STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504253	A. BUILDING _____ B. WING _____	3/8/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NSG & REHAB STERLING HEIGHTS	38200 SCHOENHERR ROAD STERLING HEIGHTS, MI 48312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Promedica Skilled Nursing and Rehab of Sterling Heights was surveyed for a Recertification survey on 3/8/23. Intakes: MI00134562, MI00134465, MI00134600, MI00133600, and MI00134043. Census= 107.	F0000		
F0557 SS= D	Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure resident personal belongings were accounted for, affecting one sampled Resident (R121), resulting in missing personal items, the potential for further missing/unaccounted for items, and resident/family dissatisfaction. Findings include: On 3/6/23 at 2:33 PM, an interview was completed with R121 and Family Member "A". They explained that upon admission into the facility, they brought in a suitcase and a duffle bag full of clothing, including a winter	F0557	Element 1 Resident #121 has been offered reimbursement for her missing items. Element 2 All residents have the potential to be impacted. Facility managers have completed resident rounds to identify any lost or missing items and identified issues have received appropriate follow up. Element 3 The Administrator and DON have reviewed the facility's policies regarding resident belongings and have determined it to be adequate to meet the regulatory requirements. A root cause analysis was completed through the facility's privileged QAPI process and the need for additional education of nursing and housekeeping staff has been identified. Nursing and housekeeping staff have been educated. The facility resident rounds have been updated to identify issues or concerns related to residents' personal property. Managers will complete resident rounds to ensure residents'	3/28/2023

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

Electronically Signed | 03/26/2023

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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	coat, and designer slippers however, none of those items can be located. They further explained that it has been approximately six weeks since their concerns have been brought to the facility, and they have yet to hear anything about their concerns. At this time, Family member "A" provided a copy of the inventory sheet R121 completed upon admission. A review of the "Inventory of Personal Effects" listed the following items: 1 coat 1 dress 2 house coat/robe 2 overnight case/luggage 1 shoes (pair) 5 slacks 1 slippers (pair) 9 socks (pair) 5 sweaters 4 underwear/panties 1 dentures blanket		belongings are secured to their satisfaction. The rounding will be done daily M-F for one month and twice weekly for 2 months to ensure sustained compliance. Identified issues will be addressed promptly and the results of the rounds will be reviewed in QA.	

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	phone phone charger crossword puzzle A review of R121's medical record revealed that they were admitted into the facility on 1/19/23 with diagnoses that included Kidney Failure, Diabetes and Hypertension. Further review revealed that they were cognitively impaired, and required supervision to extensive assistance for Activities of Daily Living. On 3/7/23 at 10:51 AM, a request of R121's inventory of personal effects was requested from the facility, and in response to this request, the Nursing Home Administrator stated the following via email on 3/7/23 at 11:51 AM, "Attached is the internal communication regarding [R121's] concerns regarding missing clothing. I approved reimbursement but that's still in process." A review of the internal communication revealed a concern form regarding the missing items dated for 2/7/23, an initial email sent to Social Worker "C" on 2/21/23 from Family Member "A", and another follow-up email on 2/28/23 expressing their frustration with not receiving a response from someone. On 3/8/23 at 9:37 AM, R121 was asked if they had heard anything about their missing			

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	items/reimbursement. R121 explained that they had not heard anything. On 3/8/23 at 2:06 PM, Social Worker "C" was asked about R121's missing items, and explained that they searched the building, followed up with housekeeping, and were still unable to locate the items therefore, reimbursement is the next step. On 3/8/23 at 11:58 AM, the NHA was asked about resident personal property being lost, and he explained that they have redone and updated their inventory process which started last week. This included a building wide sweep in response to an uptick in concerns about missing items. A review of the requested personal property policy from the facility revealed a document titled "Focus on F tag", contained regulatory language, and did not address the facility's policy and procedure for handling missing items.			
F0658 SS= D	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to pass medications in a	F0658	Element 1 Resident #41 is free from any negative impact from the medication error. The nurse for resident #41 has received additional education on properly documenting medications. Resident #40's physician was notified of the late medication administration and no new orders were given. Resident #40 remains free from any negative impact. Element 2	3/28/2023

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	timely manner and per physician's orders and standards of practice affecting two residents (R41 and R40), resulting in resident dissatisfaction, and the potential for adverse effects. Findings include: On 3/7/23 at 8:51 AM, Licensed Practical Nurse (LPN) "K" (agency nurse) was seen on the east wing at Cart #1 passing medications. LPN "K" was observed to have a wireless headphone bud in her right ear. LPN "K" indicated that R41 would be the next resident for medication pass. On 3/7/23 at 9:00 AM, LPN "K" returned to the medication cart and no longer had the headphone bud in her ear. LPN "K" removed a cup of pills from one of the middle drawers on the cart and indicated she had already pulled R41's medications, but that the resident had left his room to go get some sugar so she stored them in the cart. The medication cup was not labeled with any identifying information as to whose pills were in it. R41's scheduled morning medications were reviewed with LPN "K" and included a topical lidocaine patch, Budesonide Inhalation Suspension (breathing treatment), and Polyethylene Glycol 3350 Powder (mixed into a cup of water). The resident's medications due at this time also included the following nine pills (one of each): 1) Carbamazepine ER (extended release) Oral Tablet 200 Mg (milligram) 2) Furosemide Oral Tablet 20 Mg (milligram) 3) Multivitamin Oral Tablet 4) Venlafaxine HCl ER 37.5 Mg Capsule		All Residents have the potential be impacted. The facility has audited medication administration and has followed up as appropriate. Element 3 The Administrator and DON have reviewed the medication administration policy and determined that it's adequate to administer medications as-ordered. As part of the facility's privileged QAPI process a root cause analysis was completed and the need for additional nursing education was identified. Licensed nurses have been educated about medication administration and documentation. Element 4 The DON or designee will utilize the Medication Administration Audit report through the facility's EHR system to ensure timely and correct medication administration. This review will occur daily (M-F) for one month and then twice weekly for 2 months and as-needed thereafter to ensure sustained compliance. Issues identified will be addressed promptly and findings will be reviewed in QAPI.	

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5) Folic Acid

6) Levetiracetam Oral Tablet 750 Mg

7) Tamsulosin HCl Oral Capsule 0.4 Mg

8) Risperdal Oral Tablet 0.25 Mg

9) Thiamine HCl Oral Tablet 100 Mg

This surveyor asked to look in the medication cup and counted eight pills. When queried regarding there being a missing pill, LPN "K" proceeded to compare the pills in the cup with the resident's pill packages in the cart. LPN "K" indicated that the Tamsulosin was missing due to there not being a pill in the cup that looked like the Tamsulosin. LPN "K" took a Tamsulosin pill out of the package and put it in the unmarked cup with the rest of the pills and proceeded into R41's room. R41 was observed sitting in his wheelchair in his room. The resident had long hair and beard growth. LPN "K" gave R41 the cup of pills.

