STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634021	A. BUILDING _____ B. WING _____	2/2/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN HEALTH AND REHABILITATION CENTER	19933 WEST THIRTEEN MILE ROAD SOUTHFIELD, MI 48076

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F0000 SS=	INITIAL COMMENTS Evergreen Health and Rehabilitation Center was surveyed for an abbreviated survey on 2/2/23. Intakes: MI00131467, MI00129114, MI00129393, MI00130132, MI00130404, MI00130776, MI00130799, MI00130964, MI00131102, MI00131224, MI00131384, MI00131549, MI00132138, MI00132706, MI00132957, MI00133066, MI00133191, and MI00134162 Census = 150	F0000		
F0551 SS= D	Rights Exercised by Representative §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the	F0551	- Resident # 818 is no longer residing at this facility. - All current residents who have assigned guardian were reviewed to ensure residents□ input regarding their code status were considered to honor residents□ wishes. No discrepancies were identified. - Facility Advance Directive Policy was reviewed and deemed appropriate. All Social Workers, Physicians (including Physician C), Physicians Extenders, Palliative Team, Psychiatric Team and Nurses were re educated on facility□s policy with the focus to ensure those residents who have Guardianship, have their input considered regarding their code status. Education included effective communication between disciplines , proper documentation and accurate signing a Do □ Not -Resuscitate Order including Attestation of Witnesses section. Social Work is to monitor code status for every new resident and current resident specifically focusing on those residents who have guardians to ensure those resident□s input about their code status is considered. -To ensure continuous compliance, Director of	2/28/2023

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

Electronically Signed | 02/17/2023

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

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	resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00134162 Based on interview and record review, the facility failed to consider the resident's input regarding their code status for one (R818) of		Social Services/Designee with randomly audit 5 residents from each nursing unit weekly for 4 weeks and monthly thereafter to ensure facility Advance Directive policy Is followed and to ensure that those residents who have guardian have correct code status which reflects their input. Results of those audits will be presented weekly to the QAPI Committee for 90 days and monthly thereafter until QAPI Committee determines substantial compliance. Responsible for compliance: Director of Social Services	

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	two residents reviewed for resident rights, resulting in the resident's legal guardian changing their code status to Do-Not-Resuscitate (DNR) when the resident voiced their wish to receive Cardiopulmonary Resuscitation (CPR). Findings include: Review of R818's clinical record revealed R818 was admitted into the facility on 11/7/19, readmitted on 11/25/22, and discharged on 12/18/22 with diagnoses that included: end stage renal disease (ESRD) with dependence on renal dialysis, hypertensive chronic kidney disease, and vascular dementia. Review of a Minimum Data Set (MDS) assessment dated 8/12/22 revealed R818 had intact cognition and rejected care. Review of an MDS assessment dated 11/11/22 revealed R818 had moderately impaired cognition and no behaviors. Review of a "Letters of Guardianship" form for R818 revealed R818 was assigned a legal guardian on 4/12/21. Review of Physician's Orders for R818 revealed an order dated 11/3/21 that read "Adv (advance) Directive: Full Cardiopulmonary Resuscitation (an emergency lifesaving procedure performed when the heart stops beating)". This order was discontinued on 10/28/22. The documented reason was "signed DNR (a directive to medical professionals to inform them the resident does not want CPR/life saving procedures performed) received from Guardian". An order dated 10/28/22 revealed, "Adv. Directive: Do Not Resuscitate..." Review of a "Do-Not-Resuscitate Order at			

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	Skilled Nursing Facility" form revealed the order was issued by Physician 'C' for R818. The form was signed by R818's legal guardian on 10/28/22 in the section that noted, "I authorize that in the event the ward's heart and breathing should stop, no person shall attempt to resuscitate the ward. I understand the full import of this order and assume responsibility for its execution. This order will remain in effect until it is revoked as provided by law." The form was signed by Physician 'C' on 11/1/22. In the section titled, "Attestation of Witnesses", it was noted, "The individual who has executed this order appears to be of sound mind, and under no duress, fraud, or undue influence. Upon executing this order, the individual has received an identification bracelet that indicates a DNR. Two witnesses signed the form, one on 10/28/22 and the second two days later on 10/30/22. Review of R818's progress notes revealed the following: A "COMMUNICATION - with Family/NOK (next of kin)/POA (power of attorney)" progress note, dated 10/12/22, noted, "Manager placed call to guardian (public guardian)...Manager spoke to...case manager. We discussed resident slow but progressive decline w/AMS (altered mental status) and refusing dialysis, medications and vital signs. (Case Manager) stated she would need a letter from physician requesting advance directives to be changed. Then Guardian would complete a face time call with resident. manager will be following up as needed and keeping guardian updated as well". A "Nursing - Progress Note" dated 10/19/22			

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	noted, "Manager met with physician to discuss advance care planning due to general decline. Physician provided verbal order for psych services and psychology for 1:1 (one on one) visits...Physician will see resident tomorrow". A "Psychiatry" progress note dated 10/20/22 noted, "...complaint: Depression/anxiety...First contact with...Psychiatrist...Her mood has been stable. No anxiety or psychosis reported. She has a public guardian...She was calm and did not appear to be in any distress...PSYCH EXAM...Eye Contact: Good...Level of Consciousness: Alert...Mental Status Exam: ...cooperative...Orientation: Person; Place; Situation...Attention/Concentration: Good...Judgment: Fair...Insight: Fair...Impulse Control: Has been good...Thought Process: Organized...Flight of Ideas: None...Loosening of Associations: Normal...Thought Content: Normal...Memory/Immediate: Grossly Intact...Memory/Recent: Grossly Intact...Memory/Remote: Grossly Intact...Fund of Knowledge: Normal...Mood: Normal...Affect: Congruent with mood...Delirium: Absent...No psychotropic medication changes recommended at this time..." A "Palliative" Progress Note dated 10/20/22 noted, "The reason for this initial Palliative Care consult is for opinions/advice regarding symptoms management and advanced decision making...CHIEF COMPLAINTS: ESRD...Generalized weakness...Goals of care...(R818) was seen today sitting up in her wheelchair, she is alert and oriented x 3...Per medical record, she has hx (history)			

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	of non-compliance with medications, showers, dialysis, etc. Her BP (blood pressure) often remains high d/t (due to) medication non-compliance...On examination patient is well nourished, afebrile, not in any distress, alert and oriented x 3...Patient is pleasant, cooperative. Mood and affect appropriate...(R818) agreed to the Palliative Care consult. Palliative discussed with goals of care, symptom management and palliative recommendations...Alternative management options discussed...Code status including all resuscitative measures were explained. Discussed that the prognosis in the event of cardiopulmonary resuscitation in the setting of advanced malignancy or terminal diagnosis will result in poor outcome with less than 5 (percent) of patients returning to their baseline health status. Patient is unlikely to survive or benefit from cardiopulmonary resuscitation as quality of life would be dramatically changed...ADVANCE DIRECTIVES DISCUSSED: Yes...DISCUSSED WITH: patient...CODE STATUS: FULL code...RECOMMENDATIONS: ...Goals of care...(R818) is alert and oriented x 3. palliative discussed with goals of care, symptoms management and palliative recommendations including DNR. She states she wants to have CPR done if needed in the future, because she wants to be here for her children. She does not appear to fully understand the potential of a poor outcome if undergoing CPR in the future...Code Status: FULL code..." A "COMMUNICATION" progress note dated 10/26/22 noted, "MD (physician) letter to Guardian to change advance directives emailed to Guardian case manager. Awaiting next step. Letter given to medical records to			

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scan..."

A "Social Work" progress note dated 10/26/22 noted, "DNR document sent to pt (patient) case worker. Case worker is waiting to hear back from pt family regarding code status..."

An "I-SNP (Institutional Specialized Needs Plan) progress note written by Nurse Practitioner (NP) 'G' on 10/27/22 noted, "...Resident reports she would still like CPR performed in the case she would need it - does not fully understand the poor outcomes associated with CPR. Continue to have goal of care conversation at next visits..."

A "COMMUNICATION" progress note dated 10/27/22 noted, "Manager assisted resident with face time call with guardian. Awaiting further guidance from Guardian. SW Director updated".

A "Nursing - Progress Note" dated 10/28/22 noted, "Manager received signed DNR from Guardian via email. Guardian also approving hospice. Manager spoke with physician and received verbal order for DNR and Hospice eval (evaluation) and tx (treatment)..."

