observed outside a air mattress in place, d frail, was awake with eyes ffed animal and rosery. R21 o be verbal and appeared uch call light located out of of pillow. Folding chair was a along with bedside table ofaom cups with straws that orange juice and water. willity Matrix, dated 12/11/22, s not receiving Hospice DS, dated 10/24/22, 7/24/22 ected R21 was not receiving IR on 12/12/22 reflected R21 hysician order for hospice						

	IENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140		À. ÉUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STAT	STATE, ZIP CODE		
MOMENTOU	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETION DATE	
	prognosis and el cooperatively wi	t, reflected,"I have a terminal lected to have HospiceWork th hospice team to ensure otional, intellectual, physical are met"						
	Director of Nursi had been a Hosp months and report have an order fo had been the MI reported R21's N	iew on 12/20/22 at 1:35 PM, ing (DON) "B" reported R21 bice resident for several borted would expect R21 to r hospice. DON "B" reported DS nurse prior to DON and ADS should reflect hospice did not it was an error.						
	Hospice CNA "PI bathing services Wednesday and during lunch to a reported facility reported R21 wa from Hospice se breakdown relat brief area and fa	iew on 12/21/22 at 12:25 PM P" reported provided R21 two times weekly on Friday and often comes assist with meals. CNA "OO" had been short staffed and s going to be discharged rvices and skin started to ed to incontinants located in cility moved R21 from north ospice CNA "OO" reported						
	Hospice offered R21 did not rece "OO" reported w hospice binder w	music and pet therapy but ive and was unsure why. CNA vas told yesterday that vould be located in front of e difficult to locate staff for						
F0656 SS= E	§483.21(b) Com	ent Comprehensive Care Pla prehensive Care Plans ne facility must develop and	F0656	for resid	onalized care plans were deve dents #21, #18, #50, #14 by th on 1-18-2023.		1/31/2023	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CON	ISTRUCTION		ATE SURVEY LETED	
		134140	B. WING			12/22	12/22/2022	
IAME OF PRC	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	TATE, ZIP CO	DE	
IOMENTOU	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490 ⁷	017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPRO DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE	
	care plan for each the resident righ and §483.10(c)(3 objectives and ti resident's medic psychosocial ne- comprehensive a comprehensive a following - (i) The furnished to atta highest practical psychosocial we §483.24, §483.22 services that wo under §483.24, § not provided due rights under §48 refuse treatment Any specialized rehabilitative ser provide as a resi recommendation the findings of th its rationale in th (iv)In consultation resident's represi resident's goals outcomes. (B) Ti potential for futu document wheth return to the con any referrals to I other appropriate (C) Discharge pl care plan, as ap the requirements this section. §48 provided or arran outlined by the con	as. If a facility disagrees with the PASARR, it must indicate e resident's medical record. In with the resident and the sentative(s)- (A) The for admission and desired he resident's preference and re discharge. Facilities must teer the resident's desire to munity was assessed and ocal contact agencies and/or e entities, for this purpose. ans in the comprehensive propriate, in accordance with s set forth in paragraph (c) of 3.21(b)(3) The services nged by the facility, as oomprehensive care plan, turally-competent and		the intecare pla develop 3. The previewe QAPI T Plan De , includ on 1-12 4. 25% for deve thereaff were br complia 5. The plants	udit of all care plans was co rdisciplinary team on 1-26- ans in need of development bed by the IDT Team. policy on Care Plan Develo de and deemed appropriate eam on 1-12-2023. The Po- evelopment was reviewed w ing the IDT Team , by the a 2-2023 and 1-13-2023. of all resident care plans w elopment weeklyx4 and mo- ter by the DON/Designee. F ought to QAPI Committee f ance and process improven Administrator is responsible correction.	2023. Any t were pment was by the licy on Care vith all staff administrator vill audited nthly Results for ongoing nent.		

STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING		ISTRUCTION		DATE SURVEY PLETED
		134140	B. WING _			_ 12/22	2/2022
NAME OF PROV	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DDE
MOMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490)17	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	This REQUIREN evidenced by:	IENT is not met as					
	This citation pert	ains to intake MI00130932					
	review the facility implement comp (Resident #'s 14, reviewed for com	ation, interview and record / failed to develop and prehensive care plans for 6 18, 21, 27, 48 and 50) of 15 prehensive care planning, potential for unmet care es.					
	Findings include:						
	Resident #50						
	Minimum Data S 10/10/22, Reside old female admit	clinical record, including the et (MDS) dated 7/10/22 and ent 50 (R50) was a 91 year ted to the facility in July uses that included ase.					
	in her room, she questions, but dii greeted her. On t was notebook pa observed with ke English i.e. hola- Review of R50's	2:17 PM, R50 was observed did not respond to simple d smile when surveyor the wall next to R50's bed , per taped to the wall by words from Spanish to Hello, aqua-water etc medical record revealed					
	language was Sp was bilingual. On 12/14/22 at 9	Mexico and her primary banish, but at one point R 50 :15 am, during an interview member "FF", they verified					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	PLE CONSTRUCTION	COM	B) DATE SURVEY MPLETED /22/2022		
	VIDER OR SUPPLIE S HEALTH AT BA			STREET ADDRESS, CITY, 675 WAGNER DR BATTLE CREEK, MI 490				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHOULD REFERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE		
	Spanish and her Per family memb English and they how to, which wa posted the noted order to assist st On 12/13/22 at 1 with Director of N serves as the MI were reviewed a care plan, create could speak Eng so if mad or irrite was for R50 to b to antidepressar and no intervent language or com the mood care p communication i							
	was admitted to diagnoses that ir osteomyelitis, di- and dementia. Th with an Assessm 11/18/22 reveale (severe cognitive Interview for Me screening tool) a	edical record revealed R27 the facility on 8/12/22 with included chronic abetes, anxiety, depression, he Minimum Data Set (MDS) ent Reference Date (ARD) of ed R27 scored 00 out of 15 e impairment) on the Brief intal Status (BIMS-a cognitive and required extensive e person for bed mobility.						

TATEMENT OF DI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		134140	B. WING _		12/22	12/22/2022		
IAME OF PROVIDI	ER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CC	ODE	
IOMENTOUS H	EALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49	017		
	EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
as m. fic an ur fo Or as an an ur dr nc a l Re re m. Re 9/ kn co ga Re No of ca bia ro Re	leep in bed wit attress (APM) s pat. R27 had a d incontinence inder her left stu- ot. In 12/20/22 at 0 leep in bed. R2 nputation site l ind the alternation polugged and r essing in place of have a pression blanket rolled u eview of the Ph vealed "APM m anagement". eview of the Ph 11/22 revealed use daily dressi wer with dry ga uze. eview of R27's r otes dated 11/2 floading boot a lcaneus" (heel) anket behind le lling the stump eview of R27's r	99:25 AM, R27 was observed h an alternating pressure dressing on her left stump, pad rolled up and placed imp, and a boot on her right 19:55 AM, R27 was observed 7's left below the knee had one 4x4 gauze in place ng pressure mattress was hot functioning. R27 had a on her right foot, but did ure relieving boot in place or up under her left stump. ysician's Order dated 6/6/22 hattress in place for wound ysician's Order dated an order for a left below the ng change which included to auze and secure with border most recent Wound Clinic 21/22 revealed "Z flex at all times to right and "Keep a rolled up eft knee to keep her from b behind the upper thigh". Potential/Actual Skin plan, revealed an						

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT OF E AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	À. BUILDING	3	ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		134140	B. WING _			12/22	/2022
	DER OR SUPPLIE	R	STREET ADDRESS, CITY, S			STATE, ZIP CC	DE
IOMENTOUS H	IEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49		
(X4) ID		TEMENT OF DEFICIENCIES	ID		/IDER'S PLAN OF CORREC		(X5)
	(EACH DEFICIEN FULL REGULA	ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	PREFIX TAG	COR	RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	COMPLETIO DATE
I	ntervention of a	pressure reducing mattress.					
		Actual Skin Impairment to					
		the Sacrum care plan					
		vention of APM mattress. did not mention a boot to					
	•	a rolled-up blanket behind					
	ne left knee.						
		n 12/20/22 at 09:58 AM,					
		al Nurse (LPN) "K" reported					
		pairments. When asked why not functioning, LPN "K"					
		om and reported the					
		t plugged in and she was					
		it had been unplugged.					
		n 12/20/22 at 10:06 AM,					
		ng (DON) "B" reported R27					
		essing on her left below the n incision, a functioning					
	-	sure mattress, and a boot to					
		place. During the interview,					
		room and then came back					
		Physician was in the					
	-	uld complete R27's dressing					
	•	. On 12/21/22 at 08:53 AM,					
		d R27 should have a boot to place at all times.					
C)n 12/20/22 at 1	10:56 AM, R27's left stump					
d	ressing change	was completed. R27's					
		gged in and she had a boot					
to	o the right foot	in place.					
Ir	n an interview o	n 12/21/22 at 08:53 AM,					
D	ON "B" reporte	d R27 should have a boot to					

STATEMENT O AND PLAN OF 0	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	PLE CON G	ISTRUCTION	(X3) D/ COMP	ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STATE,	710.00	
						ZIP CO	DE
MOMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR(FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	the right foot in p	place at all times.					
	Resident #18(R18	3)					
	Set (MDS) dated 70 year old male 9/1/20, with diag hypertension, per and mood disord had a BIM (assess indicated his abil was cognitively in During an observ 12/11/22 at 10:27 wheelchair in roo interest in captivi	vation and interview on 7 a.m., R18 was sitting in om. R18 reported not a lot of ities offered at facility. R18 watch TV but not many					
	Review of the mo (Activities) Assess reflected R18 pre playing cards, exc baking/cooking, chats, watching T parties/social eve news. Review of R18 Ac 12/20/22 at 11:15 [named R18] I Pro am an Army Vete traveling. I enjoye	ost recent Life Enrichment sment, dated 9/3/20, iferred activities included ercise, sports, reading, music, trips/traveling, talking/coffee V, watching movies, ents and keeping up with stivity Care Plans on 5 AM, reflected, "My name Is efer to be called [named]. I eran for 3 yearsI enjoyed ed riding motorcyclesI am erian. I played the drumsI					

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 134140		(X2) MULTI A. BUILDIN B. WING _	G			
	VIDER OR SUPPLIE S HEALTH AT BA		STREET ADDRESS, CITY, ST 675 WAGNER DR BATTLE CREEK, MI 4901				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	and drag racing. enjoy therapeuti Crayons Revision on: 04/(maintain involve stimulation, social activities as desir dateIntervention in activities of my context next review date activitiesProvide individual activit encourage me to attending activit Plans reflected in activities. Review of the Act dated 11/1/22 the R18 only particip TV/movie/music of R18 other area Resident #21(R2 Review of the Fa Set (MDS) dated	red through review insI will attend/participate hoice (3-5 times weekly) by Invite me to scheduled e me with an activities tify me of any e me with materials for ies as I desireStaff will b wear a maskThank me for y functions. The Activity Care o mention of R18 preferred tivity Task documentation, prough 12/19/22, reflected wated in social hour, and bingo with no evidence as of interest.					

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G	ISTRUCTION		ATE SURVEY
		134140					
AME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STA	TE, ZIP CC	DDE
IOMENTOU	S HEALTH AT BA	TTLE CREEK					
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPR DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE
	dementia, corona failure, periphera disorder, schizop depression. The II BIM (assessment her ability to mal severely impaired person physical a transfers, locome eating, toileting, During an obsen AM, R21 was layi positioned low w head awkwardly strong smell of u open with stop s "aerosol generat indicated require and eye protection Protective Equippe door. R21 had ar appeared thin ar open holding stu- did not appear to calm with soft to reach under top noted at bedside with 2 large Styre appeared to be of During an obsen	diagnoses that included ary heart disease, heart ary heart disease, heart al vascular disease, seizure whrenia, and mantic MDS reflected R 21 had a tool) score which indicated ke daily decisions was d, and she required one assist with bed mobility, btion on unit, dressing, hygiene, and bathing. vation on 12/11/22 at 9:07 ng on an air mattress vith hospital gown on with positioned to the left with rine in room. R21 door was ign on door that read, e\ing procedure" that ed use of gloves, mask, gown, on, with no Personal ment(PPE) observed outside n air mattress in place, nd frail, was awake with eyes uffed animal and rosary. R21 o be verbal and appeared uch call light located out of of pillow. Folding chair was e along with bedside table ofoam cups with straws that orange juice and water. vation on 12/11/22 at 3:45 ued to lay in bed with gown					

TATEMENT OF I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G	STRUCTION		DATE SURVEY PLETED
		134140	B. WING _		_ 12/22/2022		
AME OF PROVID	DER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE
IOMENTOUS I	OMENTOUS HEALTH AT BATTLE CREEK				675 WAGNER DR BATTLE CREEK, MI 490	017	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
C a r t l l l k v v r r E F S S C C i i i r r E S S C C C i i i i r r v v r r r t l l l v v r r r r r r r r r r r r r r r	Certified Nurse A assisted R21 for not able to recall out reported had iquids from kitch incomes how to car verbal report at se eported unsure esident diets are SMR. CNA "MM" hospitality aid has tyrofoam cups to orange juice after informed aid to to eported R21 con oned interview or CNA staff to SMR and reported ncluding diets fr change and sign esident liquid m During an interview cross to Kardex care and diet mo consistencies. CM interview verified MM" had heard unsure how to en						
A c	AM, CNA "KK" ar observed in R21'	vation on 12/14/22 at 9:20 nd Administrator "A" 's room. R21 was noted n bed awkwardly leaning to					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G	STRUCTION		ATE SURVEY PLETED
		134140	B. WING			12/22/2022	
ME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	TATE, ZIP CC	DE
OMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490 ⁷	17	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROI DEFICIENCY)	E CROSS-	(X5) COMPLETIC DATE
	assist with boost ADM "A" asked H At 9:27 AM R21's heard alarming v observed four sta light on as indica door. At 9:31 AW with bag of soile turned off. At 9:3 R21 room with C "NN" and CNA "H including linen. F brief and hospita not apply moistu surveyor observe programmed to, television show). During an observ AM R21's meal th room and placed to the bed and s noted in bed and and untouched. S and smell of outs down from R21 r eating lunch. Thi observe outside turned on at 12:2 room, turned off something to eat untouched meal 12:37 PM, CNA "	K" then asked CNA "NN" for ing R21 up in bed because her to make R21 comfortable. Is call light was observed and with door closed and aff pass R21's room with call the dby light illuminated over I CNA "KK" exited R21 room d items and call light was 4 AM this surveyor entered NA "KK" and observed CNA KK" finish R21 morning care t21 was repositioned and I gown changed. Staff did tre barrier cream to R21. This is d television was on "Two broke girls"(current vation on 12/14/22 at 11:33 ray was delivered to her I on the bedside table next taff exited the room. R21 was I the meal tray was covered Several staff noted on hall side food noted one door oom with several staff noted s surveyor continued to R21's room and R21 call light 23 PM. CNA "M" entered R21 the call light, offered R21 the call light, offered R21 the call light, offered R21 the call light, offered R21 tray and R21 accepted. At M" exited R21 ate about uding mandarin oranges					

ATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G	STRUCTION		ATE SURVEY PLETED
	134140	B. WING _		_ 12/22	_ 12/22/2022	
AME OF PROVIDER OR SUPPL	IER			STREET ADDRESS, CITY, S	STATE, ZIP CO	DDE
OMENTOUS HEALTH AT B	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490)17	
PRÉFIX (EACH DEFICIE TAG FULL REGUL	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY ATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE
which was no lo reported R21 d verified dishes reported trays 11:30 a.m. and tray. Review of the,	e beef/broccoli or magic cup onger cold to touch. CNA "M" rank quite a bit. This surveyor were not warm. CNA "M" vere delivered to unit about was unsure who delivered R21 Life Enrichment (Activities)					
indicated the for important or so choose clothing meals, choose t family involved music, be arour people, favorite religious service R21 preferred a crafts, music, sp	ted 1/27/21, reflected R21 illowing were either very mewhat important to her: to wear, snacks between ype of bathing, bedtime, in care, private calls, listen to ad animals/pets, groups of activities, outdoors, and es. The assessment indicated ctivities were playing cards, iritual religious activities,					
listening to rad parties/social e	outdoors, watching TV, o, watching movies and vents. This surveyor had not ut of bed or offered any					
12/11/22 throu was walked in r corridor, and ha Resident not ob	DL documentation, dated gh 12/14/22, reflected R21 oom, transferred, walked in ad locomotion on and off unit. oserved out of bed and staff ated R21 had not been out of					
Review of the L	ife Enrichment assessment,					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CON G	ISTRUCTION		ATE SURVEY PLETED	
		134140	B. WING				12/22/2022	
ME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DE	
OMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490)17		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE	
		, reflected R21 church vel of participation was						
	dated 12/1/22 th	tivity Task documentation, arough 12/14/22, reflected on to reflect preferred actives						
	through 11/25/2 incontinent of Be d/t progressive o	21 Care Plans, dated 1/29/17 2, reflected, "I am owel and Bladder potentially dementia. My guardian has hospice services and a ndition is						
	impaired r/t inco will be free of oc dignityInterven incontinence car	My skin will not become ontinence by next reviewl lor while maintaining my tionsAssist me with e post incontinent episodes.						
	or compromise, cream with each Assist me to cha require extensive	in, inspect for skin irritation and apply moisture barrier change of briefs or linens. nge my clothing as neededI e assistance for toileting. v and change as needed						
	bed most days. I and enjoy lookir snacks(cheese p enjoy bingo but on the correct sp need it in a cup	ned R21]. I prefer to be in my do get up from time to time g out my windowAlso like uffs and ginger ale). I also need help placing the chip bace. I like to have a pop but with handlesRevision on: alI will maintain						

TATEMENT OF D ND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G	STRUCTION		PATE SURVEY
		134140	B. WING _		12/22	12/22/2022	
AME OF PROVID	DER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CC	DDE
OMENTOUS F	IEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49	017	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE
0 a p w A h s a a o p p ir f f a o p p ir f f f a o p p ir f a c o o s i e c f f f f f f f f f f f f f f f f f f	ctivities I am att hysical and mer vith known inter dapted as need olders if I lack h egmentation), C nd abilities; and n: 02/07/2017 rior level of acti nerests by talkin amily on admiss evision on: 02/0 edside/in-room Date Initiated: 02 9/08/2020I pr roups, I am not 2/07/2017 Revis 2/07/2017 Revis 2/07/2017 Revis 2/07/2017Intr imilar backgrou ncourage/facilit nitiated: 02/07/2 2/07/2017Invi Date Initiated: 02	erventionsEnsure that the tending are: Compatible with that capabilities; Compatible ests and preferences; led(such as large print, and strength, task Compatible with my needs Age appropriate. Revision Establish and record my vity involvement and ng with me, caregivers, and ion and as necessary. 07/2017. I need 1:1 o visits 3x a week with LEAs. 2/07/2017 Revision on: efer to socialize with: small very social. Date Initiated:					
g 0 n c C D 0	oing outside wi 2/07/2017 Revis ne a program of mpower me by hoice, self-expre Pate Initiated: 02 2/07/2017. Prov	vatching the news, talking, nen it is nice. Date Initiated: sion on: 02/07/2017. Provide f activities that interest and encouraging/allowing my ession and responsibility. 2/07/2017Revision on: vide me with an activities ify me of any changes. Date					

TATEMENT OF ND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	G	STRUCTION	ĊOMF	ATE SURVEY PLETED	
AME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST 675 WAGNER DR BATTLE CREEK, MI 4901				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ITEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	LIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE	
	02/07/2017Wh participate in org watch TV, go out chat 1:1 for social Date Initiated: 02 02/07/2017 I need assistance r/t dx of dement anemia, seizures, osteoarthritis, an elected I receive decline in my con have a DX of CHI 01/31/2017 Revi: will achieve optir with staff assistance, as I to date. Revision or 01/03/2023I pr with handles of r Revision on: 11/0 for personal care 05/29/2020Res areas of adl'sRe MOBILITY: I requ for turning and r Please offer assis least Q 2 hours v 11/05/2018EAT to total assistance	ident is EXT - TOTAL with all evision on: 11/29/2021BED ire extensive assistance x1 epositioning when in bed. tance with repositioning at while in bedRevision on: 'ING: I benefit from extensive e with feeding, as I am tensils with my right						

TATEMENT OF DEFICIENCI ND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		DATE SURVEY PLETED	
	134140	B. WING	B. WING			
AME OF PROVIDER OR SU	PLIER		STREET ADDRE	SS, CITY, STATE, ZIP CO	DDE	
OMENTOUS HEALTH A	BATTLE CREEK		675 WAGNER BATTLE CREE			
PRÉFIX (EACH DEF	STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY ILATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION REFERENCED TO T DEFICI	I SHOULD BE CROSS- THE APPROPRIATE	(X5) COMPLETIO DATE	
or impaired making dec bipolar, anx enjoy to im quality if life I am at nutr conditions. malnutrition I am edentu require a m thickened li have low BN nutritional s assistance v receive diur related weig receive med appetite. I r decline in m Initiated: 01 11/09/2022 as feasible ordered sup date. Target 1/3/2023 meals and e wheelchair 01/29/2017 me my pref cream, hot	ed cognitive function/dementia nought processes r/t Difficulty ions, dx of schizophrenia, tyEngage me in activities that I ove my focus and enhance my Revision on: 11/29/2021 onal risk r/t my chronic nave schizophrenia, COPD, dementia, GERD, anemia. ous and do not wear dentures. I chanically altered diet with uids. My appetite is poor and I . I have impaired skin requiring pplements. I require 1:1 th meals. I have a food allergy. I ic therapy, fluid t changes are anticipated. I cations that may impact my reve hospice services and a condition is expected. Date 29/2017 Revision on: GoalMinimize risk of aspiration will accept at least 50% of lements through next review lated terventionsAssist me with my courage me to be in my nile eating. Date Initiated: evision on: 05/03/2017Offer red choices of food - I like ice ogs, roast beef, grilled chops. Given my diet texture one of my favorite foods are not					

STATEMENT O AND PLAN OF 0	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:			ISTRUCTION		ATE SURVEY LETED
		134140	B. WING			12/22	/2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STAT	E, ZIP CO	DE
MOMENTOUS	6 HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	permitted.			1			
	Revision on: 05/0	9/2020					
	eating and drinki comfort care with 11/29/2021Inte bites and sips usi do not allow me Initiated: 11/29/2 eat in an upright each bite thoroug Initiated: 11/29/2 extensive assistan I am at risk for im to poor nutrition also need assista 02/21/2022Inte repositioning me chairKeep my u independently(R2 incontinent of bc me when soiled. when I am in bed 08/19/2022Kee lotion or A&D or reposition me ev keep my off my b times I have a rash of th	npaired skin integrity related and recent weight loss. I nce with adls Date Initiated: rventionsAssist in frequently in my bed or rinal in reach since I use it 21 is a famale). I am owels so check and change I use an incontinent pad I-no brief. Date Initiated: p my skin clean and dry. Use n dry skinTurn and ery two hours as tolerated to back except during meals the under bilateral breast r/t st infection. Date Initiated: rventionsEncourage me to					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Á. BUILDIN	IG	STRUCTION	. COMF	DATE SURVEY
		134140	B. WING			12/22	2/2022
NAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE
MOMENTOU	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49	017	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIOI DATE
	have Hospice. D 01/08/2020Inte cooperatively wi my spiritual, ema and social needs reflected no mer services R21 rec company or frec During an obser AM, R21 was lay closed, wearing on bedside table meal meal tray of with 2 bowls of untouched and a and empty gluce reported meals in breakfast was bi Continue to obs off and no music activities on hall During an interv at 3:10 PM, Activ reported had be November 2021 responsible for of admission activit reported complet they pop up and activity assessme "P" verified R21"	erventionsWork th hospice team to ensure otional, intellectual, physical s are met" Care Plans ntions of what hospice eived or what hospice juency of services. vation on 12/20/22 at 8:20 ing on back in low bed, eyes a hospital gown, with 2 mugs e with straws. Observe R21 on hall cart with CNA "M" pureed items. One bowl was on with maybe one bite taken erna on the tray. CNA "M" hot posted but reported scuits and gravy and sausage. erve R21 in room with lights c, no staff entered, no type of					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	G	STRUCTION	ĊOMF	ATE SURVEY PLETED /2022	
	IAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST 675 WAGNER DR BATTLE CREEK, MI 4901				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
	completed Janua AD "P" reported responsible for r Plans until two n Director of Nursi "P" reported R21 room activity an documented in R "P" reported R22 preferences and when on north u denomination. During an interv DON "B" reporte R21 Hospice tha that day no histo with care conferr plans to involve residents Care C forward. DON "E binder was signe been signed by s hospice staff and correction movir reported R21's C personalized inc provided. During an observa- unit with two star residents in roor	R21 should of had one ary 2022 and was unsure why. was no aware she was maintaining Activity Care nonths ago when current ing(DON) "B" took over. AD I should have daily 1:1 in d would expect it to be EMR, including refusals. AD is unaware of R21's religious verified did have rosary init but was unsure of her iew on 12/20/22 at 3:30 PM, ed had a care conference with t today and reported prior to ory of hospice involvement ences. DON "B" reported Hospice companies with onferences now moving i" reported document in ed today and should have staff receiving report from d will be part of plan of ng forward. DON "B" care Plans should be luding Hospice services vation on 12/21/22 at 9:43 ed activities noted on south off observed reading to ms. Activity staff observed in is than three minutes.						

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	G	STRUCTION	COMP	ATE SURVEY PLETED
		134140	D. WING _			_ 12/22	12022
AME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	TATE, ZIP CC	DE
	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	17	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE
	CNA "M" reported complain of noth reported new ow facility bus and r they used to be a can not. CNA "M hospice spiritual CNA who provid weekly. CNA "M" religious prefere (LPN) "OO" joine had cared for R2 enjoy regular trip "OO" reported h bed in two week events. LPN "OO liked music and r using rosary and necklace she was reported was un background and observed hospic R21. LPN "OO" a were unsure wha from hospice and hospice tablet af During an intervit Hospice CNA "Pf bathing services Wednesday and during lunch to a reported facility	ew on 12/21/22 at 10:45 AM, ad residents are bored and hing to do. CNA "M" mer took over and sold the ow residents complain that able to go out and now they " reported had never seen care in for R21, only hospice ed baths usually 2 times reported was unsure of R21 nce. Licensed Practical Nurse d the interview and reported 1 for several years and use to os out of the facility. LPN ad not observed R21 out of s and does not like group " reported was unsure if R21 reported long history of had always had cross s very attached to. LPN "OO" sure of R21's religious reported had never e spiritual services visiting nd CNA "MM" both reported t services R21 was receiving d reported they only sign ter visits for CNA and Nurse. ew on 12/21/22 at 12:25 PM 2" reported provided R21 two times weekly on Friday and often comes assist with meals. CNA "OO" had been short staffed and s going to be discharged					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/22/2022
	VIDER OR SUPPLIE S HEALTH AT BA			STREET ADDRESS, CI 675 WAGNER DR BATTLE CREEK, MI	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR CORRECTIVE ACTION SHOU REFERENCED TO THE AP DEFICIENCY)	ILD BE CROSS- PROPRIATE DATE
	breakdown relate brief area and fac to south unit. Ho Hospice offered of R21 did not recei "OO" reported w hospice binder w building because nurse to sign for Resident #48 (R48 Review of R48's el upon R48 was adm 6/17/2022 hospice Diagnoses included (causes weakness a Dementia, muscle Record review of a assessment, dated "Brief Interview for of zero out of 15, v severely impaired the MDS R48 requ maximum assistan During an intervier with Licensed Praa- regarding care coo "N" stated when he R48 she had no ide stated there was a nurse's station. Record review of H Certified Nurse Ai R48 had received s) lectronic medical record (EMR) nitted to the facility on services were already in place. d congestive heart failure and shortness of breath),			

STATEMENT O AND PLAN OF 0	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:			ISTRUCTION	(X3) D/ COMP	ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
NAME OF PROV	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	ZIP CO	DE
MOMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
		2, 11/14/22 and 11/07/22. pice binder revealed no hospice					
	"U" stated hospice	12/13/22 at 08:23 AM, CNA provided showers on the shower days. Writer inquired if showers a day.					
	Director of Nursin thought hospice C facility scheduled facility CNAs. DC	w on 12/21/22 at 09:05 AM, g (DON) "B" stated she NAs provided all showers on shower day, instead of the DN "B" further stated the facility howers if the hospice CNA did					
	contain a care plar care), physician or nor nurses' notes w R48's care plan, no ever put in place ro he was receiving a were in place for c	R48's hospice binder did not h, Kardex (CNAs direction of ders, schedule of hospice visits, vere in the binder. Review of o comprehensive care plan was egarding R48 hospice services nd therefor no interventions oordination of care such to bice was providing.					
	Resident #14						
	10/1/19 with diag renal disease, ast obstructive pulm lymphoblastic leg failure. Review of with an Assessmu 10/20/22 reveale Interview for Mer 13 (cognitively in	4) admitted to facility gnoses including end stage thma, anemia, chronic onary disease, acute ukemia, and congestive heart f Minimum Data Set (MDS) ent Reference Date (ARD) of d R14 to have a Brief ntal Status (BIMS) score of ttact). Section G of MDS 4 was independent with bed					

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G	STRUCTION		PATE SURVEY	
		134140	B. WING _	B. WING			12/22/2022	
AME OF PROV	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, S	STATE, ZIP CO	DDE	
IOMENTOUS	BHEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	17		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
	•	t up, independent with eating		1				
		nd required one person re with transfers and dressing.						
	5	vation and interview on						
		AM, R14 was observed Ichair at bedside with oxygen						
	5	rs per minute via nasal						
		ted that her kidneys were						
		ne had started hemodialysis						
	in October of 20	22 and held up her right arm						
		he fistula that could be seen						
		er arm. Per R14, she left the						
		kimately 6:30 AM every						
		sday, and Friday for dialysis						
	and returned at	approximately 12:00 PM.						
	Review of R14's	Care Plan Focus created						
		ed, "I am receiving Dialysis r/t						
	(related to) my r	enal failure M-W-F at [name						
		dialysis center]". Care Plan						
		ill have immediate						
		uld any signs and symptoms						
		from dialysis occur" with						
		ted date and 11/15/2022 are Plan Intervention stated,						
		ns and symptoms of fluid						
	-	ch as) shortness of breath,						
	•	tremity swelling. Monitor me						
		mptoms of pain" with						
		ated date. No additional						
		ted to reflect resident						
		ntions i.e. R14's routine						
		ansportation to/from dialysis						
		ccess site, potential						
		at could arise from dialysis						

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140		À. BUILDIN	G		(X3) DATE SURVEY COMPLETED 12/22/2022	
NAME OF PROVIDER OR SUPPLIER MOMENTOUS HEALTH AT BATTLE CREEK			STREET ADDRESS, CITY, 675 WAGNER DR BATTLE CREEK, MI 49				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (EA RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIATE DEFICIENCY)	SS- COMPLETI	
	information. In an interview of "B" stated that a formulated when treatment and th include dialysis I information, indi and times, special instructions from should be sent w site location and complications the treatment. Review of facility 5/1/2022, indica related to poten fluid volume, po alteration in nutti integrity, risks for and psychosocial assessed, and im addressed in the An individual can and followed in a comprehensive a	Ilysis center contact In 12/20/22 at 2:46 PM, DON dialysis care plan should be a resident begins dialysis that the care plan should boation and contact vidualized dialysis schedule fic resident centered a dialysis (i.e. snacks that vith resident), dialysis access monitoring, and potential at could arise post dialysis r policy titled "Dialysis" dated ted that "2) Risk factors tial for bleeding, alteration in tential for infection, rition, alteration in skin r adverse medication effects I needs should be identified, terventions to manage individualized care plan5) re plan should be developed coordination with the assessment8) Emergency I be identified and to the individual care plan"					
F0657 SS= E	Comprehensive comprehensive Developed within	g and Revisio §483.21(b) Care Plans §483.21(b)(2) A care plan must be- (i) n 7 days after completion of ive assessment. (ii)	F0657	#40,#5 1-24-20 2. An a	care plans of residents #1, #48, # 1, #21were revised by the IDT tea 023. udit of all resident care plans for ary revisions was conducted by th	mon	