LPN "K" then set up R41's breathing treatment. At this time, a review of R41's medication administration record (MAR) revealed that LPN "K" documented that she already gave R41 his ordered Ketoconazole External Shampoo. When queried regarding having gotten his ordered medicated shampoo, R41 became very upset and stated, "I wanted it, but I'm sick of being jerked around by the girls up there. Every time I go up to the nurses' station and sit there, no one ever asks if they can help me." R41 explained that earlier this morning, he asked staff for his medicated shampoo but was ignored. R41 added, "They came down finally and said, 'Well are you ready for your shower?' I said no, I don't even want it anymore."

LPN "K" was queried at this time as to why she

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had documented that she gave R41 his medicated shampoo when he had not used it yet. LPN "K" responded that she hadn't gotten it out yet and proceeded to ask the resident when he would like to take a shower.

On 3/8/23 at 9:53 AM, the Director of Nursing (DON) was interviewed. When queried regarding LPN "K" being observed with an ear bud in her ear during medication pass, the DON stated that was not her expectation. The DON was then queried regarding the expected process for medication administration, and was given the details regarding what was observed with R41 and LPN "K". The DON stated, "In that instance, our pills come in individual packages. [The nurse] should probably start over when the patient is available again, especially if a pill was noted to be missing." When queried regarding medication administration documentation, the DON stated that documentation should only be done after a medication is administered or task is completed.

Resident 40 (R40)

On 3/6/2023 at 10:30 AM, R40 was observed sitting in the hallway near the nurse's station. R40 stated that they were waiting on a pain pill and for their IV (Intravenous) antibiotic to be hung. R40 stated that they were on Vancomycin (antibiotic) which takes about two hours to run. R40 stated that the nurse told them they were going to break and would complete it after they returned.

A review of the medical record revealed R40 admitted into the facility on 11/1/2022 with the following diagnoses, Urinary Tract Infection and Hypertension. A review of the Minimum Data Set (MDS) assessment dated 12/8/2022 did not assess cognition. R40 also required one person supervision with bed mobility and transfers.

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	A review of the physician orders revealed that R40 Vancomycin was scheduled to be hung at 10:00 AM, everyday. At 11:03 AM and 11:15 AM, R40 was observed in their wheelchair in the hallway. R40 stated they were still waiting for the nurse to return so they could get their IV and their pain pill. At 11:55 AM, R40 was observed following their nurse (NUrse "L") into their room so their Vancomycin could be administered. On 3/6/2023 at 12:03 PM, an interview was conducted with Nurse "L" regarding R40 IV being administered late. Nurse "L" stated that the antibiotic was administered late because they "just had a lot of patients". On 3/8/2023 at 1:02 PM, an interview was conducted with the Director of Nursing (DON) regarding medication administration. The DON stated that medication should be administered within the standard, which is an hour before and an hour after. The DON stated that they also spoke with the nurses because of the labs that need to be completed with the administration of it. The DON stated that if they are going to be late, then the physician should be notified and a progress note entered. A review of the facility's policy/procedure titled, "Medication Administration: Medication Pass," dated 06/2021, revealed, "Purpose: To safely and accurately prepare and administer medication according to physician order and resident needs...Read transcribed physician order on MAR: resident name, medication name, dosage, route and interval ordered · Remove medication from cart · Compare MAR with medication label for accuracy...Administer medication in accordance with frequency prescribed by			

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	physician -within 60 minutes before or after prescribed dosing time; if resident is not in room to receive medication, flag MAR and at conclusion of medication pass, roll cart to resident's location and administer medications · Lock medication cart when not in direct view of nurse administering medication...Remain with resident until administration of medication complete ·Document initials on MAR for each medication administered..." A review of the facility's policy/procedure titled, "Medication Storage Guidance," dated 2022, revealed, "Properly handle and dispose of any expired or unused product in accordance with facility policy or local, state, and federal regulations..."			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: This citation pertains to Intake: MI00134600 and MI00134043. Based on observation, interview, and record review, the facility failed to provide showers as scheduled for two residents (R40, and R75) and a bed pan for one resident (R24) out of ten reviewed for Activities of Daily Living (ADL's), resulting in dissatisfaction with care and fustration. Findings include:	F0677	Element 1 Residents #84, 24, #40, and #75 have been provided with showers following survey and their shower preferences have been reviewed. Element 2 All residents have the potential to be impacted. The facility has completed resident rounds and screened for unmet shower preferences. Identified issues and requests have been addressed. Element 3 The Administrator and DON have reviewed the policy regarding resident ADL care and have validated that it's adequate to ensure bathing is provided according to resident preferences. A root cause analysis was completed as part of the facility's privileged QAPI process and the need for additional licensed nurse and certified nurse aide	3/28/2023

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	Resident 24 (R24) On 3/6/2023 at 10:30, R24 call light appeared to be activated. R24 stated that they were waiting to be put on the bed pan and that it usually takes a while for someone to come answer their light. R24 stated that their light had already been on 15 minutes prior to surveyor entering room. At 10:40 AM, a certified nursing assistant (CNA) was observed walking past the light. At 10:45 AM, multiple staff were observed sitting at the nurse's station on the unit. At 11:05, the nurse from the other hallway came and answered R24's call light and getting a CNA to enter the room and answer the light. A review of the medical record revealed that R24 admitted into the facility on 7/7/2017 with the following diagnoses, Paraplegia and Morbid Obesity. A review of a Minimum Data Set (MDS) assessment dated 12/21/2022 revealed a Brief Interview for Mental Status score of 15/15 indicating an intact cognition. R24 also required extensive two person assist with bed mobility. At 12:30 PM, an interview was conducted with R24 regarding the long wait to be placed on a bed pan. R24 stated again that it is not unusual to wait so long. R24 stated that they had soiled themselves because they		education was identified. Licensed nurses and certified nurse aides are receiving education related to honoring resident bathing preferences. Element 4 The facility resident rounds have been updated to validate residents are receiving bathing according to their preferences.. Managers will complete resident rounds to ensure residents are being bathed according to their preferences. The rounding will be done daily M-F for one month and twice weekly for 2 months to ensure sustained compliance. Identified issues will be addressed promptly and the results of the rounds will be reviewed in QA.	

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could not wait and had to be cleaned up and have the sheets changed.

On 3/8/2023 at 1:02 PM, an interview was conducted with the Director of Nursing (DON) regarding R24 waiting to be put on the bed pan.

The DON stated that they expect for lights to answered within a reasonable amount of time. The DON stated that 45 minutes is certainly not their expectation regarding wait time for R24 to be placed on a bed pan.

Resident 40 (R40)

On 3/6/2023 at 10:30 AM, R40 was observed in the hallway in their wheelchair. R40 appeared disheveled with greasy hair. R40 stated that they were waiting for their pain pill.

A review of the medical record revealed R40 admitted into the facility on 11/1/2022 with the following diagnoses, Urinary Tract Infection and Hypertension. A review of the Minimum Data Set (MDS) assessment dated 12/8/2022 did not assess cognition. R40 also required one person supervision with bed mobility and transfers.

A review of shower documentation for the last thirty days revealed one shower sheet dated 2/22/23 to which refused was written on the sheet. No accompanying documentation was provided.

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Resident 75

On 3/8/2023 at 10:20 PM, R75 was observed in their bed in an upright position. R75 stated that they had just finished breakfast and was having some pain in their left shoulder. R75 was interviewed regarding their care in the facility. R75 stated that they prefer bed baths, however they had not received a bed bath in over a month. R75 stated that they will ask someone to do it and they say they will be back, but they never come back.