On 1/31/23 at 1:28 PM, an interview was conducted with the Director of Social Services (DSS 'A'). When queried about when a legal guardian could change a resident from a full code status to a DNR, DSS 'A' reported the guardian had to have communication with the resident and the doctor within a 14 days window before signing a resident on as DNR. When queried about whether the resident, despite having a legal guardian, should have been included in the discussion and if their expressed wishes

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	should have been honored, DSS 'A' reported if the resident wanted to be a full code, the doctor discussed that decision with the resident and their guardian and the residents wishes would have been taken into consideration. When queried about why R818 was changed to a DNR after they expressed wanting CPR during the palliative care consultation, DSS 'A' reported they would have to look into it. On 1/31/23 at approximately 2:00 PM, DSS 'A' provided a letter written by Physician 'C' on 10/12/22 (eight days prior to R818's documented conversation with palliative care where R818 expressed the wish for CPR) that documented, "...The patient has recently been on a downward trend of increased confusion, paranoia, increasingly refusing medications and vital signs to monitor condition. (R818) has also occasional refused dialysis treatment as recent as 10/10/22...The gradual decline has become significantly enough to require advance care planning. Due to the patient's frail disposition the risks of cardiopulmonary resuscitation (CPR) outweigh the benefits. (R818's) comorbidities and other factors leave her to be less likely to survive CPR and, in the event, medical staff are successful in resuscitation her there is a likelihood of detrimental consequences and lack of quality of life. it is in my professional opinion the patient is a candidate for palliative care and for a do-not-resuscitate (DNR) order for the symptom management and perseverance of her dignity..." It should be noted that on 10/20/22, R818 was evaluated by a psychiatrist who documented R818 did not have any impairment to alertness, orientation, mood, thought process, and memory. The psychiatric consultation			

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	occurred on the same day (10/20/22) as the palliative care consultation where it was documented that R818 wanted CPR despite the risks being discussed with them. On 2/2/23 at 8:40 AM, an interview was conducted with the Director of Nursing (DON). When queried about why R818 was changed to a DNR by their legal guardian despite R818's documented wishes to receive CPR, the DON reported R818 refused dialysis at times and medications and fluctuated with cognition. The DON reported that the guardian and the physician felt it was in R818's best interest. When queried about whether R818's stated wishes should have been considered, the DON reported she acknowledged that they should have. Policies regarding advance directives and code status changes were requested from the Administrator. However, the policies were not received prior to the end of the survey. a			
F0580 SS= D	Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F0580	- Resident # 809 was assessed by Physician team for the change in condition with the focus on peg tube site. Resident #809 currently is at base line stable condition. Resident□s # 809 peg tube site is clean, dry and intact without signs and symptoms of infection. Resident□s #809 legal guardian /representative is notified about Resident□s #809 current status. - All current residents who have peg tube were reassessed for any signs and symptoms of infection around their peg tube site. All current residents were reassessed by Physicians/Physicians□ Extenders for any change in condition to ensure there is no delay in needed treatment and to ensure legal	2/28/2023

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	treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: This citation pertains to Intake #MI00131224 Based on observation, interview and record review the facility failed to notify the resident's legal guardian/representative of a change in condition (peg tube cellulitis) for one of one resident reviewed for change in condition. Findings include: A complaint was filed with the State Agency		guardian/representatives were notified about residents change in condition. Identified residents plan of care were reviewed and revised as needed to address their change in condition. Identified residents legal guardian/representatives were notified about residents change in condition per facilitys updated policy. - Facilitys Change in Condition policy was reviewed and updated to reflect timely guardians/family update about residents change in condition. Physicians, Physicians Extenders and Nurses were educated on facility Change in Condition policy specifically addressing notification of residents guardians/family about residents condition change, the importance of documenting it and to ensure there is not delay in treatment. Nurse Manager/Designee is to do daily rounds and is to review electronic reports for change in residents condition to ensure residents legal guardian/family are notified timely about residents condition change and to ensure those changes are addressed timely with no delay in treatment. - To ensure continuous compliance Director of Nursing (DON)/designee will randomly audit 5 resident from each nursing unit weekly for 4 weeks and monthly thereafter for change in condition and to ensure change in condition is addressed timely and to ensure residents legal guardian/family are notified about residents condition change. Results of those audits will be presented weekly for 90 days and monthly thereafter to QAPI Committee until QAPI Committee determines substantial compliance. DON is responsible for compliance.	

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	(SA) that alleged the facility failed to inform the legal guardian that R809 had cellulitis around their peg tube and was put on IV antibiotics. On 1/31/23 at approximately 10:05 AM, R809 was observed lying in bed. The resident was alert but unable to answer questions asked. A review of R809's clinical record revealed the resident was admitted to the facility on 9/14/21 with diagnoses that included: cerebral infarction, malignant lung cancer, anxiety disorder and vascular dementia. A review of the resident's Minimum Data Set (MDS) indicated the resident was significantly cognitively impaired and required extensive one to two person assist for most activities of daily living. R809 had enteral feeding via PEG tube. Continued review of the resident's clinical record documented, in part, the following: 8/18/22 Nursing Progress Note: " ...Resident peg tube site is red with odor ...Logged for Dr." 8/22/22 Nursing Progress Note: "Pt peg was bleeding around the site doctor notified and verbal order given to clean area bandage and to monitor site ...". 8/22/22 Physician Team -Progress Note: "Reason for visit ...PEG site bleeding ...will order zinc oxide cream qday. Wound care consult ...". 8/24/22 Physician Team - Progress Note: ...*There was no documentation from Physician "B" that noted the resident's PEG site. 8/29/22: Physician Team- Progress Note: "Reason for visit... for cellulitis ...1. Cellulitis: foul drainage and redness around PEG, will start IV (intravenous) Vanco. Pharmacy to dose. Will			

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	monitor ...". *It should be noted that there was no documentation that indicated R809's legal guardian was notified about the resident's Cellulitis and order for IV antibiotic (Vanco). On 2/2/23 at approximately 8:45 PM an interview and record review were conducted with the Director of Nursing (DON). The DON was asked to provide any documentation that noted R809's Guardian was notified of their change in condition. The DON reported that there was no documentation and confirmed that per the facility's policy the Guardian should have been notified. On 2/2/23 at approximately 10:44 AM, an interview and record review were conducted with the facility Medical Director (MD)"C". When queried as to a possible delay in treating R809's Cellulitis at their PEG site, specifically the 8/18/22 note that indicated a red area with order around the peg site and the 8/22/22 note that indicated the PEG site was bleeding and a start date of the Antibiotic on 8/29/22, MD "C" indicated that they most likely would have started the antibiotic sooner. When asked if the family/guardian should have been notified as to the infection, MD 'C" responded that they should have been notified. A request for a facility policy pertaining to informing resident's guardians/representatives of a change in condition. The document provided titled, "Change in Condition" (8.8.2022) did not address informing guardians/family.			
F0684 SS= G	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the	F0684	- Resident # 804 is no longer resides at the facility. Resident # 807 is no longer resides at the facility. - All current residents who have skin	2/28/2023

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	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation has two deficient practice statements (DPS). DPS #1 This citation pertains to Intake Number(s): MI00132706, MI00131102, and MI00129114. Based on interview and record review, the facility failed to implement treatment in a timely manner, administer treatment consistently according to physicians orders, and identify the worsening condition of an arterial ulcer for one (R804) of two residents reviewed for non-pressure skin impairments, resulting in a maggot infestation of the wound located on R804's left great toe. Findings include: Review of a complaint submitted to the State Agency revealed it was alleged R804's left foot wound had maggots in it and the dressing had not been changed "in a while". Review of a second complaint submitted to the State Agency revealed it was alleged maggots were found in R804's wound. An unannounced, onsite investigation was completed from 1/31/23 through 2/2/23.		impairments/pressure and non pressure wounds were reassessed to make sure accurate treatment to every wound is ordered, implemented per Physician/Wounds Care Team recommendations and administered consistently in a timely manner according to Physician□s order and to make sure that worsening condition of every wound is identified and addressed timely. It is ensured that those residents receive incontinent care so no one is covered in feces. All current residents were reassessed for change in condition by the Medical Team to ensure changes in residents□ condition are addressed in a timely manner and the root cause of a change in condition are thoroughly evaluated to avoid a delay in treatment including sending residents to the hospital. - Facility□s Skin and Wound policy was reviewed and deemed appropriate. All Nurses were educated on this policy specifically addressing the importance of consistent implementation and administration of treatment to open wounds per Physician□s order and identification and a follow up for any worsening wounds in a timely manner. Nurse Manager/Designee is to check nursing assignments daily every shift to ensure wounds treatments are completed consistently. Facility□s Change in Condition policy was reviewed and updated. Director of Nursing and all nurses were reeducated on this policy with the focus on importance of following Physician□s order in a timely manner, addressing resident□s condition timely per Physicians□ order and transferring residents to the hospital timely per Physician□s order to avoid delay in treatment. Nurse K is no longer employed at the facility. Nurse Manager/Designee is to do daily rounds every shift to ensure changes in residents□ condition are addressed timely to	