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDIN		ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		134140	B. WING _			12/22/	2022
NAME OF PROV	IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MOMENTOUS	HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	includes but is no attending physici with responsibility nurse aide with re (D) A member of staff. (E) To the e participation of th resident's repressimust be included record if the partit their resident rep- not practicable for resident's care pl staff or professio determined by the revised by the inflexibility each assessment comprehensive a assessments. This REQUIREM evidenced by: Based on observa- review, the facility for 4 (Residents # reviewed for care potential for inac plan intervention Findings include: Resident #1 Resident #1 (R1) 4/8/2016 with dia	initially admitted to facility agnoses including multiple , right ankle contracture, left		plans ir interdis 3. The reviewe -12-202 with all 2023 ai 4. The of 5 res monthly revision brough improve 5. The	ciplinary team on 1-18-2023. Ar n need of revision were updated ciplinary team on 1-18-2023. policy for care plan revision was ad and updated by the QAPI Tea 23. The updated policy was revie staff by the Administrator on 1-7 nd 1-13-2023. DON/Designee will complete an ident care plans weekly x4 and y thereafter to ensure appropriat Addit results will be trended an t to the QAPI Committee for pro- ement. Administrator is responsible for t correction.	by the am on 1 ewed 12- audit re nd cess	

TATEMENT OF D ND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G	STRUCTION		DATE SURVEY PLETED
		134140	B. WING _			12/22/2022	
AME OF PROVID	ER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE
IOMENTOUS H	IEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49	017	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
R ar 11 In (s W ev d d P t V S d al S c s t V S d d in O la b b a P m f e in (- - - - - - - - - - - - - - - - - -	eview of the Mi n Assessment R 1/6/22 revealed therview for Men severe cognitive 1DS revealed the xtensive assistant ressing, eating, erson total dep- wo-person total ection H of MD lways incontinent ection M of MD sk of developing vo Stage 1 press /6/22 revealed to eveloping press adicated to have 0n 12/11/22 at 1 ack with head of pproximately se tending resident adicating "Hospi HA) "E" stated the xtensive assist a attermittently assist onsume 50 to 7 0n 12/13/22 at 3 lurse (LPN) "C" of rder for oral car	and urge incontinence. nimum Data Set (MDS) with eference Date (ARD) of that R1 had a Brief ntal Status (BIMS) score of 6 impairment). Section G of at R1 required one-person nce with bed mobility, and personal hygiene; one- endence with toilet use; and dependence with transfer. S reflected that R1 was nt of bowel and bladder. S indicated that R1 was at g pressure injuries and had sure injuries. The MDS dated that R1 was at risk for ure injuries but was not e any at time of assessment. 1:50 AM, R1 was observed facility gown, positioned on f bed elevated to venty-five degrees. Staff o be sitting at bedside and with staff name tag itality Aide". Hospitality Aide nat resident required t meals and that when she sisted her to eat, R1 would 5% of meal. ::01 PM, Licensed Practical confirmed that R1 had an e and that she would either care or verify with the					

STATEMENT OF DEFICIENC AND PLAN OF CORRECTION		PPLIER/CLIA JMBER:	(X2) MULTIPLI A. BUILDING _	E CON	STRUCTION	(X3) DATE SURVEY COMPLETED	
	134140		B. WING			12/22/2022	
NAME OF PROVIDER OR SU	PPLIER				STREET ADDRESS, CITY, STATE,	ZIP COI	DE
MOMENTOUS HEALTH A	T BATTLE CREEK				675 WAGNER DR BATTLE CREEK, MI 49017		
PRÉFIX (EACH DEF	Y STATEMENT OF DEFICIE ICIENCY MUST BE PRECE SULATORY OR LSC IDENTI INFORMATION)	EDED BY F	ID PREFIX TAG	CORF	IDER'S PLAN OF CORRECTION (E/ RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIATI DEFICIENCY)	SS-	(X5) COMPLETION DATE
completed. extensive to care as R1 I hands to as In an interv Certified Ni R1 required CNA "M" st assist with she tried to During the that a CNA resident wo determine required. C kardex which assistance f and oral ca according t could basic with only v staff. CNA ' inaccurate total assist Review of F 4/11/2016 stated, "I no (Activities c weakness a Care Plan C current leve	le that the care had been LPN "C" stated that R1 re complete assistance with ad limited dexterity in ar sist with completion of ta ew on 12/13/22 at 3:06 P rse Aide (CNA) "M" state "full/total assist" with or ated that R1 sometimes r are including oral care bu complete daily. same interview, CNA "M" that was unfamiliar with a uld look at the Kardex to he assistance level that a IA "M" proceeded to rev h stated, "I need limited om you with personal hy e". CNA "M" stated that b the kardex, it appeared ally complete oral care or rbal cues and minimal as M" confirmed that this wand stated again that R1 re vith oral care. 1's Care Plan Focus created ind last revised on 11/25, ed assistance with ADL's f Daily Living) d/t (due to and difficulty in walking fro pal stated, "I will maintain of functioning through "	equired th oral rms and ask. PM, ed that ral care. refused ut that ' stated a or resident riew R1's ygiene that R1 n her own ssist from ras needed /2022 om" n my the					

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	IA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		134140	l	B. WING _			12/22/	2022
NAME OF PROVIDE	ER OR SUPPLIEI	R				STREET ADDRESS, CITY, STATE,	ZIP CO	DE
MOMENTOUS H	EALTH AT BA	ITLE CREEK				675 WAGNER DR BATTLE CREEK, MI 49017		
PRÉFIX (E	EACH DEFICIEN	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)		ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
Int ne pe 3/ Re "H HY wi HC far inc as: Re 10 rer ob lyr fai wi 10 Int 13 rev mo an lim	tervention state eed limited assis ersonal hygiene 10/2020 initiate eview of R1's Ka lygiene/Oral Ca (GIENE: I need I th personal hyg owever, the MD miliar with resid dicated that R1 sist with oral hy esident #14 (R14 0/1/19 with diag nal disease, asth ostructive pulmo mphoblastic leu ilure. Review of th an Assessme 0/20/22 revealed terview for Men 6 (cognitively int vealed that R14 obility after set id toilet use, and nited assistance an interview or NA "M" confirm	on date. Care Plan ed, "PERSONAL HYGIENE: I stance from you with and oral care" with ed and revision date. rrdex included under re" that for "PERSONAL limited assistance from you giene and oral care. S and staff that were lent's current status required extensive to total rgiene. 4) admitted to facility moses including end stage hma, anemia, chronic onary disease, acute ikemia, and congestive heart Minimum Data Set (MDS) ent Reference Date (ARD) of d R14 to have a Brief tatal Status (BIMS) score of tact). Section G of MDS was independent with bed up, independent with eating d required one-person e with transfers and dressing. In 12/21/22 at 11:12 AM, ed that she was familiar ked with her frequently.						

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 134140		Á. BUILDIN	G	STRUCTION	ĊOMF	3) DATE SURVEY OMPLETED 2/22/2022	
NAME OF PROVIDER OR SUPPLIER MOMENTOUS HEALTH AT BATTLE CREEK					STREET ADDRESS, CITY, STATE, ZIP CODE 675 WAGNER DR BATTLE CREEK, MI 49017			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE	
	independent" in	that R14 was "really cluding with transfers and d that she only assisted her						
	CNA "KK" stated but had worked to her that date. referenced the K and that R14 rec dressing and me	In 12/21/22 at 11:20 AM, that she was new to facility with R14 and was assigned CNA "KK" stated that she cardex for resident care needs juired set up assist for tals but that she was endent with transfers and						
	10/28/2019 with stated, "I require with ADL's" Ca remain in the fac needs". Care Pla "Resident requir	Care Plan Focus created no indicated revision date supervision and assistance are Plan Goal stated, "I will cility for my long-term care n Intervention stated, es limited with all areas of e" with 7/21/2021 initiated e.						
	1/5/2020 and re am at risk for fal problems" Car be free from fall next review" with 11/15/2022 revise Interventions stat in the bathroom	Care Plan Focus created vised 11/26/2021 stated, "I Is r/t (related to) gait/balance e Plan Goal stated, "I hope to s without a serious injury by n 1/5/2020 created date and sion date. Care Plan ted, "Do not leave me alone " with 1/5/20220 initiated ision date noted.						

	PLAN OF CORRECTION IDENTIFICATION NUMBER:		Á. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
NAME OF PROVIDER OR SUPPLIER MOMENTOUS HEALTH AT BATTLE CREEK					STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 4901	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE	
	Care Plan Goal si with 5/6/2022 cr revision date. Ca "transfers indepe- initiated and revi Review of R14's of 10/9/2019 and re need assistance of Goal stated, "I wi of functioning th 10/9/2019 create revision date. Ca included, "TOILE" myself" with 10/7 revision date, an with supervision. help set up" w revision date. Review of R14's I Plan Intervention resident "transfe I dress myself wi staff PRN [as nee "Do not leave mo DON "B" stated to with bed mobilit set up, required transfers and dre	"MY TRANSFER STATUS". tated, "I will transfer safely" eated date and 11/15/2022 re Plan Interventions stated, endently" with 5/6/2022 ision date. Care Plan Focus created evised 10/24/2019 stated, "I with my ADL's" Care Plan ill maintain my current level arough the review date" with ed date and 11/15/2022 re Plan Interventions T USE: I am able to toilet 24/2019 initiated and d "DRESSING: I dress myself . Assistance by staff PRN to ith 11/26/2021 initiated and Kardex reflected the Care hs which included that rs independently", "Dressing: th supervision, assistance by eded] to help set up", and e alone in the bathroom". n 12/21/22 at 12:17 PM, that R14 was independent y and personal hygiene after up to limited assist with essing since starting dialysis, dependent with toileting.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	Á. BUILDIN	IG	STRUCTION	ĊOMF	DATE SURVEY PLETED 2/2022	
NAME OF PROVIDER OR SUPPLIER MOMENTOUS HEALTH AT BATTLE CREEK			STREET ADDRESS, CI 675 WAGNER DR BATTLE CREEK, MI					
(X4) ID PREFIX TAG	(EACH DEFICIEI FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L VIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
	10/20/22 accura and that the car- interventions ne revised to reflect level of care whi with transfers ar Review of facility Plans" dated 5/1 2)The care plan from a thorough gathered as part assessment13 ongoing and car information abo residents' condit Interdisciplinary update the care conjunction with assessment" Resident #40 According to the Minimum Data S resident 40 (R40 admitted to the f include severe in onset Alzheimer Down syndrome Review of the M R40 was always bladder, require toilteintg, hygier required 1 perso	y policy titled "Resident Care /2022, indicated that " in interventions are derived analysis of the information t of the comprehensive) Assessment of residents are re plans are revised as ut the residents and the tions change14) The Team must review and pland. At least quarterly, in in the required quarterly MDS e clinical record including the Set (MDS) dated 11/19/22)) was a 58 year old female, acility with diagnosis that intellectual disabilities, early 's, Bi-polar disorder, anxiety,						

STATEMENT OF DEFICI AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		A (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA COMPI	ATE SURVEY LETED
		134140	В. \	WING			12/22/	2022
NAME OF PROVIDER O	R SUPPLIE	R				STREET ADDRESS, CITY, STATE,	ZIP CO	DE
MOMENTOUS HEALTH AT BATTLE CREEK						675 WAGNER DR BATTLE CREEK, MI 49017		
PRÉFIX (EACH	I DEFICIEN REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PRE TA	FIX	CORI	VIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRU FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
cognitiv	ve impairn	lected a score of 00, severe nent. Of note, R40 resided cked dementia unit.						
wande had mi hair wa form fit observ one sic was a v the sar observ Practic Assista and an None o have n and ne On 12/ observ light gr were o saggin the brie On 12/ wande rooms, pants f navy bl remain right si On 12/ wande rooms, pants f navy bl remain right si	ring aroun s matched is messy, ting yoga i ed to be o le to the be very punge ne observ ations of F al Nurse (unidentified oticed R40 ed for inco 12/22 at 0 ed walking ay sweat p bserved d g bulge wa ef that hun 12/22 10:2 ring in and R40 was rom the da lue with la ed soiled/2 de, there w 13/22 at 0 valking with lad of a soiled/2 de, there w	9:03 AM, R40 was observed d the unit, she was barefoot, I clothing clothing on, her R40 was observed to have type pants on her brief was verly saturated and hung to ack of R40's knee, there ent urine odor. At 9:30am ation of R40 was made, R40 walk by Licensed LPN) "R", Certified Nursing d GG, Hospitality Aide "HH" ed Activity staff person. tified staff were observed to D's disheveled appearance ontinent care. 8:05 AM, Resident # 40 g in hall wearing tight fitting bants, the back of the pants iscolored/ (wet), a large as observed on the back of g just above R40's knees. 28 AM R40 was observed I out of other residents observed to be wearing the ay before (yoga type pants, rge roses on them) her brief saturated and hung to the vas a strong odor of urine. 8:47 AM, R40 was observed h an unidentified Activity strong odor of feces, al Nurse (LPN) "N" was passed R40 in the dining r residents and staff were						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED 12/22/2022
NAME OF PROVIDER OR SUPPLIER MOMENTOUS HEALTH AT BATTLE CREEK				STREET ADDRESS, (675 WAGNER DR BATTLE CREEK, M	CITY, STATE, ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR CORRECTIVE ACTION SHO REFERENCED TO THE A DEFICIENC	DULD BE CROSS- COMPLÉT APPROPRIATE DATE
	"Stinky." In which observed to inver- LPN's "N"'s cond- wander. Observation of F revealed R40 ha pants for 3 conse- was observed to hanging in it. Review of R40's bladdar with a re- reflected in part ' hours during the needed." The go maintain dignity. Living Care plan date of 4/26/21 r with my ADLs. I my roomate's be current level of fi- included check a hours, set up wit with bed mobility hygeine, dressin Activity care plar reflected R40 en and picture book On 12/20/22 03: with Activity Direct not know until 2 was responsible reassessments. During a follow u Director "P" on 1 reported R40 no	rbalizing someone was n no staff present were stigate or attempt to correct zern, and R40 continued to R40 on 12/14/22 at 09:34 AM, d been wearing the same ecutive days. R40's closet have ample clothing care plan for bowel and vision date of 4/26/21 'Check me at least every 2 day and change my brief if al was to be free of odor and Review of the Activity Daily with a most recent revision eflected "I need assistance at times choose to sleep in d." the goal was to maintain unction, and interventions and change resident every 2 h meals, limited assistance r, transfers, toileting, g, bathing, and eating. The n with a most dated 12/10/20 joyed puzzles and coloring is. 07 PM, during an interview ctor "P" stated she had been tor for over a year, but did to 3 months ago that she for updating care plans and up interview with Activity 2/21/22 12:44 PM, she longer colors, does not like ising. Activity Director "P"			

[
STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	PLE CON G	STRUCTION		DATE SURVEY PLETED
		134140	B. WING _			12/22	2/2022
NAME OF PROVID	ER OR SUPPLIEI	२			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE
MOMENTOUS H	IEALTH AT BA ⁻	ITLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49	017	
(X4) ID PREFIX TAG	EACH DEFICIEN	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING FORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
ex ro re re R R S A d fa d d fa d d fa d fa d fa d fa d fa d fa d fa d fa d fa fa	xcept wander in borns and contin- esidents belonginesidents belonginesidents on the u- esident #21(R21 eview of the Fac- et (MDS) dated 7 79 year old fem n 1/24/17, with o ementia, corona ailure, peripheral isorder, schizoph epression. The N IM (assessment 1 er ability to make everely impaired erson physical ar ansfers, locomo- ating, toileting, h uring an observe M, R21 was layir ositioned low wi ead awkwardly p trong smell of ur pen with stop sig- aerosol generate ndicated required nd eye protection rotective Equipm oor. R21 had an ppeared thin and pen holding stud						

	A. BUILDING	STRUCTION	(X3) DATE SURVEY COMPLETED				
134140 B	B. WING		12/22/2022				
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE,	ZIP CODE				
MOMENTOUS HEALTH AT BATTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 49017					
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY PR	REFIX CORF	IDER'S PLAN OF CORRECTION (E/ RECTIVE ACTION SHOULD BE CRC FERENCED TO THE APPROPRIATE DEFICIENCY)	SS- COMPLÉTION				
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							
STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDIN		STRUCTION	(X3) DA COMPI	ATE SURVEY LETED
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		134140	B. WING _			12/22/	2022
	/IDER OR SUPPLIE	P			STREET ADDRESS, CITY, STATE,		DE
							DE
MOMENTOUS	S HEALTH AT BA	TILE GREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR(FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	activities.						
	12/11/22 through was walked in roo corridor, and had Resident not obsi interviews indicate bed. Review of the Life dated 1/26/2017, affiliation and lev catholic mass. Review of the Act dated 12/1/22 th no documenting for R21. Review of the R 2 through 11/25/22 [named R21]. I pr days. I do get up looking out my w (cheese puffs and bingo but need h correct space. I life in a cup with han 04/01/2021Goa involvement in co activities as desire dateTarget Date 01/03/2023Inte	ognitive stimulation, social ed through review					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMF	(X3) DATE SURVEY COMPLETED	
		134140	B. WING			12/22	2/2022	
NAME OF PRC	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE	
MOMENTOU	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
	Adapted as need holders if I lack I segmentation), (and abilities; and on: 02/07/2017 prior level of act interests by talki family on admiss Revision on: 02// bedside/in-room Date Initiated: 02 09/08/2020I pr groups, I am not 02/07/2017 Revi 02/07/2017 Revi 02/07/2017Int similar backgrou encourage/facili Initiated: 02/07// 02/07/2017Inv Date Initiated: 02 02/07/2017 Revi me a program o empower me by choice, self-expr Date Initiated: 02 02/07/2017. Pro calendar and no Initiated: 02/07// 02/07/2017Wh participate in org watch TV, go out	rests and preferences; ded(such as large print, hand strength, task Compatible with my needs d Age appropriate. Revision .Establish and record my ivity involvement and ng with me, caregivers, and sion and as necessary. 07/2017. I need 1:1 n visits 3x a week with LEAs. 2/07/2017 Revision on: refer to socialize with: small very social. Date Initiated: sion on: roduce me to others with atte my interaction. Date 2017. Revision on: preferred activities are: watching the news, talking, hen it is nice. Date Initiated: sion on: 02/07/2017. Provide f activities that interest and encouraging/allowing my ession and responsibility. 2/07/2017Revision on: vide me with an activities tify me of any changes. Date 2017 Revision on: vide me with an activities tify me of any changes. Date 2017 Revision on: vide me with an activities tify me of any changes. Date 2017 Revision on: vide me with an activities tify me of any changes. Date 2017 Revision on: vide me vith an activities tify me of any changes. Date 2017 Revision on: vide me vith an activities tify me of any changes. Date 2017 Revision on: vide me vith an activities tify me of any changes. Date 2017 Revision on: vide me vith an activities tify me of any changes. Date 2017 Revision on: ven I choose not to ganized activities, I prefer to tside, have pet visits, and al and sensory stimulation.						

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			. COM	(X3) DATE SURVEY COMPLETED 12/22/2022	
IAME OF PRC	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE	
IOMENTOUS HEALTH AT BATTLE CREEK					675 WAGNER DR BATTLE CREEK, MI 49	017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
	Date Initiated: 02 02/07/2017"	2/07/2017 Revision on:						
	AM, R21 was lay closed, wearing a on bedside table observe R21 in r	vation on 12/20/22 at 8:20 ng on back in low bed, eyes a hospital gown, with 2 mugs with straws. Continue to boom with lights off and no ntered, no type of activities 5 a.m.						
	at 3:10 PM, Activ reported had be November 2021, responsible for c admission activit reported comple they pop up and	ew and record on 12/20/22 ity Director (AD) "P" en in position since AD "P" reported was ompleting annual and new y assessments. AD "P" ted annual reviews when residents should have an ent at least once per year. AD						
	"P" verified R21's assessment had reported was un AD "P" reported completed Janua AD "P" reported responsible for r	s most recent activity been completed 1/27/21 and sure who generates them. R21 should of had one my 2022 and was unsure why. was no aware she was maintaining Activity Care						
	Director of Nursi "P" reported R21 room activity and documented in F "P" reported was preferences and	nonths ago when current ng(DON) "B" took over. AD should have daily 1:1 in d would expect it to be MR, including refusals. AD unaware of R21's religious verified did have rosary nit but was unsure of her						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	NG	ČOM	(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLIE S HEALTH AT BA				STREET ADDRESS, CITY, STATE, ZIP CO 675 WAGNER DR BATTLE CREEK, MI 49017	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (EACH RECTIVE ACTION SHOULD BE CROSS- FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
	AM, first observe unit with two star residents in room R21 room for less During an intervi CNA "M" reported complain of noth reported new ow facility bus and re they used to be a can not. CNA "M hospice spiritual CNA who provid weekly. CNA "M" religious prefere (LPN) "OO" joine had cared for R2 enjoy regular trip "OO" reported h bed in two week events. LPN "OO liked music and pusing rosary and necklace she was reported was unit background and	vation on 12/21/22 at 9:43 ed activities noted on south ff observed reading to ns. Activity staff observed in s than three minutes. ew on 12/21/22 at 10:45 AM, ed residents are bored and ning to do. CNA "M" oner took over and sold the ow residents complain that able to go out and now they " reported had never seen care in for R21, only hospice ed baths usually 2 times " reported was unsure of R21 nce. Licensed Practical Nurse d the interview and reported 1 for several years and use to os out of the facility. LPN ad not observed R21 out of s and does not like group " reported long history of had always had cross s very attached to. LPN "OO" sure of R21's religious reported had never e spiritual services visiting					
F0677 SS= E	§483.24(a)(2) A carry out activitie	led for Dependent Residents resident who is unable to as of daily living receives the ses to maintain good	F0677	facility. plans re	dent #40 no longer resides at the Residents #28, #51, #21 had their care wiewed by the IDT Team and updated I-2023. POC Kardex were also updated		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:	IA (X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY LETED
	134140	B. WING _		12/22/	2022
NAME OF PROVIDER OR SUPP	LIER		STREET ADDRESS, CITY,	STATE, ZIP CO	DE
MOMENTOUS HEALTH AT	BATTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 490	017	
PRÉFIX (EACH DEFIC	STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY LATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHOULD REFERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
hygiene; This REQUIR evidenced by This citation p Based on obs review, the fa residents of e receive the ne activities of d unmet care ne Findings Inclu Resident #210 Review of the Set (MDS) dat a 79 year old on 1/24/17, w dementia, cor failure, periph disorder, schit depression. T (assessment t ability to mak impaired, and physical assis locomotion o toileting, hygi	ertains to intake M100130932 ervation, interview and record cility failed to ensure two (ght residents (R21and R40) cessary care and services for aily living resulting in potential peds. de:		for residents #48, #51, and #21 of The DON verified the updated AI were being met for residents #48 #21 on 1-26-2023. 2. All residents have the potentia affected by the deficient practice. was done by the DON/Designee ensure that there were no resider unmet ADL care needs. 3. The policy for ADL care was re deemed appropriate by the QAPI on 1-12-2023. All staff were educ facility Policy for ADL Care by the administrator on 1-12-2023 and ' 4. To ensure compliance, 25% of will be audited for ensuring prope was performed. This audit will be performed by the DON/Designee be completed 2x a month for 3 m then as QAPI recommendations. 5. The Administrator is responsib plan of correction.	DL needs 8,#51, and I to be . An audit 1-25-2023 to nts with eviewed and I Committee cated on the e 1-13-2023. f all residents er ADL care a be 2. Audits will ionths and	

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AND PLAN OF	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		ISTRUCTION		DATE SURVEY PLETED
		134140	B. WING _			12/22	2/2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY	, STATE, ZIP CO	DDE
MOMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR		
					BATTLE CREEK, MI 4	9017	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PRO\	I /IDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY	PREFIX	COR	RECTIVE ACTION SHOULI	D BE CROSS-	COMPLÉTION
TAG		TORY OR LSC IDENTIFYING NFORMATION)	TAG	RE	EFERENCED TO THE APPI DEFICIENCY)	ROPRIATE	DATE
					22.1012.101.)		
		positioned to the left with					
	-	rine in room. R21 door was					
		ign on door that read,					
	-	e\ing procedure" that					
		d use of gloves, mask, gown,					
		on, with no Personal ment(PPE) observed outside					
		air mattress in place,					
		d frail, was awake with eyes					
		iffed animal and rosary. R21					
		be verbal and appeared					
		uch call light located out of					
		of pillow. Folding chair was					
	noted at bedside	along with bedside table					
	with 2 large styro	ofaom cups with straws that					
	appeared to be o	orange juice and water.					
	During an observ	vation on 12/11/22 at 3:45					
	p.m., R21 continu	led to lay in bed with gown					
	on with neck turr	ned to left in dark room.					
	During an intervi	ew on 12/11/22 at 2:45 PM,					
	5	id (CNA) "MM" reported					
		preakfast and reported was					
		what R21 ate for breakfast					
		either nectar or honey thick					
	liquids from kitch	nen. CNA "MM" reported					
		re for each resident by					
	verbal report at s	hift change. CNA "MM"					
	•	ents in Electronic Medical					
		nurse station only because					
		e access to hall monitors					
		sure how to determine what					
		ts are including restrictions					
		'M" joined interview in hall					
l	and verified no w	vay for CNA staff to					I

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				ISTRUCTION		(X3) DATE SURVEY COMPLETED	
		134140	B. WING			12/22	2/2022	
AME OF PROVIDER OF	SUPPLI	ĒR			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE	
OMENTOUS HEALT	H AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49	017		
PRÉFIX (EACH	DEFICIEI REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE	
reporte diets fro sign in a modific During CNA "M access t care and consiste intervie "MM" h unsure During AM, CN observe position left side assist w ADM "/ At 9:27 heard a observe light on door. A with ba turned R21 roc "NN" ar includir brief an not app surveyo	d aware of m verba main kitc ation and an interv " report o Kardes d diet mo encies. Cl w verifier ad hearc how to e an obser A "KK" a d in R21 d in R21 aed low i c. CNA "K ith boos" asked AM R21' larming s d four st as indict t 9:31 AN g of soile off. At 9:: m with C ad CNA " g linen. I d hospit. ly moistur r observer	ent diet from EMR and of resident care including I report at shift change and hen with resident liquid d consistency. iew on 12/11/22 at 2:55 PM, ed had forgot that they have to reach resident that had odifications including liquid NA "MM" also present for d that was the first CNA I about the Kardex and was ven look at it. vation on 12/14/22 at 9:20 nd Administrator "A" 's room. R21 was noted in bed awkwardly leaning to K" then asked CNA "NN" for ting R21 up in bed because her to make R21 comfortable. s call light was observed and with door closed and aff pass R21's room with call ated by light illuminated over A CNA "KK" exited R21 room ed items and call light was B4 AM this surveyor entered CNA "KK" and observed CNA KK" finish R21 morning care R21 was repositioned and al gown changed. Staff did ure barrier cream to R21. This ed television was on "Two broke girls"(current						

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 490						
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L VIDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE		
	AM R21's meal t room and placed to the bed and s noted in bed and and untouched. and smell of out down from R21 f eating lunch. Thi observe outside turned on at 12: room, turned off something to ea untouched meal 12:37 PM, CNA " the meal tray an 25% of meal incl mostly, did not v pureed possible which was no lor reported R21 dra verified dishes w reported trays w 11:30 a.m. and w tray. Review of the Ca reflected, "I am i Bladder	vation on 12/14/22 at 11:33 ray was delivered to her d on the bedside table next taff exited the room. R21 was d the meal tray was covered Several staff noted on hall side food noted one door room with several staff noted s surveyor continued to R21's room and R21 call light 23 PM. CNA "M" entered R21 t the call light, offered R21 t and drink from the tray and R21 accepted. At M" exited R21's room with d reported R21 ate about uding mandarin oranges vant mashed potato's or beef/broccoli or magic cup nger cold to touch. CNA "M" ank quite a bit. This surveyor ere not warm. CNA "M" ere delivered to unit about vas unsure who delivered R21 me Plans, revised 5/3/17, ncontinent of Bowel and							

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 134140		Á. BUILDIN	G	ISTRUCTION	. COMF	B) DATE SURVEY MPLETED /22/2022	
NAME OF PROVIDER OR SUPPLIER MOMENTOUS HEALTH AT BATTLE CREEK				STREET ADDRESS, CITY, ST 675 WAGNER DR BATTLE CREEK, MI 4901			DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
	maintaining my incontinence car Clean and dry sk or compromise, cream with each Assist me to cha require extensive Check frequently Assist me with m to be in my whe Initiated: 01/29// Revision on: 05// with my ADL's d dementia, bipola seizures, rheuma and COPD. My g hospice services condition is exper (7/23/18). Date I on: 11/29/2021 hygiene and gro as I tolerate, thre Revision on: 10// 01/03/2023I pr with handles of Revision on: 11// for personal care 05/29/2020Res areas of adl'sRe MOBILITY: I required	free of odor while dignity. Assist me with e post incontinent episodes. in, inspect for skin irritation and apply moisture barrier change of briefs or linens. nge my clothing as needed. I e assistance for toileting. y and change as needed. ny meals and encourage me elchair while eating. Date						

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CON G	ISTRUCTION		(X3) DATE SURVEY COMPLETED	
	134140	B. WING _			_ 12/22	2/2022	
R OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DDE	
ALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	17		
ACH DEFICIEN	NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING	ID PREFIX TAG	COR	RECTIVE ACTION SHOULD E	BE CROSS-	(X5) COMPLETIO DATE	
DS/2018EAT otal assistance ble to hold u dRevision of aired cogniti- aired though cing decisions olar, anxiety oy to improve lity if lifeRev ing an obsern R21 was layi ed, wearing a bedside table al meal tray of pouched and of empty gluce orted meals r akfast was bis ing an obsern R21 was layi s closed wear and no music m with no sta- bugh 10:45 a. ing an intervi	TING: I benefit from extensive the with feeding, as I am tensils with my right in: 07/05/2019I have we function/dementia or it processes r/t Difficulty s, dx of schizophrenia, Engage me in activities that I e my focus and enhance my vision on: 11/29/2021" vation on 12/20/22 at 8:20 ing on back in low bed, eyes a hospital gown, with 2 mugs with straws. Observe R21 in hall cart with CNA "M" pureed items. One bowl was on with maybe one bite taken erra on the tray. CNA "M" not posted but reported scuits and gravy and sausage. vation on 12/20/22 at 9:50 ing in low bed on back with ring hospital gown with lights c. Continued to observed R21 aff entering R21 room up m. even n12/21/22 at 10:45 AM,						
	R OR SUPPLIE ALTH AT BA UMMARY STA ACH DEFICIEN ULL REGULA' II t Q 2 hours v 05/2018EAT otal assistance ble to hold u dRevision of aired cogniti aired though sing decision: olar, anxiety oy to improve lity if lifeRev ing an obsen . R21 was layi ed, wearing a bedside table al meal tray of a 2 bowls of p bouched and of empty gluce orted meals r akfast was bis ing an obsen .R21 was layi s closed wear and no music m with no sta bugh 10:45 a. ing an intervit A "M" reported	RECTION IDENTIFICATION NUMBER:	RECTION IDENTIFICATION NUMBER: A. BUILDIN 134140 B. WING _ R OR SUPPLIER ALTH AT BATTLE CREEK MUMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG t Q 2 hours while in bedRevision on: 05/2018EATING: I benefit from extensive otal assistance with feeding, as I am ble to hold utensils with my right dRevision on: 07/05/2019I have aired cognitive function/dementia or aired thought processes r/t Difficulty king decisions, dx of schizophrenia, olar, anxietyEngage me in activities that I oy to improve my focus and enhance my lity if lifeRevision on: 11/29/2021" ing an observation on 12/20/22 at 8:20 R21 was laying on back in low bed, eyes eed, wearing a hospital gown, with 2 mugs bedside table with straws. Observe R21 al meal tray on hall cart with CNA "M" to 2 bowls of pureed items. One bowl was bouched and on with maybe one bite taken empty glucerna on the tray. CNA "M" torted meals not posted but reported akfast was biscuits and gravy and sausage. ing an observation on 12/20/22 at 9:50 R21 was laying in low bed on back with a closed wearing hospital gown with lights and no music. Continued to observed R21 m with no staff entering R21 room up bugh 10:45 a.m. ing an interview on 12/21/22 at 10:45 AM, A "M" reported residents are bored and	RECTION IDENTIFICATION NUMBER: A. BUILDING 134140 B. WING R OR SUPPLIER ALTH AT BATTLE CREEK UMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PRON COR RE t Q 2 hours while in bedRevision on: 05/2018EATING: I benefit from extensive otal assistance with feeding, as I am ble to hold utensils with my right dRevision on: 07/05/2019I have aired tought processes r/t Difficulty sing decisions, dx of schizophrenia, olar, anxietyEngage me in activities that I oy to improve my focus and enhance my lity if lifeRevision on: 11/29/2021" ing an observation on 12/20/22 at 8:20 .R21 was laying on back in low bed, eyes ed, wearing a hospital gown, with 2 mugs bedside table with straws. Observe R21 al meat tray on hall cart with CNA "M" or 2 bowls of pureed items. One bowl was bouched and on with maybe one bite taken empty glucerna on the tray. CNA "M" orted meals not posted but reported akfast was biscuits and gravy and sausage. ing an observation on 12/20/22 at 9:50 R21 was laying in low bed on back with s closed wearing hospital gown with lights and no music. Continued to observed R21 m with no staff entering R21 room up rugh 10:45 a.m. ing an interview on 12/21/22 at 10:45 AM, A "M" reported residents are bored and	IDENTIFICATION NUMBER: A. BUILDING 134140 B. WING ROR SUPPLIER STREET ADDRESS, CITY, S ALTH AT BATTLE CREEK BATTLE CREEK UMMARY STATEMENT OF DEFICIENCIES (NED DEFICIENCY MUST BE PRECEDED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOLLD E REFERENCED TO THE APPRC DEFICIENCY 10 cm	LEECTION IDENTIFICATION NUMBER: A. BUILDING COMF 134140 B. WING 12/22 R OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP OC ALTH AT BATTLE CREEK STREET ADDRESS, CITY, STATE, ZIP OC UMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST BE PRECEDED BY ID INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) tQ 2 hours while in bedRevision on: 105/2018EATING: Ibenefit from extensive otal assistance with feeding, as I am ble to hold utensils with my right dRevision on: 07/05/2019I have aired thought processes r/L Difficulty sting decisions, dx of schizophrenia, Jar, anxietyEngage me in activities that I y to improve my focus and enhance my lity if lifeRevision on: 11/29/2021" ing an observation on 12/20/22 at 8:20 R21 was laying on back in low bed, eyes ed, wearing a hospital gown, with 2 mugs bedside table with straws. Observe R21 al meal tray on hall cart with CNA "M" a 2 bowls of purced items. One bowl was buched and on with maybe one bite taken empty glucerna on the tray. CNA "M" at das laying in low bed on back with a closed wearing hospital gown with lights and no music. Continued to observed R21 m with no staff entering R21 room up ugh 10:45 a.m. ing an interview on 12/21/22 at 10:45 AM, 'M'' reported residents are bored and Interview on 12/21/22 at 10:45 AM, 'M'' reported residents are bored and	