A review of the medical record revealed R75 admitted into the facility on 3/5/2021 with the following diagnoses, Idiopathic Peripheral Autonomic Neuropathy and Atrial Fibrillation. A review of the Minimum Data Set assessment dated 2/10/2023 revealed a Brief Interview for Mental Status score of 14/15 indicating an intact cognition. R75also required extensive one person assist with bed mobility and transfers.

A review of the shower task for the last thirty days revealed the following, "2/9-Resident Refused, 2/16-Bed Bath, 2/23-Bed Bath."

On 3/8/2023 at 1:02 PM, an interview was conducted with the Director of Nursing (DON) regarding showers in the facility. The DON stated that showers are always a problem and when they hear that there is a problem then they try and address it. We have also done education regarding

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	education with the staff, as well as agency staff. A review of a facility policy titled; "Bathing" did not address Activities of Daily Living.			
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 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 practices. Deficient practice #1. This citation pertains to Intake MI00134465. Based on interview and record review, the facility failed to adequately assess and monitor a skin alteration for one resident (R283) of two reviewed for quality of care, resulting in an unmonitored infection, gangrene, and ultimately, amputation of the right great toe. Findings include: A complaint filed to the State Agency was reviewed and included the following: "...On 01/25/23 a podiatrist came to clip [R283's] toe nails. He had an ingrown toe nail that was	F0684	Element 1 Residents #333 and #283 no longer in facility. Care plan conferences have been held with residents #40 and #37 to ensure their plans of care reflect their current need levels. The residents' care plans have been updated. Element 2 All residents have the potential to be impacted. The facility has completed resident rounds and have addressed identified unmet needs. Element 3 The Administrator and DON have reviewed the applicable policy and determined that it is adequate to ensure resident needs are being met appropriately. As part of the facility's privileged QAPI a root cause analysis was completed and the need for additional education of licensed nurse and nurse aides was identified. Licensed nurses and nurse aides have been educated on meeting resident needs. Element 4 The facility resident rounds have been updated to identify unmet resident needs. Managers will complete resident rounds to	3/28/2023

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	infected on his right foot, big toe. Antibiotic cream was use (sic) and a dressing applied. On 02/04/23 the resident's [family] visited...[R283's] big toe was blue and dark black...On 02/08/23 the resident had his big toe amputated because he had gangrene." A review of R283's record revealed that the resident was admitted into the facility on 12/9/22 and discharged on 2/5/23. A review of R283's Minimum Data Set (MDS) assessment dated 12/14/22 revealed that the resident was cognitively intact and required extensive assistance from staff for activities of daily living (ADLs). R283's medical diagnoses included Right Femur Fracture, Cerebrovascular Disease, Peripheral Vascular Disease, Hemiplegia/Hemiparesis Affecting Left Side, and Type 2 Diabetes Mellitus. A review of R283's medical record revealed a photo taken on 2/5/23 of the resident's right toe, along with an incomplete (unsigned) skin assessment. The photo showed R283's right foot with the top of the right toe discolored black/purple and appearing leathery (indicating gangrene) down to the bottom of the nail bed. A review of R283's hard copy chart from the facility revealed documentation from a podiatry visit at the facility on 1/25/23. The podiatrist documented the following: -"Chief Complaint: Painful dystrophic toenails, Painful lesion - R (right) hallux nail... R Hallux (R1, or Right Great Toe)- medial border - Erythema, Incurvation, Painful Nail Boarder (sic), Breakdown, Paronychia (an infection of the skin that surrounds a toenail or fingernail)... Treatment: Podiatic E/M		ensure resident needs are being met. The rounding will be done daily M-F for one month and twice weekly for 2 months to ensure sustained compliance. Identified issues will be addressed promptly and the results of the rounds will be reviewed in QA.	

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(evaluation/management) & Hx (history), Debrided mycotic toenails 1-5 B, I & D (incision and drainage) of infected toe - R1, Antibiotic Ointment and Dsg (dressing) applied - R1."

A review of R283's electronic medical record and progress notes did not reveal any documentation related to the visit from the podiatrist, nor indicate that there was an issue with R283's feet/toes prior to the podiatry visit.

A review of R283's physician orders did not reveal any related to the treatment of the resident's right foot/toe until 2/4/23, and did not reveal an order to send R283 to the hospital at any point for further evaluation of the toe.

Continued review of R283's progress notes revealed the following:

-2/4/2023 19:01 (7:01 PM) General Progress Note Note Text: Resident observed with redness to upper back, swelling and discoloration to right big toe during shower. MD (Physician), Unit Manager, and son informed of finding. Daughter admitted to cutting residents toe nails multiple times since January 23rd. Family very rude to nurse and unit manager on phone. Family demanded resident be sent out 911. Residents family then changed their mind. Writer inserted order of TOA (topical antibiotic) and dry dressing BID..." Written by Licensed Practical Nurse (LPN) "H".

-2/4/23 19:40 (7:40 PM) General Progress Note Text: "...writer was informed by nurse on duty with family concerns to residents right great toe, resident is seen and followed by outside podiatrist and was seen recently, daughter...admitted to cutting residents toe nails several times during the residents stay without having staff awareness. Talked to son on phone about concerns, he was

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rude, verbally aggressive, and upset the physician would not sent resident out 911, resident and family refused to leave and remained at the hospital. TX (treatment) order was applied to toe by nurse, resident will be followed by wound NP (Nurse Practitioner) on 2-6-2023. Physician aware of current plan of care." Written by LPN "I".

-2/5/2023 11:04 (AM) General Progress Note Text: "Yesterday (2/4/23) medical doctor (MD) gave order to go to hospital, pt (patient) refused to leave, Transportation offered and set up, PT taken by family out of facility, instructed to go straight to emergency room. All risks discussed and understood." Written by Licensed Practical Nurse (LPN) "H".

A review of the facility provided, hard-copy "Skin Worksheets" for R283 revealed:

-1/11/23 worksheet, marked as "abnormal," with the right foot/leg circled and two areas on the resident's back marked as abnormal. No details regarding the skin concern circled on the right foot/leg were present on the sheet, nor in the resident's medical record upon review. No corresponding progress note to the skin worksheet dated 1/11/23 was found, however, a progress note for a body audit on 1/12/23 noted, "No new skin concerns."

No "Skin Worksheets" for R283 were provided by the facility after 1/18/23, although the resident remained in the facility until 2/5/23.