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	Review of R804's clinical record revealed R804 was admitted into the facility on 8/11/22 and discharged on 9/5/22 with diagnoses that included: peripheral vascular disease, gangrene (death of body tissue due to a lack of blood flow or a serious bacterial infection), congestive heart failure (CHF), type 2 diabetes mellitus, and anemia. Review of a Minimum Data Set (MDS) assessment dated 8/17/22 revealed R804 had moderately impaired cognition, no behaviors, required extensive assistance for bed mobility, had two unhealed stage 2 pressure ulcers (partial thickness skin loss with exposed dermis) that were present on admission, four venous and arterial ulcers (ulcers caused by damaged veins and arteries due to lack of blood flow), and a surgical wound. Review of a run sheet completed by the local fire department revealed they responded to R804 at the facility on 9/5/22 and documented, "...weak and hypotensive (low blood pressure)...covered in feces...On assessment, clusters of maggots found on...foot wrapped...due to peripheral vascular disease and gangrene..." Review of R804's hospital records revealed the following: An "ED (emergency department) Provider Note" dated 9/5/22 at 9:33 AM, noted, "...dry gangrene (gangrene associated with arterial obstruction) on both BL (bilateral) LE (lower extremities) ...presenting to the ED with AMS (altered mental status). Patient lives at nursing facility and was last visited by his friend and daughter on Saturday. Patient at the time was well per daughter. Over the past 2 days nursing staff noted the patient to become more altered. He was attempting to		avoid delay in treatment including sending residents to the hospital per Doctor□s order. - To ensure substantial compliance Director of Nursing/Designee will randomly audit 5 residents who have wounds from every unit weekly for 4 weeks and monthly thereafter to ensure treatments to every wound are implemented and consistently administered per Physician□s order. Director of Nursing/Designee will randomly audit 5 residents from every unit weekly for 4 weeks and monthly thereafter to ensure change in residents□ conditions are identified and addressed timely to avoid delay in necessary treatments and hospitalization per Physician□s order. Results of those audits will be presented weekly for 90 days and monthly thereafter to QAPI Committee until QAPI Committee determines substantial compliance. DON is responsible for compliance.	

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have a bowel movement and had been constipated over the weekend and nursing staff gave him a bowel regimen. He was found today in feces...BL LE gangrene with maggots ...ED Course/Medical Decision Making: ...Upon arrival to the ED patient was noted to be hypotensive blood pressure 82/53 otherwise saturating 98% on room air. Temp was noted to be 99.2. On exam, patient is altered but awake, responds to painful stimuli. Notable bilateral lower extremity dry gangrene with maggots ..."

An "ED Nurse Note" dated 9/5/22 at 9:45 AM noted, "Patient has dressings applied to multiple sites on lower extremities dated last changed 9/2. Multiple maggots moving in between left foot toes once dressing taken off and wound exposed ..."

Further review of R804's clinical record from the facility revealed the following:

Review of a "Skin & Wound - Total Body Skin Evaluation" dated 8/11/22 revealed, "Stitches to left inner thigh and calf. IV to left upper arm. Port to left side of neck with 3 lumen. Bruises to abdomen, hands, and arms. Scratch to left inner arm. Healing abrasion to left knee. Open area to left buttocks 3x6 cm"

Review of a "Nursing - Progress Note" dated 8/11/22 revealed, "Skin assessment in place. Resident has catheter 16 FR (french). IV (intravenous) to left upper arm. Port to left side of neck with 3 lumen. Stitches to left inner calf and thigh. Scratches to left upper arm. Healing abrasion to left knee-tissue pink intact. Bruises to abdomen,arms. Gangrene to bilateral great toes. Open areas to left buttocks 3x6 cm (centimeters). Open area to right buttocks 3x7 cm. Open area to left outer

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ankle 3x7 cm. Open area to left outer calf 4x5 cm. Blister noted by calf stitches."

Review of Physician's orders for R804 revealed the following orders dated 8/11/22:

1. "Cleanse outer ankle with NS (normal saline) then apply dry dressing Q (every) daily, every day shift"

2. "Cleanse outer left calf with normal saline then apply dry dressing Q daily every day shift"

3. "Consult Wound Care: Gangrene bilat (bilateral) feet. Multiple wounds"

There were no orders to address the surgical wound to the left inner calf or the gangrene to bilateral great toes.

Review of a "Wound Rounds Note" dated 8/16/22 (five days after R804 was admitted into the facility) revealed the following documentation: "Wound Consult...I was referred..ro consult re: (regarding) numerous wounds...At time of admission noted to have multiple wounds...

...Left lateral leg surgical incision line proximal half CDI (clean, dry, intact) approximated with sutures. Distal half dehiscence, base covered with loosening nonviable tissue... Recommend Tx (treatment): M.Honey (medihoney) cover with dry dressing 3x/week...

...Left medial (inner) leg vascular wound, minimal drng (drainage)...base covered with destabilizing eschar (dead or devitalized tissue) Recommend Tx (treatment): M Honey

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	cover with dry dressing 3x/week... ... Left lateral ankle vascular wound...base granular rim surrounding tight necrotic tissue...Recommend Tx: M.Honey cover with dry dressing 3x/week... ...Left great toe to 1st MTH (metatarsal head - bone in the foot behind the big toe) arterial wound...base covered with stable eschar...Recommend Tx: wipe with betadine (an antiseptic solution to aide in prevention of infection) cover with dry dressing 3x/week... ...Right great toe to 1st MTH arterial wound...base covered with stable eschar...Recommend Tx: wipe with betadine cover with dry dressing 3x/week..." Further review of R804's Physicians Orders revealed the following orders dated 8/17/22: 1. "Wound Care Order Site: Left Great Toe...cleanse wound cleanser...Wiper with betadine wipes...Wrap in kerlix (rolled gauze dressing) if indicated every day shift every Tue (Tuesday), Thu (Thursday), Sat (Saturday) for wound care" 2. "Wound Care Order Site: Right Great Toe...cleanse wound cleanser...Wiper with betadine wipes...Wrap in kerlix (rolled gauze dressing) if indicated every day shift every Tue (Tuesday), Thu (Thursday), Sat (Saturday) for wound care" 3. "Wound Care Order Site: Left medial leg ...cleanse ...pat dry ...apply medihoney ...cover with ABD (abdominal pad) ...wrap in kerlix...every Tue, Thu, Sat for wound care..."			

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4. "Wound Care Order Site: Left lateral ankle...cleanse...Pat dry...Apply medihoney...Cover with ABD (5x9 gauze)...wrap in kerlix...every day shift every Tue, Thu, Sat for wound care..."

Review of the physician's orders revealed the treatment for R804's left lateral leg surgical incision was not changed to Medihoney according to the wound consult note on 8/16/22. The order remained in place to cleanse with normal saline and apply dry dressing with a start date of 8/12/22.

It should be noted that there were no treatment interventions put into place for the vascular/arterial wounds to R804's left medial leg and bilateral great toes until five days after they were admitted into the facility.

Review of R804's Treatment Administration Records (TAR) for August and September 2022 revealed multiple missed treatments, as evidenced by no nurse's signature to indicate the treatment was completed. The following treatments were missed:

Treatment to the left great toe was not done on 8/20/22, 8/25/22, and 9/3/22. Because the treatment to this site was ordered on Tuesday, Thursday, and Saturday, there were gaps of four to five days between treatments due to the days missed. The last treatment prior to R804 being transferred to the hospital was on 9/1/22. When R804 was assessed by EMS (emergency medical services) and in the ED, maggots were found in that wound.