TATEMENT OF DEFICIENCI	S (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED
	134140	B. WING		12/22/2022
AME OF PROVIDER OR SU	PLIER		STREET ADDRESS, CI	TY, STATE, ZIP CODE
OMENTOUS HEALTH A	BATTLE CREEK		675 WAGNER DR BATTLE CREEK, MI	49017
PRÉFIX (EACH DEF	STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY JLATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR CORRECTIVE ACTION SHOL REFERENCED TO THE AP DEFICIENCY)	JLD BE CROSS- PROPRIATE DATE
weekly. CN/ religious pro- (LPN) "OO" had cared for enjoy regula "OO" report bed in two y events. LPN liked music using rosary necklace sh reported wa background observed ho	wided baths usually 2 times "M" reported was unsure of R21 ference. Licensed Practical Nurse bined the interview and reported R21 for several years and use to trips out of the facility. LPN d had not observed R21 out of eeks and does not like group OO" reported was unsure if R21 nd reported long history of and had always had cross was very attached to. LPN "OO" unsure of R21's religious and reported had never spice spiritual services visiting D" and CNA "MM" both reported			
were unsure from hospic hospice tab During an ir	what services R21 was receiving and reported they only sign it after visits for CNA and Nurse. erview on 12/21/22 at 12:25 PM			
bathing sen Wednesday during lunc reported fac reported R2 from Hospic breakdown brief area au	"PP" reported provided R21 ces two times weekly on and Friday and often comes to assist with meals. CNA "OO" lity had been short staffed and was going to be discharged e services and skin started to elated to incontinence located in d facility moved R21 from north . Hospice CNA "OO" reported			
R21 did not	ed music and pet therapy but eceive and was unsure why. CNA d was told yesterday that			

STATEMENT OF O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI, IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	PLE CON G	STRUCTION	(X3) DATE SURVEY COMPLETED	
		134140	B. WING _			12/22/	2022
NAME OF PROV	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE,	ZIP CO	DE
MOMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
		ould be located in front of difficult to locate staff for visits.					
	Resident #40						
	Minimum Data S resident 40 (R40) admitted to the f include severe in onset Alzheimer's Down syndrome Review of the MI R40 was always in bladder, required toilteintg, hygien	clinical record including the et (MDS) dated 11/19/22 was a 58 year old female, facility with diagnosis that tellectual disabilities, early s, Bi-polar disorder, anxiety, unspecified. DS dated 11/19/22 reflected moontinent of bowel and extensive assistance with e extensive assistance and n physical assistance with					
	dressing and hyg Mental Status ref cognitive impairr	piene. The Brief Interview for flected a score of 00, severe nent. Of note, R40 resided ocked dementia unit.					
	wandering aroun had mis matched hair was messy, F form fitting yoga observed to be o one side to the b a very pungent u same observation observations of F Practical Nurse (L	9:03 AM, R40 was observed d the unit, she was barefoot, l clothing clothing on, her R40 was observed to have type pants on her brief was verly saturated and hung to ack of R40's knee, there was rine odor. At 9:30am the n of R40 was made, R40 walk by Licensed .PN) "R", Certified Nursing d GG, Hospitality Aide "HH"					

STATEMENT OF DI AND PLAN OF COF		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	(1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING			(X3) DA COMPI	ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
NAME OF PROVIDE	ER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE,	ZIP CO	DE
MOMENTOUS H	EALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
	EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
No ha an Or ob lig we sa th Or wa ro pa na re rig Or to aid b f ro pa na re rig Or to aid c f ro pa na re rig Or to aid c f ro pa na re ro c f f f f we sa th Or ob sa th Or sa th Or sa th Or sa th Or sa th Or sa sa th Or sa ro c f f f f ob sa th Or sa ro c f f f f f f f f f f f f f f f f f f	one of the ident ave noticed R40 and need for inco- n 12/12/22 at 00 pereobserved walking ght gray sweat pereobserved di- ingging bulge ware e brief that hun n 12/12/22 10:2 andering in and ooms, R40 was of andering in and ooms, R40 was of ants from the da avy blue with lar mained soiled/s ght side, there w n 12/13/22 at 00 be walking with de, R40 had a st censed Practical perved to avalk oom where othe resent while vert tinky." In which perved to invest 2N's "N"'s conce ander. beservation of R2 vealed R40 had ants for 3 conse	ed Activity staff person. tified staff were observed to 's disheveled appearance ontinent care. 8:05 AM, Resident # 40 in hall wearing tight fitting bants, the back of the pants scolored/ (wet), a large is observed on the back of g just above R40's knees. 8 AM R40 was observed out of other residents observed to be wearing the ay before (yoga type pants, ge roses on them) her brief saturated and hung to the vas a strong odor of urine. 8:47 AM, R40 was observed h an unidentified Activity trong odor of feces, 1 Nurse (LPN) "N" was passed R40 in the dining r residents and staff were balizing someone was no staff present were tigate or attempt to correct trn, and R40 continued to 40 on 12/14/22 at 09:34 AM, been wearing the same cutive days. R40's closet was ample clothing hanging in					

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		ATE SURVEY LETED
		134140	B. WING		12/22	/2022
NAME OF PRO	VIDER OR SUPPLIE	R		STREET ADDRESS, CITY, ST	ATE, ZIP CO	DE
MOMENTOU	S HEALTH AT BA	TTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 4901	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	it.					
	with Director of N Residents were to every 2 hours and	:05am during an interview Nursing (DON) "B" verbalized b be checked and changed d as needed, DON "B" and nation for R40's care.				
F0679 SS= E	§483.24(c) Activi facility must prov comprehensive a and the preferen- ongoing program choice of activitie group and indivic independent acti- interests of and s and psychosocia resident, encoura and interaction in This REQUIREM evidenced by: This citation pert Based on observa- review, the facility meaningful activi R21and R40) of s meaningful activi	vities, designed to meet the support the physical, mental, I well-being of each aging both independence the community. IENT is not met as ains to intake: MI00130932 ation, interview and record y failed to provide ties for three Resident (R18, even residents reviewed for ties. This deficient practice otential for boredom and y of life.	F0679	 Resident #40 no longer resides facility. Resident #51 's care plan v updated to include 1:1 in room acti appropriate for her dx of dementia 2023 by the Director of Activities #21 's care plan was updated to indicate activities appropriate to her diagno 2023 by the activity director. Resid care plan was updated for current activities for his age and diagnoses 2023 by the activity director. All residents have the potential t affected by this deficient practice. Activity Care Plans and resident at preferences was completed by the Director and the administrator on 1 1/27/2023. Any care plans needing were promptly updated by the Activities a Care Plans was reviewed by the Q Committee on 1-12-2023 and deer appropriate. All staff were inservice policy for Activities and Activity Care F Resident Activity preferences will b completed monthly by the NHA/De brought to QAPI to ensure complia federal and state regulations, as w process improvement. 	vas vities on 1-17- Resident clude sis on 1-17- ent #18's appropriate on 1-17- o be An audit of tivity /26/2023 or update vity /26/2023 or update vity API ned d on the re Plans by d 1-13- Plans and e signee and nce with	1/31/2023

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CON	STRUCTION		ATE SURVEY PLETED
		134140	B. WING		12/22/2022		
AME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DE
OMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIC DATE
	Set (MDS) dated 70 year old male 9/1/20, with diag hypertension, pe and mood disord had a BIM (asses indicated his abi was cognitively i During an obsen 12/11/22 at 10:2 wheelchair in roo interest in captiv reported likes to activities of inter Review of the me (Activities) Asses reflected R18 pre playing cards, ex baking/cooking, chats, watching parties/social even news. Review of R18 A: 12/20/22 at 11:1 [named R18] I Pr am an Army Veto traveling. I enjoy religious Presbyt am also into raci	vation and interview on 7 a.m., R18 was sitting in om. R18 reported not a lot of ities offered at facility. R18 watch TV but not many			Administrator is responsible correction.	for this	

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA COMPLI	TE SURVEY ETED
		134140	B. WING _		12/22/2	022
NAME OF PRO	VIDER OR SUPPLIE	R		STREET ADDRESS, CITY, S	TATE, ZIP COD	E
MOMENTOUS	S HEALTH AT BA	TTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 490 [.]	17	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPRO DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	enjoy therapeutio Crayons	c coloring and I prefer to use				
	Revision on: 04/0 maintain involver stimulation, socia					
		ed through review nsI will attend/participate				
	next review date. activitiesProvide calendar and not changesProvide individual activiti encourage me to attending activity	hoice (3-5 times weekly) by Invite me to scheduled e me with an activities ify me of any e me with materials for es as I desireStaff will wear a maskThank me for functions. The Activity Care o mention of R18 preferred				
	dated 11/1/22 th R18 only particip	tivity Task documentation, rough 12/19/22, reflected ated in social hour, and bingo with no evidence as of interest.				
	Resident #21(R21	1)				
	Set (MDS) dated a 79 year old fem on 1/24/17, with dementia, corona	te Sheet and Minimum Data 10/24/22, reflected R21 was hale admitted to the facility diagnoses that included ary heart disease, heart I vascular disease, seizure				

TATEMENT OF DEFICIE ND PLAN OF CORRECT		PROVIDER/SUPPLIER/CLIA ITIFICATION NUMBER:			STRUCTION		PATE SURVEY
	134	140	B. WING _		12/22	12/22/2022	
AME OF PROVIDER OR	PPLIER				STREET ADDRESS, CITY,	STATE, ZIP CO	DDE
IOMENTOUS HEALT	T BATTLE	CREEK			675 WAGNER DR BATTLE CREEK, MI 49	017	
PRÉFIX (EACH	FICIENCY M GULATORY	INT OF DEFICIENCIES UST BE PRECEDED BY OR LSC IDENTIFYING MATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
depressi BIM (ass her abili severely person p transfers eating, t During a AM, R21 position head aw strong s open wi "aerosol indicated and eye Protectiv door. R2 appeare open ho did not a calm wit reach ur noted at with 2 la appeare During a p.m., R2 on with	The MDS ment tool) o make da paired, and sical assist boom as assist boom as a signation as laying or low with he ardly positi II of urine i stop sign of nerate\ing equired use betection, wi equipment(and an air in hin and frai ng stuffed a bear to be v off touch c r top of pill edside alon e styrofaom o be orang observation other and to be or and to be or and to be or and to be or and to be or and to be or and to be or and to be or and to be	a, and mantic reflected R 21 had a score which indicated ly decisions was she required one with bed mobility, on unit, dressing, ne, and bathing. on 12/11/22 at 9:07 n an air mattress ospital gown on with oned to the left with n room. R21 door was n door that read, procedure" that of gloves, mask, gown, th no Personal PPE) observed outside nattress in place, l, was awake with eyes animal and rosary. R21 rerbal and appeared all light located out of ow. Folding chair was g with bedside table cups with straws that e juice and water. on 12/11/22 at 3:45 o lay in bed with gown o left in dark room. on 12/14/22 at 9:34 red R21 room with CNA A "NN" and CNA "KK"					

	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	À. BUILDIN	G	STRUCTION	COMP	ATE SURVEY PLETED
		134140	B. WING _			12/22	/2022
ME OF PROV	/IDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DE
MENTOUS	HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 4901	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIC DATE
	was repositioned changed. Staff di cream to R21. Th television was or broke girls"(curre Review of the, "L Assessment, date indicated the foll important or son choose clothing " meals, choose ty family involved in music, be around people, favorite a religious services R21 preferred ac crafts, music, spin spending time ou listening to radio parties/social eve observed R21 ou activities. Review of the AE 12/11/22 throug was walked in ro corridor, and had Resident not obs interviews indica bed. Review of the Lift dated 1/26/2017	ng care including linen. R21 and brief and hospital gown d not apply moiture barrier is surveyor observed a programmed to, "Two ent television show). ife Enrichment (Activities) ed 1/27/21, reflected R21 owing were either very newhat important to her: to wear, snacks between pe of bathing, bedtime, in care, private calls, listen to d animals/pets, groups of activities, outdoors, and trivities were playing cards, ritual religious activities, utdoors, watching TV, watching movies and ents. This surveyor had not t of bed or offered any DL documentation, dated h 12/14/22, reflected R21 om, transferred, walked in d locomotion on and off unit. erved out of bed and staff ted R21 had not been out of e Enrichment assessment, reflected R21 church rel of participation was					

STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	PLE CON G	ISTRUCTION		ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MOMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	catholic mass.						
	dated 12/1/22 th no documenting for R21. Review of the R 2	tivity Task documentation, rough 12/14/22, reflected to reflect preferred actives 21 Care Plans, dated 1/29/17 2, reflected, "My name is					
	[named R21]. I pr days. I do get up looking out my w (cheese puffs and bingo but need h	refer to be in my bed most from time to time and enjoy vindowAlso like snacks d ginger ale). I also enjoy help placing the chip on the					
	in a cup with han 04/01/2021Goa involvement in co activities as desir	ognitive stimulation, social ed through review					
	activities I am att physical and mer with known inter	z. rventionsEnsure that the ending are: Compatible with ntal capabilities; Compatible ests and preferences; ed(such as large print,					
	holders if I lack h segmentation), C and abilities; and on: 02/07/2017	and strength, task ompatible with my needs Age appropriate. Revision Establish and record my					
	interests by talkir family on admiss Revision on: 02/0	vity involvement and ng with me, caregivers, and ion and as necessary. 17/2017. I need 1:1 visits 3x a week with LEAs.					
		/07/2017 Revision on: efer to socialize with: small					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Á. BUILDIN	G	STRUCTION	_ COMF	DATE SURVEY
		134140	B. WING _			12/22	2/2022
IAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CC	DDE
OMENTOU	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49	0017	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
	02/07/2017 Revi 02/07/2017 Revi 02/07/2017Intr similar backgrou encourage/facili Initiated: 02/07/2017Invi Date Initiated: 02/07/2017Invi Date Initiated: 02/07/2017My watching Cops, v going outside w 02/07/2017 Revi me a program o empower me by choice, self-expr Date Initiated: 02/07/2017. Proi calendar and no Initiated: 02/07/2017Wh participate in org watch TV, go ou chat 1:1 for socia Date Initiated: 02/07/2017" During a confide at 3:05 PM, Conf reported facility interest to men. on what activity pond and given with, occasional do." Resident rej TV all day and st	very social. Date Initiated: sion on: oduce me to others with nd, interests and tate my interaction. Date 2017. Revision on: te me to scheduled activities. 2/07/2017. Revision on: preferred activities are: watching the news, talking, hen it is nice. Date Initiated: sion on: 02/07/2017. Provide f activities that interest and encouraging/allowing my ession and responsibility. 2/07/2017Revision on: vide me with an activities tify me of any changes. Date 2017 Revision on: en I choose not to ganized activities, I prefer to tside, have pet visits, and al and sensory stimulation. 2/07/2017 Revision on: ential interview on 12/12/22 idential Resident "QQ" did not offer activities of Resident reported had gone staff call fishing trip to local kid character pole to fish bowling is ok, "something to ported otherwise they watch ated, "this place to me is me to die and I'm not ready					

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		DATE SURVEY PLETED	
		134140	B. WING			12/22	12/22/2022	
IAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY	, STATE, ZIP CO	DDE	
OMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49	9017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULE FERENCED TO THE APPF DEFICIENCY)	D BE CROSS-	(X5) COMPLETIO DATE	
	for that yet." Res video games occ	ident reported they do offer asionally.						
	AM, R21 was layi closed, wearing a on bedside table meal meal tray o with 2 bowls of p untouched and c and empty gluce reported meals r breakfast was bis Continue to obse off and no music activities on hall During an intervi	vation on 12/20/22 at 8:20 ing on back in low bed, eyes a hospital gown, with 2 mugs with straws. Observe R21 in hall cart with CNA "M" oureed items. One bowl was on with maybe one bite taken erna on the tray. CNA "M" not posted but reported scuits and gravy and sausage. erve R21 in room with lights c, no staff entered, no type of until 10:45 a.m. we and record on 12/20/22 ity Director (AD) "P"						
	reported had be November 2021. responsible for c admission activit reported comple they pop up and activity assessme "P" verified R21's assessment had reported was un AD "P" reported completed Janua	en in position since AD "P" reported was ompleting annual and new y assessments. AD "P" ted annual reviews when residents should have an ent at least once per year. AD s most recent activity been completed 1/27/21 and sure who generates them. R21 should of had one ary 2022 and was unsure why.						
	AD "P" reported responsible for n Plans until two n Director of Nursi	was no aware she was naintaining Activity Care nonths ago when current ng(DON) "B" took over. AD should have daily 1:1 in						

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	G	STRUCTION	ĊOMF	DATE SURVEY PLETED
ME OF PRO	VIDER OR SUPPLIE				STREET ADDRESS, CITY, S		
OMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	17	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE
	documented in E "P" reported was preferences and when on north u denomination. During an observe unit with two star residents in room R21 room for les During an intervi CNA "M" reported complain of noth reported new ow facility bus and r they used to be a can not. CNA "M hospice spiritual CNA who provid weekly. CNA "M" religious prefera (LPN) "OO" joine had cared for R2 enjoy regular trip "OO" reported h bed in two week events. LPN "OO liked music and using rosary and necklace she was reported was un background and	d would expect it to be SMR, including refusals. AD a unaware of R21's religious verified did have rosary nit but was unsure of her vation on 12/21/22 at 9:43 ed activities noted on south ff observed reading to ns. Activity staff observed in s than three minutes. ew on 12/21/22 at 10:45 AM, ed residents are bored and hing to do. CNA "M" vner took over and sold the low residents complain that able to go out and now they " reported had never seen care in for R21, only hospice ed baths usually 2 times " reported was unsure of R21 nce. Licensed Practical Nurse d the interview and reported 1 for several years and use to os out of the facility. LPN ad not observed R21 out of s and does not like group " reported was unsure if R21 reported long history of had always had cross s very attached to. LPN "OO" sure of R21's religious reported had never e spiritual services visiting					

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:	A (X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	134140	B. WING _		_ 12/22/2022
NAME OF PROVIDER OR SUPP	LIER		STREET ADDRESS, CITY, S	STATE, ZIP CODE
MOMENTOUS HEALTH AT	BATTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 490	
PRÉFIX (EACH DEFIC	TATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY LATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD REFERENCED TO THE APPRO DEFICIENCY)	BE CROSS- COMPLÉTION
were unsure v from hospice hospice table During an inte Hospice CNA bathing servid Wednesday a during lunch reported facil reported facil reported R21 from Hospice breakdown re brief area and to south unit. Hospice offer R21 did not re Resident #40 According to Minimum Dat resident 40 (F admitted to t include severe onset Alzhein Down syndro Review of the R40 was alwa bladder, requ toilteintg, hyg required 1 pe dressing and	" and CNA "MM" both reported that services R21 was receiving and reported they only sign after visits for CNA and Nurse. erview on 12/21/22 at 12:25 PM "PP" reported provided R21 es two times weekly on and Friday and often comes o assist with meals. CNA "OO" ty had been short staffed and was going to be discharged services and skin started to lated to incontinence located in facility moved R21 from north Hospice CNA "OO" reported ed music and pet therapy but ceive and was unsure why. the clinical record including the a Set (MDS) dated 11/19/22 40) was a 58 year old female, the facility with diagnosis that intellectual disabilities, early er's, Bi-polar disorder, anxiety, ne unspecified. MDS dated 11/19/22 reflected rs incontinent of bowel and red extensive assistance with iene extensive assistance with tygiene. The Brief Interview for reflected a score of 00, severe			

STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		STRUCTION	(X3) DATE SURVEY COMPLETED		
		134140	B. WING _		12/22		2/2022	
NAME OF PROV	/IDER OR SUPPLIE	ĒR			STREET ADDRESS, CITY, STATE	E, ZIP CO	DE	
MOMENTOUS	HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE	
		ment. Of note, R40 resided		1				
	on the facility's l	ocked dementia unit.						
	was dated 12/15 coloring, small g Throughout the 12/22/22 R40 was involved in any s coloring. There w Aide following R converse with R4 and out of other	last Activity progress note /21 and reflected R40 liked roups and 1:1 visits. survey of 12/11 through as not observed to have been small group activity or vas observations of Activity 40, attempt to interact or 40- strictly followed R40 in residents rooms. There was olan in place that identified nterests.						
	with Activity Direct the Activity Direct not know until 2	07 PM, during an interview ector "P" stated she had been ctor for over a year, but did to 3 months ago that she for updating care plans and						
	Director "P" on 1 reported R40 no not like painting Director "P" elab anything except resident rooms a	up interview with Activity 12/21/22 12:44 PM, she longer enjoys coloring, does or exercising. Activity borated that R40 didn't do wander in and out of other and continuously takes other jings which makes other unit angry.						
F0684 SS= E		§ 483.25 Quality of care s a fundamental principle that	F0684		dent #20 was assessed for pair on the ambulance to pick her u		1/31/2023	

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY LETED	
	134140			12/22	/2022	
IAME OF PROVIDER OR SUPP	LIER		STREET ADDRESS, CIT	Y, STATE, ZIP CO	DE	
MOMENTOUS HEALTH AT	BATTLE CREEK		675 WAGNER DR BATTLE CREEK, MI	49017	7	
PRÉFIX (EACH DEFIC	TATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY ATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SHOUL REFERENCED TO THE APP DEFICIENCY)	LD BE CROSS-	(X5) COMPLETIOI DATE	
facility resider comprehensiv the facility mu treatment and professional s comprehensiv and the reside This REQUIR evidenced by: This citation h Statements: (A (A) Based on obse review, the fac post fall asses completion of (Resident #20 quality of care identification increased pair Findings inclu Resident # 20 facility 8/5/21 readmission 9 including cere mellitus, chron left femur, and Minimum Dat Assessment R 11/13/22 reve	EMENT is not met as as 2 Deficient Practice as 2 Deficient Practice b) & (B) ervation, interview, and record ility failed to complete routine sments and ensure timely a stat x-ray order for 1 of 15 residents reviewed for , resulting in delayed and treatment of a fracture, and b.		is Ax0x4, and was able to state pain. A new assessment was of the DON/Designee during surv her pain is been appropriately Resident #21, #48, and #32 w by the facility IDT Team and the teams and an interdisciplinary and care plans updated to ensi- care on 1-23-2023. 2. All residents have the ability by this deficient practice. An a on 1-26-2023 by the DON/Desi- that there were no residents w needs were not being met. No were noted. 3. The Policy for Resident Car- was reviewed by the QAPI Tea- 2023 and deemed appropriate staff were inserviced on the Po Resident Care on by the NHA/ 2023 and 1-13-2023. 4. To ensure compliance, 5 re- audited for ensuring proper ca- delivered by the DON /Designu- be reviewed and reported to the Compliance Committee by the DON/Designee. Audits will be monthly for 3 months, and their recommended by the QAPI Co 5. The Administrator is respon- plan of correction.	completed by vey to ensure managed. vere evaluated neir hospice note completed sure quality of v to be affected udit was done signee to ensure hose care other concerns re and Hospice am on 1-12- . All nursing blicy for vDON on 1-12- sidents will be re was ee. Audits will he QAPI completed n as pommittee.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	À. BUILDIN	G	ISTRUCTION	ĊOMF	PATE SURVEY PLETED
		134140	B. WING		_ 12/22	12/22/2022	
JAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DDE
IOMENTOU	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490)17	17	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD I FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
	Interview for Mei (severe cognitive MDS revealed th extensive assistal person total dep person total dep independent with two- person total and two-person personal hygiene that R20 used be Discharge MDS of R20 had an unpla care hospital and facility was antici During an observe 12/11/22 at 12:5 was observed lyi dressed in facility in place at 3 liter cannula. Bilateral the bed trapeze stated that she re approximately the broke her left leg legs to reposition slide off the edge roll out of bed an that she put on h could arrive to as slid to the floor. on the floor, she running". Per R20	vation and interview on 4 PM, Resident #20 (R20) ng in bed, on left side, y gown. Oxygen noted to be s per minute via nasal quarter side rails and over noted to be in place. R20					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140		À. BUILDIN	G	STRUCTION	_ COMF	ATE SURVEY PLETED
IAME OF PRO	ATTLE CREEK		STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 490			DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L VIDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
	Incident Report A Nursing Home A indicated "Perso Assistant Director "Incident Locatio "Resident's Roor Description" the indicated that "R floor in bedroom completed, vitals normal limits), sl the "Resident De "Resident stated equipment to re titled "Immediat that EMS was co fall care, stat x-ra femur, and that I hospital. Within status both at tir incident was ind place, situation, able to commun report, pain leve of incident and a within report titl Incident." Review of R20's with the followin	her back into bed. dated 9/16/22, provided by administrator (NHA) "A", n Preparing Report" to be or of Nursing (ADON) "L" with on" indicated to be m". Within "Incident "Nursing Description" desident observed laying on n on left side, assessment s obtained WNL (within kin tear to right elbow" and escription" indicated she was attempting to use position self in bed." Section e Action Taken", indicated ntacted to assist with post ay ordered of left knee and R20 was not taken to the same report, R20's mental me of incident and post icated as oriented to person, and time and that she was icate with EMS/Staff. Within I was indicated as "3" at time as "2" post incident. Section ed "Injuries Report Post ed "No injuries observed medical record complete og findings noted: ed 9/16/22 at 7:11 PM, proximately 1730 (5:30 PM)					

TATEMENT OF ON TATEMENT OF O	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	Á. BUILDIN	G	STRUCTION	ĊOMF	DATE SURVEY PLETED
		134140	B. WING _			_ 12/22	/2022
AME OF PRO	/IDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DDE
IOMENTOUS HEALTH AT BATTLE CREEK					675 WAGNER DR BATTLE CREEK, MI 490)17	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
	parallel to and fa "My legs starte just followed." Assessed for in notified, orders in Pain Tool assess 5:49 PM, indicate section titled "Lo via Numerical Pain with indication t meds (medication Numerical Pain S when pain was a titled "What Mall "Movement" was score of "8" whe section titled "Eff (Activities of Dai and mobility are Within "Comment form, there was ordered related Nurses note data indicated "Restir meds given at 4: for right leg pain X-ray image, ma distress noted WNL"	lent laying on right side acing bedresident stated ed going, and the rest of me Called Lifecare for lift assist juriesMD (Medical Doctor) received to obtain X-Rays." ment dated 9/16/2022 at ed "Left knee (front)" within boction". "Current Pain Level" in Scale indicated as an "8" hat "PRN (as needed) pain ins)" makes the pain better. Scale score indicated as a "2" t its least. Within section test the Pain Worse?", indicated with the Scale noted to indicate a n pain is at its worst. Within fects of Pain on ADLS by Living)", Physical activity indicated to be affected. hts" section of the same indication that "X-Rays to pain after fall". ed 9/17/2022 at 5:29 AM, ng in bed comfortable, pain 30 AM with good effective h, X-ray tech unable to obtain nager notify, no acute neuro (neurological) check					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		(X3) DATE SURVEY COMPLETED	
		134140	B. WING _			12/22	2/2022	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE	
MOMENTOU	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49	017			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
	left knee, LLE (le ankle".	ft lower extremity), and left						
	discontinuation Give 1 tablet by needed" and new time stated, "No (HYDROcodone-	8/22 at 11:12 AM, indicated of "Norco Tablet 5-325 MG mouth every 12 hours as w order with same date and rco Tablet 5-325 MG Acetaminophen) *Controlled ilet by mouth every 8 hours in".						
	"Voltaren Gel 1 S to affected areas	8/22 at 11:13 AM, stated % (Diclofenac Sodium). Apply s topically every 8 hours as 2 grams to affected areas."						
	10:14 AM, indica resident's fall tha 1730 (5:30 PM). Resident was ob after falling from that she was mo rolled out of the getting resident care conference, requested for th around in her be Inclusive Care fo	(IDT) Notes dated 9/19/22 at ted that "IDT met to discuss at occurred on 09/16/2022 at Fall was unwitnessed. served laying on the floor a her bed. Resident reported ving in the bed and her body bed. Lifecare came to assist back into her bed. At last resident and family e strap to help resident move ed. P.A.C.E (Program of All- r the Elderly) will be asked to rentions put in place by them.						
	Neuros started, pain medication and vitals taken. (Director of Nurs	pain assessment completed, given and effective post fall, P.A.C.E. doctor and DON sing) notified, and X-Rays lan reviewed and updated."						