A review of R283's medication/treatment administration records (MAR/TAR) revealed the order, "Body Audit every night shift every Wednesday, Saturday for Body Audit." There was no documentation present indicating that the body audit was completed per the order on

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	Saturday, 1/28/23, and no corresponding progress note was found. It was documented that a body audit was completed on Wednesday, 2/1/23, however, no corresponding progress note nor skin assessment/worksheet was found. A review of R283's hard copy chart from the facility revealed that the resident's family member signed the resident out AMA (against medical advice) on 2/5/23 at 11:00 AM. On 3/6/23 at 2:13 PM and 3/7/23 at 10:38 AM, Confidential Witness "J" was interviewed via phone. When queried regarding what occurred over the weekend prior to R283 leaving the facility, Witness "J" explained, "February 4th my [family member] was visiting [R283]... [The resident's] toe was completely black - not bruised - it was black. Ten days prior, a podiatrist had come in per the facility and clipped [R283's] toenails, he had an ingrown toenail - the paperwork went into a binder and didn't get put into the computer system. No one was paying attention to [R283's] feet. [R283] has bad blood circulation to his feet and diabetes." Witness "J" explained that photos were sent to the supervising nurse of the toe LPN "I" (who was not working in the building when the issue with the toe was discovered, but was corresponding over the phone). Witness "J" stated, "The nurse (LPN "I") said the doctor was saying just to put cream on it and would have someone look at it on Monday. We were telling them [R283] needed to go to the hospital." When asked if family had cut the resident's toenails, Witness "J" stated that family cut the resident's toenails on the smaller toes but, "Not the big toes, because there was an ingrown toenail...We asked the facility if they could do it and they said they would get podiatry set up." Witness "J" explained that is why R283 ended up being seen by the podiatrist in the facility in the first place. Witness "J" stated the resident's family wanted R283 to go to the hospital on 2/4/23 but			

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the facility would not send him out. When asked if any of the family or R283 ever changed their mind about wanting to send the resident to the hospital, Witness "J" stated, "No." Witness "J" continued and stated, "I went there on Sunday (2/5/23) morning and looked at the toe myself and talked to the nurses and supervisors. They said it's okay, someone will look at it tomorrow (2/6/23). I asked them to override the doctor." When queried regarding the documentation in R283's record by LPN "H" and LPN "I" from 2/4/23 and 2/5/23, Witness "J" stated it was incorrect. Witness "J" stated that R283's family was adamant on the resident needing to be sent to the hospital, and added, "That's absolutely not what happened at all. Why would [family] sign AMA paperwork if the doctor had given an order to send [R283] to the hospital? They did absolutely nothing for [R283] as it related to that toe...We saw the toe on the 4th (February), and it was done on the 25th (January)...[R283] supposedly had four showers between those two dates, no one was paying attention during his showers as to having an open wound on his toe and no one said anything to us."

R283's hospital documentation was obtained, reviewed, and revealed the following:

-"Note From Your Admission on 02/05/23...ED (Emergency Department) Provider Notes...Chief Complaint: Foot discoloration...

Physical Exam: ...Skin:...Right great toe has partial nail evulsion with necrotic region around right first toe distal nail bed. Right dorsal foot erythema. +1 bilateral lower extremity edema...

Medical Decision Making: I am concerned about osteomyelitis and necrosis of the patient's right great toe. Patient will be given vancomycin and Zosyn (antibiotics) and will admit for podiatry

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	evaluation and IV (intraveneous) antibiotics. X-ray indicates no fracture." -"OR (Operating Room) Brief Operative Note...Date of Surgery: 2/8/2023 11:07 AM...Preoperative Diagnosis: gangrene right great toe, Postoperative Diagnosis: Same, Procedure(s): amputation of the great right toe..." On 3/8/23 at 8:32 AM, Licensed Practical Nurse (LPN) "H" was interviewed regarding her involvement in the discovery of the deterioration of R283's right great toe. When queried regarding conflicting information about whether the resident was ordered to be sent to the hospital versus being signed out AMA, LPN "H" stated that R283's family wanted the resident to be sent out. LPN "H" further explained that R283's [family member], "Was rude and didn't want to talk to me because I'm not a RN (Registered Nurse)...and was upset there was no RN in the building. [R283's family member] was talking with the Unit Manager (LPN "I") on the phone but she wasn't here to see it, she just talked to [family member], it was after hours...[Family] signed [the resident] out AMA the next day." LPN "H" explained that she and the aide on duty on 2/4/23 did what they were supposed to do by noticing the toe when taking the resident for a shower and completing a skin assessment. LPN "H" stated that she didn't work for days before the condition of R283's toe was noticed so, "Can't say what happened between then because I wasn't here." When queried regarding a treatment being in place for R283's right great toe after the podiatrist had seen the resident on 1/25/23, LPN "H" explained that doctors are, "Supposed to put orders in a book and flag it so the nurses can see it on the rack and it can get put in...But I don't believe the podiatrist put an order in...He treated the toe but we looked for an order and couldn't find one."			

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	On 3/8/23 at 9:53 AM, the Director of Nursing (DON) was interviewed. The DON was asked to review the podiatry note for R283 dated 1/25/23 that noted the I&D, inflammation, and skin breakdown of the resident's right great toe. When asked about orders being put into place to treat the toe after said visit, the DON stated she didn't believe the podiatrist put any orders in, "To do anything extra at that point...[The] nurses didn't know anything concerning about the toe until days later." When asked about how R283's toe was being monitored after the visit from podiatry, the DON explained that staff does body audits and is confident that staff reports things that they see. The DON stated, "For it to not be noticed...I'm not sure if [R283] had a shower in-between." When queried regarding the skin worksheet dated 1/11/23 with the circled area on the right foot/leg, the DON responded that there was a 1/12/23 note indicating no new skin issues. The DON reviewed a 1/25/23 practitioner note and stated she was hoping it would have acknowledged the podiatry visit, however, it did not. When queried regarding the missing MAR/TAR body audit documentation on 1/28/23, the DON acknowledged the missing information. The DON was unable to locate an accompanying note to the documented 2/1/23 body audit checked off on the MAR/TAR. A review of the facility's policy/procedure titled, "Skin Management Guidelines," dated 03/2022, revealed, "...Skin alterations and pressure injuries are evaluated and documented by the licensed nurse:...Using the Skin Alteration Record or Skin/wound application in PCC (if enabled) weekly by the licensed nurse for non-pressure injuries - Whenever there is a significant change in condition or clinically indicated...Body audits are completed: By the licensed nurse daily for patients with pressure injuries and documented on			

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	the eTAR; new findings are documented in a progress note; By the licensed nurse weekly for patients without pressure injuries and documented on the eTAR; new findings are documented in a progress note; By the nursing assistant during scheduled baths/showers, and if indicated during routine daily care and documented on the Skin Worksheet...The Skin Worksheet is used by the nursing assistant to document skin observations. The worksheet is completed at least twice/week with the patient ' s bath/shower. Completed worksheets are given to the licensed nurse for validation and action planning as indicated..." A review of the facility's policy/procedure titled, "Change of Condition Protocol," dated 06/2021, revealed "Purpose: To provide guidance in the identification of clinical changes that may constitute a change in condition and require intervention and notifications...Nurse ' s Responsibility:...Identify the resident involved and the issue - ask when the incident/change began and/or when was it identified? Is the resident known to the nurse? Has this occurred before...Review previous condition and current medication orders...Decision Phase: Determine whether this is an unusual incident for this resident; Evaluate whether additional information is needed; Evaluate the seriousness of the issue; Determine whether a call to 911 is indicated; Determine whether the physician needs to be consulted; Determine whether the issue is within the confines of the Nurse Practice Act; Evaluate whether a physician visit to the community is indicated or whether the resident needs to be sent out for an evaluation..." Deficient practice #2. This citation pertains to intake MI00133600. Based on observation, interview, and record			