Treatment to the left lateral ankle was not done on 8/20/22, 8/25/22, and 9/3/22. Because the treatment to this site was

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	ordered on Tuesday, Thursday, and Saturday, there were gaps of four to five days between treatments due to the days missed. Treatment to the left medial leg was not done on 8/20/22, 8/25/22, and 9/3/22. Because the treatment to this site was ordered on Tuesday, Thursday, and Saturday, there were gaps of four five days between treatments due to the days missed. Treatment to the right great toe was not done on 8/20/22, 8/25/22, and 9/3/22. Because the treatment to this site was ordered on Tuesday, Thursday, and Saturday, there were gaps of four five days between treatments due to the days missed. Treatment to the outer left calf was not done on 8/12/22, 8/17/22, 8/19/22, 8/20/22, 8/21/22, 8/22/22, 8/26/22, 9/3/22, and 9/4/22. On 2/2/23 at 9:05 AM, an interview was conducted with the Director of Nursing (DON). When queried about the facility's skin management protocols, the DON reported upon admission, the floor nurse did the initial skin assessment and documented any skin issues on the "Total Body Assessment". The DON explained, the floor nurse was not supposed to stage or diagnose the wound, but to document the description of the wound. The DON further explained, if a skin impairment was identified, the unit manager was notified and they would assess the resident's skin the next day and determine if they needed to be evaluated by the wound care practitioner. If the resident was determined to need a wound consult, the wound practitioner evaluated the resident the next time they were in the facility on			

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	Tuesdays. At that time, R804's clinical record was reviewed with the DON. When queried about why there were no treatments implemented upon admission for the arterial wounds to R804's right and left great toes and medial left leg, the DON reported the nurse may have thought it did not need a treatment. The DON further explained that due to the amount of wounds R804 was admitted with, the nurse should have called the attending physician to discuss any needed treatments until the wound practitioner could come see the resident. When queried about the missing treatments on R804's TARs, the DON reported the treatments should have been done according to the physician's orders. The DON reported they received a grievance regarding the maggots found in R804's wound, investigated it, they did not substantiate anything. At that time, the DON provided the facility's investigation and the grievance form. Review of a "Grievance Documentation, Investigation & Follow-Up" form dated 9/9/22. The following was documented, "Nurse liaison reported concern from (hospital) that resident had maggots in his left lower extremity and gangrene...Investigation: ...Nurses that provided wound care to (R804) on Saturday 9/3 and Sunday 9/4 report no findings of maggots to bilateral feet and feet were noted to be clean and dry eschar..." It should be noted that R804's TAR indicated no wound care treatment was provided on 9/3/22 or 9/4/22 and the last time it was signed off as completed was on 9/1/22. Review of a facility policy titled, "Skin & Wound Policy" revised 2/2022, revealed, in part, the following: "...All wounds will have treatment orders from the physician			

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team...Wound treatments will be provided in accordance with physician orders...In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse...Treatments will be documented on the Treatment Administration Record..."

DPS #2

This citation pertains to Intake Number(s): MI00131467.

Based on interview and record review, the facility failed to address changes in condition in a timely manner and thoroughly evaluate the root cause of a change in condition for one (R807) of six residents reviewed for changes in condition, resulting in a delay in sending R807 to the hospital where it was determined the resident had a stroke. Findings include:

R807

A Complaint was filed with the State Agency (SA) that alleged R807 had a stroke on 7/17/22 on or about 5-6 AM. The facility was asked to send the resident to the hospital but was told they needed to get approval from the Administrator. The resident was sent to (name redacted) hospital on 7/17/22 at 8:30 AM and passed away in the hospital on 7/24/22. The Complaint was interviewed on the phone and indicated that Nurse "J" informed them that the resident had already had a stroke when they got to work at 7:00 AM and the supervisor (name not known) told them not to send the resident to the hospital.

A review of (name redacted) hospital records documented, in part: " ...ED (emergency

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department) notes (9:14 AM) ...Pt to EMS for extremity weakness ...upon arrival pt. has fixed gaze preference to R side. L side weakness ...unable to squeeze on L side ...Stroke Team: 7/17/22: Time arrived: 8:50 AM: ...slight drift noted on the L side ...does not have dentures in and not sure of slight facial ...daughter stated that resident does not want aggressive measures ...I informed her that patient is having another major stroke with symptoms of fixed gaze/Aphasia ...Hospital Course: ...presented to Hospital on 7/17/2022 from facility with a chief complaint of possible stroke. Patient suffered a CVA and was deemed a 21(severe stroke) on the NIH (National Institutes of Health) stroke scale" ...After 48 hours patient had no improvement I neurological recovery, a decision was made to have the patient be made comfort care ...passed away peacefully on 7/24 ...".

A review of R807's clinical record revealed the resident was initially admitted to the facility on 6/7/22 and readmitted on 6/7/22 with diagnoses that included: Gastrointestinal hemorrhage, hypertensive heart and chronic kidney failure, personal history of transient ischemic attack (TIA) and dementia. A review of the resident's Minimum Data Set (MDS) indicated the resident was severely cognitively impaired and required extensive one to two person assist for most Activities of Daily Living.

Continued review of R807's clinical record documented, in part:

7/17/22 -Progress Note (7:40am): "Resident able to use call light ...upon entering room at 6:30 am resident was staring and not alert .... Resident non-verbal .... Notified 11-7 am supervisor who assessed resident also Notified. Dr. "B" who requests for resident to be sent out 911. 11-7 am supervisor notified DON (name redacted) and

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said there (sic) not sending resident out. 7-3 am supervisor aware and 7-3 nurse aware ...7-3 am supervisor aware and will update Dr." B"." (Authored by Nurse "I").

7/17/22- Progress Note (8:29 am): "Resident received stroke like symptoms. Nurse writer spoke to Nurse Supervisor and DON, and they agreed to send resident to (name redacted) hospital. Nurse writer spoke to Resident daughter (name redacted), and she is aware of what is going on ...'. (Authored by Nurse "J").

An attempt to contact Nurse "J" via phone was made on 2/1/23 at approximately 2:50 PM. A voice mail message was left, and no return call was made before the end of the survey. It should be noted that Nurse "J" is no longer employed by the facility.

On 2/2/23 at approximately 9:51 AM a phone interview was conducted with Nurse "I". Nurse "I" reported that they had been employed by the facility for over 20 years and generally worked the night shift (11 PM to 7 AM). Nurse "I" was queried about the R807 and the note that was authored on 7/17/22. Nurse "I" recalled that they noticed the resident was showing signs of mental status change and they contacted Dr. "B" who indicated based on their observation that the resident should be sent to the hospital via 911. Nurse "I" reported they told Nurse Supervisor "K" that the resident was showing significant mental status changes and Dr "B" wanted the resident sent to the hospital. Nurse "I" stated that Nurse "K" called the DON and was told not to send the resident out to the hospital. Nurse "I" stated they endorsed the information on to Nurse "J" and then left the facility.

On 2/2/23 at approximately 1:46 PM an interview and record review were conducted with the DON.

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When asked about R807 and why there was a delay in sending R807 after Nurse "I" spoke to Dr. "B", the DON indicated that they recalled speaking with Nurse Supervisor "K" who noted that the resident was stable and sending the resident out was not urgent.

On 2/2/23 at approximately 4:15 PM a phone interview was conducted with Nurse "K". Nurse "K" reported that they had worked at the facility for approximately two years as a House Supervisor on the afternoon and mid-night shifts but was no longer employed by the facility. When queried as to the incident involving R807 on 7/17/23, Nurse "K" reported that Nurse "I" did report that the resident was exhibiting some changes but was not able to recall what they were. Nurse "K" stated that they recalled the resident had a history of starring into space and noted that when they went to see the resident, they took some vitals that were fine, remembered the resident was reaching for their TV remote and did not believe there was anything wrong with the resident. They then informed the DON, and the resident was not sent out. When asked if they had completed an assessment or documented their observation, Nurse "K" responded that they did not. When informed that the resident was sent to the hospital that day at approximately 8:30 AM, they noted that they had left the building by that time.