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER: 134140		Á. BUILDIN	G	STRUCTION	ĊOMF	(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLIE S HEALTH AT BA				TATE, ZIP CODE			
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	indicated "info results of her x-r. femur and that th (Emergency Med be sent to Hospi manager she call DON". Nurse Note date indicated "LATE I care conference post new bed mo positioning strap safety to include bed mobility equ ordered for resid strap until new e new orders recei Neurological Ass at 5:30 PM and n 9/20/22 included monitoring, pupi level of consciou but provided no of motion or add Review of R20's I dated 9/21/22-9, ray results with in displaced suprace femur".	ed 9/21/2022 at 6:48 PM, rmed by PACE that the ay was FX (fracture) of the hey were sending EMTS lical Technicians) for her to talcalled the south unit led the administrator and the d 9/23/2022 at 9:47 AM, ENTRY-PACE provider in for in reference to recent fall obility equipment including by New interventions for new evaluation of use of hipment by pace PT/OT. X-ray lent. Removal of positioning valuation of use. No other ved." sessment beginning 9/16/22 toted to continue through d routine vital sign I response, eye response, sness and motor response indication of extremity range litional physical assessment. Hospital After Visit Summary /22/22, included left femur x- ndication of "acute mildly ondylar fracture of the distal						

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	IG	STRUCTION	ĊOMF	ATE SURVEY PLETED
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AME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DE
MOMENTOUS HEALTH AT BATTLE CREEK					675 WAGNER DR BATTLE CREEK, MI 4901	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE
	reflected no add	itional nurses notes or					
	resident assessm	ents during the period from					
		fall (9/16/22 at 5:30 PM) to					
		0 was transferred to the					
		2). No comprehensive					
		assessment was noted to be 7/22 after the 5:29 AM					
		ry nor was a comprehensive					
		assessment noted to be					
		8/22, 9/19/22, 9/20/22, or on					
		or at the time of R20's					
		ospital. Additionally, no					
		ss Note was noted to be					
	complete during	this time.					
	In an interview o	n 12/21/22 at 4:20 PM, DON					
		n "Accident and Incident/Fall					
	Episode Checklis	t" was used by the facility					
		guidance in the completion					
		sments post fall. Per DON					
	•	essment should include a risk					
		bort, a head-to-toe physical ding range of motion, and					
		cks, and that this assessment					
		nursing staff on the need to					
		/ treatment versus hospital					
	transfer. DON "B	" stated that the checklist					
	does not indicate	e the frequency or duration					
		essment post fall and stated					
		aware of a facility policy that					
	indicated this inf verbalize this inf	ormation nor was she able to ormation.					
	During the same	interview, DON "B" stated					
		informed that R20's ordered					
	x-ray was not co	mplete and confirmed that					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CON	ISTRUCTION		ATE SURVEY PLETED
		134140	B. WING			_ 12/22	/2022
IAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, S	STATE, ZIP CO	DDE
OMENTOU	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	17	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
	that the primary further review of "B" stated that si routine nursing a documentation of regarding reside the fall to the tim DON "B" reviewe 9/18/22 orders f and that the exp complete nursin assessments to r order changes th pain medication review of R20's r confirmed that t documentation of physician's asses fall within the m additional assess provided prior to In an interview of ADON "L" stated assigned nurse of that she was in D was notified that ADON "L" Stated R20's room, resid on her right side "L" stated that sh assigned nurse t room had comp "L", EMS was cor	within a progress note int status from the time of ne of the hospital transfer. ed and acknowledged R20's for pain medication increase rectation would be to g documentation and pain reflect the rationale for the nat warranted an increase in . Additionally, upon further medical record, DON "B" here was no noted regarding the primary ssment of R20's status post edical record with no ssment documentation					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER: 134140		À. BUILDIN	G	STRUCTION	(X3) DATE SURVEY COMPLETED 12/22/2022	
	IDER OR SUPPLIE				STREET ADDRESS, CITY, STA 675 WAGNER DR BATTLE CREEK, MI 49017		DDE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L VIDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPF DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
	stated that the as physician followi order was obtain although she rec pain at time of fa obtained as a pre assessment was of However, a Pain medical record di indicated left kne fall with "movem During the same that the expectat assessment to be documented eve assessment inclu physical assessm vital signs. ADON although neurolo completed, no co assessment was of 5:29 AM through transferred to the "L" also confirme would be for a ne with any new or acknowledging t on 9/17/22 regar in R20's pain met corresponding ne indicate these or the changes.	ry shift for 72 hours with the ding a comprehensive ent, pain assessment and J "L" confirmed that ogical monitoring was omprehensive physical completed from 9/17/22 at the time R20 was e hospital on 9/21/22. ADON ed that the expectation urses note to be completed changed orders, hat although orders received rding increase and addition					

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140		Á. BUILDIN	G	ISTRUCTION	COMF	DATE SURVEY PLETED 2/2022	
NAME OF PROVIDER OR SUPPLIER MOMENTOUS HEALTH AT BATTLE CREEK				STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 490				
(X4) ID PREFIX TAG	(EACH DEFICIEI FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD :FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
	contacted by R2 early AM (morni that R20's x-rays completed by th ADON "L" stated and the NHA at additional involv on 9/17/22 and was notified. Up record, ADON "I no documentati notification of ir rays and procee not documented During same int an interdisciplin completed on 9, between 9/19/2; facilitated and si completed on 9, between 9/19/2; facilitated and si completed on 6, between 9/19/2; facilitated and si completed on 7, between 9/19/2; facilitated and si completed that si physician assess post fall but upo confirmed that r available to refle additional assess to survey exit. A although the co been requested, received. Review of the fa Incident/Fall Epi	nome when she was O's assigned nurse in the ng) of 9/17/22 and notified is were unable to be the mobile x-ray company. If that she notified DON "B" that time but had no rement in R20's plan of care did not know if the physician on review of R20's medical _" confirmed that there was on regarding physician tability to obtain ordered x- ded to state "if something is d, then it wasn't done." erview, ADON "L" stated that ary team meeting was /19/22 and that sometime 2 and 9/21/22, PACE ent own mobile x-ray unit for 20's ordered x-rays. ADON the could not confirm whether ment of R20 was completed on review of medical record, no physician notes were exit and provided no sment documentation prior DON "L" also stated that mpleted x-ray reports had that they had never been cilities "Accident and sode Checklist" included the dent is injured obtain order						

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI, IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDIN	PLE CON G	ISTRUCTION		ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP COI	DE
MOMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
		other testing that can be ediately) within the facility or gency Room)".					
	Incident Investiga indicated that "TI be initiated when 3) DON/Design document finding Review documen assess need for a 4) The resident 24-hour report al hours (3 days) po "B" Based on observ review the facilit necessary care a to two out of 15 maintain the hig	:					
	(EMR) upon R48 facility on 6/17/2 already in place.	electronic medical record was admitted to the 2022 hospice services were Diagnoses included f left lower extremity with art of lower leg.					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140		À. BUILDING	3	STRUCTION	ĊOMF	(X3) DATE SURVEY COMPLETED 12/22/2022	
NAME OF PROV	TTLE CREEK		STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 490					
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E :FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
	(MDS) assessme revealed R48 ha that develops d Record review of revealed a focus 09/12/22 related status. Review of dated 09/12/22 dressing change physician. Obse	of a "Minimum Data Set" ent, dated 7/1/2022, ad a one venous ulcer (ulcer ue to poor circulation). of the care plan in place s of venous ulcers dated d in impaired vascular of the interventions in place revealed to complete es as ordered by the rve dressing daily for nage and compression.						
	Follow skin mar report any abno Record review of assessments rev	agement program and ormalities to physician. of R48's weekly skin/wound realed R48 had vascular the back of the left calf,						
	on 09/12/22, 09 and 11/11/22, w assessments do month period. 1	und assessments revealed /19/22, 09/26/22, 10/04/22 vere the only skin/wound cumented over a two- There were no assessments er 11/11/22 through						
	AM, DON "B" re wound care asso completed, DON wounds had hea	view on 12/21/22 at 09:05 egarding R48's weekly essments not being N "B" stated, R48 vascular aled up so that may be the eekly assessment. No						
	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140		Á. BUILDIN	G	ISTRUCTION	ĊOMF	(X3) DATE SURVEY COMPLETED 12/22/2022	
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	VIDER OR SUPPLIE				STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 490	,	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD I FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
	healing/healed Observation on revealed R48's H right shine, ankl that were not h Facility had not complete weekl and monitoring Resident #21(R2 Review of the Fa Set (MDS) dated was a 79 year of facility on 1/24/1 included dement heart failure, per seizure disorder depression. The BIM (assessmer her ability to mal severely impaire person physical transfers, locom eating, toileting, During an obser AM, R21 was lap positioned low w head aukwardly strong smell of u open with stop s "aerolol generate indicated require gown, and eye p Pertective Equip	12/21/22 at 10:00 AM had an open wound on his e and calf of the left leg ealed. followed orders to y assessment, measuring						

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CON	STRUCTION		(X3) DATE SURVEY COMPLETED	
		134140	B. WING _		_ 12/22	2/2022		
	VIDER OR SUPPLIE S HEALTH AT BA				STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 490		ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD I :FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
	open holding studid not appear to calm with soft tor reach under top noted at bedside with 2 large styrc appeared to be o Review of the far reflected R21 was services. Review of the MI and 1/21/22, refl- hospice services Review of the EM R21 did not have hospice services During an intervi Director of Nursi had been a Hosp months and repor have an order fo had been the MI reported R21's M services and if it Review of the R2 through 11/25/22 terminal prognos Hospice. Date In 01/08/2020Inte cooperatively with my spiritual, emo and social needs reflected no men services R21 ref	MR on 12/12/22 reflected a physician order for 5. ew on 12/20/22 at 1:35 PM, ng (DON) "B" reported R21 bice resident for several orted would expect R21 to r hospice. DON "B" reported DS nurse prior to DON and MDS should reflect hospice did not it was an error. 21Care Plans, dated 1/29/17 2, reflected, "I have a bis and elected to have						

STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		(X3) DATE SURVEY COMPLETED		
		134140	B. WING _			_ 12/22	2/2022
AME OF PROVID	DER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DDE
IOMENTOUS H	IEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490)17	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
DRttwprefebbhcRir DCsiwLttfetrhw"Cahaohs", srevi DCSiwLttfetrhw"Cahaohs", srevi DHbY	DON "B" reporte 21 Hospice that hat day no history ith care conferent lans to involve levelow esidents Care Converd. DON "B inder was signed een signed by so ospice staff and orrection movin 21's Care Plans including Hospic During an intervit CNA "M" reporter piritual care in finder was ips out of the far ad not observed veeks and does DO" reported long ad always had trached to. LPN f R21's religious ad never obserner ervices R21 was eported they onlisits for CNA an During an intervit lospice CNA "P athing services Vednesday and	ew on 12/20/22 at 3:30 PM, d had a care conference with t today and reported prior to ry of hospice involvement ences. DON "B" reported Hospice companies with conferences now moving "reported document in ed today and should have staff receiving report from I will be part of plan of g forward. DON "B" reported s should be personalized e services provided. ew on 12/21/22 at 10:45 AM, d had never seen hospice or R21, only hospice CNA ths usually 2 times weekly. al Nurse (LPN) "OO" joined I reported had cared for R21 and use to enjoy regular cility. LPN "OO" reported d R21 out of bed in two not like group events. LPN s unsure if R21 liked music g history of using rosery and cross necklace she was very "OO" reported was unsure s background and reported ved hospice spiritual R21. LPN "OO" and CNA ted were unsure what s receiving from hospice and by sign hospice tablet after d Nurse. ew on 12/21/22 at 12:25 PM P" reported provided R21 two times weekly on Friday and often comes ssist with meals. CNA "OO"					

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 134140		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLIE S HEALTH AT BA				STREET ADDRESS, CITY, STAT 675 WAGNER DR BATTLE CREEK, MI 49017	E, ZIP CO	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
F0686 SS= D	reported R21 wa from Hospice se breakdown relati brief area and fa to south unit. Ho Hospice offered R21 did not rece CNA "OO" repor hospice binder w building because nurse to sign for Treatment/Svcs Ulcer §483.25(b Pressure ulcers. comprehensive a the facility must receives care, cc standards of pra ulcers and does unless the individ demonstrates th and (ii) A resider receives necess consistent with p practice, to prom	to Prevent/Heal Pressure) Skin Integrity §483.25(b)(1)	F0686	her phy place for 12/23/2 2. All re- by this on 1/16 there w unaddr concern 3. The QAPI C All nurs and 1-1 new po	dent #1 was assessed by nurs rsician and a plan of care was or all of her pressure ulcers on 2022. esidents have the ability to be a deficient practice. An audit was /2023 by the DON/Designee to rere no residents who had essed pressure ulcers. No other as were noted. policy for wound care was revi committee and updated on 1-1: 3-2023 by the DON/Designee licy. In addition, the ADON was ad to directly oversee all wound	affected s done o ensure er ewed by 2-2023 2-2023 on the s	1/31/2023
	evidenced by: This citation perf Based on observ review, the facilit injury risk, and fa routinely assess	TENT is not met as trains to M100130932. ation, interview, and record ty failed to assess pressure hiled to accurately and and document pressure on in one of five residents		4. To e audited place b will be complia comple QAPI c 5. The	company the wound care NP or rounds on 1-13-2023 by the D nsure compliance, 5 residents to ensure proper wound care. y the Administrator/Designee. reviewed and reported to the C ance committee. Audits will be ted monthly for 3 months and ommittee recommendations in Administrator is responsible fo correction.	ON. will be Is in Audits API then as dicate.	

	INT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140		À. BUILDIN	G	ISTRUCTION	(X3) DATE SURVEY COMPLETED 12/22/2022		
	VIDER OR SUPPLIE S HEALTH AT BA				STREET ADDRESS, CITY, STA 675 WAGNER DR BATTLE CREEK, MI 49017		E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPF DEFICIENCY)	N (EACH CROSS-	(X5) COMPLETIC DATE	
	resulting in the p	iewed for pressure injuries otential for delayed healing, tion, and the formation of ure injuries						
	Findings include:	-						
	sclerosis, anemia ankle contracture polyneuropathy, Review of the Mi an Assessment R 11/6/22 revealed Interview for Mer (severe cognitive MDS revealed th extensive assistant dressing, eating, person total dep two-person total Section H of MD always incontine Section M of MD risk of developin two Stage 1 pres 8/6/22 revealed the developing press indicated to have On 12/11/22 at 1 lying in bed, in fat back with head of approximately set	agnoses including multiple , right ankle contracture, left e, osteoporosis, and urge incontinence. nimum Data Set (MDS) with eference Date (ARD) of that R1 had a Brief ntal Status (BIMS) score of 6 impairment). Section G of at R1 required one-person nce with bed mobility, and personal hygiene; one- endence with toilet use; and dependence with transfer. S reflected that R1 was nt of bowel and bladder. S indicated that R1 was at g pressure injuries and had sure injuries. The MDS dated that R1 was at risk for ure injuries but was not e any at time of assessment. 1:50 AM, R1 was observed ncility gown, positioned on f bed elevated to venty-five degrees. Purple tor was noted at right heel						

			G	STRUCTION	COM	(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STATE, ZIP CODE 675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L VIDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	In an interview of Assistant Director stated that R1 har related to incomp pressure, and a m pressure. ADON knowledge regat presentation as a Nursing (DON) " assessments. On 12/13/22 at a completion of R Practical Nurse (Aide (CNA) "M". and completed p cleansing wipes incontinent of so was noted to be noted to present thin layer of adh aspect of wound pink tissue surro wound borders. intact pink epith hands, placed gl with normal salin area dry with 4 b bordered foam of wound presente and commented or better."	e dressing beneath. n 12/13/22 at 1:29 PM, or of Nursing (ADON) "L" ad a wound on her bottom inence, a left ear scab from ight heel wound form "L" denied additional rding wound formation and stated that Director of B" completed weekly wound 1:33 PM, observed 1's wound care by Licensed LPN) "C" and Certified Nurse CNA "M" unfastened brief beri care using personal as R1 noted to be oft brown stool. No dressing present to sacrum. Sacrum t with small open wound with erent yellow tissue at central l base and thin line of dark unding and extending to Surrounding tissue with elial tissue. LPN "C" washed oves, cleansed sacral wound he and 4 by 4 gauze, patted by 4 gauze, and applied dressing. LPN stated that d similar as in previous week , "It hasn't gotten any worse					

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	À. BUILDIN	G	ISTRUCTION		ATE SURVEY PLETED
		134140	B. WING _			12/22	/2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DE
MOMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
	protector and ga heel. Right latera dime size area of with intact pink t Left ear presente open areas noted Review of R1's m the following find 8/24/2022 Weekl Care Nurse form acquired in house indicated as Mois Dermatitis (MASI Suspected Deep was indicated to by 1.2cm by 0.1cl epithelial tissue in drainage, and int "Treatment" secti dry dressing". 8/31/2022 Weekl Wound Care Nur alteration to be a with entry blank Other". Under "Pr indicated as a SD measure 2.3cm b present with epit scant serous drai	edical record complete with					

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140 ME OF PROVIDER OR SUPPLIER DMENTOUS HEALTH AT BATTLE CREEK		Á. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
					STREET ADDRESS, CITY, ST 675 WAGNER DR BATTLE CREEK, MI 4901			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORF	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE	
	Wound Care Nui alteration as MA Wound was india 1.2cm by 0.1cm a epithelial tissue i drainage, and in "Treatment" sect with dry dressing 9/13/2022 Week Wound Care Nui alteration to be a with entry blank Other". Under "P indicated as SDT measure 2.5cm k wound base, sca intact peri-woun to be selected. Ir redness indicate under "Treatmer medihoney to or 9/20/2022 Week Wound Care Nui alteration to be l to measure 2.5cm present with gra base and scant s was indicated to	ly Wound Healing Record- rse form reflected sacral an "other" type of alteration under prompt to "Specify ressure Ulcer Stage", wound I. Wound was indicated to by 1.2cm by 0.1cm with dry nt serous drainage, and d. No tissue type was noted ifflammation and slight d to be present with box it" noted to state "Add der". ly Wound Healing Record- rse form reflected sacral MASD. Wound was indicated in by 1.5cm by 0.1cm and to nulation tissue in wound erous drainage. Peri-wound be "Normal for resident". tment" section noted to state noney".						

STATEMENT OF D AND PLAN OF COF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	Á. BUILDIN	G	ISTRUCTION	COMF	DATE SURVEY PLETED 2/2022
NAME OF PROVID					STREET ADDRESS, CITY, ST 675 WAGNER DR	TATE, ZIP CO	DDE
(X4) ID PREFIX (TAG	EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	BATTLE CREEK, MI 4901 /IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BI FERENCED TO THE APPROF DEFICIENCY)	ON (EACH E CROSS-	(X5) COMPLETION DATE
ali m wu tis wu re st of pr 10 W ali wi no to pr ba wu Bo ch gr 10 W ali W ali W ali W ali W ali W ali St to pr 10 St St to pr 10 W ali St to pr 10 St St St To pr 10 W ali St To pr 10 St St To pr 10 St St To pr 10 St St To pr 10 St St St To pr 10 St St To pr 10 St St To pr 10 St St To pr 10 St St St To To pr 10 St St St St St St St St St St St St St	teration as MA: easure 2.7cm E ound base and ssue type was n ound was indic sident". Box wi ated, "No chan wound bed to roduction". D/4/2022 Week Yound Care Nun teration to be a thentry under oted to state "s measure 2.6cm resent with gran ase and scant s as indicated to pox within "Treat nanges this wee anulation tissu D/11/2022 Week Yound Care Nun teration to be a Yound Care Nun teration to yound Yo	rse form indicated sacral SD. Wound was indicated to by 1.4cm by 0.1cm with dry scant serous drainage. No noted to be selected. Peri- ated to be "Normal for thin "Treatment" section ges, continue light softening increase epithelial ly Wound Healing Record- se form reflected sacral an "other" type of alteration prompt to "Specify Other" acral". Wound was indicated in by 1.4cm by 0.1cm and to nulation tissue in wound erous drainage. Peri-wound be "Normal for resident". tment" section stated, "No ek as wound is healing, more e present". kly Wound Healing Record- se form indicated sacral a Stage 2 Pressure Injury. ed to measure 2.5cm by and to present with e in wound base and small irainage. Peri-wound was Normal for resident". Box it" section stated, kly Wound Healing Record-					

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Á. BUILDIN	G	ISTRUCTION	ĊOMF	PATE SURVEY PLETED	
	134140	B. WING _			_ 12/22	2/2022	
ME OF PROVIDER OR SUPPL	IER			STREET ADDRESS, CITY, S	STATE, ZIP CO	DDE	
OMENTOUS HEALTH AT B	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	49017		
PRÉFIX (EACH DEFICIE	ATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY ATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD I FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
alteration to be Wound was no 3.0cm by 0.2cm granulation tiss serous drainag be "Intact norm within "Treatment Medihoney". 12/8/2022 Wee Wound Care N alteration to be Wound was no 5.0cm with no to indicated to pro- with intact peri "Treatment" se Normal Saline . Review of R1's Treatment Adm August 2022 th reflected the for Treatment Orda to "Cleanse sac dryCover with dressingever Weekly Wound form reflected in hou treatment orde Treatment orde	rise form indicated sacral a Stage 2 Pressure Injury. ted to measure 2.8cm by and to present with ue in wound base and scant e. Peri-wound was indicated to al color for resident". Box ent" section stated, "Continue kly Wound Healing Record- urse form indicated sacral a Stage 2 Pressure Injury. ted to measure 3.5cm by noted depth. Wound base was esent with epithelial tissue wound. Box within ction stated, "Cleanse with .Cover with Optifoam". Sacral treatment orders and inistration Record from rough December 19, 2022, llowing: er dated 8/23/2022, indicated rum with Normal SalinePat o Xeroform and Optifoam rday". Although 8/24/2022 Healing-Wound Care Nurse hat sacral alteration was se on 8/17/2022, no r noted until 8/23/2022. er dated 9/2/2022, indicated rum with Normal SalinePat						

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CON	STRUCTION	(X3) D/ COMP	ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE,	ZIP CO	DE
MOMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	dryCover with (three days"	OptifoamChange every					
	to "Cleanse sacru	dated 9/13/2022, indicated im with Normal SalinePat Medihoney and Optifoam					
	to "Cleanse sacru	dated 11/25/2022, indicated m with Normal SalinePat OptifoamEveryday"					
	Care Nurse form pressure injury ac 9/21/2022. Wour 0.3centimeters (c to present with d black, leather, sca indicated to be "n within "Treatmen	y Wound Healing-Wound reflected a Stage 2 left ear cquired in house on nd was indicated to measure m) by 2.0cm by 0.1cm and ry, necrotic tissue (brown, ab-like). Peri-wound normal for resident". Box t" section stated, "Dry sect, reduce infectionadd					
	Care Nurse form pressure injury. V measure 0.3cm b indication of wou as all areas withir blank. Peri-woun- within "Treatmen changesContin medihoney".	y Wound Healing-Wound reflected a Stage 2 left ear Vound was indicated to y 1.8cm by 0.1cm. No ind base presentation noted n "Visible Tissue" section d indicated to be intact. Box t" section stated, "No ue same treatment of					
	10/11/2022 Weel	kly Wound Healing-Wound					

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTI	PLE CON	STRUCTION		ATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:				COM	PLETED
	134140	B. WING _			12/22	2/2022
NAME OF PROVIDER OR SUPPLI				STREET ADDRESS, CITY,	STATE, ZIP CC	DDE
MOMENTOUS HEALTH AT B	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	017	
PRÉFIX (EACH DEFICIE TAG FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR(DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
pressure injury. measure 0.2cm indication of wc as all areas with blank. Peri-wou within "Treatme continue to enc leftkeep pillow 10/18/2022 We Care Nurse form pressure injury. measure 0.3cm indication of wc as all areas with blank. Peri-wou within "Treatme treatment of Xe Review of R1's I September 2022 reflected the fol Treatment orde to "Clean left ea cover with gauz Treatment orde to "Clean left ea Xeroformcove with tapeever Treatment orde to "Clean left ea	eft ear treatment orders from 2 through December 20, 2022 lowing: r dated 9/20/2022, indicated r with Normal Saline (NS), e and tapeat bedtime" r dated 9/27/2022, indicated r with NScover with er with dry gauze and secure					

TATEMENT OF DE ND PLAN OF COR				(X3) DATE SURVEY COMPLETED 12/22/2022			
AME OF PROVIDE			STREET ADDRESS, CITY 675 WAGNER DR BATTLE CREEK, MI 4				
PRÉFIX (E	ACH DEFICIEN	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E :FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
no Nu rig to Rev fro 202 Tre "Ri rig pre "Ri rig ker Rev for De For ski alti	Weekly Woun rse form was of the heel wound current date of view of R1's rig m October 20, 22 reflected th atment order ght Heel Treat the heel area evention". The theel area evention were the heel area evention were ght Heel Treat the heel area evention were the heel area evention were ght Heel area evention were the heel area evention area evention area evention were the heel area evention area evention area evention area evention the heel area evention area	ght heel treatment orders 22 through December 20,					

STATEMENT OF DEFI		(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDING	PLE CON	ISTRUCTION	(X3) D/ COMP	ATE SURVEY LETED
		134140				12/22/	2022
NAME OF PROVIDER	OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MOMENTOUS HEA	LTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
PRÉFIX (EA	CH DEFICIEN	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
[derr Note oper Form but o Form issue incor Form skin i altho Wou left e 9/21, Form issue Form skin i altho Wou left e 9/21, Form	matitis]" and as on same for a area on sacc a dated 9/2/2 otherwise bla a dated 9/8/2 as noted" but a dated 9/8/2 as noted" but a dated 9/15/ as notedtrea ntinence derr a dated 9/22/ issues noted' bugh 9/27/20 und Care Nurs ear pressure i /2022. a dated 9/29/ as noted" but a dated 10/6/ issues noted' but a dated 10/12 sure Injury at sure Injury wi d.	ated as "incontinence derm indicated to be a "Stage 2". orm stated, "noted to have rumtreatment in place". 2022 indicated "Skin intact" nk. 2022 indicated "No new skin otherwise blank. 22 indicated "No new skin atment in place for n" but otherwise blank. 22 Weekly Wound Healing- se form reflected a Stage 2 njury acquired in house on 22 indicated "No new skin otherwise blank. 22 Weekly Wound Healing- se form reflected a Stage 2 njury acquired in house on 22 indicated "No new skin otherwise blank. 22 indicated a Stage 2 Coccyx and a Left Ear th no additional details D/2022 indicated "No new " but otherwise blank.					

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDIN	PLE CON G	STRUCTION	(X3) DA COMP	ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STATE,		
	S HEALTH AT BA				675 WAGNER DR	ZIP CO	DE
					BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
		7/2022 indicated "No new		[
	skin issues noted	" but otherwise blank.					
		/2022 indicated "No new " but otherwise blank.					
		7/22 indicated "has e, no new areas of concern" ink.					
	Pressure Injury at Pressure Injury at details noted. No "Resident with pr	/2022 indicated a Stage 2 Right Heel and a Stage 2 Coccyx with no additional tes on same form stated, evious right heel ulcer and eatments continueOther					
	with previous rigl	/2022 indicated "Resident ht heel ulcer and coccyx is continueOther skin					
		5/2022 indicated "Noted treatment in place".					
		ogress Notes from August cember 20, 2022 reflected					
	indicated "Nurse	ote dated 8/30/2022, in to assess wound on nis intact, redness, and					
	A Skin/Wound N	ote dated 9/13/2022,					

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	G	ISTRUCTION	. COMF	DATE SURVEY PLETED
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, 5 675 WAGNER DR	STATE, ZIP CC	DDE
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PRO	BATTLE CREEK, MI 490		(X5)
PREFIX TAG	(EACH DEFICIEN FULL REGULA	NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	PREFIX TAG	COR	RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	COMPLETIO DATE
		erventions for sacral wound be MASDobtained order to "					
	indicated "skir Recommendati on it. Order is or Administration F	ions: clean and put dressing n the TAR (Treatment Record)". No additional ed within note regarding					
	indicated "has	lote dated 9/27/2022, wound on buttocks that iDleft ear that presents as "					
	indicated "wou healing as it is sr	lote dated 10/4/2022, und on ear appears to be maller in size and has new elial tissuesacral wound is					
	indicated "she treatment for he sacral area" No	lote dated 10/24/2022, is currently receiving r left ear, right heel and o additional assessment tained within note indicating ments or wound					
	continues to re heel, ear, and sa evidence by new	ated 11/9/2022, indicated " ceive wound care on her crumwounds are healing as epithelial tissue growth on heel is soft" No additional					

STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULTIF A. BUILDING	PLE CON	ISTRUCTION	(X3) DA COMP	ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE,	ZIP CO	DE
MOMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
		mation contained within round measurements or ion.					
	wound on her e has a scabRigh skin on sacrum a additional assess	ated 11/25/2022, indicated " har is 0.2 by 0.1 by 0.1 and t heel is softhas delicate and is incontinent" No ment information contained ating wound measurements tation.					
	indicated "has and right heel"	ote dated 11/30/2022, wound on left ear, sacrum, No additional assessment ained within note indicating nents or wound					
	9/8/2022, 10/4/2	an Progress Notes dated 022, 11/3/2022 and ete with no indication of oted.					
	completion of a E	ssessments revealed no Braden Scale (an assessment ss risk for developing a ince 7/7/2021.					
	Director of Nursin had been complete responsible for the assessments and was in the process	n 12/20/22 at 11:52 AM, ng (DON) "B" stated that she eting and was currently still ne completion of R1's wound documentation but that she es of transitioning the wound DN "L". DON "B" stated that					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G	STRUCTION		DATE SURVEY PLETED
		134140	B. WING _			_ 12/22	2/2022
AME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DDE
MOMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	17	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
	on R1's wounds assessment shou measurements a orders, review of coordination wit DON "B" stated assessments sho R1's medical rect Wound Healing DON "B" confirm active left ear, sa pressure injuries record, DON "B" weekly documer ear and sacrum v and that weekly initiated for R1's stated that the la wounds was on that time the rig and presented with s scant drainage. I documentation v assessments tha 12/8/2022 but th remained approp although weekly completed since stated was appro- transitioned to th Nursing, assessm	was to assess and document each week and that each and presentation, review of interventions and h physician as warranted. that the weekly wound uld be documented within ord using the "Weekly Record-Wound Care" form. the d that R1 currently had crum, and right heel . Upon review of R1's medical confirmed that the last tted assessment for the left was complete on 10/18/2022 assessments had never been right heel wound. DON "B" ast time she visualized R1's 12/8/2022 and stated that at th theel wound was closed ith dry necrotic tissue in both the sacrum and left ear uperficial open areas with DON "B" stated that vas not complete for the t she completed on nat the ordered treatments all priate. DON "B" stated that assessments had not been 10/18/2022, which she poximately the time that she ne facilities Director of nents, and documentation dy Wound Healing Record- ould still have been					

TATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		DATE SURVEY PLETED
		134140	B. WING _			12/22/2022	
AME OF PROV	/IDER OR SUPPLIE	ER			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE
OMENTOUS	B HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49	017	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
	further confirmer Predicting Press completed quart medical record, I one that was cor and was unable t assessment. In a follow-up in AM, ADON "L" st process of assum ADON "L" confir she assessed and wound for the fir the right heel or completing any of since. A review of the f Care" dated 5/1/ nursing staff and assess and docu significant risk fa pressure sores describe and doo pressure sore inc length, width and exudates or necr mobility status including suppor The National Pre (2016) updated s Stage 1, Stage 2,	weekly basis. DON "B" d that a Braden Scale for ure Ulcer Risk should be terly but upon review of R1's DON confirmed that the last mplete was dated 7/7/2021 to provide a more recent terview on 12/22/22 at 9:03 tated that she was in the ning the wound nurse role. med that on 12/8/2022 that d documented on R1's sacral rst time but denied assessing left ear wounds or of the wound assessments acility policy titled "Wound (2022, indicated that "The I Attending Physician will ment an individual's actors for developing In addition, the nurse shall cumentFull assessment of cluding location, stage, d depth, presence of rotic tissuepain assessment current treatments, rt surfaces."					