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	review, the facility failed to ensure skin treatments, PICC (Peripherally Inserted Central Catheter) line dressing changes and medications were provided in accordance with professional standards of quality were provided for three residents(R37, R40, and R333) reviewed for quality of care from a total sample of ten, resulting in dissatisfaction with care and delay in care and treatment. Findings include: Resident 37 (R37) On 3/6/2023 at 10:30 AM, R37 was observed sitting in their wheelchair. R37 stated that they were waiting for someone to look at their legs. Upon observation, R37 lower legs were red and flaky. R37 stated that they were red and itchy. A review of the medical record revealed that R37 admitted into the facility on 7/5/2022 with the following diagnoses, Dementia and Peripheral Vascular Disease. A review of the Minimum Data Set (MDS) assessment dated 2/28/2023 revealed a Brief Interview for Mental Status score of 5/15 indicating an impaired cognition. R37 also required one-person extensive assist for transfers. A review of physician orders noted the following order, "Order: BLE [Bilateral Lower Extremity]: apply bacitracin ointment to legs and apply tubi grips (elastic support bandage) q [every] day. Directions: Everyday shift for wound. Status: Active. Start Date:2/24/2023." On 3/6 and 3/7,no tubi grips were observed on R37.			

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	On 3/7/2023 at 11:00 AM, an interview was conducted with R37. R37 stated that no one put anything on their legs and that they did not know what tubi grips were. On 3/7/2023 at 12:56 PM, an interview was conducted with the Infection Preventionist (IP) who was also serving as the second floor Unit Manager. IP stated was interviewed regarding the care that was supposed to be provided to R37's legs. IP stated that the tubi grips should be applied everyday after the bacitracin is applied. IP was informed that the tubi grips had not been observed on R37 during survey observations. IP stated that they would look further into it. On 3/8/2023 at 1:02 PM, an interview was conducted with the Director of Nursing (DON) regarding following the order for Bacitracin and Tubi Grips. The DON stated that they expect for physician's orders to be followed. The DON stated that sometimes the resident will refuse, but they should follow the process when there is an refusal. Resident 40 (R40) On 3/7/2023 at 10:22 AM, R40 was observed in their bed. R40 stated that their PICC line site was itching a little. Upon observation the dressing was dated 2/27/2023. R40 was asked when does their dressing get changed. R40 stated that it is usually changed every Monday, however the nurse yesterday stated that they would not be able to get to it. A review of the medical record revealed R40 admitted into the facility on 11/1/2022 with the following diagnoses, Urinary Tract Infection and Hypertension. A review of the Minimum Data Set assessment dated			

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	12/8/2022 did not assess cognition. R40 also required one person supervision with bed mobility and transfers. A review of the physician orders did not reveal an order for a PICC line dressing change. On 3/7/2023 at 12:50 PM, an interview was conducted with IP regarding the order not being in and R40's dressing not being changed. IP stated that the dressings are usually changed every Monday or as needed. IP was asked if there are usually orders for the dressing change. IP stated yes there is usually a order for the dressing change and that they would be entering one for R40. Resident 333 (R333) A review of complaint called into the State Agency noted the following, " ...1. Failing to properly review the medication list and provide [R333] with all prescribed medications. The result was [R333] went into severe withdraw (Effexor - anti-depression medication)." A review of the medical record revealed that R333 admitted into the facility on 12/7/2022 with the following diagnoses, Muscle Weakness and Acute Myeloblastic Leukemia, Not having achieved remission. A review of the Minimum Data Set (MDS) assessment dated 12/13/2022 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 indicating intact cognition. R333 also required extensive assistance with bed mobility and transfers. A review of R333's hospital discharge			

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	paperwork revealed the following, "Continue to take these medications: Venlafaxine 150 MG (milligram) 24. Commonly known as: Effexor XR. Take one capsule (150 mg total) by mouth daily." A review of physician orders noted the following order, "Order: Effexor XR Oral Capsule Extended Release 24 Hour 150 MG ...(Venlafaxine HCL). Directions: Give 1 capsule by mouth one time a day for depression. Start Date: 12/12/2022." A review of the progress notes revealed the following, "12/12/2022 13:00 [1:00PM]. Note Text: Notified [Nurse Practitioner] about resident missing transfusion appointment today and about missing doses of Effexor from admission until this morning." On 3/8/2023 at 1:02 PM, an interview was conducted with the facility's Director of Nursing (DON). The DON stated that they do not know what happened with R333's admission medications orders. A review of a facility policy titled, "Physician Orders" did not address quality of care.			
F0688 SS= D	Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F0688	Element 1 Resident #75 did not have a negative outcome related to the splint. The resident has been screened by Occupational Therapy and will be receiving services. At this time the resident does not require a splint and the order has been discontinued. Element 2 Residents who require splints have the	3/28/2023

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	§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to apply a splint to one resident (R75) out of one reviewed for limited range of motion, resulting in the potential for the worsening of a contracture. Findings include: On 3/7/2023 at 1:06 PM, an interview was conducted with R75 regarding their stay in the facility. R75 stated that they can roll on their right side. R75 right hand appeared to be contracted. R75 was asked if they had a splint for their right hand. R75 stated that they had a splint but haven't had one in over a year. A review of the medical record revealed R75 admitted into the facility on 3/5/2021 with the following diagnoses, Idiopathic Peripheral Autonomic Neuropathy and Atrial Fibrillation. A review of the Minimum Data Set assessment dated 2/10/2023 revealed a Brief Interview for Mental Status score of 14/15 indicating an intact cognition. R75also required extensive one person assist with bed mobility and transfers.		potential to be impacted by this practice. The facility has audited orders for splints and ensured that orders are being followed. Element 3 The Administrator and DON have reviewed the applicable policy and determined it is adequate to meet resident needs. A root cause analysis was completed though the facility's privileged QAPI process and the need for additional licensed nurse education regarding splint orders has been identified. Licensed nurses are being educated on the correct process to follow when splint orders are received. Element 4 The DON or designee(s) will audit the application of splint placements weekly for three months to ensure ordered splints are being applied per physician orders. Any identified issues will be addressed promptly. The findings of this audit will be reviewed in the facility's QAPI to ensure sustained compliance.	