On 2/3/23 at approximately 4: 15 PM, a phone interview was conducted with Dr. "B". Dr. "B" was queried as to R807 and their recommendation to send the resident to the hospital after being notified of a change in mental status by Nurse "I". Dr. "B" reported that they did not have the resident's records in front of them but stated that if they indicated a resident should be sent out to the hospital the facility should have sent the resident out. When asked if the facility policy indicated the DON needed to confirm the resident

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	needed to be sent out following their recommendation, Dr. "B" noted that was not the policy. A review of the facility policy titled, "Change in Condition" (8/8/2022) revealed, in part: "...Resident who exhibit signs and symptoms of change in condition shall be evaluated by the nurse immediately upon identification...3. A progress note, or...Assessment should be documented...detailing the assessment and all interventions performed...".			
F0692 SS= G	Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: This Citation pertains to Intake #MI00132138 Based on interview and record review the facility failed to consistently monitor, obtain monthly	F0692	- Resident # 803 is no longer resides at the facility; - All current residents who require assistance for eating were reassessed for significant weight loss to ensure consistent monitoring, obtaining monthly weights and implementation of interventions to prevent a significant weight loss. Identified residents plan of care were reviewed and revised as needed to reflect accurate interventions to prevent further weight loss. Identified residents are monitored by Attending Physician /Physician Extenders and Dietitian to ensure proper interventions are in place. - The facility Nutritional Management Policy was reviewed and deemed appropriate. Nurses, Certified Nursing Assistants, Dietitian, Physicians, Physicians Extenders and Recreational Activity were re educated on this policy specifically addressing an importance of consistent monitoring , obtaining monthly weights and timely implementation of intervention which are documented in residents care plans to prevent significant weight loss. Dietician/Designee is to routinely round on residents who require assistance with meals to ensure those residents receive needed assistance with meals and any changes in resident s nutritional intake are	2/28/2023

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	weights and implement interventions to prevent a significant weight loss for one (R803) of two residents reviewed for nutrition/hydration, resulting in R803 sustaining a significant weight loss (25.3) pounds (lbs.) in two months, change in mental status and hospitalization. Findings include: A Complaint was filed with the State Agency (SA) that alleged R803 was not eating and was found emaciated on or about 11/12/23, was transferred to the hospital and diagnosed with severe dehydration. A review of (name redacted) Hospital records documented, in part: " R803 was admitted to the emergency department with dehydration on 11/12/22 ...Physician consult dated 11/13/22 ...R803 presents to hospital on 11/12 with decreased mentation and poor oral intake ...sister visited her yesterday and was alarmed at her decrease in mental status ...Impression: ...the patients delirium is attributed to dehydration ...Weight is 115 lbs. ... Patient's Hospital Course ...was admitted for hypernatremia dehydration, improved with IVF(intravenous fluid) ...severe protein calorie malnutrition, had peg tube placed. 11/12/22 ...Need for artificial feeding is needed ...patient remains at risk of malnutrition due to weight loss, inadequate energy intakes and increased nutrient needs ...Gastroenterology consult ...reason for consultation: PEG (percutaneous endoscopic gastrostomy) tube placement Interventions ...insert enteral feeding tube ...peg placed 11/25, tf (tube feeding) started ...". A review of R803's clinical record revealed the resident was admitted to the facility on 5/31/22 with diagnoses that included: vascular dementia, chronic pain and history of stroke. A review of		timely addressed. - To ensure continuous compliance, Dietitian/Designee will randomly audits 5 residents from each nursing unit weekly for 4 weeks and monthly thereafter to ensure residents receive consistent monitoring to prevent significant weight loss, and residents monthly weights are obtained timely and necessary interventions are implemented and it is reflected in residents care plans. Results of those audits will be presented weekly for 90 days and monthly thereafter to QAPI Committee until QAPI Committee determines substantial compliance. Dietitian is responsible for compliance.	

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the Minimum Data Set (MDS) indicated the resident was severely cognitively impaired and required extensive one person assist for eating.

Continued review of the R803's clinical record documented, in part, the following:

Weight Summary: three weights were taken in June 2022 with an end weight on 6/16/22 of 156.8 lbs. Five weights were taken in July 2022 with an end weight on 7/26/22 of 144.0 lbs. Three weights were taken in August 2022 with an end weight on 8/18/22 of 140.2 lbs. Only one weight was taken in September 2022 dated 9/1/22 with a weight of 139.8 lbs. No weights were obtained in the Month of October 2022. One weight was obtained in November (11/9/22) with a weight of 114.5 lbs. indicating a 25.3 lbs. weight loss/18.2%.

R803's Care Plan: Focus: "Resident is at nutritional risk with risk for ... weight loss. Chronic illness, variable oral intake, Need for altered diet, with risk of dehydration (date initiated 6/7/22) ...Goal: Resident will have no significant wt. loss (6/7/22) ...Interventions/Tasks ...Monitor and record weight per policy (6/7/22) ...Monitor for signs of malnutrition (pale skin, dull eyes, swollen lips, swollen gums, magenta tongue, poor skin tugur ...physical evidence of muscle and fat loss (6/7/22) ...Pt requires 1:1 assist with meals (6/7/22) ...Supplements as ordered ...". *It should be noted that no interventions were place in the resident's care plan after 6/7/22. Further, there was no indication in R803's care plan that indicated they refused to eat.

Kardex review: "one person assists for feeding."

Nutritional/Dietary Note (7/19/22): " ...Current weight is 144lbs as re-weight with first weigh last

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	week of 144.4 lbs. x30 days 155.8 lbs. reflecting 7.1% loss in one month which is significant ...". *It should be noted that no interventions and/or supplements were ordered. Nutritional/Dietary Note (7/25/22): "Nutritional follow-up; resident seen today at lunch ...Resident eating independently ...Oral intake is variable. There were no further Nutritional notes found in the resident's clinical record until 11/10/22: " ...Weight loss follow up: Weights: 114.5 lbs. as of this month, refused 30 days ago ...Continue on diet as ordered ...Refuses to eat ...weight loss of 25 lbs. in 60 days ...". On 2/1/23 at approximately 1:55 PM an interview and record review were conducted with Registered Dietician (RD) "H". RD "H" was queried as to the facility policy pertaining to obtaining resident weights. RD "H" reported that upon entry weights are obtained every week for four weeks and once per month thereafter unless a resident was having nutritional concerns. When queried as to why the resident was not weighed in October 2022, RD "H" reported that the resident had refused. RD "H" was asked to provide documentation that indicated the resident refused to be weighed in October 2023. When queried as to whether staff communicated concerns as to the resident's refusal to eat and/or observations that the resident was losing weight, RD "H" reported that she was not aware of the weight loss until 11/10/22. When asked what interventions they might have recommended if they had been notified earlier as to the resident's refusal to eat and/or weight loss, RD" H" reported that they would have suggested interventions such as Hospice, tube feeding, food stimulant medication and/or enhanced food options. *It should be noted that no documentation			

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	pertaining to October 2022 weights was provided by the end of the survey. On 2/1/23 at approximately 3:41 PM an interview was conducted with the Director of Nursing (DON). When asked as to the facility policy pertaining to resident weights, the DON indicated that weights should be obtained weekly upon admission for four weeks and then monthly unless nutritional concerns are noted. When asked about R803's 25 lb. weight loss in two months, the DON indicated that the resident should have been weighed at least monthly and if weight loss and/or refusal to eat was noted additional interventions should have been implemented. The facility policy titled, "Nutritional Management Policy" (approved 10.22) was reviewed and documented, in part: " ...Policy: the facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in context of his or her overall condition ...Compliance Guidelines: a. Nursing staff shall obtain the resident's height and weight upon admission, and subsequently in accordance with facility policy ...c. Developing and consistently implementing pertinent approaches ...d. Monitoring the effectiveness of interventions and revising them as necessary ...4. Care plan implementation: The resident's goals and preferences regarding nutrition will be reflected in the resident's plan of care ...b. The resident will be monitored for complications associated with interventions. c. The care plan will be updated as needed, such as when the resident's condition changes ...d. The physician will be notified of 1. Significant changes in weight, intake or nutritional status ...6. Informed consent: ...The comprehensive care plan should describe any interventions offered but declined by the resident or the resident's representative ...".			