STATEMENT OF DEFICIENCIES (X1) PROVIDED AND PLAN OF CORRECTION IDENTIFICATION	R/SUPPLIER/CLIA ON NUMBER:	(X2) MULTIP A. BUILDING		STRUCTION	(X3) DA COMPL	ATE SURVEY LETED
134140		B. WING _			12/22/	2022
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE,	ZIP COI	DE
MOMENTOUS HEALTH AT BATTLE CREEK				675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DE (EACH DEFICIENCY MUST BE P FULL REGULATORY OR LSC ID INFORMATION)	RECEDED BY	ID PREFIX TAG	CORI	IDER'S PLAN OF CORRECTION (E/ RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIATI DEFICIENCY)	DSS-	(X5) COMPLETION DATE
Deep Tissue Injury as follows:						
"Stage 1 Pressure Injury-nonbla erythema. Intact skin with non-1 redness of a localized area usua bony prominence. Darkly pigme may not have visible blanching. Stage 2 Pressure Injury Partial-t of skin with exposed dermis. Th is viable, pink or red, moist, and present as an intact or ruptured blister. Adipose (fat) is not visib tissues are not visible. Granulati slough and eschar are not prese Stage 3 Pressure Injury: Full-thic loss Full-thickness loss of skin, i adipose (fat) is visible in the ulc granulation tissue and epibole (edges) are often present. Sloug eschar may be visible. The dept damage varies by anatomical lo of significant adiposity can deve wounds. Undermining and tunn occur. Fascia, muscle, tendon, li cartilage and/or bone are not et slough or eschar obscures the et loss this is an Unstageable Press Stage 4 Pressure Injury: Full-thic and tissue loss Full-thickness sk loss with exposed or directly pa muscle, tendon, ligament, cartil- in the ulcer. Slough and/or esch	blanchable ally over a ented skin thickness loss be wound bed d may also d serum-filled le and deeper ion tissue, ent. ckness skin in which er and (rolled wound h and/or th of tissue ocation; areas elop deep heling may gament, xposed. If extent of tissue sure Injury. ckness skin tin and tissue lipable fascia, age, or bone					

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDIN	PLE CON G	ISTRUCTION	(X3) D/ COMP	ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
NAME OF PROV	IDER OR SUPPLIE	R	•		STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MOMENTOUS	HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	anatomical locati obscures the external Unstageable Press Unstageable Press thickness skin and skin and tissue lo tissue damage with confirmed becaus or eschar. If sloug Stage 3 or Stage revealed. Stable e intact without ery heel or ischemic lo or removed. Suspected Deep maroon localized skin or blood-fille underlying soft ti shear." Additionally, the following informa Ulcer Assess the press assess it at least v results of all wou document physic location, category color, peri-wound	sure Injury: Obscured full- d tissue loss Full-thickness ss in which the extent of thin the ulcer cannot be se it is obscured by slough th or eschar is removed, a 4 pressure injury will be eschar (i.e. dry, adherent, thema or fluctuance) on the imb should not be softened Tissue Injury: Purple or area of discolored intact ed blister due to damage of ssue from pressure and/or NPUAP provides the tition regarding Pressure					

STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	Á. BUILDI	NG			ATE SURVEY LETED 2022
	H AT BA	TTLE CREEK	ID		STREET ADDRESS, CITY, STA 675 WAGNER DR BATTLE CREEK, MI 49017 /IDER'S PLAN OF CORRECTION	N (EACH	(X5)
TAG FULL (http://www.content/	REGULAT IN /w.npuap /uploads/ DIGITAL-N	ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION) 2.org/wp- /2014/08/Quick-Reference- IPUAP-EPUAP-PPPIA-	PREFIX TAG		RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPR DEFICIENCY)		DATE
SS= D ensure t receive a professi compret and the This RE evidence Based ou facility fa routine p and doc (Residen resulting change i dialysis t Findings Resident 10/1/19 renal dis obstruct lymphot failure. F with an 10/20/21 Interview 13 (cogr	hat resid such sen onal stan residents QUIREM ed by: n intervie ailed to e post dialy umentati th #14) of g in the p in conditi treatmen s include: t #14 (R1 with diag sease, ast vive pulm clastic let Review of Assessme 2 reveale w for Mer nitively in		F0698	by the l she had 14-202 2. All re to be ai Admini- commu dialysis resulted the dial sheet v and sel 3. The Commu Commu license update Commu by the J 4. An a Admini- sheets update Commu by the J 5. The	dent #14's dialysis sheets we NHA/Designee for 30 days to d no more missing dialysis sh 3. No sheets were found to be esidents on dialysis have the p ffected. An audit was complet strator/Designee' on 1-27-202 inication sheets of all resident a. Any missing communication d in a call from the DON/Designes ysis clinic to ensure a commu- vas generated after each dialy in back to the facility. procedure for Dialysis Patient unication was reviewed by the ttee and updated on 1-12-202 d nurses were educated on th d procedure for Dialysis Patient unication on 1-12-2023 and 1: Administrator/designee'. udit will be completed by the strator/Designee' of the comm of all residents on dialysis we onthly thereafter. All results we and brought to QAPI Meetin g and ongoing process impro- Administrator is responsible for correction.	ensure eets on 1- e missing. potential red by the 23 of the is on sis gnee to unication vsis visit t a QAPI 23. All he nt -13-2023 punication reklyx4 ere g for verment.	1/31/2023

	ROVIDER/SUPPLIER/CLIA	(X2) MULTIF A. BUILDING	PLE CON	STRUCTION	(X3) DA COMPI	ATE SURVEY LETED
13414	0	B. WING _			12/22/	2022
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE,	ZIP COI	DE
MOMENTOUS HEALTH AT BATTLE (CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG FULL REGULATORY OI INFORM	ST BE PRECEDED BY R LSC IDENTIFYING	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR(FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
dialysis treatment, at an center, on Mondays, We Fridays.						
During an observation a 12/11/22 at 9:47 AM, R1 sitting in a wheelchair at in place at 3 liters per m cannula. R14 stated that weak and that she had s in October of 2022 and I and pointed at the fistul in her right upper arm. P facility at approximately Monday, Wednesday, ar and returned at approxim Review of R14's medical "Dialysis Communication noted to include three su Top: Facility Pre-Dialysis including date/time, resi medications administerer meal/snack sent, shunt I additional information si signs, and nurse signatu Middle: Dialysis Center I pre and post weight, flui meal/snack intake, shurr additional information (o medications administerer	4 was observed t bedside with oxygen inute via nasal ther kidneys were tarted hemodialysis held up her right arm a that could be seen Per R14, she left the 6:30 AM every nd Friday for dialysis mately 12:00 PM. record included a n Form" which was ections: Information ident name, ed prior to dialysis, ocation/status, ince last visit, vital re. nformation including id removed, t location/status, changes in condition,					

			G	STRUCTION	COMP	(X3) DATE SURVEY COMPLETED 12/22/2022	
	IDER OR SUPPLIE				STREET ADDRESS, CITY, STATE, ZIP CODE 675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	including date/ti	Post-Dialysis Information me, bruit/thrill present, Il condition of resident, vital signature.					
	Forms located w	Dialysis Communication ithin the medical record ne following findings noted:					
	Dialysis Informat date/time, asses bleeding, genera signs, and nurse on 10/31/2022, 11/ 11/14/2022, 11/	of the Dialysis Form titled "Facility Post- cion" which included sment of bruit/thrill, al condition of resident, vital signature noted to be blank 11/4/2022, 11/11/2022, 18/2022, 11/20/2022, 30/2022, 12/2/2022, and					
	within R14's med treatment that re receive on 10/24	munication Forms noted dical record for the dialysis esident was scheduled to /2022, 10/26/2022, 7/2022, 11/28/2022, 12/14/2022.					
		f R14's medical record ne following findings noted:					
	stated "received stating that vein attempting to st	ed 10/26/2022 at 9:02 AM, phone call from dialysis had infiltrated when art dialysis. Give instructions a every 20 minutes, off for 20					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	134140	B. WING _		12/22/2022
NAME OF PROVIDER OR SUPPL	 IER		STREET ADDRESS, CITY	. STATE, ZIP CODE
MOMENTOUS HEALTH AT B	ATTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 4	
PRÉFIX (EACH DEFICIE	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY ATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SHOUL REFERENCED TO THE APP DEFICIENCY)	D BE CROSS- COMPLÉTION
Stated to expect right arm when observed, but s fistula." Nurses Note da stated "Doctor and surroundin time." Physician Progr 2:00 PM, stated pain scale 0 o out of 10" Ho documentation fistula noted. Physician H & F 12/8/2022 12:4 appears to be v further assessm information reg presentation no Review of nurse through 12/20/ further notes id post dialysis as review of vital s period included reflect post dial On 12/20/22 at Administrator (e's notes from 10/1/2022 2022 complete with no entified to include resident sessment information, and ign section for this same time I no routine documentation to			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		134140	B. WING				12/22/2022	
AME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE	
OMENTOU	S HEALTH AT BA	ATTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 490				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
	11/7/2022, 11/20 12/14/2022 that the medical record In an interview of Director of Nursi nurse assigned the a Dialysis Common complete the Factor section prior to a on each schedul DON "B" stated to sent with the resi and that the resi same form with the Center Informatic center. Per DON be that upon resi post dialysis, the comprehensive a vital signs and si documented the Dialysis Commun "Facility Post-Dia DON "B" stated to time getting the dialysis forms we medical record. If of any other local where post dialy complete if not of Communication	In 12/21/22 at 8:56 AM, ing (DON) "B" stated that the o the resident should initiate unication Form and cility Pre-Dialysis Information a resident leaving the facility ed dialysis treatment day. that the form would then be ident to the dialysis center dent should return with the the section titled "Dialysis on" complete by the dialysis "B", the expectation would ident return to the facility assigned nurse completed a assessment which included te assessment and information on the same nication Form within the alysis Information" section. that the facility had a difficult return paperwork from the nd acknowledged that several ere missing from R14's DON "B" denied knowledge ation in R14's medical record sis assessments would be complete on the Dialysis Form or any other location and Dialysis Communication						

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140		À. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STAT 675 WAGNER DR BATTLE CREEK, MI 49017	E, ZIP CO	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETIC DATE	
	request was made Dialysis Commun 10/24/2022, 10/2 11/7/2022, 11/20 12/14/2022 that the medical records the medical records the requested Different for R14 were una additional inform end of the survey A Review of the dated 5/1/2022, adequately asses care goals which practicable level stage renal disea Procedure: 22 potential for blev volume, potentia nutrition, alteratia adverse medicat needs should be	11:48 AM, NHA "A" fter checking with both and the Unit Manager, that ialysis Communication Forms able to be located with no nation provided prior to the						
F0725 SS= E	Staff. The facility staff with the app skills sets to pro-	g Staff §483.35(a) Sufficient must have sufficient nursing propriate competencies and vide nursing and related re resident safety and attain	F0725	citation 2. All re have th	pecific residents were listed in sidents of Momentous Battle C e potential to be affected by th t practice. An audit was done of	Creek is	1/31/2023	

STATEMENT OF DEFICIENC AND PLAN OF CORRECTION			PLE CONSTRUCTION G		ATE SURVEY LETED
	134140	B. WING _		_ 12/22/	2022
NAME OF PROVIDER OR SU	PPLIER		STREET ADDRESS, CITY, S	STATE, ZIP CO	DE
MOMENTOUS HEALTH A	T BATTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 490	17	
PRÉFIX (EACH DEF	Y STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY SULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPRC DEFICIENCY)	BE CROSS- PRIATE	(X5) COMPLETION DATE
mental, and resident, as assessmen and consid diagnoses in accordar required at facility mus numbers of personnel of nursing car with residen waived und licensed nu personnel, aides. §483 under para facility mus serve as a This REQU evidenced This Citatio MI0012836 MI0012967 Based on o review the nursing star members, r residents w attain or m physical, m	n Pertains To Intakes: I, MI00130337, MI00130932, 2, oservation, interview, and record acility failed to ensure sufficient f for 8 of 9 resident council esulting in the potential for all 54 no resided at the facility to not intain their highest practicable ental, and psychosocial well-being.		past two weeks comparing the sta the census/ acuity level by the NH on 1-23-2023.No new concerns n 3. The facility policy on Adequate reviewed by the QAPI Committee deemed appropriate. The schedul weeks ahead is now being postec scheduler/designee and updated daily census and staffing review a meeting. This was updated as of 4. To ensure compliance two wee audits will be completed weekly x monthly thereafter by the NHA/De Results will be brought to QAPI C Process Improvement. 5. The Administrator is responsibl plan of correction.	IA/ Designee oted. Staffing was and e for 4 I by the following a t a.m. 1-15-2023. k staffing 4 and signee'. ommittee for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	PLE CON G	STRUCTION		ATE SURVEY LETED
	134140				12/22/	
	10-1-0	D. WING _			12/22/	LULL
NAME OF PROVIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MOMENTOUS HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
PRÉFIX (EACH DEFICIEN TAG FULL REGULA	NTEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (I RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
12/11/22 reveale 54, of which 48 r two staff for bat of one or two sta assistance of one 38 required assis toilet use, and 2° or two staff for e revealed 6 reside for bathing, 0 we dressing, 7 were transferring, 9 w toilet use, and 2 eating. Review of the PE through 6/30/22 triggered for fail coverage 24 Hot within the quarte During an interv 12/21/22 at 3:40 Scheduler "GG" + (Sunday), 5/31/2 (Sunday), 5/30/2 (Saturday), 6/5/2 (Sunday), 5/30/2 (Sunday), 5/30/2 (Sunday), 5/30/2 (Sunday), 5/30/2 (Sunday), Scheduler mid Ju not submit data "GG" reported co census per direct Scheduler "GG" +	ditions of Residents dated ed the facility's census was equired assistance of one or ning, 52 required assistance aff for dressing, 38 required e or two staff for transferring, stance of one or two staff for 1 required assistance of one eating. The CMS-672 also ents were dependent on staff ere dependent on staff for depending on staff for ere dependent on staff for were dependent on staff for were dependent on staff for depending on staff for ere dependent on staff for were dependent on staff for were dependent on staff for were dependent on staff for depending on staff for ere dependent on staff for depending on staff for mere dependent on staff for were dependent on staff for mere dependent on staff for depending on staff for ere dependent on staff for mere dependent on staff for depending on staff for mere dependent on staff for depending on staff for mere dependent on staff for prove distance dependent on staff for prove distance dependent on staff for mere depend					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				DATE SURVEY PLETED
		134140	B. WING			12/22	2/2022
NAME OF PROVIDE	R OR SUPPLIE	R	STREET ADDRESS, CITY, ST			ATE, ZIP CO	DDE
MOMENTOUS HE	ALTH AT BA	TTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 490			7	
PRÉFIX (E	ACH DEFICIEN	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
Pra and onu day Fac pro cer det rep sta Sch 202 onl Rev "[fa sta Op 7ar Nu 7pi Acc 7ar ma 7pi Min	actical Nurses a d reported they e works night s y shift. Schedu illity Owner "Ll ovides staff to in sus and provide cermine require orted no know fing RN staff a neduler "GG" v 22 the facility w y from 6am to view of provide acility name] Pa ffing was as for timal in to 7pm(days rse/20 Resider m to 7am(nigh ceptable in to 7pm=1:12 nager weekda m to 7am=1:16 nimal	s)=1 CNA/9 Residents(1:9); 1 hts(1:20). hts)=1:14; 1:28 2; 1:25. Plus one unit ys.					

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140 134140		À. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
NAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, STA	ATE, ZIP CO	DE	
MOMENTOU	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I /IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPF DEFICIENCY)	CROSS-	(X5) COMPLETION DATE	
	manager weekda	ays.						
	7pm to 7am=1:2	20; 1:36.						
	reflected 1 super nights and 1 rest Continued review resident acuity. On 12/13/22 at 7 Resident Counci reported they has staff and the call the participants to wait for an ho assistance. Review Meeting minutes these concerns of of the Nine partir receive showers	w of the staffing tool rvisor on weekends and torative aid on weekdays. w reflected no mention of 10:00 am, during the I meeting, 8 of 9 participants ad concerns with sufficient I light response time. One of reported it was not unusual our or more to receive w of Resident Council s reflected they had voiced on 6/8, 7/6, 8/3, and 9/7. Six cipants reported they do not twice weekly as scheduled ifficient nursing staff.						
	On 12/14/22 at interview with D she reported she October 2022 ar	11:41 AM, during an irector of Nursing (DON) "B" had had the position since ad offered no explanation for bught forth by Resident						
F0726 SS= E	Services The fac nursing staff with competencies an nursing and rela resident safety a	ing Staff §483.35 Nursing cility must have sufficient in the appropriate and skills sets to provide ted services to assure and attain or maintain the pole physical, mental, and	F0726	checko 2023. 2. All re by the o conduc	ursing staff received compete ff by the DON 0n 1-25, 1-26, esidents have the ability to be deficient practice. An audit wa ted by the HR Coordinator of nel files on 1-23 and 1-24 to i	and 1-27- affected	1/31/2023	

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140			À. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			ATE SURVEY PLETED
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 490		DDE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	LIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
	determined by re individual plans in number, acuity a resident populati facility assessme §483.35(a)(3) Th licensed nurses competencies and care for resident through resident described in the Providing care in assessing, evalu- implementing re- responding to re Proficiency of nu- ensure that nurs demonstrate cor techniques nece needs, as identif assessments, an care. This REQUIREN evidenced by: Based on intervis facility failed to a Practical Nurses competencies an resident needs, f Nursing Assistant two CNA's review competencies has competency eva techniques nece resulting in the p lack the necessal	All-being of each resident, as esident assessments and of care and considering the and diagnoses of the facility's ion in accordance with the ent required at §483.70(e). The facility must ensure that have the specific and skill sets necessary to s' needs, as identified assessments, and plan of care. §483.35(a)(4) nocludes but is not limited to laating, planning and sident care plans and sident's needs. §483.35(c) urse aides. The facility must e aides are able to mpetency in skills and lessary to care for residents' ied through resident and described in the plan of MENT is not met as ew and record review, the ensure three Licensed (LPN C, N, II) had specific ad skills necessary to meet failed ensure two Certified tts (CNA "GG" and "JJ") of wed for nursing ad their required annual luation in skills and ssary to care for residents, potential for nursing staff to ry qualifications and training the for the needs of the		checko 3. The 3 Competend commit facility of educati 2023. A last yea D.O.N./ 4. An a competend DON/D thereafed QAPI C improve 5. The 3	facility policy on Nursing St tencies was reviewed by the tee and updated on 1-12-2 updated their system for sta on and competency trainin and competency trainin and staff who were not tested ar will be tested by the 'Designee by 1-27-2023 udit of 25% of nursing depa encies will be completed by esignee weekly x 4 and the ter. All results will be broug committee for trending and	aff the QAPI 2023. The aff g on 1-12- d within the artment y the en monthly ht to the process	

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	IA ((X2) MULTIF A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED	
		134140	ſ	B. WING _			12/22/	2022
NAME OF PROVIDER OR S	UPPLIE	R				STREET ADDRESS, CITY, STATE,	ZIP CO	DE
MOMENTOUS HEALTH	-					675 WAGNER DR BATTLE CREEK, MI 49017		
PRÉFIX (EACH D		TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)		ID REFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
Hospitalit staff prov practice. Findings i On 12/21 Personne with a him hire date date of 5/ competer Review of "GG" hire date of 1" evaluation to care fo On 12/21, with Hum Director of they were explanatic nursing st lists were Resident = 4/8/2016 sclerosis, ankle con polyneuro	y Aide de ser hclude (22 at 4 record e date of 3/19 19/20 locies ar CNA p d 4/8/1 /02/21 n in skil reside (22 at 9 an Res f Nursi new to on as to aff cor not co #1 with di anemia tractur pathy, the M	4:45PM, during a review of ds, it was discovered LPN "C" of 12/14/21, LPN "N" with a /14 and LPN "II" with a hire did not have any nurse do or performance reviews. Dersonnel records for CNA 5 and CNA "JJ" with a hire had no annual competency ls and techniques necessary ents. 5:05PM, during an interview ource Director (HR) "S" and ng (DON) "B" both reported their role and offered no o why personal files, required appetencies and skills check						

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	G		ĊOMF	DATE SURVEY PLETED
		134140	D. WING _			12/22	12022
ME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DDE
OMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 4901	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIC DATE
	11/6/22 revealed	that R1 had a Brief					
		ntal Status (BIMS) score of 6					
	(severe cognitive	impairment). Section G of					
		at R1 required one-person					
		nce with bed mobility,					
		and personal hygiene; one- endence with toilet use; and					
		dependence with transfer					
	On 12/11/22 at 1	1:50 AM, R1 was observed					
	, 0	facility gown, positioned on					
		of bed elevated to					
		eventy-five degrees. Staff to be sitting at bedside and					
		with staff name tag					
		itality Aide". Hospitality Aide					
		nat R1 required extensive					
	assist at meals ar	nd that when she					
		sisted her to eat, R1 would					
		5% of meal. R1 was observed					
		es of food as provided by HA et stated mechanical soft					
		liquids, and mugs with lid					
	and straw.						
		n 12/13/22 at 10:42 AM,					
		ng (DON) "B" stated that a					
	1)	s job description included					
		eping tasks and stated that o any hands-on skilled care					
		ng. DON "B" stated that the					
		provided feeding education					
		lospitality Aides regarding					
		s and that these trained HA's					
	could feed a resi	dent.					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140		À. ÉUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
NAME OF PROVIDER OR S				STREET ADDRESS, CITY, ST 675 WAGNER DR BATTLE CREEK, MI 4901				
PRÉFIX (EACH D	FICIE	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	COF	UDER'S PLAN OF CORREC RECTIVE ACTION SHOULD EFERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
Nursing H the HA jo deliver mu had not w to feed re assist a re confirmed provided Therapist feed a res In a follow PM, DON and that t provided Aides and Aides and Aides and Aides sho On 12/21, (HR) "S" c Hospitalit Review of "S", includ Review of Descriptic 5/1/22, in do tasks i to resider dietDeli a mechan " The jol that the H	ome / o desc al traj ent thi ident that : eedin out th dent. -up ir 'B" st eedin confii uld nc 22 at ponfirm / Aide educa ed no for the fa n for cally a desc cospita	on 12/13/22 at 11:51 AM, Administrator "A" stated that ription included the ability to ys to a resident but that they rough the training required s and therefore could not with feeding. NHA "A" some of the HA's had been g training by the Speech at these HA's still could not hterview on 12/13/22 at 12:13 ated she had been mistaken eech Therapist had not g training to the Hospitality rmed that the Hospitality at be feeding residents. 2:05 PM, Human Resources hed that HA "E" was a with a 10/24/22 date of hire. ation record, provided by HR education regarding feeding. hcility document titled Job the Hospitality Aide dated d "Essential FunctionsCan ngDeliver water and snacks on a mechanically altered eals to residents not receiving altered diet during mealtime ription provides no indication hity Aide can feed a resident mechanically altered diet.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	Á. BUILDIN	IPLE CONSTRUCTION	_ COMP	ATE SURVEY LETED /2022	
	OVIDER OR SUPPLIE S HEALTH AT BA			STREET ADDRESS, CITY 675 WAGNER DR BATTLE CREEK, MI 4		DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHOUL REFERENCED TO THE APP DEFICIENCY)	D BE CROSS-	(X5) COMPLETION DATE	
F0727 SS= D	 §483.35(b) Regis Except when wai (f) of this section, services of a regiconsecutive hour §483.35(b)(2) Exparagraph (e) or must designate a as the director of §483.35(b)(3) The serve as a charg facility has an avor fewer resident This REQUIREM evidenced by: Based on interviei facility failed to envidenced by: Based on interviei facility failed to envidenced by: Based on interviei facility failed to envidence of the serve as a charg facility failed to envidence of the serve of the serve as on dur day for seven day likelihood of inaction energency or root clinical outcomess residing in the facting include Review of the PB. through 6/30/22, triggered for faili coverage 24 Hou within the quarteen During an interviti 12/21/22 at 3:40 	ENT is not met as ew, and record review, the ensure that a Registered ty for 8 consecutive hours a ys a week, resulting in the dequate coordination of utine care with negative is affecting all 53 residents cility. J report, dated 4/1/22 , reflected facility was ng to have Licensed Nursing rs/Day for four or more days	F0727	 The facility updated its sched RN coverage 7 days per week to out. The schedule was communistaff and on-call personnel on 1 All residents have the ability by the deficient practice. An autweeks of schedules was conduistaffer on 1-13-2023. No issues coverage were found. The facility policy on RN Statiweek was reviewed by the QAF and updated on 1-12-2023. The updated the staff schedule to in coverage daily and the on-call of 13-2023. An audit of the nursing departs schedule will be completed by the NHA/Designee weekly x 4 and thereafter. All results will be broc QAPI Committee for trending an improvement. The Administrator is respons plan of correction. 	for 1 month hicated to all I-12-2023. to be affected dit of the last 2 cted by the s with RN ffing 7 days per PI committee e facility hiclude RN coverage on 1- rtment the monthly bught to the nd process	1/31/2023	
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTR D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 134140 B. WING			COMF	(X3) DATE SURVEY COMPLETED 12/22/2022		
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ME OF PROVIDER OR					STREET ADDRESS, CITY, 675 WAGNER DR BATTLE CREEK, MI 490		DDE
PRÉFIX (EACH	DEFICIEI REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORREC [*] RECTIVE ACTION SHOULD FERENCED TO THE APPR(DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE
(Saturda (Sunday schedule not subr "GG" rep census p Schedul since 7/ attempt each 24 Practical and repo one wor day shift Facility 0 provides census a determin reported staffing Schedul 2022 the only from Review 0 "[facility staffing Optimal 7am to 7	y), 6/5/2). Schedu er mid Ju nit data borted co er direc- er "GG" 1/21. Sch s to sche hours b Nurses borted the ks night c. Schedu Dwner "L s staff to nd provide a facility m 6am t of provice name] F was as for 7pm(day 0 Reside	2 (Monday), 6/4/22 2 (Sunday), 6/19/22 Jer "GG" reported started as ine 2022 and reported does for PBJ reports. Scheduler reates schedules according to tion of Facility Owner "LL". reported had been the owner heduler "GG" reported dule Registered Nurses in ut agency staff are Licensed and not always an option ey only have two RN staff and shift and one was per-diem lier "GG" reported provides L" with census and he resident ratio according to ided example of tool used to red staff. Scheduler "GG" wledge of requirement for apposed to LPN staff. /erified on Saturday May 21, was staffed with LPN nurses to 6am on 5/22/22. Hed staffing tool, labeled, tar Calculator", reflected bilows: s)=1 CNA/9 Residents(1:9); 1 nts(1:20). hts)=1:14; 1:28					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CON NG	ISTRUCTION		ATE SURVEY LETED
		134140	B. WING			12/22/2022	
NAME OF PRC	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, ST	ATE, ZIP CO	DE
MOMENTOU	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 4901	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE
	Acceptable						
	7am to 7pm=1:1 manager weekd	2; 1:25. Plus one unit ays.					
	7pm to 7am=1:1	6; 1:30.					
	Minimal						
	7am to 7pm=1:1 manager weekd	4; 1:30. Plus one unit ays.					
	7pm to 7am=1:2	20; 1:36.					
	reflected 1 supe nights and 1 res	w of the staffing tool rvisor on weekends and torative aid on weekdays. w reflected no mention of					
F0730 SS= D	Service §483.35 education. The f performance rev least once every provide regular i on the outcome training must co of §483.95(g). This REQUIREN evidenced by: Based on intervi facility failed to on Nurse Aides (CN	rm Review-12 hr/yr In- (d)(7) Regular in-service acility must complete a iew of every nurse aide at 12 months, and must n-service education based of these reviews. In-service mply with the requirements MENT is not met as ew and record review, the ensure that two Certified A "GG" and "JJ") whose in- iles were reviewed, had the	F0730	2. All re by this Resour personn evaluat DON th perform 3. The was rev on 1-12 Perform staff on adminis 4. The review thereaf	esidents were identified in the sidents have the ability to be deficient process. The Huma ces Coordinator audited all of hel files for up-to-date C.N.A ions on 1-25-2023, and there is to of C.N.A. staff that need nance review 1-25-2023. policy for C.N.A. Performand riewed by the QAPI Team an 2-2023. The policy for C.N.A nance Review was reviewed 1-12-2023 by the strator/designee. Human Resources Coordina 5 personnel files weeklyx4 a ter. Results were brought to ttee for review and process	e affected an C.N.A. a gave the ed ce Review nd updated with all ator will and monthly	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CON		3) DATE SURVEY MPLETED
		134140	B. WING		12	/22/2022
AME OF PRC	VIDER OR SUPPLIE	ĒR			STREET ADDRESS, CITY, STATE, ZIF	CODE
IOMENTOU	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORF	IDER'S PLAN OF CORRECTION (EACH RECTIVE ACTION SHOULD BE CROSS FERENCED TO THE APPROPRIATE DEFICIENCY)	
	resulting in the peducational need	rs of in-service training, potential for unmet ds and missed opportunity ality of care and services residents.			ement. Administrator is responsible for this correction.	
	Findings include	:				
	"GG" hired 4/8/1 date of 11/02/21	bersonnel records for CNA 5 and CNA "JJ" with a hire 1 revealed there was not 12 9, education and or in-service.				
	with Director of Human Resource they had a recen December, HR "S approximately 2 the only docume training she had the last 12 mont requirement was the facility did not in-services upon facility did not h annual basis. DC	2:05 pm, during an interview Nursing (DON) "B" and es (HR) "S" they reported at mandatory training in early S" stated the training was hours in length and that was ented education, in-service for any of the CNA's over hs. When queried why the s not met, DON "B" reported ot have time to train provide orientation therefore the ave time to do it on an DN "B" stated she was aware e and planned to take it to e meeting.				
F0744 SS= E	(3) A resident will with dementia, re treatment and se his or her highes	ce for Dementia §483.40(b) ho displays or is diagnosed eceives the appropriate ervices to attain or maintain st practicable physical, chosocial well-being.	F0744	were re and upo dement Team	care plans for residents #48, #40, #4 viewed by the IDT team on 1-20-20 dated as needed to ensure appropri- ia services are delivered by the IDT sidents have the ability to be affected	23 ate

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDII	NG	STRUCTION		ATE SURVEY LETED 2022
(EACH DEFICIEN FULL REGULAT	R	ID PREFIX TAG	PROV CORF	STREET ADDRESS, CITY, ST. 675 WAGNER DR BATTLE CREEK, MI 49013 'IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	ATE, ZIP CO 7 N (EACH CROSS-	
evidenced by: Based on intervie review, the facilit educated in beha of three resident behavioral care r 24 residents resid receive adequate Include; Resident #49 (R4 Review of the me was originally ad 06/15/2022 with Disease. Record review or behavior notes o minute checks be wondering in his In an interview o Social Worker (S) does not have a was provided do minute checks be "D" was asked wi minute checks. S why we put him of During an interview	edical record reflected R49 mitted to the facility a diagnosis of Alzheimer's n 07/29/2022 reflected on R49 who continues 15- ecause other residents were		plans for dement the Dire 2023_t dement needed 3. The p and the were re includin process 4. The I Service of 5 res related thereaft and bro and pro 5. The <i>i</i>	deficient practice. An audit o or all residents with a demen ia-related diagnosis was cor octor of Recreational Service o ensure appropriate plans of ia are in place and updated Scope of Care for the Demo viewed for accuracy and up by the QAPI Committee on icy for Dementia Care and S Scope of Care for the Demo viewed with all staff and mai g those involved in the admi o on 1-12-2023 by the DON// Director of Recreational s/Designee' will review the of diagnosis weekly x4 and mo er 1-31-2023. Results will bu ught to QAPI Committee for cess improvement. Administrator is responsible correction.	tia or npleted by s on 1-27- of care for as d Services entia Unit dated as 1/12/2023. Services entia Unit nagers, ission Designee. care plans ementia- onthly e trended trending	

STATEMENT OF DEFICI AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	IA (X2) A. B	MULTIF	PLE CON	STRUCTION	(X3) DA COMPI	ATE SURVEY LETED
		134140	B. V	VING _			12/22/	/2022
NAME OF PROVIDER OF	R SUPPLIE	R	-			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MOMENTOUS HEALT	ГН АТ ВА	TTLE CREEK				675 WAGNER DR BATTLE CREEK, MI 49017		
PRÉFIX (EACH	I DEFICIEN REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREF TAC		COR	VIDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
comple	eted. She o	etencies had not been lid not have any on staff behavioral training.						
Reside	nt #40							
Minimu residen admitte include onset A Down s Review R40 wa bladdet toilteint require dressin Mental cognitiv on the f On 12/ wander had mis hair wa form fit observ one sid the san observ Assista and an None o have ne and ne to enga	Im Data S Im Data S Im Data S Im Oata V (R40 Im Oata V (Im	clinical record including the et (MDS) dated 11/19/22) was a 58 year old female, acility with diagnosis that tellectual disabilities, early s, Bi-polar disorder, anxiety, unspecified. DS dated 11/19/22 reflected incontinent of bowel and l extensive assistance with e extensive assistance with giene. The Brief Interview for flected a score of 00, severe ment. Of note, R40 resided to the unit, she was barefoot, l clothing clothing on, her R40 was observed to have type pants on her brief was verly saturated and hung to ack of R40's knee At 9:30am ation of R40 was made, R40 walk by Licensed LPN) "R", Certified Nursing d GG, Hospitality Aide "HH" ed Activity staff person. tified staff were observed to D's disheveled appearance ontinent care, or attempted er. R40 was continued to be der in and out of other						

STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULTIF A. BUILDING		ISTRUCTION		ATE SURVEY
		134140	B. WING _			12/22	/2022
NAME OF PROV	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	TATE, ZIP CC	DE
MOMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 4901	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	residents rooms.						
		8:05 AM, Resident # 40 ring the unit, entering other					
	wandering in and	28 AM R40 was observed d out of other residents room 117 where R40 took a					
	overheard that R- Practical Nurse (R40 would have "N" stated she wa but thought it was wandering in and and taking their b was further if R40	t 8:14am several staff were 40 will be a 1:1, Licensed LPN) "N" it was queried why a 1:1 assigned to her. LPN as not completely certain, s due to her continuous d out of other resident rooms belongings. When LPN "N" 0 behavior was the same on , LPN "N" stated yes it no explanation.					
		:19am R40 was observed room 103 (not R40's room).					
	to be walking with	8:47 AM, R40 was observed h an unidentified Activity eded to enter rooms with owing her.					
	# 40 observed was behind the nurse	9:36 AM observed Resident andering unit, including s station, staff observed to attempt engage or redirect.					
		as observed wandering nit and in and out of other					
	Review of R40's	clinical record, including					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		OATE SURVEY PLETED	
		134140	B. WING _			12/22/2022		
	VIDER OR SUPPLIE		STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 490					
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROV CORF	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY)	FION (EACH BE CROSS-	(X5) COMPLETIO DATE	
	reflected 1 episo Further review o R40 was put on was a check off supervision from 12/16, and 12/17 corresponding b identify the rease supervision." On 12/21/22 09: with Director of queried why R40 and or 15 checks the same thing, a implemented du "B"further stated correlating notes management as was implemente reviewed and D0 documented rea medical record. On 12/21/22 at 7 interview with So reported R40 wa resident rooms of she is not involve just walk. SW "D activities they wa coloring. SW "D" behavioral mana but do discuss is offered no expla	ehavior log, progress note to on for the "Close 17 AM, during an interview Nursing (DON) "B" it was was on closer supervision 5. DON "B" stated they were						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	Á. BUILDIN	IPLE CONSTRUCTIONS			ATE SURVEY LETED 2022
	DVIDER OR SUPPLIE			675 WA	ADDRESS, CITY, STAT GNER DR E CREEK, MI 49017	E, ZIP CO	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	CORRECTIVE	LAN OF CORRECTION ACTION SHOULD BE C ED TO THE APPROPRI/ DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	was to occupy R4 During an intervi on 12/21/22 12:4 longer enjoys col or exercising. Act that R40 didn't d and out of other continuously take belongings which the unit angry. On 12/21/22 at 2 with Director of I Human Resource they had a recen December, HR "S approximately 2 include dementia facility provided	ted the Activity department 40. ew with Activity Director "P" 44 PM, she reported R40 no foring, does not like painting tivity Director "P" elaborated o anything except wander in resident rooms and es other residents in makes other residents on 2:05 pm, during an interview Nursing (DON) "B" and es (HR) "S" they reported t mandatory training in early "stated the training was hours in length and did a care. When queried if the education on behavioral S" reported that was not					
F0756 SS= E	O §483.45(c) Dro §483.45(c)(1) The resident must be month by a licen- (2) This review m resident's medical pharmacist must the attending phy medical director these reports mu Irregularities incl any drug that me	eview, Report Irregular, Act ug Regimen Review. e drug regimen of each reviewed at least once a sed pharmacist. §483.45(c) nust include a review of the al chart. §483.45(c)(4) The report any irregularities to vsician and the facility's and director of nursing, and ust be acted upon. (i) ude, but are not limited to, rets the criteria set forth in this section for an	F0756	reviewed by the completed regim 2023. 2. All residents h by this deficient on 1-23-2023 to residents who ha being done. No of 3. The policy for reviewed and up on 1-12-2023. A educated on by t	7 & #49 drug regimer DON and physicians hens are up to date as practice. An audit was ensure there were no ad drug Regimen Revie other concerns were r Drug Regimen Revie odated by the QA Com All Nursing Staff were the Administrator/Des policy on 1-12-2023 a	and affected s done riew not noted. w was mittee ignee'	1/31/2023