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	A review of the physician orders revealed the following, "Order: Right hand splint. Status: Active." On 3/7/2023 at 3:15 PM, an interview was conducted with the Director of Rehab (DOR) regarding R75's splint. The DOR stated that the last time R75 was seen by rehab was 12/29/2022 and there was no splint in the evaluation. The DOR stated that they would have R75 evaluated to see if they still need the splint. On 3/8/2023 at 1:02 PM, an interview was conducted with the Director of Nursing (DON) regarding the splint for R75. The DON stated that they looked at the order and they believe the Doctor or physicians Assistant ordered the splint. The DON stated that if an order is put in by the physician, then they should follow up that it is happening. The DON stated that they do not know what happened with R75, but therapy was going to evaluate them and see if a splint was needed. A review of a facility document titled, "Braces/Splints" revealed the following, "Purpose: To maintain functional range of motion, decrease muscle contractures and provide support and alignment for weakened limb through use of braces and/or splints."			
F0727 SS= F	RN 8 Hrs/7 days/Wk, Full Time DO §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the	F0727	Element 1 No specific residents were identified in this citation.	3/28/2023

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	services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed accurately document the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, resulting in the potential for inadequate coordination of care and negative clinical outcomes, potentially affecting all 107 residents currently residing in the facility. Findings include: On 3/8/23 at 8:10 AM, the Nursing Home Administrator (NHA) provided daily staff postings and explained that due to a staffing change, they were still looking for additional postings. A review of the postings that were available revealed the following: October 2022: No RN coverage noted. November 2022: No RN coverage noted. December 2022: 12/8, 7 hours of RN		Element 2 All residents benefit from adequate Registered Nurse coverage in the facility. A review of systemic issues resulting in undocumented RN coverage was confirmed to have not negatively impacted resident care. Element 3 The Administrator and DON have reviewed the facility's staffing policy and have validated that it is adequate to ensure RN coverage is scheduled and documented according to regulatory requirements. As part of the facility's privileged QAPI process, a root cause analysis was completed and the need for changes to the way employee hours are tracked was identified and provided. The facility is actively transitioning to a new scheduling software and the facility's scheduler has been educated on the process for properly coding hours in the new system. Element 4 The facility Administrator, DON and staffing coordinator meet daily M-F to review staffing and to provide corrective intervention when staffing challenges are identified. The daily staffing meeting minutes have been updated to ensure that a minimum of 8 hours of daily RN coverage are validated. The Administrator or designee will audit the daily staffing meeting minutes weekly X3 months to monitor for trends, root causes or other factors adversely impacting staffing. The results of the audits will be reviewed in the facility's QAPI to ensure systemic improvement and sustained compliance.	

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	coverage. January 2023: No RN coverage. On 3/8/23 at 11:00 AM, the Nursing Home Administrtor (NHA) and DON (Director of Nursing) were queried regarding multiple months of staff postings with no RN coverage noted, and they stated that this was incorrect, which they became aware of when they obtained a 1 star staffing rating (star rating system which rates 1 star and low performing and 5 stars as high performing). They also explained that they think there was something wrong with their scheduling system. On 3/8/23 at 11:06 AM, Staff Scheduler "B" was asked why there are no RNs documented on the daily staff postings, and indicated that she would get back with the surveyor however, she did note that they have daily meetings where they discuss staffing to ensure there is always RN coverage. On 3/8/23 at 11:42 AM, Staff Scheduler "B" explained that they have RN coverage in the building Monday through Friday by their Minimum Data Set assessment Registered Nurse and DON, however they don't "clock in". Staff Scheduler "B" further explained that they have coverage by a supervisor that is an RN on the weekends. Staff Scheduler "B" explained that the supervisor does "clock in" however, obtaining those payroll reports maybe difficult due to not having access to			

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	the reports during the corporation change. On 3/8/23 at 1:11 PM, the DON was asked about RN coverage, and explained that there were some discrepancies and issues with the reporting program and as a result, there were some coding issues that weren't done correctly. A review of the faciltiy's "Staffing Strategy" policy was reviewed and did not address RN coverage for at least 8 consecutive hours a day, 7 days a week.			
F0732 SS= F	Posted Nurse Staffing Informatio §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F0732	Element 1 No specific residents were identified in this citation. Element 2 All residents benefit from the facility's staffing remaining transparent. No negative outcome is noted nor have any resident concerns been voiced related to missing staffing sheets from prior months. Element 3 The administrator and DON have reviewed the facility staffing policy and determined it's adequate to ensure staffing postings are maintained for the required 18 months. Through the facility's privileged QAPI process a root cause analysis was completed and the need for additional education for the scheduler was identified. The scheduler has been identified on the posting and retention of staffing in accordance with policy and	3/28/2023

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	§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to display current nurse staffing information daily, and failed to maintain 18 months of daily staff postings, affecting all 107 facility residents, resulting in the likelihood of necessary staffing information not being available to residents and visitors. Findings include: On 3/6/23 on 12/10 PM, a daily staff positing was observed posted, and dated for 1/31/23. On 3/8/23 at 8:10 AM, the Nursing Home Administrator (NHA) provided daily staff postings and explained that due to a staffing change, they were still looking for additional postings. A review of the postings revealed the following: February 2022: Daily Staff postings were provided for 2/8, 2/9, 2/10 and 2/11. March 2022, missing the following dates: 3/1, 3/2, 3/3, 3/4, 3/5, 3/6, 3/7, 3/8, 3/9, 3/10, 3/12, 3/13, 3/18, 3/19, 3/20, 3/25 3/26 and 3/27.		regulation. Element 4 The administrator will audit the daily staffing sheets have been saved. This audit will occur weekly X3 months and any issues identified will be addressed promptly. The findings of the audit will be reviewed in QAPI for three months and as-needed thereafter to ensure sustained compliance.	

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	April 2022, missing the following dates: 4/2, 4/3, 4/9, 4/10, 4/12, 4/14, 4/15, 4/16, 4/17, 4/23, 4/24, 4/25, 4/26, 4/27, 4/28, 4/29, and 4/30. May 2022: No postings provided. June 2022: No postings provided. July 2022: Daily Staff postings were provided for 7/28 and 7/29. August 2022, missing the following dates, 8/6, 8/7, 8/10, 8/13, 8/14, 8/15, 8/20, 8/21, 8/22, 8/27, 8/28, and 8/30. September 2022, missing the following dates: 9/1, 9/2, 9/3, 9/4, 9/5, 9/9, 9/10, 9/11, 9/14, 9/17, 9/18, 9/22, 9/23, 9/24, and 9/25. October 2022, missing the following dates: 10/1, 10/2, 10/3, 10/4, 10/5, 10/8, 10/9, 10/15, 10/16, 10/18, 10/22, 10/23, 10/26, 10/29, and 10/30. November 2022, missing the following dates: 11/5, 11/6, 11/9 to 11/14, 11/19, 11/20, 11/22, 11/24, 11/26, 11/27, and 11/29. December 2022, missing the following dates: 12/2 to 12/4. 12/9 to 12/15; 12/17, 12/18, 12/22, 12/24, 12/25, 12/26, 12/29, 12/30, and 12/31. January 2023, missing the following dates: 1/1, 1/2, 1/3, 1/4, 1/7, 1/8, 1/9, 1/13, 1/14,			

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	1/15, 1/18, 1/21, 1/22, 1/25, 1/28, and 1/29. February 2023: Not provided. March 2023: Not provided. On 3/8/23 at 11:06 AM, Staff Scheduler "B" was asked about the daily staff postings and explained that she has been in the position since January, and that the previous scheduler kept all the staff postings in a file cabinet. On 3/8/23 at 1:11 PM, the Director of Nursing (DON) was asked about the daily staff postings, and explained that they make every effort to get them done, and that the missing postings may have been misplaced. On 3/8/23 at 2:25 PM, a policy regarding staff postings were requested from the facility, and was not received by the end of survey.			
F0761 SS= D	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide	F0761	Element 1 No specific residents were identified in this citation. Element 2 Residents who require insulin have the potential to be impacted. The facility's 8 medication carts have been audited for proper labeling and dating of insulin. Any issues identified were addressed promptly. Element 3	3/28/2023