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F0698 SS= E	Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00134162 Based on interview and record review, the facility failed to ensure consistent coordination of care between the facility and dialysis center for two (R818 and R811) of two resident reviewed for dialysis. Findings include: Review of a complaint submitted to the State Agency alleged on 12/16/22, R818 arrived at the dialysis center after missing several sessions, did not appear well, and needed to be sent to the hospital. The complaint noted that the dialysis center contacted the facility and spoke with Nurse 'E' (Nurse Manager) who told the dialysis center not to send R818 to the hospital because she was "DNR/DNH (Do-Not-Resuscitate/Do Not Hospitalize) at the facility". The complaint further alleged that they were notified R818 was sent to the hospital a few days later from the facility and later died. They were concerned that the proper information was not being communicated with the dialysis center by the facility. Review of R818's clinical record revealed R818 was admitted into the facility on 11/7/19, readmitted on 11/25/22, and discharged to the hospital on 12/18/22 with diagnoses that included: End Stage Renal Disease (ESRD). Review of a Minimum Data Set (MDS) assessment dated 11/11/22 revealed R818 had	F0698	1. Resident # 818 no longer resides at facility. Resident # 811 remains at facility at baseline stable condition. 2. All residents who require hemodialysis were audited to ensure consistent and accurate coordination of care between the facility and dialysis center. It was ensured that dialysis communication forms are fully filled out and kept in residents medical record. 3.Facility s Hemodialysis policy was reviewed and was deemed appropriate. Nurse E and all Nurses were educated on hemodialysis policy and procedure to ensure dialysis services were provided consistent with professional standards of practice and comprehensive person-centered care. Education was focused on ensuring that resident s goals and preferences are met, and consistent coordination of care between the facility and dialysis center are followed and that dialysis communication forms are completely filled out and kept in residents medical records when resident receives dialysis services. 4. Director of Nursing Services (DON) or designee will randomly audit 5 residents a week for four weeks and monthly thereafter to ensure dialysis services were provided consistent with professional standards of practice and comprehensive person-centered care plan, and the resident s goals and preferences are met and consistent coordination of care between the facility and dialysis center are followed and that dialysis forms are accurately completed in their entirety and kept in residents medical record when resident received dialysis services. The Director of Nursing will report findings to QAPI Committee weekly for 90 days and then monthly thereafter until the QAPI committee determines compliance. The Director of	2/28/2023

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	moderately impaired cognition. Review of R818's progress notes revealed R818 refused to go to dialysis on 12/12/22 and 12/14/22. On 12/16/22, the following was documented in a "Nursing -Progress Note": "Resident assisted to WC (wheelchair) and taken to front lobby for Dialysis. Resident changing her mind back and forth about going to dialysis. Several staff members encouraging resident to attend treatment. Resident stated she wasn't feeling good. Staff explained to resident that was due to missing 2 dialysis treatments and not taking scheduled medications. Resident eventually consented to attend dialysis. Manager spoke to Dialysis Nurse regarding her direction to assigned nurse to send to ER. Manager reminded her resident is comfort care, DNR/DNH. Dialysis verbalized understanding." On 1/31/23 at 2:03 PM, Nurse Manager, Nurse 'E' was interviewed. When queried about any communication with R818's dialysis center about being sent to the hospital on 12/16/22, Nurse 'E' reported the dialysis nurse told them if R818 did not go to dialysis on that day, they would not be able to accept them for dialysis any longer and would have to go to the emergency room. Nurse 'E' reported R818 agreed to go to dialysis and they did not have any further conversation with the dialysis center. When queried about the documentation that R818 was DNH, Nurse 'E' reported that might have been a mistake. When queried about how the facility and dialysis center coordinated and communicated about the resident, Nurse 'E' reported a communication sheet was completed by the facility before leaving for dialysis and after the resident returned to the facility and the dialysis completed a portion of the form as well. At that time, Nurse 'E' was asked to provide the dialysis communication sheet for R818 for the date of 12/16/22.		Nursing is responsible to maintain substantial compliance.	

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	On 2/1/23 at 8:45 AM, a telephone interview was conducted with a manager at the R818's dialysis center, Dialysis Staff 'N'. When queried about whether they had any documentation on file from R818's dialysis session on 12/16/22, Dialysis Staff 'N' reported they did not keep the communication sheets on file and they were sent with the resident back to the facility. Dialysis Staff 'N' confirmed R818 was dialyzed on 12/16/22. When queried about whether they were aware of any need for R818 to go to the hospital during that time, Dialysis Staff 'N' reported there was nothing on file that said R818 needed to go to the hospital, but the nurse who worked that day was told by the facility nurse manager that R818 was not to be sent to the hospital due to their code status and DNH order. It was explained that the dialysis nurse was surprised when they found out R818 was sent to the hospital by the facility a few days later when they called to see why the resident had not been to dialysis. A dialysis communication form for R818 on 12/16/22 was not provided by Nurse 'E'. On 2/2/23 at 8:40 AM, the Director of Nursing (DON) was interviewed. When queried about how the facility and dialysis communicated with one another about residents, the DON reported a communication form was completed by both the facility and dialysis center. When queried about any communication about R818 needing to go to the hospital while at dialysis, the DON was not sure. At that time, the DON was asked to provide all dialysis communication forms for R818 from October 2022 through December 2022, including 12/16/22. Review of R818's "Hemodialysis Communication" forms revealed the following: On 10/12/22, the "Pre-Dialysis Vital Signs"			

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	section was not complete and a weight was not documented, the section to be completed by the dialysis center was left blank, and the "Post-Dialysis Vital Signs" section was left blank and a weight was not documented. R818's code status was not documented. On 10/17/22, the section to be completed by the dialysis center was not signed by staff and post-dialysis vital signs were not documented. On 10/19/22, the "Pre-Dialysis Vital Signs" section was not complete and no weight was documented, the section to be completed by the dialysis center was left blank, and the "Post-Dialysis Vital Signs" section was left blank and no weight was documented. On 10/21/22, the "Pre-Dialysis Vital Signs" section was not complete and a weight was not documented, the section to be completed by the dialysis center was left blank, and the "Post-Dialysis Vital Signs" section was left blank and a weight was not documented. On 10/26/22, the "Pre-Dialysis Vital Signs" section was not complete and no weight was documented, the section to be completed by the dialysis center was left blank, and the "Post-Dialysis Vital Signs" section was left blank and no weight was documented. On 10/28/22, the section to be completed by the dialysis center was not signed by staff and post-dialysis vital signs and weight were not documented. On 11/2/22, the "Pre-Dialysis Vital Signs" section was not complete and a weight was not documented, the medications given prior to dialysis and medications sent with resident was left blank, and "Post Dialysis Vital Signs" were			

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not completed and a weight was not documented. R818's code status was not consistent with what was on file at the facility (DNR). The form documented R818 was "Full Code".

On 12/2/22, a pre-dialysis weight was not taken, the section to be completed by the dialysis center was left blank, and a post-dialysis weight was not documented.

There were no "Hemodialysis Communication" forms for the following dates: 10/3/22, 10/5/22, 10/7/22, 10/10/22, 10/14/22, 10/24/22, 10/31/22, 11/9/22 11/14/22, 11/16/22, 11/18/22, 11/21/22, 11/25/22, 11/28/22, 11/30/22, 12/5/22, 12/7/22, 12/9/22, and 12/16/22.

R811

On 1/31/23 at approximately 10:22 AM, R811 was observed lying in bed. The resident was alert and able to answer most questions asked. The resident reported that they had been at the facility for over a year and went to dialysis three times per week.

A review of R811's clinical record revealed the resident was initially admitted to the facility on 10/30/2021 with diagnoses that included: End Stage Renal failure and Type II diabetes and received dialysis treatment at (name redacted) center on Monday, Wednesday and Fridays.