STATEMENT OF DEF AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:			ISTRUCTION		ATE SURVEY LETED
		134140	B. WING			12/22/	2022
NAME OF PROVIDER	R OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MOMENTOUS HE	ALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
PRÉFIX (EA TAG F	ACH DEFICIEN ULL REGULAT IN	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR RE	VIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
note mus repo and of n resi irreg atte resi irreg any ther or h reco deve proo revi time evid Base revid Base revid Resi	ed by the phai st be documer ort that is sent that is sent that is sent dent's name, gularity the ph ending physicia dent's medica gularity thas be re is to be no c attending phy er rationale in ord. §483.45(c relop and mair cedures for th few that includ e frames for th cess and step en he or she is uires urgent a s REQUIREM denced by: ed on observa- ted on observa- ted the facility riscian reviewed dications and ude: ident 27 (R27)	g. (ii) Any irregularities macist during this review thed on a separate, written to the attending physician nedical director and director ts, at a minimum, the the relevant drug, and the armacist identified. (iii) The an must document in the l record that the identified een reviewed and what, if een taken to address it. If change in the medication, sician should document his the resident's medical c)(5) The facility must thain policies and e monthly drug regimen le, but are not limited to, the different steps in the s the pharmacist must take dentifies an irregularity that ction to protect the resident. ENT is not met as tion, interview, and record failed to ensure the d and acted upon identified ten irregularities for three 7, and #49) of five reviewed, otential for unnecessary adverse reactions. Findings		audited and Fa the Adr reviewe complia comple the QA 5. The	nsure compliance, 5 residents w I for Completed Drug Regiman F cility Response. will be performe ministrator/Designee. Audits will ed and reported to the QAPI ance committee. Audits will be ited monthly for 3 months and th PI committee recommends. Administrator is responsible for the correction.	Review ed by be en as	

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		À. BUILDIN	G	ISTRUCTION	ĊOMF	(X3) DATE SURVEY COMPLETED _ 12/22/2022	
NAME OF PROVIDER (STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 490	R		
PRÉFIX (EAC	H DEFICIEN	NTEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I /IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
and d with a 11/18 (sever Interv screer On 12 asleep In an Direct pharm Septe that h times. not w vascu Revier 10/18 currer 75 mg Aspiri notes [Aspir days ((for in After antip] physic the pl	ementia. Tl an Assessm /22 revealed re cognitive iew for Me iew for Me ing tool). 2/20/22 at (0 o in bed. 2/20/22 at (0 o in bed. 2/20/20 at (0 o in b	abetes, anxiety, depression, ne Minimum Data Set (MDS) ent Reference Date (ARD) of ed R27 scored 00 out of 15 e impairment) on the Brief intal Status (BIMS-a cognitive 09:55 AM, R27 was observed 2/22/22 at 08:27 AM, ng (DON) "B" sent R27's ation regimen reviews for ober, and November 2022 eviously requested three eported the physician did ease R27's Plavix due to her nd medical history. Pacy reviews dated 9/13/22, (22 revealed "The patient s both Clopidogrel [Plavix] ns] QD [every day] and D. Current recommendation latelet therapy, namely ASA vix, is only indicated for 30 artery stenting) or 90 days arge artery atherosclerosis). reatment period, only ONE ld be administered." The t sign or document any of views. visician's orders revealed R27						

STATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) M A. BUI	ULTIPL DING	E CON	STRUCTION	(X3) DA COMPL	ATE SURVEY LETED
		134140	B. WII	NG			12/22/	2022
NAME OF PROVIDER O	OR SUPPLIE	R				STREET ADDRESS, CITY, STATE,	ZIP COI	DE
MOMENTOUS HEAL	TH AT BA	TTLE CREEK				675 WAGNER DR BATTLE CREEK, MI 49017		
PRÉFIX (EACI	H DEFICIEN L REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG		COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	ill prescribe n 81 mg da	ed Plavix 75 mg daily and ily.						
DON " facility and Na was ur Physic regard provid Reside Accord Minim reveal facility (sever Intervi screer Review and re 27, 20 "Evalu in the candid There Physic from F that a recom	'B" reported last week - ovember p nable to loc ian docume ling R27's p led prior to ent #22 ding to the um Data So led Resider on 8/12/2' re cognitive iew for Men ning to 1). w of R22's commenda 21 pharma lated the pa chart and r date for pne was no writ cian, and no R22's legal signed phy umendation /14/22 at 1 iew with Din ported beir ave an insig	an 12/22/22 at 09:18 AM, d the physician was in the and signed R27's October harmacy reviews, but she state the signed documents. entation was requested oharmacy reviews and not the survey exit. clinical record, including the et (MDS) dated 11/18/22 at 22 was admitted to the l, (R22) scored 00 out of 15 impairment) on the Brief tal Status (BIMS-a cognitive monthly pharmacy reviews ations reflected the January cy recommendation read atient immunological history toticed this patient may be a sumococcal vaccination." tten response from the o signed consent or refusal guardian. It was requested sician copy of the pharmacy be provided on 12/20/22 1:41 AM, during an rector of Nursing (DON) "B" ng new to her role and did ht or knowledge how s work, along with the						

STATEMENT OF DEFICIENC AND PLAN OF CORRECTIO	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140		IPLE CONSTRUCTION	_ COMF	(X3) DATE SURVEY COMPLETED 12/22/2022	
NAME OF PROVIDER OR SI		 	STREET ADDRESS, CITY 675 WAGNER DR BATTLE CREEK, MI 4		DDE	
PRÉFIX (EACH DE	Y STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY GULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHOUL REFERENCED TO THE APPI DEFICIENCY)	D BE CROSS-	(X5) COMPLETION DATE	
pharmacy	l protocols. R22's signed ecommendation for January 2021 ted at that time.					
that she ha Pharmacy attempt to document, made for F recommen Physician o regarding	ported on 12/20/22 10:10 am, d located a very large binder with ecommendations and would locate the Physician signed at this time a 2nd request was 22's January 2021 pharmacy Jation signed by the Physician. ocumentation was requested 22's pharmacy reviews and not rior to the survey exit.					
was origina 06/15/202	9 (R49) he medical record reflected R49 lly admitted to the facility with a diagnosis of Alzheimer's pression and Anxiety.					
During a re Medicatior revealed R Galantamin Give 1 tabl Tablet 100 day for par During an	cord review of a Monthly Review (MMR) on 12/12/22, 9 was ordered to receive e Hydrobromide 4 MG Tablet. et by mouth twice a day, Zoloft MG 1 tablet by mouth one time a anoid personality disorder. hterview on 12/14/22 at 11:41 AM, ated, she did not know the MMR					
Record rev	ew on 12/16/22 of R48 pharmacy					

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140		À. ÉUILDI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STAT 675 WAGNER DR BATTLE CREEK, MI 49017	E, ZIP CO	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI/ DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
F0759 SS= D	medication recorno MMR perform December 2022 On 12/20/22 at 0 DON "B" was req MMR. On 12/21/22 at 0 DON "B" was req MMR again. As of 12/22/22 at time of exit, the I were not provide Free of Medication §483.45(f) Medic Medication error greater; This REQUIREM evidenced by: Based on observa- review, the facilit medication error when five medicat from a total of tw two residents (Re reviewed for medi- resulting in a me- and the potentia	on Error Rts 5 Prent or More ation Errors. The facility : its- §483.45(f)(1) rates are not 5 percent or IENT is not met as ation, interview, and record y failed to ensure a rate of less than five percent ation errors were observed venty-nine opportunities for esident # 30 and # 8) of five dication administration, dication error rate of 17.24% I for reduced efficacy of increased risk of adverse	F0759	found to on 1-5- 2. All re- by this 5 on 1-26 DON/D pass co 3. The p was rev deemed staff we 2023 or Adminis 4. To ei audited adminis DON/D reporte for tren. 5. The p	dents # 30 and #8 were review be unaffected by medication 2023 by the DON/Designee. esidents have the ability to be a deficient practice. An audit was -2023 and 1-27-2023 by the esignee' to ensure the medicat propetency of all nursing staff policy for Medication Administr viewed by the QAPI Committee d appropriate on 1-12-2023. All ere educated on 1-12-2023 and in the policy for Medication stration by the DON/Designee. Insure compliance, 5 nurses will to ensure proper medication stration monthlyX3 by the esignee'. Audits will be reviewed d to the QAPI Compliance Con- ding and process improvement Administrator is responsible for correction.	errors ffected s done ion ation ation and nursing 1-13- I be ed and nmittee	1/31/2023

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI D PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION		ATE SURVEY PLETED
		134140	B. WING _		12/22	/2022
					ESS, CITY, STATE, ZIP CC	
MOMENTOUS HEALTH AT BATTLE CREEK				675 WAGNER BATTLE CRE		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORRECTIVE ACTIO REFERENCED TO	F CORRECTION (EACH N SHOULD BE CROSS- THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
	Findings include:					
	Resident #30					
	Nurse (LPN) "C" we multiple medicat including one Assent enteric coated ta Sodium 100mg ta medications, LPN administer the medications, LPN administer the medication of the electron of the transformation of the electron of the transformation of the electron of the transformation of the electron of the	1:33 AM, Licensed Practical was observed preparing ions for Resident #30 (R30) pirin 325milligram (mg) blet and one Docusate ablet. After preparing the 1 "C" was observed to edications to R30 and then cument the medications as ronic medical record. eview of R30's medical blete. During the review, a dated 12/24/2020 read, 25mg. Give 1 tablet by a day" and a physician's 5/2020 read, "Colace Docusate Sodium). Give 1 h one time a day" specifically for an Aspirin ce capsule. R30 was				
	administered an a and a colace tabl Resident #8	Aspirin enteric coated tablet et.				
	observed prepari for Resident #8 (I	:47 AM, LPN "C" was ng multiple oral medications R8) including one Aspirin :ablet and one Multi Vitamin				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022		
NAME OF PROVIE			STREET ADDRESS, CITY, ST 675 WAGNER DR BATTLE CREEK, MI 4901					
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD E :FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
fo th a th e g w w th th t o p o o to tr n n C W w p o o to tr 1 V o o to T e v v a a a a	br injection. LPN the insulin pen h ttach the dispos- then dial the pen intered R8's root loves, cleaned F ith an alcohol s vas dialed to 30 the insulin injection the insulin admir bserved to prime en vial) the insu bserved to admo to R8 and then p the orders as g the dications	bare R8's Basaglar Insulin pen I "C" was observed to clean ub with an alcohol swab, sable needle to the pen, and to 30 units. LPN "C" then m, sanitized hands, placed R8's left abdominal region wab, verified that the pen units, and then administered on to R8. At no time prior to histration was LPN "C" he (remove the air from the lin pen. LPN "C" was then inister the oral medications roceeded to document the iven in the electronic eview of R8's medical record uring the review, a dated 3/15/2022 read, ric coated) tablet Delayed ive 1 tablet by mouth one d a physician's order dated "Multivital Tablet (Multiple Is). Give 1 tablet by mouth " specifically for an Aspirin blet and a Multiple Is tablet. R8 was Aspirin chewable tablet and ablet (without minerals). In 12/13/22 at 10:42 AM,						

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		ATE SURVEY PLETED	
	134140	B. WING				12/22/2022	
IAME OF PROVIDER OR SUPPLI	ER			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DDE	
IOMENTOUS HEALTH AT B	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017	7		
PRÉFIX (EACH DEFICIE TAG FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE	
prior to the adm medication, the dosage, and rigl Additionally, DC manufacturer's i administration v including cleani an alcohol swab to ordered units site with an alco administering th mention the ste prior to dialing a ordered insulin Review of the fa Administration Review of the fa Administration indicated, "Proc administering th label THREE (3) resident, right m time and right m administration to 14) Insulin per the resident's na informationPr with an insulin p the correct pen No additional in policy regarding pen preparation a pen. Instructions on I	ing (DON) "B" stated that inistration of an oral right medication, right nt route should be verified. N "B" stated that the nstructions for insulin ia a pen should be followed ng the insulin pen hub with , placing a needle, dialing pen , cleaning resident injection hol swab, and then ne insulin. DON did not p to prime the insulin pen and administering the dosage. cility policy titled "Medication and dated 5/1/2022 edure7) The individual ne medication must check the times to verify the right nethod (route) of pefore giving the medication ns will be clearly labeled with ame or other identifying ior to administering insulin pen, the Nurse will verify that is used for that resident" formation noted within the the procedure for insulin or insulin administration via Basaglar Kwikpen at d.nlm.nih.gov/basaglarkwikpe						

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DPLAN OF CORRECTION IDENTIFICATION NUMBER: 134140		À. BUILDI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLIE S HEALTH AT BA				STREET ADDRESS, CITY, STA 675 WAGNER DR BATTLE CREEK, MI 49017	TE, ZIP CO	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPR DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE	
F0761 SS= D	under "Priming y before each inje removing the air Cartridge that m It is important to injection so that do not prime be get too much or your Pen, turn th unitsHold you pointing up. Tap to collect air but holding your Per up. Push the Do: "0" is seen in the see insulin at the Label/Store Drug §483.45(g) Labe Drugs and biolog must be labeled accepted profes the appropriate a instructions, and applicable. §483 State and Feder store all drugs a compartments u controls, and pe personnel to han §483.45(h)(2) TI separately locke compartments fo listed in Schedu Drug Abuse Pre	titled "Instructions for Use" you Pen" included "Prime ctionPriming means from the Needle and ay collect during normal use. prime your Pen before each it will work correctlyIf you fore each injection, you may too little insulinTo prime be Dose Knob to select 2 r Pen with the Needle the Cartridge Holder gently obles at the topContinue n with the Needle pointing se Knob in until it stops, and e Dose WindowYou should e tip of the Needle" gs and Biologicals ding of Drugs and Biologicals gicals used in the facility in accordance with currently sional principles, and include accessory and cautionary the expiration date when 45(h) Storage of Drugs and 45(h)(1) In accordance with al laws, the facility must nd biologicals in locked nder proper temperature rmit only authorized ve access to the keys. he facility must provide d, permanently affixed or storage of controlled drugs e II of the Comprehensive vention and Control Act of drugs subject to abuse,	F0761	citation on both Medica audited cleaned cleaned a. All re by the on by th were no inappro the med 3. The 1 reviewe -12-202 the Poli adminis -2023.	esidents are listed in this citat states that expired meds wer inursing units, North and Sou tion Rooms and Medication C by the administrator/Designe dout of expired or mislabelled tion on 12-23-2022. Isidents have the ability to be deficient practice. An audit wa ne NHA/Designee. to ensure to expired or mislabelled or priately stored medications o dication carts on 12-23-2022. Policy for Expired Medications ad by the QAPI Team and upo 3. All nursing staff were educ icy for Expired Medications by strator/designee on 1-12-2023 udit of 25% of all medication of	e found th. The arts were e and affected s done there n any of s was dated on 1 ated on y the and 1-13	1/31/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: IDENTIFICATION NUMBER:			A (X2) MULTI A. BUILDIN	PLE CON G	STRUCTION	(X3) DATE SURVEY COMPLETED	
		134140	B. WING _			12/22/	2022
NAME OF PROVIDE	ER OR SUPPLIEI	२			STREET ADDRESS, CITY, STATE	ZIP CO	DE
MOMENTOUS H	EALTH AT BA	ITLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
	EACH DEFICIEN	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING FORMATION)	ID PREFIX TAG	COR RE	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS- E	(X5) COMPLETION DATE
pa thu dd Th ev Ba fai thu dis po rec co Du at of rou Zi Or en En fo No M. Zi Su da "G su da su ex	ackage drug dis e quantity store se can be read his REQUIREM videnced by: ased on observati- iled to ensure nut e counter medical scarded. Resultin tency and efficad ceiving nutritions unter medications uring an observat 08:30 AM with I medications. LP oms, one on north ed room- north-(1 nc 50mg expired n 12/13/22 at 00 hvironmental to hvironmental Se llowing item wat orth Unit: edical Supply R flucerna" Rich C upplement were ate that read Mation spiration date th	ENT is not met as on and interview the facility ritional supplements and over tions were not expired and g in the potential for altered y for the 53 residents al supplements and over the s out of the medication room. ion and interview on 12/13/22 .PN "N" regarding the number N "N" stated we have 2 med h and one on south. Dementia unit) 3 bottles of on 08/22. B:45 A.M., A common area ur was continued with rvice Director "F". The		adminis thereaft to the C 5. The J	tion rooms will completed by the strator/designee weekly x4 and r er. Results will be trended and t API Meeting for process improv Administrator is responsible for t correction.	nonthly aken rement.	

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	À. BUILDIN	G	ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		134140	B. WING _			12/22/	2022
NAME OF PROV	IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE,	ZIP CO	DE
MOMENTOUS	HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
		taff discard the expired ements as soon as possible.					
SS= F	Sanitary §483.60 requirements. Th (1) - Procure food considered satisf local authorities. items obtained di subject to applica regulations. (ii) TI prohibit or prever produce grown in compliance with a food-handling pra does not preclude foods not procure (2) - Store, prepa in accordance wi food service safe This REQUIREM evidenced by: Based on observa reviews, the facilir and maintain foo effecting 53 resid increased likeliho bacterial harbora service equipmer plumbing water la Findings include: On 12/11/22 at 0 the food service of	e facility must - §483.60(i) d from sources approved or actory by federal, state or (i) This may include food rectly from local producers, ible State and local laws or his provision does not at facilities from using facility gardens, subject to applicable safe growing and actices. (iii) This provision e residents from consuming ed by the facility. §483.60(i) re, distribute and serve food th professional standards for ty. ENT is not met as ations, interviews, and record ty failed to effectively clean d service equipment ents, resulting in the od for cross-contamination, ge, decreased interior food tt illumination, and	F0812	comple The floot the diet coating dietary replace stem w 2023. 2. This affect a the kitc comple 15-202 3. The reviewe update have in for the carryov All staff kitchen 2023 b 4. The sanitati monthly and bro 5. The	vent- and hood cleaning was ted on 1-5-2023 by our outside v ors, sinks, and drains were clear ary staff. All pots and pans that I on them were disposed of by th staff by 1-23-2023.Light bulbs w d and the hand sink hot water va- ere repaired by maintenance by deficient practice has the ability II residents of the facility. An auc hen for required cleanliness leve ted by the Food Service Director 3 and all open areas were addre policy for kitchen sanitation was ad by the QAPI Committee and d on 1-12-2023. The FSD and N pplemented a new sanitation che FSD and administrator to comple er any unfinished items to comple were educated on the policy for sanitation on 1-12-2023 and 1-1 y the administrator. facility FSD/Designee will comple on checklist weekly x4 and then y thereafter. Results will be trend bught to QAPI meeting for proces ement. Administrator is responsible for t correction.	ed by had e ere alve 1-23- to lit of els was on 1- ssed. HA ecklist ete and letion. 3- ete the led is	1/31/2023

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140		À. BUILDIN	G	STRUCTION	_ COMF	(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLI				STREET ADDRESS, CITY, 675 WAGNER DR	STATE, ZIP CO	DDE	
	0				BATTLE CREEK, MI 49	017		
(X4) ID PREFIX TAG	(EACH DEFICIEI FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
	were noted:							
	conducted with regarding roden production kitch stated: " One roo trap approximat The "True" one-o observed missin One of two "Gar interior light ass functional. The "2017 FDA N 303.11 states: "T (A) At least 108 distance of 75 cc in walk-in refrige storage areas ar during periods of lux (20 foot cano FOOD is provide such as buffets a produce or PAC	09:23 A.M., An interview was Food Service Director "H" t activity within the food een. Food Service Director "H" dent was caught in a snap ely one month ago." door reach-in freezer was g the interior light bulb. land" convection oven emblies were observed non- Model Food Code" section 6- he light intensity shall be: lux (10 foot candles) at a m (30 inches) above the floor, eration units and dry FOOD id in other areas and rooms of cleaning; (B) At least 215 dles): (1) At a surface where end for CONSUMER self-service and salad bars or where fresh KAGED FOODS are sold or umption, (2) Inside h as reach-in and under-						
	75 cm (30 inches used for handwa EQUIPMENT and toilet rooms; and	ators; and (3) At a distance of s) above the floor in areas ashing, WAREWASHING, and d UTENSIL storage, and in d (C) At least 540 lux (50 foot face where a FOOD						

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDING	PLE CON	STRUCTION	(X3) D/ COMP	ATE SURVEY LETED
		134140				12/22/	2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MOMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	with UTENSILS or	king with FOOD or working EQUIPMENT such as knives, or saws where EMPLOYEE					
	observed faulty a completely close, Service Director "	t water valve stem was llowing the valve to not creating a water leak. Food H" indicated she would ince for necessary repairs as					
		lodel Food Code" section 5- PLUMBING SYSTEM shall be:					
	(A) Repaired acco Maintained in go	ording to LAW; and (B) od repair."					
	The hand sink ba accumulated dirt	sin was observed soiled with and grime.					
	surfaces (door fro	" stove/oven exterior onts, door handles, etc.) were vith accumulated and esidue.					
	observed with ac residue/splash. Tl (backsplash, unde	he Coffee Machine er splash, and spout also observed soiled with					
	observed soiled a	ces of the Coffee Urns were and stained with encrusted food residue.					

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	À. BUILDIN	G		(X3) D/ COMP	ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
NAME OF PRO	VIDER OR SUPPLIE	R	-		STREET ADDRESS, CITY, STATE,	ZIP CO	DE
MOMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
		ement): "Magnum" freezer 4) obstructed with ice dams.					
		ler condenser fan grill plate led with accumulated dust					
	601.11 states: "(A CONTACT SURFA clean to sight and CONTACT SURFA and pans shall be grease deposits a (C) NonFOOD-CC EQUIPMENT shall	Model Food Code" section 4-) EQUIPMENT FOOD- ACES and UTENSILS shall be d touch. (B) The FOOD- ACES of cooking EQUIPMENT e kept free of encrusted and other soil accumulations. DNTACT SURFACES of I be kept free of an dust, dirt, FOOD residue, and					
	observed (cracke Service Director "	ler flooring surface was d, chipped, missing). Food 'H" indicated she would ance for necessary repairs as					
	201.11 states: "Ex 201.14 and except or applications the reasons, floors, floo	fodel Food Code" section 6- scept as specified under § 6- ot for antislip floor coverings nat may be used for safety oor coverings, walls, wall eilings shall be designed, installed so they are SILY CLEANABLE." m: 4 of 11 blue tablecloths					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140				(X3) DATE SURVEY COMPLETED 12/22/2022			
NAME OF PROVIDER OR SUPPLIER MOMENTOUS HEALTH AT BATTLE CREEK			STREET ADDRESS, CITY, 675 WAGNER DR BATTLE CREEK, MI 49					
ACH DEFICIEN	CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING	ID PREFIX TAG	COR	RECTIVE ACTION SHOULD I	BE CROSS-	(X5) COMPLETIO DATE		
idue/splash. a "2017 FDA M I.11 states: "CI m FOOD resid tter." 12/12/22 at 0 Policy/Procec Jipment and L ealed under P nsils will be pro- d stored to pre- cord review of itled: "Cleanin ted (no date) fro- cord review of itled: "Cleanin ted (no date) fro- cord review of ted (no date) fro- ted (no date) fro- cord review of ted (no date) fro- cord review of ted (no date) fro- cord review of ted (no date) fro- ted (no date) fro- fro- ted (no date) fro- ted (no date) fro- ted (no date) fro- fro- ted (no date) fro- fro- ted (no date) fro- fro- ted (no date) fro- f	lodel Food Code" section 4- ean LINENS shall be free ues and other soiling 8:00 A.M., Record review of dure entitled: "Cleaning Itensils" dated (no date) olicy: "Equipment and roperly cleaned, sanitized, event contamination." the Policy/Procedure g Equipment and Utensils" urther revealed under Il culinary staff will be in- ing and sanitizing 8:15 A.M., Record review of dure entitled: "Maintenance pupment" dated (no date) olicy: "It is the policy of this alfunctions and need for sed to the Maintenance the Administrator in a timely review of the entitled: "Maintenance and							
	SUMMARY STA ACH DEFICIEN FULL REGULAT IN re observed sc due/splash. 2 "2017 FDA M .11 states: "CI m FOOD resid tter." 12/12/22 at 0 Policy/Proced igment and U ealed under P nsils will be pr stored to pre cord review of itled: "Cleanin ed (no date) fr cedure: "(4) A viced on clean ipment." 12/12/22 at 0 Policy/Proced Repairs of Ec ealed under P lity that all ma airs are report partment and nner." Record icy/Procedure pairs of Equipr ther revealed u	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The observed soiled with accumulated food due/splash. The "2017 FDA Model Food Code" section 4- .11 states: "Clean LINENS shall be free m FOOD residues and other soiling tter." T2/12/22 at 08:00 A.M., Record review of Policy/Procedure entitled: "Cleaning uipment and Utensils" dated (no date) ealed under Policy: "Equipment and nsils will be properly cleaned, sanitized, d stored to prevent contamination." cord review of the Policy/Procedure itled: "Cleaning Equipment and Utensils" ed (no date) further revealed under cedure: "(4) All culinary staff will be in- viced on cleaning and sanitizing	BUMMARY STATEMENT OF DEFICIENCIES ID ACH DEFICIENCY MUST BE PRECEDED BY PREFIX FULL REGULATORY OR LSC IDENTIFYING TAG TAG TAG *2017 FDA Model Food Code" section 4- .11 .11 states: "Clean LINENS shall be free FOOD residues and other soiling tter." 12/12/22 at 08:00 A.M., Record review of POIgy/Procedure entitled: "Cleaning	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROM COR REFIX TAG re observed soiled with accumulated food due/splash. food due/splash. re e"2017 FDA Model Food Code" section 4- .11 states: "Clean LINENS shall be free m FOOD residues and other soiling tter." food provide the section 4- .11 states: "Clean LINENS shall be free m FOOD residues and other soiling tter." 12/12/22 at 08:00 A.M., Record review of Policy/Procedure entitled: "Cleaning uipment and Utensils" dated (no date) ealed under Policy: "Equipment and nsils will be properly cleaned, sanitized, I stored to prevent contamination." .ord review of the Policy/Procedure itted: "Cleaning Equipment and Utensils" ed (no date) further revealed under cedure: "(4) All culinary staff will be in- viced on cleaning and sanitizing uipment." 12/12/22 at 08:15 A.M., Record review of Policy/Procedure entitled: "Maintenance I Repairs of Equipment" dated (no date) ealed under Policy: "It is the policy of this lity that all malfunctions and need for airs are reported to the Maintenance partment and the Administrator in a timely mner." Record review of the icy/Procedure entitled: "Maintenance and pairs of Equipment" dated (no date) ther revealed under Procedure: "(4) ventative maintenance will be provided major equipment at regular intervals. The	BATTLE CREEK, MI 490 SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD REFERENCED TO THE APPR DEFICIENCY) te observed soiled with accumulated food due/splash.	BATTLE CREEK, MI 49017 DUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) re observed soiled with accumulated food due/splash.		

STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. ÉUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ATE SURVEY LETED '2022
NAME OF PROV	/IDER OR SUPPLIE	R		STREET ADDRESS, CITY,	STATE, ZIP CO	DE
MOMENTOUS	HEALTH AT BA	TTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 49	9017	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHOULD REFERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	these check-ups system."	and in-putting into the TELS				
F0839 SS= D	qualifications. §4 employ on a full-t basis those profe out the provisions §483.70(f)(2) Pro- licensed, certified accordance with This REQUIREM evidenced by: Based on observ- review, the facilit Certified Activitie at the facility, res 53 residents to r meaningful activ In an interview of Activity Director she was not a ce director, but stat for an online pro- however, the AD program yet. Admin "A" sent a AD "P" was to st 12/14/22 at 08:5	applicable State laws. ENT is not met as ation, interview, and record cy failed to ensure that a es Director was employed sulting in potential for all not be provided with ities. In 12/14/22 at 07:59 AM certification. AD "P" stated ertified as an activity ed the facility set her up ogram. "P" had not started the an email that revealed that art her training on	F0839	 The Activity Director started h class in December of 2022. All residents have the potentia affected by this deficient practice 3. The requirement for Certified Professionals for SNF activity director's progress was updated to include update email from the instructor logged Unit completion by the N process was updated by the NH 2023 and reviewed with the acti- 1-27-2023. An audit of completed units w completed by the NHA monthly coursework and certification is c Results will be brought to QAPI compliance and process improv 5. The Administrator is responsi plan of correction. 	al to be e. Activity rectors was deemed system for classroom be a monthly tacked and HA. This A on 1-20- vity director on ill be X12 until ompleted. for ongoing ement.	1/31/2023

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED _ 12/22/2022	
	VIDER OR SUPPLIE S HEALTH AT BA				STREET ADDRESS, CITY, STATE, 675 WAGNER DR BATTLE CREEK, MI 49017	ZIP COI	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (EA RECTIVE ACTION SHOULD BE CRC FERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
F0849 SS= D	12/14/22 Writer received site dated 12/14 AD "P" had bee program at this In a continued i 12/14/22 at 07: had been in her year without tra registration for program on 12/ Hospice Service services. §483.7 (LTC) facility ma (i) Arrange for the p at the facility thre Medicare-certifier resident in transp arrange for the p at the facility thre Medicare-certifier resident in transp arrange for the p at the facility thre Medicare-certifier resident in transp arrange for the p when a resident §483.70(o)(2) If an LTC facility the specified in para with a hospice, t the following req the hospice serv standards and p individuals provi- and to the timelin Have a written a that is signed by	nterview with AD "P" on 59 AM, AD "P" stated she active role of AD for one ining prior to this the online certification 14/22. s §483.70(0) Hospice 0(0)(1) A long-term care y do either of the following: e provision of hospice an agreement with one or certified hospices. (ii) Not provision of hospice services bugh an agreement with a ed hospice and assist the ferring to a facility that will provision of hospice services requests a transfer. hospice care is furnished in mough an agreement as graph (0)(1)(i) of this section he LTC facility must meet uirements: (i) Ensure that ices meet professional rinciples that apply to ding services in the facility, ness of the services. (ii) greement with the hospice	F0849	evaluat hospice comple quality 2. All R to be at Hospice concern 3.The F QAPI T approp on the on 1-12 4. To e hospice care wa Audits QAPI C DON/D monthly recomm 5. The	dent #21 , #48, and #32 were ed by the facility IDT Team and th a teams and an interdisciplinary n ted and care plans updated to en of care on 1-23-2023. esidents on Hospice have the poi fected. An audit was completed of a residents on 1/26/2023 and no a swere noted. Policy for Hospice was reviewed b eam on 1-12-2023 and deemed riate. All nursing staff were inserv Policy for Hospice on by the NHA 2-2023 and 1-13-2023 nsure compliance, 5 residents on a will be audited for ensuring prop as delivered by the DON /Designe will be reviewed and reported to the compliance Committee by the esignee. Audits will be completed (for 3 months, and then as mended by the QAPI Committee. Administrator is responsible for the correction.	ote Isure tential on all other by the riced /DON wer ee. he	1/31/2023

STATEMENT OF D		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDING	PLE CON G	STRUCTION		OATE SURVEY PLETED
		134140	B. WING _			12/22/2022	
IAME OF PROVID					STREET ADDRESS, CITY, 675 WAGNER DR BATTLE CREEK, MI 490		
(X4) ID PREFIX TAG	EACH DEFICIEN	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTIVE ACTION SHOULD FERENCED TO THE APPRODEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
bo re at hr e ap in s p c c in d hr t p c c in d hr t p c c in d hr t p c c in d hr t p c c in d hr t p c c in n d hr t p c c in n d hr t p c c in n d hr t c in n d hr t c in n d hr t c in n d hr t c in n d hr t c in n d hr t c in n d hr t c in n d hr t c in n d hr t c in n d hr t in n in n d hr t in n d hr t in n in n in n in n in n in n in n i	efore hospice c esident. The writ t least the follow ospice will prove esponsibilities for ppropriate hospic oppropriate hospic oppropriate hospic esponsibilities for portent of the LTC rovide based on are. (D) A commission cluding how the ospice provider is resident are a er day. (E) A pro- promediately notification of the patient; nu- promediately notification and the sport of the patient; nu- portion of the patient; providing medication of the patient; nu- port, providing the target and the target of the patient; nu- portion of the patient; nu- portion of the patient; nu- port, providing medication of the patient; nu- port, providing the target of the patient; nu- port, providing the target of the patient; nu- port, providing the target of the patient; nu- port of the patient; nu- t	sentative of the LTC facility are is furnished to any tten agreement must set out ving: (A) The services the ide. (B) The hospice's or determining the bice plan of care as specified of this chapter. (C) The cach resident's plan of nunication process, e communication will be ween the LTC facility and the to ensure that the needs of addressed and met 24 hours ovision that the LTC facility fies the hospice about the ignificant change in the al, mental, social, or . (2) Clinical complications bed to alter the plan of care. Insfer the resident from the indition. (4) The resident's rision stating that the s responsibility for appropriate course of cluding the determination to of services provided. (G) An t is the LTC facility's furnish 24-hour room and t the resident's personal previded is appropriately ividual resident's needs. (H) the hospice's including but not limited to, al direction and management trising; counseling (including and bereavement); social nedical supplies, durable ent, and drugs necessary for					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	À. BUILDIN	G	ISTRUCTION	. COM	DATE SURVEY
		134140	B. WING _			12/22	2/2022
NAME OF PRC	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE
MOMENTOU	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49	017	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	associated with related condition services that are the resident's tel conditions. (I) A facility personne administration of including those t appropriate by th the hospice plan personnel may a where permitted specified by the stating that the L alleged violation neglect, or verba physical abuse, source, and miss property by hosp hospice adminis LTC facility becc violation. (K) A or responsibilities of facility to provide LTC facility staff facility arranging care under a wri designate a mer interdisciplinary working with hos coordinate care the LTC facility staff facility to assess to someone that capabilities to as designated inter responsible for t	bain and symptoms the terminal illness and is; and all other hospice an eccessary for the care of rminal illness and related provision that when the LTC I are responsible for the f prescribed therapies, herapies determined the hospice and delineated in of care, the LTC facility administer the therapies by State law and as LTC facility. (J) A provision .TC facility must report all s involving mistreatment, al, mental, sexual, and including injuries of unknown appropriation of patient bice personnel, to the trator immediately when the omes aware of the alleged lelineation of the of the hospice and the LTC e bereavement services to . §483.70(o)(3) Each LTC for the provision of hospice tten agreement must nber of the facility's team who is responsible for spice representatives to to the resident provided by staff and hospice staff. The team member must have a und, function within their ractice act, and have the the resident or have access has the skills and ssess the resident. The disciplinary team member is he following: (i) Collaborating resentatives and					

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONS	TRUCTION		ATE SURVEY
	134140				12/22/2022	
IAME OF PROVIDER OR SUPPLI	ER		s	STREET ADDRESS, CITY, S	TATE, ZIP CO	DDE
NOMENTOUS HEALTH AT B	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	17	
PRÉFIX (EACH DEFICIE TAG FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY ITORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CORRE	DER'S PLAN OF CORRECTI ECTIVE ACTION SHOULD E ERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
the hospice car residents receiv Communicating and other health in the provision illness, related of conditions, to en- patient and fam facility commun medical director physician, and of participating in i patient as need care with the m physicians. (iv) information from recent hospice patient. (B) Hos Physician certifit the terminal illn- (D) Names and hospice person of each patient. access the hospi (F) Hospice me to each patient. attending physis each patient. (V) facility staff prov policies and pro- including patien and record keep staff furnishing §483.70(o)(4) E hospice care ur ensure that eac care includes b plan of care and furnished by the maintain the res	C facility staff participation in e planning process for those ring these services. (ii) with hospice representatives neare providers participating of care for the terminal conditions, and other hsure quality of care for the ily. (iii) Ensuring that the LTC icates with the hospice r, the patient's attending other practitioners the provision of care to the ed to coordinate the hospice edical care provided by other Obtaining the following in the hospice: (A) The most plan of care specific to each pice election form. (C) cation and recertification of ess specific to each patient. contact information for nel involved in hospice care (E) Instructions on how to bice's 24-hour on-call system. dication information specific (G) Hospice physician and cian (if any) orders specific to) Ensuring that the LTC vides orientation in the breedures of the facility, t rights, appropriate forms, bing requirements, to hospice care to LTC residents. ach LTC facility providing der a written agreement must h resident's written plan of both the most recent hospice a description of the services a LTC facility to attain or sident's highest practicable I, and psychosocial well-					

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:	IA (X2) MULTII A. BUILDING		STRUCTION		ATE SURVEY LETED
	134140	B. WING _			12/22/	/2022
NAME OF PROVIDER OR SUP	PLIER			STREET ADDRESS, CITY, S	STATE, ZIP CO	DE
MOMENTOUS HEALTH AT	BATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490)17	
PRÉFIX (EACH DEFI	STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY ILATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	uired at §483.24. EMENT is not met as :					
review, the fa communicati services that two residents Hospice servi coordination Hospice. Findings inclu Resident #48 Review of R4 (EMR) upon F on 6/17/2022 in place. Diag failure (cause breath), Dem Record review (MDS) assess R48 had a "B (BIMS) score indicated R48 cognition. Fu required use assistance wi During an int with Licensed						

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	IA	(X2) MULTIF A. BUILDING		ISTRUCTION		ATE SURVEY LETED
		134140		B. WING _			12/22/	2022
NAME OF PROVIDER OR S	SUPPLIE	R				STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MOMENTOUS HEALTH	AT BA	TTLE CREEK				675 WAGNER DR BATTLE CREEK, MI 49017		
PRÉFIX (EACH D	EFICIEN EGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)		ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
to see R4 LPN "N" s cupboard Record re hospice C documen 12/12/22, 12/01/22, 11/14/22 hospice b in place. In an inte CNA "U" s the facility inquired i During ar Director of thought h on facility the facility facility CN CNA did n Record re not conta direction of hospic the binde	8 she ha stated the at the of eview of certified ted R48 12/08/ 11/28/ and 11/ inder re- rview of stated h y sched h	hen hospice would come in ad no idea what they did. here was a binder up in a hurse's station. hospice binder revealed Nurse Aide (CNA) had had received showers on 22, 12/06/22, 12/05/22, 22, 11/21/22, 11/18/22, 707/22. Further reveal evealed no hospice care plan in 12/13/22 at 08:23 AM, ospice provided showers on uled shower days. Writer ver gets two showers a day. ew on 12/21/22 at 09:05 AM, ng (DON) "B" stated she CNAs provided all showers iled shower day, instead of DON "B" further stated the v gave showers if the hospice w up. R48's hospice binder did e plan, Kardex (CNAs , physician orders, schedule nor nurses' notes were in tare plan, no comprehensive er put in place regarding R48 he was receiving and						

		i					
STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI A. BUILDING	PLE CON G	ISTRUCTION		DATE SURVEY PLETED
		134140	B. WING _			12/22	2/2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY	, STATE, ZIP CO	DDE
MOMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR		
					BATTLE CREEK, MI 4	9017	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PRO	I /IDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX			PREFIX TAG		RECTIVE ACTION SHOUL		COMPLÉTION
TAG		ORY OR LSC IDENTIFYING NFORMATION)	TAG	R	EFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
		ventions were in place for					
	hospice was prov	are such to what services					
	nospice was prov	nung.					
	Resident #21(R21	1)					
	Poview of the Ea	ce Sheet and Minimum Data					
		10/24/22, reflected R21 was					
		hale admitted to the facility					
		diagnoses that included					
	dementia, corona	ary heart disease, heart					
		l vascular disease, seizure					
		hrenia, and mantic					
		MDS reflected R 21 had a					
		tool) score which indicated ke daily decisions was					
	-	d, and she required one					
		assist with bed mobility,					
		otion on unit, dressing,					
		hygiene, and bathing.					
	During an altern						
	-	vation on 12/11/22 at 9:07 ng on an air mattress					
		ith hospital gown on with					
		positioned to the left with					
		rine in room. R21 door was					
	-	ign on door that read,					
	"aerosol generate	e\ing procedure" that					
		d use of gloves, mask, gown,					
		on, with no Personal					
		ment(PPE) observed outside					
		air mattress in place,					
		d frail, was awake with eyes					
		ffed animal and rosary. R21 b be verbal and appeared					
		uch call light located out of					
I				I			I

TATEMENT OF DEFIN ND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	Á. BUILDIN	G		ĊOMF	DATE SURVEY PLETED
			B. WING _				
AME OF PROVIDER	OR SUPPLIE	ER			STREET ADDRESS, CITY, S	STATE, ZIP CO	DDE
OMENTOUS HEA	LTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490)17	
PRÉFIX (EAC	CH DEFICIEN	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
noted with 2 apper Revie reflec servic Revie and 1 hospi Revie did n servic Durin Direc had b mont have had b repor servic Revie did n servic Revie did n servic Revie had b repor servic Revie Servic Revie Revie Servic Revie Revie Servic Revie Servic Revie Servic	d at bedside 2 large Styr ared to be of w of the fa- ted R21 was res. w of the M /21/22, refi- ice services w of the EN ot have a p res. g an interv tor of Nursi- peen a Hosp hs and repo- an order fo peen the MI ted R21's N res and if it w of the R gh 11/25/2 nal progno ice. Date In 8/2020Inte eratively wi	AR on 12/12/22 reflected R21 hysician order for hospice iew on 12/20/22 at 1:35 PM, ing (DON) "B" reported R21 bice resident for several orted would expect R21 to r hospice. DON "B" reported DS nurse prior to DON and ADS should reflect hospice did not it was an error. 21 Care Plans, dated 1/29/17 2, reflected, "I have a sis and elected to have					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		_ COMF	ATE SURVEY PLETED		
	VIDER OR SUPPLIE S HEALTH AT BA			STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 490'				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)) BE CROSS-	(X5) COMPLETIO DATE	
	During an intervi DON "B" reported R21 Hospice that that day no histo with care confere plans to involve residents Care Cd forward. DON "B binder was signed been signed by s hospice staff and correction movir reported R21's C personalized incl provided. During an intervi CNA "M" reported spiritual care in f who provided ba Licensed Practica the interview and for several years trips out of the f had not observe weeks and does "OO" reported w and reported lor had always had o attached to. LPN of R21's religious had never observ visiting R21. LPN	uency of services. We on 12/20/22 at 3:30 PM, d had a care conference with t today and reported prior to ory of hospice involvement ences. DON "B" reported Hospice companies with onferences now moving " reported document in d today and should have staff receiving report from d will be part of plan of ng forward. DON "B" are Plans should be luding Hospice services we on 12/21/22 at 10:45 AM, ed had never seen hospice for R21, only hospice CNA aths usually 2 times weekly. al Nurse (LPN) "OO" joined d reported had cared for R21 and use to enjoy regular acility. LPN "OO" reported d R21 out of bed in two not like group events. LPN ras unsure if R21 liked music ng history of using rosary and cross necklace she was very "OO" reported was unsure s background and reported ved hospice spiritual services "OO" and CNA "MM" both nsure what services R21 was						

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	Á. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLI				STREET ADDRESS, CITY, STA		
(X4) ID PREFIX TAG	(EACH DEFICIEI FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	JIDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	only sign hospic and Nurse. During an interv Hospice CNA "P bathing services Wednesday and during lunch to reported facility reported R21 wa from Hospice se breakdown relat brief area and fa to south unit. He Hospice offered R21 did not rece "OO" reported v hospice binder v	ospice and reported they e tablet after visits for CNA iew on 12/21/22 at 12:25 PM P" reported provided R21 two times weekly on Friday and often comes assist with meals. CNA "OO" had been short staffed and is going to be discharged rvices and skin started to ed to incontinence located in cility moved R21 from north ospice CNA "OO" reported music and pet therapy but tive and was unsure why. CNA vas told yesterday that vould be located in front of e difficult to locate staff for "visits.					
F0880 SS= E	Infection Contro and maintain an control program sanitary and cor help prevent the transmission of infections. §483 and control prog establish an infe program (IPCP) minimum, the fo (1) A system for reporting, invest infections and co	tion & Control §483.80 I The facility must establish infection prevention and designed to provide a safe, infortable environment and to development and communicable diseases and .80(a) Infection prevention rram. The facility must inction prevention and control that must include, at a llowing elements: §483.80(a) preventing, identifying, igating, and controlling ommunicable diseases for all volunteers, visitors, and	F0880	comple Analysi the two Infectio followin Issue A RCA -T annuall Infectio the cha on this QAPI M ensure all Infectio	cility Quality Assurance Team ted on 1-27-2023 that a Root is (RCA) to identify the concer areas of facility failure on Tag in Control . The facility identifie ag root causes (RCA): The root cause for the facility's y review and approve updated n Control Policy was determin inge in administration (DNS A the facility implemented the fo deeting -was held on 1-12-202 Infection Control Subcommitted to Control Policies and sign The NHA also reviewed the n	ns with 9 F880- ed the failure to d ed to be). Based Illowing: 3 to ee review off their	1/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT COMPLE	TE SURVEY ETED	
	134140	B. WING		12/22/2	2/22/2022	
NAME OF PROVIDER OR SUPP	LIER		STREET ADDRESS, CIT	Y, STATE, ZIP COD	E	
MOMENTOUS HEALTH AT I	BATTLE CREEK		675 WAGNER DR BATTLE CREEK, MI	49017		
PRÉFIX (EACH DEFIC	TATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY ATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR CORRECTIVE ACTION SHOU REFERENCED TO THE API DEFICIENCY)	LD BE CROSS- PROPRIATE	(X5) COMPLETIOI DATE	
contractual an facility assess §483.70(e) an standards; §44 policies, and p which must ind A system of su possible comm infections befor persons in the possible incide or infections s Standard and precautions to of infections; (should be use not limited to: the isolation, o agent or orgar requirement th least restrictivu under the circl circumstances prohibit emplo disease or infe contact with re contact sident and the correct facility. §483.80 (a)(4) incidents ident and the correct facility. §483.80 (f) An conduct an an update their p	Is providing services under a angement based upon the nent conducted according to d following accepted national 83.80(a)(2) Written standards, rocedures for the program, slude, but are not limited to: (i) inveillance designed to identify junicable diseases or re they can spread to other facility; (ii) When and to whom ents of communicable disease hould be reported; (iii) transmission-based be followed to prevent spread v)When and how isolation d for a resident; including but (A) The type and duration of epending upon the infectious ism involved, and (B) A at the isolation should be the e possible for the resident unstances. (v) The under which the facility must yees with a communicable cted skin lesions from direct sidents or their food, if direct nsmit the disease; and (vi)The procedures to be followed by n direct resident contact. A system for recording fifed under the facility's IPCP tive actions taken by the 0(e) Linens. Personnel must process, and transport linens nt the spread of infection. nual review. The facility will nual review of its IPCP and ogram, as necessary. EMENT is not met as		of annual Infection Control Pol Committee. Policy Update: The QA Comm was updated for annual Infecti Subcommittee infection contro on 1-12-2023 by the NHA. Issue B RCA-The root cause of the fac maintain appropriate infection procedures during medication and nebulizer treatments (DN for staff retraining on the spect medication pass and infection need for supplies and clearer p communication for residents o treatments. Training: All Staff were retrained Infection Control and specifica 1. Standard Infection Control F 2. Infection Control During Me 3. Infection Control during neb treatments. Competency: Staff were tested procedure for Infection Contro Pass and Nebulizer Treatment and 1-27-2023. Staff who did n reeducated and retested. Policies: The facility policies for Control and Nebulizer Treatment and 1-27-23 by the DON. Staff trainings will be educated prior shift. QAPI Meeting : was held on 1 members of the QAPI Commit the Infection Control Policies. Auditing: As part of the ongoin ensure compliance, 3 residen Treatments will be audited to 6 compliance. Medication Pass and then by the Director of Nursing/Des	Agenda on Control of policy review cility's failure to control administration S B) is the need ifics on control and the postings and n nebulizer ed on the illy on: Practice dication Pass. Fractice dication Pass. Fractice don the proper l, Medication ts on 1-26-2023 not pass were or Infection ents were staff on 1-26-23 ff not at the r to their next -12-2023 with all tee to review of auditing to ts on Nebulizer ensure will be audited 5x per month		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	G	STRUCTION	COMP	
	VIDER OR SUPPLIE S HEALTH AT BA		STREET ADDRESS, CITY, 675 WAGNER DR BATTLE CREEK, MI 49				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE
	This citation inclu Statements A and	udes two Deficiet Practice d B.			n Control Standards are ma iss, nebulizer treatments, a		
	review the facility Control Policies a resulting in the po- most current Infe Practice and resu	ration, interview, and record and Program annually otential of not following the ction Control Standards of ulting in the potential for the on for all 53 Residents that lity.					
	policies regarding documents listed were implemente	d: view of the provided facility g Infection Control no a date that the policies ad and no date that the n reviewed annually.					
	Nursing Home A that the facility In reviewed annual Assurance) Com to provide docum review of the faci had been comple explained that sh	n 12/21/22 08:43 a.m. dministrator "A" explained fection Control Policies are ly in a QA (Quality mittee meeting. When asked nentation demonstrating that lity Infection Control Policies beted annually, NHA "A" ne would have to locate that would provide it would be					
	Nursing Home A explained that sh (Quality Assuran and could not find Control Policies I	n 12/21/22 12:59 p.m. dministrator (NHA) le had reviewed all the QA ce) Committee meetings d that facility Infection had been reviewed annually. ed that the facility could not					
STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) MULTIF A. BUILDING		ISTRUCTION		PATE SURVEY
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		134140	B. WING _			12/22	2/2022
NAME OF PROV	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE
MOMENTOUS	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	017	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
		umentation that the facility Policies had been reviewed					
	DPS B						
	review the facility control process f #7, #8 #30) out of reside at the faci prevention and/of during medicatio catheter care res of infection for al the facility.	ration, interview, and record y failed to follow infection or three Residents (Resident of all 53 Residents that lity was followed for or transmission of infections n administration and sulting in potential for spread I 53 Residents that reside at					
	Resident #7						
	(R7) was admitte and transferred t R7 had diagnosis	clinical record, Resident 7 d to the facility on 02/09/21 o the hospital on 12/15/22, s that include dementia and that required a urinary					
	catheter bag and in the dining/act were made on 12 observation inclu during the noon 12/14/22 throug During an intervi (DON) "B" she or reported the exp	tions were made of R7's I tubing resting on the floor ivity area, these observations 2/11 at 9:20am this uded no dignity bag, 12/11 meal, 12/13 at 8:44 am and hout the day. ew with Director of Nursing n 12/21/22 at 11:50 am, she ectation was the tubing and be on the ground.					

STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDIN		STRUCTION		ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
NAME OF PROV	/IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MOMENTOUS	HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	Resident #30						
	On 12/13/22 at 8 Nurse (LPN) "C" of multiple medication 50 milligrams, 1 of directly on top of LPN "C" popped pack. LPN "C" wat tablet with her but the medication of prepared medication medications, LPN administer the medications, LPN preparation of Por milliequivalents, drop directly on after LPN "C" pop blister pack. LPN up the tablet with it into the medication, L administer	8:33 AM, Licensed Practical was observed preparing ions for Resident #30 (R30). on preparation of Tramadol tablet was observed to drop f the medication cart after the tablet out of the blister is then noted to pick up the are fingers and place it into up with the remainder of the tions. After preparing the I "C" was observed to redications to R30. B:47 AM, LPN "C" was ing multiple medications for During medication otassium Chloride 10 1 tablet was observed to top of the medication cart oped the tablet out of the "C" was then noted to pick h her bare fingers and place tion cup with the remainder medications. After preparing .PN "C" was observed to to redications to R8. in 12/13/22 at 10:42 AM, ing (DON) "B", stated that the g oral medications for ould include verifying					

TATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION		DATE SURVEY PLETED
		134140	B. WING _		12/22	_ 12/22/2022	
AME OF PROVIDER (OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE
OMENTOUS HEAI	LTH AT BA	TTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 4			
PRÉFIX (EAC	CH DEFICIEN	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
not p media pack. would on to media media media media Revie Admi 22) 1 infect handy for th Durin 12/14 door Gener notec date o Aeros perfo that u treatr the fo time o time o	hysically to cation was DON "B" st d be to disp p of the me cation prep cation to be wof facility nistration" of Staff shall for cion control washing, an ue administr of medication A/22 at 12:2 of Room 13 rating Proce d to be blan of "12/14/2 sol Generati rmed in this upon compl ment (an ae orm would I of the proce staff and vis an N95 resp nistration. L must be wo ue duration nebulizer ac ated that th	ion, dose, and route and to uch the pill when the popped out of the blister rated that the expectation rose of a medication that fell edication cart during aration and for a new e dispensed. policy titled "Medication dated 5/1/2022, included " pollow established facility procedures (e.g., tiseptic technique, gloves) ation of medications" on pass observation on 4 PM, a sign on the closed 82 indicated, "Aerosol edure Sign". The sign was k except for the handwritten 2" after the statement "An ng Procedure was s room on". LPN "C" stated etion of the nebulizer rosol generating procedure), pe updated to indicate the edure and the duration of sitors must enter the room birator mask post PN "C" stated that an N95 porn when entering the room of the precautionary period diministration. The sign e precautionary period was anges per hour in this room"					

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G	STRUCTION		ATE SURVEY PLETED	
		134140	B. WING _		_ 12/22	12/22/2022		
NAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, S	STATE, ZIP CC	DE	
MOMENTOU	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD I FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
	changes in that u "C" stated that s to figure out the precautionary pe administration. L that there was a not state what it follow-up before treatment admir On 12/14/22 at ' to unit with a ne space provided to per hour in the r precautionary m minutes post ne on the 4-air chan Per LPN "C", she form prior and h regarding the co In an interview o "K" stated "I'm g then proceeded agency nurse an facility policy wa administration. L was assigned to and had adminis earlier that shift. 129 with a blank Procedure Sign" open door. LPN the door was jus	eriod post nebulizer PN "C" stated that she knew certain time frame but could was and needed time to a proceeding with nebulizer nistration. 12:48 PM, LPN "C" returned w sign indicating a "4" in the to indicate the air changes room and stated that easures will continue for 104 bulizer administration based nges per hour in the room. had never completed the had never received education ompletion of the form. an 12/14/22 at 1:20 PM, LPN to state that she was an d did not know what the						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	G	STRUCTION		ATE SURVEY PLETED /2022	
	/IDER OR SUPPLIE				STREET ADDRESS, CITY, STATE, ZIP CO 675 WAGNER DR BATTLE CREEK, MI 49017		DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIC DATE	
	No personal prot noted outside of denying knowled PPE. LPN "K" stat only additional P administering ar gloves as already on. LPN "K" denia administering ne facility. In an interview of DON "B" stated t be for staff to fol the completion of procedure. Per D signs posted out rooms to notify s receiving an aero and that PPE pre- to including the u gown, and gloves During the same confirmed that an Procedure Sign" each room where procedure was ac include nebulizer the room air chan a calculation com staff and a prior anyone entering N95 mask for the	itional needed to be done. sective equipment (PPE) was Room 129 with LPN "K" Ige as to the location of the ed that at the facility, the PE that she wore when hebulizer treatment was and N95 and safety glasses ed wearing a gown when bulizer treatments at the In 12/20/22 at 11:35 AM, hat the expectation would low the facility policy during of an aerosol generating ON "B", there are isolation side of the designated taff that an individual was usage of N95, goggles, s. interview, DON "B" n "Aerosol Generating was placed on the outside of e an aerosol generating dministered and this would treatments. Per DON "B", nges per hour in a room was pleted by environmental nurse consultant and that the room needed to wear an e period of time handwritten time an aerosol generating						

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDIN	PLE CON G	ISTRUCTION		ATE SURVEY
		134140				12/22	/2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DE
MOMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 4901	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	unable to explain hour was obtained 132, or the durat worn when enter generating proce- based on the roce was uncertain as information could In a follow up int DON "B" stated the environmental set changes per hout the ventilation sy follow-up with of proceed and had to provide at that 12/21/22, DON " sign down and the the sign posted of "There are 4 air of room". DON "B" minutes, but I just to the period of the should be worn to administration of procedure. Review of the face Generating Proced 5/1/2022, indicat signage should be	erview on 12/21/22 8:56 AM, that had discussed with ervices staff and that the "air r" calculation was based on rstem but was going to utside resources on how to I no additional information					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDI	NG	ISTRUCTION		ATE SURVEY LETED
ME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STAT	E, ZIP CO	DE
OMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETIC DATE
	when it will be sa 4) Full Personal P including N95 m	ne procedure being done and offe again to enter the room. Protective Equipment (PPE) ask, gowns and gloves must o the procedure being done					
F0883 SS= E	§483.80(d) Influe immunizations §- facility must deve to ensure that- (i influenza immun resident's repres regarding the be effects of the imm is offered an influ 1 through March immunization is n the resident has during this time p the resident's rep opportunity to rel (iv)The resident's documentation th the following: (A) resident's repres education regarco potential side effi immunization; ar either received th did not receive th due to medical c §483.80(d)(2) Pr facility must deva to ensure that- (i pneumococcal in or the resident's education regarco	eumococcal Immunizations enza and pneumococcal 483.80(d)(1) Influenza. The elop policies and procedures) Before offering the ization, each resident or the entative receives education nefits and potential side nunization; (ii) Each resident uenza immunization October 31 annually, unless the medically contraindicated or already been immunized beriod; (iii) The resident or oresentative has the fuse immunization; and s medical record includes hat indicates, at a minimum, That the resident or entative was provided ling the benefits and ects of influenza influenza immunization or he influenza immunization ontraindications or refusal. heumococcal disease. The elop policies and procedures) Before offering the mmunization, each resident representative receives ling the benefits and ects of the immunization; (ii)	F0883	assess absenc 2023 by were of prefere 2. All ref by the of on 1-25 there w with imm noted. 3. The p reviewe QAPI T on 1-12 Adminis 4. To el audited immuni thereafi adminis reviewe Complia improve complia 5. The of	esidents have the ability to be a deficient practice. An audit was 5-2023 by the DON/Designee to ere no residents who had conc munizations. No other concern policy for resident immunization ed and updated on 1-12-2023 b feam. All Nursing Staff were ed 2-2023 and 1-13-2023 by the strator on the updated policy. Insure compliance, 5 residents to ensure appropriate proper zation tracking weekly x4 and n ter. Audits will be performed by strator/designee. Audits will be ed and reported to the QAPI ance Committee for process ement and to ensure ongoing	cts from -15- ents off their ffected done o ensure cerns s were n was by the ucated will be monthly the	1/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	134140	B. WING _		_ 12/22/2022
NAME OF PROVIDER OR SUPPLI	ER		STREET ADDRESS, CITY, S	STATE, ZIP CODE
MOMENTOUS HEALTH AT B	ATTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 490	017
PRÉFIX (EACH DEFICIE TAG FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD REFERENCED TO THE APPRO DEFICIENCY)	BE CROSS- COMPLÉTION
immunization, u medically contra already been in the resident's re opportunity to re (iv)The resident documentation the following: (<i>A</i> resident's repre education regar potential side ei immunization; a either received immunization oi pneumococcal i contraindication This REQUIRE evidenced by: Based on obser review the facili pneumococcal a for three Reside #357) out of 6 r written declinat refused for two #29) out of six F potential for inc transmitting, or of pneumococcal	MENT is not met as vation, interview and record cy failed to offer and influenza immunization nts (Residents #22, #356, and eviewed and failed to provide on of those immunizations Residents (Residents #6 and tesidents resulting in the reased risk of acquiring, experiencing complications al or influenza disease and miscommunication and ng of Residents immunization			

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140		À. BUILDIN	IG	STRUCTION	ĊOMF		
	OVIDER OR SUPPLIE		STREET ADDRESS, CITY, ST 675 WAGNER DR BATTLE CREEK, MI 4901				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
	admitted to the diagnoses that in mellitus, paranoi dementia with b dysphagia (diffic kidney disease, h heart disease (bu on the walls of a failure, hyperma levels in the bloc block (slow conc node of the hear Data Set (MDS), Reference Date (revealed R6 had Status (BIMS) of cognition and co correctly) out of Review of R6 me the Pneumovax (pneumococcal i refused, which w Immunization R6 refusal was foun no date of the re Immunization R6 was found in R6 demonstrated re benefits and tha immunization has representative. N	edical record revealed that Dose 1 Immunization immunization) had been vas evident on the R6 ecord. No declination for d in the medical record and efusal was present on the R6 ecord. No documentation 's medical record that eceipt of education regarding t side effects of the ad been provided to R6's No declination or education coccal immunization was					

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140		Á. BUILDIN	G	STRUCTION	(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STATE, ZIP CODE 675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L VIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD I FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
		ion on 12/21/2022 at 01:23 erved lying in bed and sleeping.					
	was admitted to diagnoses that in dependence, coo hemiplegia and l bipolar disorder, the brain is disru traumatic brain i disorder, anxiety the blood), hype pulmonary disea esophageal reflu Data Set (MDS), Reference Date (revealed R29 had Status (BIMS) of	edical record revealed R29 the facility 05/15/2019 with included depression, alcohol caine dependence, left sided hemiparesis (paralysis), epilepsy (nerve activity in ipted causing seizures), njury, attention deficit , hyperlipidemia (high fat in rtension, chronic obstructive se (COPD), and gastro- x. The most recent Minimum with an Assessment (ARD) of 011/17/2022, d Brief Interview for Mental 01 (severely impaired					
	Influenza Vaccin times, Previnar 1 immunization) re (pneumococcal i time, which was Immunization Re refusal was foun no date of the re Immunization Re	edical record revealed that ation had be refused three 3 (pneumococcal efused one time, Previnar 20 mmunization) refused one					

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 134140	À. BUILDIN	G			ATE SURVEY LETED /2022
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STAT 675 WAGNER DR BATTLE CREEK, MI 49017	E, ZIP CO	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/ IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	benefits and side had been provide No declination or immunization or immunization wa exit. During observation 12/21/2022 at 01 setting up in bed were going well at to answer any que vaccination statu Resident #356 (R Review of the me was admitted to diagnoses that in femur, depression hallucinations, ar Admission Minim completed as of Admission Assess revealed that he place, and time. Review of R356 m his Immunization or No declination for immunization or	356) edical record revealed R356 the facility 12/09/2022 with included fracture of the right in, hypertension, ind homelessness. R356 num Data Set (MDS) was not this survey. R356 "Nursing sment", dated 12/10/2022, was orientated to person, inedical record revealed that a Record contained no he status of a pneumococcal an influenza immunization. or pneumococcal influenza immunization was dical record and none was					

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140			(X2) MULTI A. BUILDIN B. WING _	3	(X3) DATE SURVEY COMPLETED _ 12/22/2022		
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 4901		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIC DATE
	12/21/2022 at 0° sitting up in a wit that someone fro- into his room an Immunizations b pneumococcal ir vaccination had I Resident #357 (R Review of the me was admitted to diagnoses that ir skin infection) rig chronic pain, typ vascular disease, emphysema (lun of breath), depre hyperlipidemia (l gastro-esophage Minimum Data S as of this survey. Assessment", dar she was orientation time. Review of R357 r her Immunization information on t immunization or No declination for immunization or	edical record revealed R357 the facility 12/07/2022 with included cellulitis (bacterial ght and left lower limb, e 2 diabetes, peripheral edema, morbid obesity, g condition causes shortness sission, hypertension, high fat in the blood), and eal reflux. R357 Admission et (MDS) was not completed R356 "Nursing Admission ted 12/8/2022, revealed that ed to person, place, and medical record revealed that in Record contained no he status of a pneumococcal an influenza immunization. or pneumococcal influenza immunization was dical record and none was					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER: 134140 134140		À. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
	IDER OR SUPPLIE				STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 490			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
		on on 12/21/2022 at 01:19 oserved lying in bed and sleeping.						
	Director of Nursi the process for p residents would resident, explaini a consent form, t given to the resid be upload into th record. DON "B" refused the same	n 12/21/2022 at 10:25 a.m. ng (DON) "B" explained that providing immunizations to consist of asking the ing the risk and benefits, sign then the vaccination was dent, and the consent was to ne computerized medical explained that if a Resident e process would be followed unization would not be						
	Director of Nursi it was her expect offered within 72 "B" could not exp pneumococcal ir present for R6 in "B" could not exp influenza immun immunizations w the medical reco R356 and R357 s immunization red both in the medi	n 12/21/2022 at 12:30 p.m. ng (DON) "B" explained that ation that immunizations are thours our admission. DON plain why a declination for nmunization were not the medical record. DON plain why a declination for izations and pneumococcal rere not present for R29 in rd. DON "B" explained that hould have had data in their cord and a declination for cal record. She could not unizations had not been and R357.						
	Resident #22							