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	separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store medications per professional standards during medication administration, and failed to label/date insulin pens in two of four medication carts, resulting in the potential for medication error. Findings include: On 3/7/23 at 8:51 AM, Licensed Practical Nurse (LPN) "K" (agency nurse) was seen on the east wing at Cart #1 passing medications. LPN "K" was observed to have a wireless headphone bud in her right ear. LPN "K" indicated that R41 would be the next resident for medication pass. On 3/7/23 at 9:00 AM, LPN "K" returned to the medication cart and no longer had the headphone bud in her ear. LPN "K" removed a cup of pills from one of the middle drawers on the cart and indicated she had already pulled R41's medications, but that the resident had left his room to go get some sugar so she stored them in the cart. The medication cup was not labeled with any identifying information as to whose pills were in it. R41's scheduled morning medications were reviewed with LPN "K" and included a topical lidocaine patch, Budesonide Inhalation		The Administrator and DON have reviewed the medication administration policy and determined that it's adequate to ensure insulin is dated and stored properly. As part of the facility's privileged QAPI process a root cause analysis was completed and the need for additional licensed nurse training was identified. Licensed nurses have been re-educated on the medication administration policy, including labeling and dating insulin. Element 4 The unit managers or designee(s) will audit the medication carts for proper labeling and dating of insulins 2 times a week for 1 month and 1 time weekly for 2 months. Identified issues will be addressed promptly. The findings of the audits will be reviewed in the facility's QAPI to ensure sustained compliance.	

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	Suspension (breathing treatment), and Polyethylene Glycol 3350 Powder (mixed into a cup of water). The resident's medications due at this time also included the following nine pills (one of each): 1) Carbamazepine ER (extended release) Oral Tablet 200 Mg (milligram) 2) Furosemide Oral Tablet 20 Mg 3) Multivitamin Oral Tablet 4) Venlafaxine HCl ER 37.5 Mg Capsule 5) Folic Acid 6) Levetiracetam Oral Tablet 750 Mg 7) Tamsulosin HCl Oral Capsule 0.4 Mg 8) Risperdal Oral Tablet 0.25 Mg 9) Thiamine HCl Oral Tablet 100 Mg This surveyor asked to look in the medication cup and counted eight pills. When queried regarding there being a missing pill, LPN "K" proceeded to compare the pills in the cup with the resident's pill packages in the cart. LPN "K" indicated that the Tamsulosin was missing due to there not being a pill in the cup that looked like the Tamsulosin. LPN "K" took a Tamsulosin pill out of the package and put it in the unmarked cup with the rest of the pills and proceeded into R41's room. R41 was observed sitting in his wheelchair in his room. The resident had long hair and beard growth. LPN "K" gave R41 the cup of pills. On 3/8/23 at 9:53 AM, the Director of Nursing			

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	(DON) was interviewed. The DON was queried regarding the expected process for medication administration and storage, and was given the details regarding what was observed with R41 and LPN "K". The DON stated, "In that instance, our pills come in individual packages. [The nurse] should probably start over when the patient is available again, especially if a pill was noted to be missing." The DON indicated that pre-pouring medications was not her expectation. A review of the facility's policy/procedure titled, "Medication Administration: Medication Pass," dated 06/2021, revealed, "Purpose: To safely and accurately prepare and administer medication according to physician order and resident needs...Read transcribed physician order on MAR: resident name, medication name, dosage, route and interval ordered · Remove medication from cart · Compare MAR with medication label for accuracy...Administer medication in accordance with frequency prescribed by physician -within 60 minutes before or after prescribed dosing time; if resident is not in room to receive medication, flag MAR and at conclusion of medication pass, roll cart to resident's location and administer medications · Lock medication cart when not in direct view of nurse administering medication...Remain with resident until administration of medication complete ·Document initials on MAR for each medication administered..." A review of the facility's policy/procedure titled, "Medication Storage Guidance," dated 2022, revealed, "Properly handle and dispose of any expired or unused product in accordance with facility policy or local, state, and federal regulations..." On 3/6/2023 at 10:20 AM, an observation of medication cart two was completed with			

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	Nurse "M". During the observation two insulin pens were noted to not be labeled properly. A Novolog (short acting insulin) pen was noted to not have a name on it, just initials. A Lispro (short acting insulin) pen was noted to have no open date, expiration date, or name to identify who it belonged to. On 3/6/2023 at 10:23 AM, Nurse "M" was asked if they knew who the insulin pens belonged to, or when they were opened. Nurse "M" stated that they knew who the Novolog belonged to and when it was opened, but not the Lispro. On 3/6/2023 at 12:05 PM, an observation of medication cart three was completed with Nurse "L". During the observation two insulin pens were noted to not be labeled properly. A Levemir (long-acting insulin) pen was noted to have no name on it to identify who it belonged to. A Lispro (short acting insulin) pen was noted to have no open date, expiration date, or name to identify who it belonged to. On 3/6/2023 at 12:06 PM, Nurse "L" was asked if they knew who the insulin pens belonged to, or when they were opened. Nurse "L" stated that they did not know. On 3/8/2023 at 1:02 PM, an interview was conducted with the Director of Nursing (DON) regarding medication storage. The DON stated that all insulin pens should be labeled with the pen date, expiration date,			

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	and have the label of who the pen belongs to on it.			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food items were dated, failed to ensure staff with facial hair donned beard restraints, and failed to maintain kitchen equipment in a sanitary manner. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 3/6/23 between 9:00 AM-9:45 AM, during an initial tour of the kitchen with Chef "Y", the following items were observed: In the walk-in cooler, there was an undated	F0812	Element 1 No specific residents were identified in this citation. Element 2 All residents have the potential to be affected by this practice. A review of concern forms, QAPI data and resident council minutes do not demonstrate any negative outcomes to residents related to this practice. Element 3 The Administrator and facility chef have reviewed the relevant policies and have determined that they are adequate to meet regulatory requirements. Through the facility's privileged QAPI process a root cause analysis was completed and the need for additional dietary staff education was identified. Dietary staff have been re-educated on proper kitchen sanitation practices. Element 4 The facility Chef or designee will complete kitchen sanitation rounds daily (M-F) for one month and twice weekly for two months. Issues identified will be corrected promptly. The findings from these audits will be reviewed in the facility's QAPI meetings to ensure sustained compliance.	3/28/2023

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	container of sliced tomatoes, an undated container of soup, and an undated container of chopped lettuce. In addition, there were 2 one pound containers of opened, undated sour cream, with a manufacturer's best by date of 3/5. In the Hoshizaki reach-in cooler, there were 2 undated bowls of soup. According to 2017 FDA Food Code section 3-501.17: "Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety." The shelving underneath the food			

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	preparation counter, located next to the steam table, was observed with a heavy buildup of dried up food debris and crumbs. In addition, there was an uncovered, unlabeled container of white powder on the shelf. The rolling cart next to the steam table, which was being utilized for the storage of bread products, was observed to be heavily soiled with sticky, dried on spills and crumbs. On the shelf underneath the steam table, there were 2 containers of puree bread, and the lids of the containers were heavily soiled with a brown, sticky substance. In addition, there was a plastic container of parsley flakes that was uncovered. The surface of the shelf was soiled with a brown dried up substance. When queried, Chef "Y" stated that the steam table has been leaking underneath. The top surface of the plate base warming unit was heavily soiled with crumbs and dried on food splatter. According to the 2017 FDA Food Code section 4-602.13 Nonfood-Contact Surfaces, "Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues." The 2 ceiling vent covers located next to the dietary office were observed to be soiled with dust.			