A review of the facility Hemodialysis Communication forms contained three sections. Section one was to be completed by the facility prior to sending a resident to dialysis and required the facility to answer questions including, but not limited to notes, vitals, medications and resident code status.. Section two was to be completed by the Dialysis center and required the Dialysis center to enter information including, but not

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	limited to: Vitals, notes etc. . Section three was to be completed by the facility upon the resident's return from dialysis and requires the facility to enter a resident's vitals and any notes. A review of R811's Dialysis Communication forms from 12/16/22 to 2/1/23 noted the following forms were missing documentation: Section 1 1/23/22 Section 2 12/23/22, 12/28/22, 1/9/22 Section 3 12/16/22, 12/19/22, 12/23/22 On 2/2/23 at approximately 1:10 PM an interview was conducted with the Director of Nursing (DON). The DON was asked about the facility's policy pertaining to Dialysis communication. The DON reported that the forms should be fully completed by the facility and the Dialysis center. Review of a facility policy titled, "Hemodialysis" dated 4/1/22, revealed, in part, the following: "...The facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice. This will include:...The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility...Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments...Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services...The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form, that will include, but not limit itself to: ...Timely			

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	medication administration...by the nursing home and/or dialysis facility...vital signs...Advance Directives and code status...Dialysis treatment provided and resident's response..."			
F0758 SS= D	Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the	F0758	1. Resident #806 no longer resides at facility. 2. All current residents with Physicians orders for antipsychotic and antianxiety medications prescribed on a as needed (PRN) basis were audited to ensure that justification for the use of the medication given is documented in medical record, targeted behaviors are identified and person-centered non-pharmacological interventions are provided prior to administering antipsychotic and anti-anxiety medications. Identified residents plan of care were reviewed and updated as needed. 3. Facility Use of Psychotropic Medication policy was reviewed and deemed appropriate. Physicians, Psychiatric Services, Nurses and Certified Nursing Assistants, Social Workers , Activities department and Therapy department were educated on facility policy use of psychotropic medication to ensure that justification for the use of antipsychotic and anti-anxiety medication given on an as needed (PRN) basis, targeted behaviors are identified and consistently implement person centered non-pharmacological interventions prior to administering anti-psychotic and anti-anxiety medications. Social Services is to routinely monitor us of prn antipsychotic and antianxiety medications to ensure that non-pharmacological interventions are used prior to administering prn anti-psychotic and anti anxiety medications and that justification for the use of those medications and targeted behaviors are identified and documented in residents medical record. 4. Director of Social Services or designee will randomly audit 3 residents from each nursing	2/28/2023

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	resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00131549. Based on interview and record review, the facility failed to provide justification for the use of antipsychotic and antianxiety medication given on an as needed (PRN) basis, identify targeted behaviors, and consistently implement person-centered non-pharmacological interventions prior to administering the medications for one (R806) of one resident reviewed for unnecessary medications. Findings include: Review of a complaint submitted to the State Agency revealed an allegation that R806 was administered unnecessary psychotropic medications without consulting with their long time psychiatrist which resulted in the resident being sedated. On 2/2/23 at 10:00 AM, a phone interview was conducted with the complainant. The complainant expressed concern about the regimen of psychotropic medications prescribed to R806. The complainant explained that R806 had bipolar disorder and had been treated long term by a psychiatrist and had been stable for many years. The complainant reported multiple requests to discuss R806's medication regimen were made and there was a delay in consulting with R806's long time psychiatrist. The complainant further reported the facility administered an injection of antipsychotic medication on multiple occasions even after the facility's consultant psychiatrist discontinued it.		unit weekly for 4 weeks week for four weeks and monthly thereafter to ensure justification for the use of antipsychotic and anti-anxiety medication given on an as needed (PRN) basis, targeted behaviors are identified and consistently implement person centered non-pharmacological interventions prior to administering anti-psychotic and anti-anxiety medications. Director of Social Services will report findings to QAPI Committee weekly for 90 days and then monthly thereafter until the QAPI committee determines compliance. The Director of Social Services is responsible to maintain substantial compliance.	

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	Review of R806's clinical record revealed R806 was admitted into the facility on 7/28/22 and discharged on 9/1/22 with diagnoses that included: wedge compression fracture of first lumbar vertebra, generalized anxiety disorder, bipolar disorder, chronic obstructive pulmonary disease, and major depressive disorder. Review of a Minimum Data Set (MDS) assessment dated 8/3/22 revealed R806 had clear speech, severely impaired cognition, no behaviors, required limited assistance with walking, had two or more falls since their admission date of 7/28/22, and received antipsychotic, antianxiety, and antidepressant medications. Review of R806's hospital discharge summary revealed R806 was prescribed the following psychotropic medications: Depakote (a medication used to treat manic episodes of bipolar disorder 500 mg (milligrams) QAM (every morning) Depakote 500 mg ER (extended release) 3 tablets QHS (at bedtime) Neurontin (a medication used to treat anxiety associated with bipolar disorder) 300 mg QHS Lorazepam (a medication used to treat anxiety) 0.5 mg (there were no instructions regarding frequency of use) Paxil (a medication used to treat depression and anxiety) 20 mg (there were no instructions regarding frequency of use) Seroquel (a medication used to treat psychosis) 400 mg take 200 mg QID (four times a day) Risperdal (a medication used to treat psychosis) 2 mg take 0.25 mg QD (every day)			

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Trazodone (a medication used to treat depression) 150 mg QHS

Review of R806's physician's orders implemented at the facility upon admission included the following:

Depakote ER 250 mg daily and 500 mg 3 tablets QHS

Lorazepam 0.5 mg Q12 (every 12 hours) PRN

Neurontin 300 mg QHS

Paxil 20 mg daily

Seroquel 200 mg QID

Risperdal 0.25 mg daily

Trazodone 150 mg QHS

Further review of R806's physician's orders revealed the following changes were made:

On 8/3/22 at 12:45 PM, Haldol 1 mg IM Q4 hours PRN was ordered "for agitation for 14 days" and discontinued on 8/4/22.

On 8/6/22, Haldol 1 mg IM was ordered "one time only".

On 8/6/22, Haldol 5mg/ml 1 mg IM Q6 hours PRN was ordered and discontinued on 8/8/22.

On 8/8/22, Haldol 5 mg/ml 1 mg IM Q6 hours PRN was ordered and discontinued on 8/16/22.

On 8/6/22, lorazepam was increased to 0.5 mg 2 tablets every 6 hours (which doubled the dose and

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increased the frequency). This was not ordered PRN. This order was discontinued on 8/22/22.

On 8/16/22, Lorazepam Solution 2 mg/ml 0.5 IM Q8 hours PRN was added and discontinued on 8/22/22. (This was in addition to the scheduled lorazepam order above).

Review of R806's Medication Administration Record (MAR) from August 2022 revealed Haldol IM was administered to R806 on 8/3/22 at 3:17 PM, 8/6/22 at 12:26 PM and 8:02 PM, and 8/8/22 at 5:01 PM.

Review of R806's progress notes revealed there was no documentation prior to the administration of IM Haldol at 3:17 PM to indicate the psychotic symptoms and/or behaviors exhibited by R806 and what non-pharmacological interventions were attempted prior to administering the antipsychotic medication.

Review of a progress note written by attending Physician 'B' on 8/3/22 did not document justification for administration of a PRN antipsychotic medication (Haldol). The progress note documented, "Dementia w/ (with) behavioral disturbance: multiple reports from nursing staff of patient agitation. Will increase Ativan (lorazepam) 0.5 mg PO q6 prn..." There was no indication that the root cause of R806's "agitation" was determined. Physician 'B's progress note did not document anything about Haldol.

Review of a "Psychiatry" progress note written by the facility's consulting psychiatric Nurse Practitioner (NP) 'L' revealed, "...Complaint: initial evaluation for bipolar disorder and med management...She is on multiple psychiatric medications. Per notes she is restless at times. She has had falls. She was originally non verbal. They

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are using both PRN Ativan and Haldol but unsure of behaviors prompting use. Nurse reports she has been doing good. She is minimally verbal. Mostly yes and no answers. No issues noted with sleep or appetite. Unable to reach any family for additional history. She is her own responsible party. She denies concerns. She does not appear in any distress ...General: Calm, attentive and in no acute distress ... ASSESSMENT & PLAN

Plan: continue PRN Ativan will DC (discontinue) PRN Haldol...Plan: Will DC Risperdal as she is only on 0.25 QD and is already on Seroquel 200 4 x a day. Continue all other current medications. She has a long psychiatric history..."

As mentioned above, the initial Haldol IM order was discontinued by NP 'L'. However, additional orders were implemented by the attending physician and the medication was administered on 8/6/22 and 8/8/22.

Further review of R806's progress notes revealed on 8/6/22, Physician 'B' documented, "...reports of agitation. Haldol 1 mg IM given. Will increase Ativan to 1 mg PO q6 PRN...Ativan increased for agitation..." There was no documentation that any underlying causes for R806's "agitation" were explored. It should be noted that Physician 'B's documented the Ativan was to be increased to 1 mg q6 PRN. However, the order that was implemented was not PRN and was every 6 hours.

Further review of R806's MAR revealed they received Ativan (lorazepam) every six hours between the dates of 8/6/22 and 8/22/22 and not PRN as the physician documented in their progress note.