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Á. BUILDING	3	STRUCTION	(X3) DATE SURVEY COMPLETED		
		134140	B. WING _		_ 12/22	12/22/2022		
AME OF PRO	VIDER OR SUPPLI	ER			STREET ADDRESS, CITY, S	STATE, ZIP CO	DE	
MOMENTOUS	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIOI DATE	
	Minimum Data S revealed Resider facility on 8/12/2 (severe cognitive Interview for Me screening tool). Review of R22's and recommend 27, 2021 pharma "Evaluated the p in the chart and candidate for pr Review of R22's dated 2/25/22 th R22's guardian a the pnumococca documentation thad occurred. Th that R22's guard provided writter the pneumococca Further review o R22 was appoint 8/2/22, there was current guardiar offered the pneu- of R22. On 12/20/22 at 2 (DON) "B" repor-	e clinical record, including the Set (MDS) dated 11/18/22 at 22 was admitted to the 21, (R22) scored 00 out of 15 e impairment) on the Brief ntal Status (BIMS-a cognitive monthly pharmacy reviews lations reflected the January acy recommendation read atient immunological history noticed this patient may be a eumococcal vaccination." Nursing progress notes nat a message was left for it the time inquiring about al vaccine. There was no that a return or follow up call here was no documentation ian at that time had been the education that pertained to cal vaccine. If the clinical record reflected ared a new guardian on s no evidence that the thad been educated and umococcal vaccine on behalf 2:32 PM, Director of Nursing ted R22's former guardian tact and could not account as no further attempt to reach						

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI I OF CORRECTION IDENTIFICATION NUMBER: 134140		(X2) MUL A. BUILDI	TIPLE CON	STRUCTION		(X3) DATE SURVEY COMPLETED	
		134140	B. WING			12/22/	2022	
IAME OF PRC	VIDER OR SUPPLIE	ĒR			STREET ADDRESS, CITY, ST	ATE, ZIP CO	DE	
MOMENTOU	S HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 4901	7		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE	
F0887 SS= E	was not aware if been informed, opneumococcal v did not believe to Review of the far "Pneumococcal v reflected all resid Pneumococcal v prevention of pr upon admission, for eligibility for vaccine series, an offered the vacc the admission to contraindicated received the vacc "Residents/Repr refuse vaccinatic entries will be do medical record i refusal of the Pn COVID-19 Immu COVID-19 Immu COVID-19 Immu must develop ar procedures to e When COVID-19 facility, each ress offered the COV immunization is the resident or s been immunized COVID-19 vaccin	aardian. DON "B" stated she R22's current guardian had educated and or offered the accine, DON "B" stated she hat had been done. cility policy titled Vaccine" dated 5/01/22 dents will be offered accines to aid in the neumonia. 1. "Prior to or residents will be assessed to receive the Pneumococcal nd when indicated, will be ine series within 30 days of the facility unless medically or the resident had already cinated." 5. esentatives have the right to on. If refused, appropriate ocumented in each resident's ndicating the date of the eumococcal vaccination." unizatio §483.80(d) (3) unizations. The LTC facility di implement policies and nesure all the following: (i) 9 vaccine is available to the ident and staff member is ID-19 vaccine unless the medically contraindicated or taff member has already l; (ii) Before offering ne, all staff members are lucation regarding the ss and potential side effects	F0887	assesse absenc residen by the I prefere 2. All re by the I there w with CC adminis	dents #6, #29, #, #25, #356, ed and found to have no ill e e of COVID Vaccine follow- ts were offered the COVID SoN/Designee and signed of nces by 1-27-2023. Isidents have the ability to b deficient practice. An audit w DON/Designee on 1-25-202 ere no residents who had co DVID Vaccine Tracking and VID Vaccine Tracking and bolicy for resident Covid 19	effects from up. All 19 vaccine off their e affected vas done 3 to ensure oncerns	1/31/2023	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	À. BUILDIN	IG	ISTRUCTION		(X3) DATE SURVEY COMPLETED	
		134140	B. WING			12/22/	2022	
IAME OF PRC	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	TATE, ZIP CO	DE	
IOMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 4901	7		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE	
	offering COVID- the resident repr education regard and potential sid COVID-19 vaccii COVID-19 vaccii doses, the reside or staff member information rega including any cha and potential sid COVID-19 vaccii consent for admi doses; (v) The re representative, or opportunity to ac vaccine, and cha resident's medica documentation the the following: (A) resident represe education regard potential risks as vaccine; and (B) vaccine due to m refusal; and (vii) documentation that following: (A) Th- education regard potential risks as vaccine; (B) Staff vaccine or inform COVID-19 vaccii vaccine status of information as in Disease Control Healthcare Safel	the vaccine; (iii) Before 19 vaccine, each resident or esentative receives ling the benefits and risks e effects associated with the ne; (iv) In situations where nation requires multiple ent, resident representative, is provided with current rding those additional doses, anges in the benefits or risks e effects associated with the ne, before requesting nistration of any additional esident, resident or staff member has the cept or refuse a COVID-19 ange their decision; (vi) The al record includes nat indicates, at a minimum, That the resident or natative was provided ling the benefits and issociated with COVID-19 Each dose of COVID-19 mered to the resident; or (C) If not receive the COVID-19 includes at a minimum, the at staff were provided ling the benefits and issociated with COVID-19 mation on obtaining ne; and (C) The COVID-19 f staff and related dicated by the Centers for and Preventio's National by Network (NHSN). IENT is not met as		12-202 were ed by the <i>i</i> 4. To e audited tracking thereaf adminis reviewe Complia improve complia 5. The	ations was reviewed and up 3 by the QAPI Team. All Nu ducated on 1-12-2023 and 1 Administrator on the update nsure compliance, 5 resider to ensure appropriate prop g and follow-up weekly x4 at ter Audits will be performe stratoi/designee. Audits will ed and reported to the QAPI ance Committee for process ement and to ensure ongoin ance. Administrator is responsible correction.	rsing Staff I-13-2023 d policy. hts will be er COVID nd monthly ed by the be		

STATEMENT OF DE AND PLAN OF CORF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	G	STRUCTION	. COMF	(X3) DATE SURVEY COMPLETED 12/22/2022	
NAME OF PROVIDEI MOMENTOUS HE			STREET ADDRESS, CITY 675 WAGNER DR BATTLE CREEK, MI 45					
PRÉFIX (E	ACH DEFICIEN	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
Bas revi Imr for 19 I rep #6, resi Imr mis Res Find Res Rev adr dia mei der dys kidt hea on failt leve blo noo Dat Ref	ew the facility nunization, of COVID-19 Im Immunization resentatives of #29, #35, #35 dents reviewe nunization re- communicati ident COVI-1 dings includer ident #6 (R6) riew of the me nitted to the i gnoses that in litus, paranoi nentia with bo phagia (diffic ney disease, h rt disease (bu the walls of a ure, hypermay els in the bloc ck (slow cond le of the hear a Set (MDS), erence Date (ealed R6 had	ation, interview and record y failed to offer COVID-19 obtain complete declination munization, provide COVID- e ducation for five resident or residents (residents 6, and #357) out of five ed for COVID-19 sulting in the potential for on and misunderstanding of 9 Immunization preferences. d: edical record revealed R6 was facility 05/22/2017 with noluded type two diabetes d schizophrenia, vascular ehavioral disturbances, ulty swallowing), chronic hypertension, atherosclerotic ildup of cholesterol plaque rteries), depression, kidney gnesemia (high magnesium bd), and first-degree heart uction of the atrioventricular t). The most recent Minimum with an Assessment ARD) of 11/11/2022, Brief Interview for Mental 00 (severely impaired						

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:				STRUCTION	(X3) DA COMPI	ATE SURVEY LETED
		134140	B. W	/ING			12/22/	2022
NAME OF PROVIDE	ER OR SUPPLIE	२				STREET ADDRESS, CITY, STATE,	ZIP CO	DE
MOMENTOUS HE	EALTH AT BA	ITLE CREEK				675 WAGNER DR BATTLE CREEK, MI 49017		
PRÉFIX (E	EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING FORMATION)	ID PREF TAG		CORI	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	gnition and cou prrectly) out of 1	ıld not repeat words 5.						
"Pr CCC fac rev 11, sig co be be Du p.r ap Re Wa dia de he bip the tra dis the rev	ublic Health De DVID-19 Immur cility on 11/22/2 vealed a handw /22/21". The do gnature of R6 re untain any docu enefits for the C ene provided or uring observation m. R6 was obse opeared to be sl esident #29 (R29 eview of the me as admitted to ta agnoses that im- pendence, coca emiplegia and h polar disorder, of e brain is disrup aumatic brain in sorder, anxiety, e blood), hyper Ilmonary diseas ophageal reflux ata Set (MDS), we ference Date (A vealed R29 had	on on 12/21/2022 at 01:23 rved lying in bed and eeping.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DA COMPL	TE SURVEY ETED
	134140	B. WING _		12/22/2	2022
NAME OF PROVIDER OR SUPPL	IER		STREET ADDRESS, CITY	, STATE, ZIP COD	ЭЕ
MOMENTOUS HEALTH AT B	ATTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 4	9017	
PRÉFIX (EACH DEFICIE	TATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY ATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SHOUL REFERENCED TO THE APP DEFICIENCY)	D BE CROSS-	(X5) COMPLETION DATE
cognition) out	of 15.				
"Public Health COVID-19 Imm facility on 11/2 revealed a hand The document representative documentation the COVID-19 I provided or dis During observa 12/21/2022 at setting up in bo were going we to answer any o vaccination sta Resident #35 (F Review of the r was admitted t diagnoses that depression, net bladder, consti swallowing), an dementia, cogr and vision loss. Data Set (MDS) Reference Date revealed R35 h Status (BIMS) o	tion and interview on D1:26 p.m. R29 was observed ed. He explained that things II at the facility but was unable questions about his tus. R35) nedical record revealed R35 o the facility 07/21/2020 with included insomnia, uromuscular dysfunction of the pation, dysphagia (difficulty xiety, restless leg syndrome, nitive communication deficit, The most recent Minimum , with an Assessment e (ARD) of 10/28/2022, ad Brief Interview for Mental of 00 (severely impaired could not repeat words				

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G	ISTRUCTION		(X3) DATE SURVEY COMPLETED	
		134140	B. WING _			12/22/2022		
IAME OF PRO	VIDER OR SUPPLIE	ĒR			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE	
IOMENTOU	OMENTOUS HEALTH AT BATTLE CREEK				675 WAGNER DR BATTLE CREEK, MI 49			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
	"Public Health D COVID-19 Immu facility on 11/22, revealed a hand document conta representative and documentation to the COVID-19 Im provided or disc During observat p.m. R35 was ob and appeared to Resident #356 (F Review of the m was admitted to diagnoses that in femur, depressic hallucinations, an Admission Minir completed as of Admission Asses revealed that he place, and time. Review of R356 f documentation f COVID-19 Immu During observat 12/21/2022 at 0	ion on 12/21/2022 at 01:30 served laying down in bed be sleeping. R356) edical record revealed R356 the facility 12/09/2022 with ncluded fracture of the right on, hypertension, nd homelessness. R356 num Data Set (MDS) was not this survey. R356 "Nursing ssment", dated 12/10/2022, was orientated to person, medical record revealed no for consent or refusal of						

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	A. BUILDIN	G	ISTRUCTION	_ COMF	DATE SURVEY PLETED
	VIDER OR SUPPLIE			STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 490			DDE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
	into his room an Immunizations a explained that h benefits of the C Resident #357 (f Review of the m was admitted to diagnoses that in skin infection) rig chronic pain, typ vascular disease, emphysema (lur of breath), depre hyperlipidemia (gastro-esophage Minimum Data S as of this survey Assessment", da she was orientat time. Review of R357 documentation f COVID-19 Immu During observat p.m. R357 was o appeared to be s In an interview of Director of Nurs the process for p	edical record revealed R357 the facility 12/07/2022 with included cellulitis (bacterial ght and left lower limb, e 2 diabetes, peripheral edema, morbid obesity, g condition causes shortness ession, hypertension, high fat in the blood), and eal reflux. R357 Admission feet (MDS) was not completed R356 "Nursing Admission ted 12/8/2022, revealed that ed to person, place, and medical record revealed no for consent or refusal of nization.					

-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Á. BUILDII	NG	STRUCTION	ĊOMP	ATE SURVEY LETED
		134140	B. WING			12/22/	2022
NAME OF PRO		ER			STREET ADDRESS, CITY, STAT	E, ZIP CO	DE
MOMENTOL	IS HEALTH AT BA	ATTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE CI FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	a consent form, given to the resi be upload into t record. DON "B" refused the same and expect that given.	ing the risk and benefits, sign then the vaccination was dent, and the consent was to he computerized medical explained that if a Resident e process would be followed immunization would not be					
	Director of Nursi is the was her ex- immunizations a our admission. D and R357 had be Immunizations a refused. DON "B documentation d medical records. for R6, R29, and what was in the accurate facility included that ed and contained a representative. D	on 12/21/2022 at 12:30 p.m. ing (DON) "B" explained that expectation that are offered within 72 hours DON "B" confirmed that R356 een offered COVID-19 and she had been told they " could not locate any of immunizations in the DON "B" reviewed consents R35. DON "B" explained that medical record was not and consent which should have ucation had been provided signature of the resident' DON "B" could not explain as were not accurate.					
F0921 SS= E	§483.90(i) Other The facility must sanitary, and cor residents, staff a This REQUIREN evidenced by:	Sanitary/Comfortable Enviro Environmental Conditions provide a safe, functional, mfortable environment for and the public. MENT is not met as	F0921	room an cleaned clutter a have ha cleaned mainter length (124, 12	esidents were listed in this citat and fire door floor transitions we d, each resident room reviewed and decluttered. All common ar ad floor and surfaces thorough d by the housekeeping and hance staff by 1-31-2023. The gaps between the metal doors 5, 142, emergency room exit b for 149 were addressed by	re I for eas y door in room	1/31/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VXQ111

STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	À. BUILDII	NG	STRUCTION	ĊOMP	(X3) DATE SURVEY COMPLETED	
		134140	B. WING			_ 12/22/	2022	
NAME OF PROV	/IDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	TATE, ZIP CO	DE	
MOMENTOUS	HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 4901	17		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE	
	and maintain the residents, resultin for cross-contam decreased illumin Findings include: On 12/12/22 at C surface was observed resident rooms 1 drywall surface a bow approximate remaining non-d corridor drywall surface On 12/12/22 at C surface was observed metal door frame The distance obs surface and meta approximately 1. On 12/12/22 at C door frame betw Resident Room 1 from the flooring side. The distance flooring surface a was approximately On 12/12/22 at C upper metal doo observed separat approximately 2.	28:35 A.M., The drywall reved bowed out between 21 and 122. The damaged lignment was observed to ely 6-inches away from the amaged symmetrical surfaces. 28:40 A.M., The flooring reved separated from the e, within Resident Room 124. erved between the flooring al door frame was		obtaine has bee areas for in the fa correcti NHA/Di Quality repairs by 1-31 Environ comme condition correcta To ensus to wait required affected NHA/Di ensure staff. 2. All ret affected compre residen floors w Environ 3.All ret affected compre residen floors w Environ 4. To et will aud meet the reviewe Complia comple thereaft 5. The J	hance and multiple repair ed d by 1-3-2023. 2. Ayers Co en engaged to correct the d or repairs of all walls and si acility by 1-31-2023 for long on of these structural issue rector of Environmental Se Concrete has been engage in the smoking area cracke -2023 by the NHA/Director imental Services. These rej nce with appropriate weath ons. All other listed repairs v ed by maintenance by 1-31 ure no safety concerns due for the weather to improve to d work, 3x a week audits of d areas will be completed b rector of Environmental Se and maintain safety for res esidents have the potential to d by this deficient practice. A thensive Environmental Aud t rooms, walls, doors, wind- vas completed by the Direct imental Services on 1-15-20 sidents have the potential to d by this deficient practice. A thensive Environmental Aud t rooms, walls, doors, wind- vas completed by the Direct imental Services on 1-15-20 nsure compliance, the NHA lit 5 rooms/corridors to ensu- te required standards. Audite and reported to the QAP ance Committee. Audits will ted weekly x4 and then mo ter. Administrator is responsible correction.	ntracting leficient nking floors p-term is by the rvices. ed for ed concrete of pairs will er were -2023. to having to do the the y rvices to idents and to be A dit of all ows, and tor of 023. b be A dit of all ows, and tor of 023. /Designee ure they ts will be I be nthly		

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	PLE CON G	STRUCTION	(X3) DA COMPI	ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
NAME OF PRO	VIDER OR SUPPLIE	R	•		STREET ADDRESS, CITY, STATE,	ZIP CO	DE
MOMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	observed cracked the metal door fr	l and chipped, adjacent to ame surface.					
	exhaust ventilation	9:01 A.M., The return air on grill was observed soiled d dust and dirt deposits, Hall.					
	surface was obse adjacent to Resid Room 150. The c	9:06 A.M., The flooring rved cracked and sinking, ent Room 121 and Resident racked and sinking area timately 12-feet-long by 8-					
	surface was obse adjacent to Resid Room 120. The c	9:10 A.M., The flooring rved cracked and sinking, ent Room 101 and Resident racked and sinking area simately 12-feet-long by 8-					
	approximately 1.0 observed betwee door surface and The metal emerg	9:15 A.M., A gap, measuring) - 1.5 inches wide, was n the metal emergency exit the metal weather stripping. ency exit door was located ent Room 107 (Central					
	surface was obse Resident Room 1 The damaged dry	9:21 A.M., The drywall rved bowed out between 17 and Resident Room 118. /wall surface alignment was approximately 6-inches ng non-damaged					

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	PLE CON G	ISTRUCTION	(X3) DA COMP	ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
NAME OF PROV	IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE,	ZIP CO	DE
MOMENTOUS	HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	symmetrical corri	dor drywall surfaces.					
	surface was obse Resident Room 1 The damaged dry observed to bow from the remainin symmetrical corri On 12/12/22 at 1 entrance door wa the metal door fr side, within Resid between the met door frame jamb inches-wide. On 12/12/22 at 0 crack was observa adjacent to the u door frame, withi drywall expansion approximately 24 inches-wide. On 12/12/22 at 0 environmental to Environmental to Environmental to Environmental Se following items w Resident Smoking was observed (cra- missing). The dar	dor drywall surfaces. 0:05 A.M., The exterior metal is observed separated from ame jamb on the left-hand ent Room 149. The distance al entrance door and metal was approximately 0.5 - 2.0 2:42 P.M., An expansion ed directly above and pper exterior metal entrance n Resident Room 117. The n crack measured -inches long by .2550 3:20 P.M., A common area ur was conducted with rivice Director "F". The					

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:	À. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	B. WING _		_ 12/22/2022
NAME OF PROVIDER OR SUF	PLIER		STREET ADDRESS, CITY, S	STATE, ZIP CODE
MOMENTOUS HEALTH AT	BATTLE CREEK		675 WAGNER DR BATTLE CREEK, MI 490	017
PRÉFIX (EACH DEFI	STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY JLATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD REFERENCED TO THE APPRO DEFICIENCY)	BE CROSS- COMPLÉTION
surface was a particulate) f One of two e surfaces wer Staff Break R interior surfa observed so residue and South Unit: Shower Rood long fluoreso non-function ventilation g accumulated On 12/13/22 environment Environment following ite South Unit: South Emerg stripping wa adjacent to t damaged we that measure by 1.5 inches	n: 12 of 20 overhead 48-inch- ent light bulbs were observed al. The return air exhaust rill was also observed soiled with dust and dirt deposits. at 08:45 A.M., A common area al tour was continued with al Service Director "F". The ms were noted: ency Exit Door: The weather s observed (worn, torn, missing), he Laundry Service. The ather stripping created a gap rd approximately 1.5 inches-wide			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER: 134140		Á. BUILDING	÷	ISTRUCTION	(X3) DATE SURVEY COMPLETED 12/22/2022		
	VIDER OR SUPPLIE S HEALTH AT BA				STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 4907			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROI DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE	
	wall/floor junctu with accumulate deposits. The vir observed missing perimeter. Staff Restroom: observed leaking upon actuation. Laundry Exit Doo stripping was ob creating an oper The gap measure wide by 2-inches plate was also of opening to the e Laundry: 6 of 10 fluorescent light functional. North Unit: Dining Room: 2 d assemblies were One stained 24-i acoustical ceiling stained from a p Oxygen Storage ventilation grill v and dirt deposits	overhead 48-inch-long bulbs were observed non- of 9 overhead light observed non-functional. inch-wide by 48-inch-long g tile was also observed revious moisture leak. Room: The return air exhaust vas observed soiled with dust						

						(Y0) D	
AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	G	ISTRUCTION		ATE SURVEY LETED
		134140				12/22	/2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STAT	E. ZIP CO	DE
	S HEALTH AT BA				675 WAGNER DR	_,	
	D NEALIN AT BA	ITLE GREEK			BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I /IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI/ DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	gap between the weather stripping approximately 2- long. Journey Room: Ti caulking was obs missing). The Act observed (worn, 1 inner Styrofoam Services Director chair in the baser today." Janitor Closet: Th observed (worn, 1 exposing the con sink basin was als accumulated and deposits. Shower Room: 4 assemblies were The commode ba observed (cracke caulking bead wa green in color for On 12/13/22 at 0 tour of sampled to	vas observed bent, creating a door surface and metal g. The opening measured inches-wide by 24-inches- he restroom commode base erved (cracked, loose, ivity Director's chair was also torn, etched), exposing the padding. Environmental "F" stated: "I have a new ment. I will replace the chair he flooring surface was etched, severely soiled), acrete sub-surface. The mop so observed soiled with I encrusted dirt/grime of 6 overhead light observed non-functional. ase caulking was also d, worn, torn, missing). The as additionally observed r approximately 4-6 inches. 11:35 P.M., An environmental resident rooms was Maintenance Supervisor "G". ms were noted:					
		de support was observed The commode support					

STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI, IDENTIFICATION NUMBER:	À. BUILDIN	G	ISTRUCTION	ĊÓMF	ATE SURVEY PLETED
		134140	B. WING _			12/22	/2022
NAME OF PROV	/IDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DE
MOMENTOUS	HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
	light system pull frayed and thread 105: The Bed 1 b observed (etcheor 116: The restroor observed loose-t support could be approximately 4- also observed dra door latch strike additionally obse the door to not of distance betweer strike plate assen approximately .2 125: The flooring unlevel. The restr caulking was also particulate). The additionally obse wall/floor vinyl b wooden wardrob 126: 1 of 2 exteri inches-wide by 4 observed cracked measured approx restroom common	6 inches. The restroom call cord was also observed dbare. edside table surface was d, scored, bubbled). m commode support was o-mount. The commode e moved from side to side 6 inches. The hand sink was aining slowly. The restroom plate and door jamb were erved with a gap, allowing close completely. The n the door jamb and latch nbly measured 550 inches. surface was observed very coom commode base o observed (chipped, cracked, flooring surface was erved separating from the ase coving, adjacent to the					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER: 134140		À. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, 675 WAGNER DR BATTLE CREEK, MI 490	R		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L IDER'S PLAN OF CORREC' RECTIVE ACTION SHOULD FERENCED TO THE APPR(DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
	soiled with food assembly upper light bulbs were functional. The re- was further obsec- commode suppor to side approxim 129: The restroo observed soiled commode base. was also observe missing). 130: The Bed 1 a observed (etchere Bed 1 overbed li long fluorescent non-functional. caulking was fur scored, stained, 136: The Bed 2 c 48-inch-long flu- observed (staine the commode base caulking was also missing). Restroo	overbed light assembly upper orescent light bulb was						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	À. BUILDIN	IG	STRUCTION	(X3) DA COMPL 12/22/2	
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STATE, 675 WAGNER DR BATTLE CREEK, MI 49017	ZIP COD	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E/ RECTIVE ACTION SHOULD BE CRC FERENCED TO THE APPROPRIATI DEFICIENCY)	DSS-	(X5) COMPLETIO DATE
	observed separation observed separation observed separation observed loc commode support to side approximately 1- perimeter wall. The also observed loc commode support to side approximately 1- 149: The restroom of the restroom entities and the second sec	m commode base caulking acked, chipped, missing). trance door metal frame was parated from the flooring between the metal door ooring surface measured 3 inches. 03:40 P.M., Record review of ly TELS Work Orders" for the aled no specific entries orementioned maintenance 04:15 P.M., Record review of dure entitled: "Homelike ted 10/27/21 revealed under s are provided with a safe, le, homelike environment to use their belongings to					
F0925 SS= E	§483.90(i)(4) Ma control program pests and rodent	ve Pest Control Program intain an effective pest so that the facility is free of s. IENT is not met as	F0925	were ch type of of Envir	dents #18 and Resident #41 's ro necked to ensure they are free of pests, insects or mice by the Dirr onmental Services on 1-25-2023 sidents have the potential to be	any ector	1/31/2023

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	à. Buildii	NG	STRUCTION	(X3) D/ COMP _ 12/22/	
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, S 675 WAGNER DR BATTLE CREEK, MI 490		DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
	reviews, and 6 of group meeting, t effective pest cou- residents, resultin for insect and row Findings include: On 12/11/22 at 0 conducted with F regarding rodent production kitch stated: "One rode trap approximate On 12/12/22 at 0 approximately 1. observed betwee door surface and panel. The metal located adjacent (Central Supply). On 12/12/22 at 1 conducted with F Director "F" rega Control Program Director "F" state is with (Pest Com Name)." Environr was queried: "Ha	 D9:23 A.M., An interview was Food Service Director "H" t activity within the food en. Food Service Director "H" ent was caught in a snap ely one month ago." D9:15 A.M., A gap, measuring 0 - 1.5 inches wide, was en the metal emergency exit I the metal weather stripping emergency exit door was to Resident Room 107 		all resid complet Mainter rooms h control 4 3. The f prevent manage 2023. A and pro by the N The TE ongoing of pests 4. The a and fac weekly were br and pro	I by this deficient practice. lent rooms and common ar ted by the Director of nance/Designee to ensure in ave been effectively treate of pests on 1-25-2023. facility policy for pest control ion was reviewed by the fa ement team and updated on II staff were educated on th cedure for pest control and VHA on 1-12-2023 and 1-1 LS System was updated to g audits to ensure no pests were present on 1-30-202 audit for Pest Control in res ility common areas will be of 4 and then monthly therea ought to the QAPI Meeting cess improvement. ministrator is responsible for ction.	reas was that all ed for ol and icility n 1-12- he policy d prevention 3-2023 o include or evidence 23. sident rooms conducted ifter. Results for trending	

FATEMENT OF D ND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		ATE SURVEY PLETED
		134140	B. WING _		12/22	/2022	
AME OF PROVID	ER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CC	DDE
OMENTOUS H	IEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	017	
(X4) ID PREFIX TAG	EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE
Er St C Si Si Si Er Si Si Er fc Si Si Er fc Si Si Er fc Si Si Er Si Si Si Si Si Si Si Si Si Si Si Si Si	nvironmental Se tated: "We have oom above the nvironmental Se dditionally state ontractual Firm emoved the Bee ervices Director lso caught three n room 122)." On 12/13/22 at 0 nvironmental to nvironmental to nvironmental Se ollowing items v outh Unit: the South Emerge tripping was obs djacent to the L amaged weather bserved to crea aches wide by 1. otential pests (r uilding. The Sou hetal threshold p bserved ill fittin he metal threshold p bserved ill fittin he metal door so een through the pproximately 1. hetes long.	"F" stated: "Yes" ervices Director "F" also had Bees in the Therapy suspended ceiling tiles." ervices Director "F" ed: "((Pest Control Name) was notified and es nest." Environmental "F" further stated: "We have e mice (2 in room 121) and (1 48:45 A.M., A common area our was continued with ervice Director "F". The vere noted: " gency Exit Door: The weather served (worn, torn, missing), aundry Service. The er stripping was also te a gap approximately 1.5 5 inches long, allowing odents) to enter the uth Emergency Exit Door blate was additionally g, creating a gap between old plate and the bottom of urface. Daylight could be e gap that measured 0 - 2.0 inches wide by 36-					

STATEMENT OF DEFICI AND PLAN OF CORREC	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER: 134140		À. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 675 WAGNER DR BATTLE CREEK, MI 49017			
PRÉFIX (EACH	I DEFICIEI REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I /IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
The ga wide by plate w openin and the Dayligh measur by 36-i Lift Roo observer residue actuato were al adjacer Harmo was ob interior North I Main P metal e gap be weathe approx long. Lift Roo observer bait res	p measur y 2-inches as also of g betwee e bottom nt could b red appro- nches lon om: One ' e attachec or plate. In so observ- nt to the ' ny Hall: C served re drawer. Jnit: arking Lo exit door v tween the er strippin imately 2 om: One ' ed triggen sidue or d	hing to the exterior grounds. ed approximately 2-inches- s-long. The metal threshold bserved ill fitting, creating an in the metal threshold plate of the metal door surface. e seen through the gap that ximately 1.0 - 2.0 inches wide g. Victor" snap trap was red with peanut butter I to the yellow plastic moontinent brief remnants ved within the storage closet, Victor" snap trap. Ine dead "Stink Bug" carcass sting within a base cabinet t Emergency Exit Door: The was observed bent, creating a e door surface and metal g. The opening measured -inches-wide by 24-inches- Victor" snap trap was red without any evidence of eceased rodent carcass. D1:35 P.M., An environmental						

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDING	PLE CON 3	ISTRUCTION	(X3) D/ COMP	ATE SURVEY LETED
		134140	B. WING _			12/22/	2022
					I		
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MOMENTOU	S HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	conducted with N The following ite 117: Ants were of	oserved foraging along the					
	strip. Food residu	II/floor vinyl base coving a and food debris were also nt to the east restroom wall					
	131: One gnat wa front of the entra	as observed flying directly in nce door.					
		vere observed flying, within he resident room hand sink					
	interviewed regar activity. Resident seen any mice?" god, lots of them "Usually at night. queried: "Have yo Resident #18 stat	3:12 P.M., Resident #18 was rding current pest (rodent) #18 was queried: "Have you Resident #18 stated: "Oh my ." Resident #18 also stated: " Resident #18 was also bu seen any mice lately?" red: "Sure. Last Night." ther stated: "I usually see the s dark outside."					
	interviewed regar activity. Resident seen any mice?" seen one." Reside travels around ar	3:22 P.M., Resident #41 was rding current pest (rodent) #41 was queried: "Have you Resident #41 stated: "I have ent #41 further stated: "He id next to the room walls."					
	011 12/ 15/22 at 0	3:45 P.M., Record review of					

ND PLAN OF C	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	À. BUILDIN	G	ISTRUCTION	. COMF	ATE SURVEY PLETED
		134140	B. WING _			12/22	/2022
AME OF PROV	IDER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CC	DE
OMENTOUS	HEALTH AT BA	TTLE CREEK			675 WAGNER DR BATTLE CREEK, MI 490	017	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE
	Services Agreem start date within contractual docu On 12/13/22 at (the (Contractual Customer Service revealed under T Record review of Name) Pest Elim Report dated 11, under Condition "Inspected and t Hallway Nurses S inspected and t Hallway Nurses S inspected and t Hallway Nurses S inspected and t Hallway Nurses S on the policy at (the Policy/Proce Environment" da Policy: "Resident clean, comfortab	04:00 P.M., Record review of Firm Name) Pest Elimination e Report dated 11/30/2022 arget Pest: "Bedbugs". f the (Contractual Firm ination Customer Service /30/2022 further revealed s Found/Actions Taken: reated selected areas. South Station and Shower Room eated. Facility team reported ug was found on shoulder chair. Bug was flushed ntified. Three office chairs of nurse's station were ower room for safe storage nt." 04:15 P.M., Record review of dure entitled: "Homelike ted 10/27/21 revealed under s are provided with a safe, ile, homelike environment to use their belongings to					
	Resident Council reported they re- the building and	10:00 am, during the meeting, 6 of 9 participants gularly see mice throughout this had been an ongoing ipant reported they					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		134140		B. WING _			12/22/	2022
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE			, ZIP CODE	
MOMENTOUS HEALTH AT BATTLE CREEK						675 WAGNER DR BATTLE CREEK, MI 49017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
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.								