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	According to the 2017 FDA Food Code section 6-501.14 Cleaning Ventilation Systems, Nuisance and Discharge Prohibition, "(A) Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials." On 3/6/23 at 11:45 AM, Dietary Staff "F" and "G" were both observed in the kitchen preparing food. both Staff "F" and "G" had visible beards, but neither staff were wearing a beard restraint. On 3/6/23 at 2:45 PM, Chef "Y" was queried about the lack of beard restraints and stated, "We have them, they just weren't using them."			
F0887 SS= D	COVID-19 Immunizatio §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where	F0887	Element 1 Residents #28, #38, #51 and #114/334 have received appropriate follow up from the Infection Preventionist to ensure they have been educated on and offered the appropriate covid19 vaccination and/or boosters. Element 2 All Residents have the potential to be impacted. The Infection Preventionist has audited COVID19 vaccination and booster logs and has provided appropriate follow up as needed to identified needs. Element 3 The administrator and DON have reviewed	3/28/2023

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	COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Preventio's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to completely and accurately document current COVID-19 vaccination status and offer		the facility's COVID19 vaccination policy and process and has found that it's adequate to ensure residents are offered, encouraged and educated about COVID19 vaccinations and boosters. A root cause analysis was completed as part of the facility's privileged QAPI process and further nursing education was identified as a need. Licensed nurses have been educated on the facility's COVID19 vaccination process. Element 4 Needed COVID19 vaccinations and boosters are identified as part of the resident admission process. New resident records are reviewed daily (M-F) by the clinical team. The DON or designee(s) will review the vaccination portion to ensure admitting nurses have documented and offered vaccinations according to the most current guidelines. The DON or designee will complete weekly audits of the COVID19 vaccinations and the findings will be reviewed in the facility's QAPI to ensure sustained compliance.	

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	the vaccine/booster if eligible for four residents (R28, R38, R51, R114) of nine reviewed for immunizations, resulting in the potential for miscommunication and misunderstanding of resident immunization preferences, and the potential for the development of severe disease if infected with COVID-19 (highly contagious respiratory virus). Findings include: On 3/7/23 at 2:22 PM, a review of the infection control task was initiated with Infection Preventionist (IP). At this time, record review was conducted with the IP for R28 and their immunizations. R28 was noted to have been admitted into the facility on 2/14/23 but complete information regarding the resident's COVID vaccination status was not found in the medical record. The IP looked up the resident in [State of Michigan online immunization database] and indicated there was no COVID immunization information present. The IP then reviewed R28's medical record for a COVID vaccination screening assessment but confirmed there was not one in the chart. The IP was then asked to provide COVID immunization information for Residents: R38, R51, and R114. On 3/8/23 at 9:03 AM, the infection control task review was continued with the IP and the Director of Nursing (DON). The DON and IP confirmed that R38's immunization tab in the medical record had not been updated. The IP was unable to find the resident's COVID vaccination information on [State of Michigan online immunization database] during the interview. The resident's admission assessment indicated that R38 had received a COVID vaccine but no date or manufacturer were documented. The DON and IP indicated they would look into this further. R51's record was then reviewed with the DON and IP and revealed that consent was marked as			

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	refused for a COVID vaccination under the immunization tab, but no signed declination/refusal assessment was found, which was confirmed by the IP. R114's record was then reviewed with the DON and IP. Upon review, R114's immunization tab did not include the resident's COVID vaccination status. The IP stated that she just entered the information into the record after reviewing [State of Michigan online immunization database]. R114 was noted to have the primary COVID vaccine series, but when queried, the IP stated R114 should have been screened through and possibly offered a booster. R114's admission assessment marked the resident as not being vaccinated for COVID despite what the IP found in the online database. When queried on the process of determining immunization status on admission, the DON stated that the nurse is supposed to ask the residents the questions on the admission assessment and is expected to review with the resident if they want a vaccine or not. The DON added that the IP and Unit Managers check charts, but the process falls on the admitting nurses if a patient wants a vaccine they have not yet received. A review of the facility's Infection Control Manual (dated 5/2022), revealed, "...COVID-19-offer upon admission either the single dose COVID-19 vaccine or one of the two (2) dose vaccines with the second dose administered per manufacturer's recommendations to eligible patients/residents who have never received or who had previously refused the COVID-19 vaccine. Additional booster doses of the COVID vaccines may be offered dependent on current potential risk of exposure or spread of other diseases. In such cases, vaccines may be			

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	authorized under an emergency use authorization for both patients/residents and employees..."			
F0925 SS= F	Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen to eliminate the harborage of gnats. This deficient practice had the potential to affect all residents in the facility. Findings include: On 3/6/23 at approximately 9:30 AM, the kitchen was observed with Chef "Y". It was observed that there was an accumulation of dried on food debris, crumbs and grease on kitchen equipment, carts and floors. In addition, there were numerous gnats observed throughout the kitchen. When queried, Chef "Y" stated that they have been short staffed in the kitchen, and that he is new to the kitchen and trying to get things in order. Review of the pest control service reports for the facility revealed the following: 2/28/23 "Poor floor sweeping- the gnats issue is a sanitation problem. The floors in kitchen have grease, food, and other substances gunk causing problem, regular	F0925	Element 1 No specific residents were identified in this citation. The areas identified in this citation have been properly cleaned to deter pests and the facility continues to utilize contracted pest control services. Element 2 All residents have the potential to be impacted. The facility has received services from our pest control vendor. A review of concern forms, QAPI data and resident council minutes to not demonstrate any negative resident outcomes or concerns related to this practice. Element 3 The administrator and Chef have reviewed the food service/pest control policy and have determined it to be appropriate to adequately ensure the facility has adequate pest control. Through the facility's privileged QAPI process, a root cause analysis was completed and the need for additional training on available resources and tools for the facility's chef was identified. The facility's chef has been educated on the resources and processes related to pest control. Element 4 The facility chef or designee will complete kitchen sanitation rounds daily (M-F) for one month and twice weekly for two months. Issues identified will be corrected promptly. The findings from these audits will be	3/28/2023

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	mopping and cleaning of floors will eliminate the problem...Dirty equipment- tables and sinks dirty with old food." 1/24/23 "Poor floor sweeping- the gnats issue is a sanitation problem. The floors in kitchen have grease, food, and other substances gunk causing problem, regular mopping and cleaning of floors will eliminate the problem...Dirty equipment- tables and sinks dirty with old food." 11/29/22 "Poor floor sweeping- the gnats issue is a sanitation problem. The floors in kitchen have grease, food, and other substances gunk causing problem, regular mopping and cleaning of floors will eliminate the problem...Dirty equipment- tables and sinks dirty with old food." According to the 2017 FDA Food Code section 6-501.111 Controlling Pests, "The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: ...4. (D) Eliminating harborage conditions."		reviewed in the facility's QAPI meeting to ensure sustained compliance.	