Review of a nursing progress note dated 8/6/22 at 4:27 PM revealed R806 had a fall in the dining

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room while self transferring, was "aggressive and combative towards staff...difficult to redirect". The nurse documented the physician was notified and an order to administer 1 ml of Haldol IM was given. A second nursing progress note dated 8/6/22 at 9:57 PM documented the physician was "contacted for order of Haldol" because R806 was "extremely agitated and combative with staff" and was unable to be controlled safely after they were redirected with "snacks, magazines and wheeled pt around unit". There was no documentation of any psychotic symptoms to justify the use of an antipsychotic medication and no indication that the root cause of R806's agitation was explored.

Review of a nursing progress note dated 8/8/22 revealed R806 made "numerous attempts to get up unassisted" and was "combative toward staff". It was documented that R806 was "toileted" but there were no other documented non-pharmacological interventions or documented attempted to determine the cause of R806's agitation. It was documented R806 was administered Haldol IM.

Further review of R806's nursing progress notes revealed R806 was "Napping for long intervals" on 8/10/22, had decrease in oxygen levels which required supplemental oxygen on 8/13/22, and "very unsteady on her feet" on 8/14/22.

Review of a "Psychiatry" progress note dated 8/14/22 revealed, "...Reviewed chart including progress notes, mediations and labs. Haldol IM was started again since last visit by PCP (primary care physician) at request of nurse. She was also started on scheduled Ativan every 6 hours. It has been used several times...She is sleepy and briefly arousable...Plan: will DC PRN Haldol and start PRN Ativan IM..."

Review of a "Physical Medicine and

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	Rehabilitation (PM&R)" progress note dated 8/17/22 revealed, "...Per nursing, she has been having issues with increased tiredness during the day..." Review of a PM&R progress note dated 8/22/22 revealed, "...She appears lethargic..." Review of a "Psychiatry" progress note dated 8/22/22 revealed, "...I received a call from the nurse, patient has been more sedated and confused. She has been falling. I also received a message from social worker to call her son...I spoke with (son) who is very concerned about her cognition decline. Prior to and after the surgery she was alert and oriented. She was living independently and managing without issues. Her bipolar was stable with close follow up with psychiatrist...who she has been seeing for over 15 years. He reports she could not be on the Ativan. Which was started at 1 mg Q6 hrs (hours) by the PCP. I did order to DC all Ativan...." Review of a second "Psychiatry" progress note dated 8/22/22 revealed, "I spoke with...patients long time psychiatrist. Discussed current status. Reviewed her medications...He also reports she has a hx of alcohol abuse sober for years and has never done well on benzos (benzodiazepines - Ativan/lorazepam)". Review of R806's PT notes revealed the following: On 8/1/22, a PT note documented R806 "fully participated with session". On 8/2/22, a PT note documented R806 fully participated in the session. On 8/5/22, a PT note documented, "Multiple attempts to see pt today, in AM, midday and late			

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PM, pts in bed asleep, unarousable..."

On 8/9/22, a PT note documented, "Pts son came in...per son will move to an ILF (independent living facility) with an option to be an ALF (assisted living facility)...difficulty staying awake...Per (son), pt's been through this before he wanted her medications reviewed 'she will snap right back if they straighten her meds first'...pleasant but not alert...unable to recite her back precautions. Nurse is aware. Pts son came in to talk to medical team re: pts meds..." (It should be noted that R806's medications were not reviewed with R806's son and R806's long time psychiatrist until 8/22/22)..."

On 8/10/22, a PT progress note documented, "...Pt demonstrates excellent progress this reporting period..."

On 8/16/22, a PT note documented, "Patient difficult to rouse this session and needed max prompting to participate in session".

On 8/17/22, a PT note documented, "Shortened session d/t (due to) patient being difficult to rouse and she required max prompting to participate in session."

On 8/18/22, a PT note documented, "Shortened session d/t patient becoming tearful and confused...unable to follow direction throughout session..."

On 8/22/22, a PT note documented, "approached numerous times to participate in therapy and was unable d/t lethargy..."

Review of R806's care plans revealed no behavior care plans that identified targeted behaviors and person-centered non-pharmacological interventions in relation to the use of PRN Haldol

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	and Ativan. On 2/2/23 at 10:41 AM, an interview was conducted with the facility's Medical Director, Physician 'C'. Physician 'C' reported that the underlying cause of a resident's behaviors should always be determined before resorting to IM Haldol. On 2/2/23 at 11:40 AM, Psych NP 'L' was interviewed via the telephone. When queried about the use of IM Haldol PRN for R806, NP 'L' reported they did not generally use PRN antipsychotic medications "unless there are serious hallucination and delusions". NP 'L' reported they would not have ordered Haldol for agitation and that decision was made by R806's attending physician. NP 'L' reported she was not made aware of R806's son's attempt to provide R806's long time psychiatrist contact information or that he had concerns regarding R806's medications until 8/22/22. It should be noted that R806's family member was in the facility and expressed concerns to the PT on 8/9/22, 13 days earlier. On 2/2/23 at 2:49 PM, a telephone interview was conducted with Physical Therapy Assistant (PTA) 'M' who reported they could not remember anything about R806 and no longer provided therapy services at the facility. On 2/2/23 at 3:05 PM, an interview was conducted with the Director of Social Services, SS 'A'. When queried about the targeted behaviors and non-pharmacological interventions for the use of IM Haldol for R806, SS 'A' reported they would have to look into it. On 2/2/22 at 3:57 PM, SS 'A' reported the Haldol order was determined by the physician after the nurse contacted them. When queried about who			

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	consented to the use of Ativan and Haldol, SS 'A' reported no consent was given because the facility could not get a hold of the family until 8/22/22 when they were given the information about R806's long time psychiatrist. SS 'A' reported she was unaware that R806's family member expressed concerns about R806's mental state and medication regimen during therapy on 8/9/22. SS' A' further explained that they did not think there was a care plan that outlined non-pharmacological interventions to use prior to administering PRN Haldol. On 2/2/23 at 4:35 PM, Physician 'B' was interviewed via the telephone. Physician 'B' did not have access to a computer and was not sure of details. When queried about why R806 was getting Haldol IM PRN, Physician 'B' reported he ordered it "for a short period of time to calm her down". When queried about whether R806 exhibited any psychotic symptoms, Physician 'B' reported he ordered it due to R806's "agitation and confusion". Physician 'B' further explained that since Haldol was not a controlled substance it could be obtained quicker. Physician 'B' stated, "I wouldn't order more than two to three doses max." When queried about what was done to rule out any underlying conditions that could have contributed to R806's agitation and confusion and whether they were contacted when R806 became lethargic, sleepy, and unable to participate in therapy, Physician 'B' reported he did not have access to a computer and could not remember, but reported anything he addressed would be documented in a progress note. On 2/2/23 at 5:04 PM, an interview was conducted with the Director of Nursing (DON). When queried about who consented to the use of PRN IM Haldol and Ativan for R806 and why R806's long time psychiatrist was not collaborated with until 8/22/22, the DON reported the facility was unable to get in touch with R806's			

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	family. The DON reported they were unaware the son brought concerns up to PTA 'M' on 8/9/22. Review of a facility policy titled, "Use of Psychotropic Medication" dated 9/2022, revealed, in part, the following: "...Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication (s)...The attending physician or designated psych services will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents, their families and/or representatives, other professionals, and the interdisciplinary team...The indications for use of any psychotropic drug will be documented in the medical record...For psychotropic drugs that are initiated after admission to the facility, documentation shall include the specific condition as diagnosed by the physician...Psychotropic medications shall be initiated only after medical, physical, functional, psychosocial, and environmental causes have been identified and addressed...Non-pharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation...PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration...Acute of emergency situations....A clinician in conjunction with the IDT (interdisciplinary team) shall evaluate and document the situation to identify and address any contributing and underlying causes of the acute condition and verify the need for a psychotropic medication...Enduring conditions...An evaluation shall be documented to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634021	A. BUILDING _____ B. WING _____	2/2/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	determine that the resident's expressions or indications of distress are...Not due to a medical condition or problems that can be expected to improve or resolve as the underlying condition is treated or the offending medication(s) are discontinued...Not due to psychological stressors, anxiety, or fear stemming from misunderstanding related to his or her cognitive impairment that can be expected to improve or resolve as the situation is addressed...Persistent, and negatively affect his or her quality of life..."			