STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F0000 SS=	INITIAL COMMENTS Bay County Medical Care Facility was surveyed for a Combined Standard/Abbreviated Survey exiting on 03/07/2023. Event ID: 1C7711 Intake Numbers: MI00129583, MI00131322, MI00131323, MI00131415, MI00134337, MI00134723. Census: 90 Bay County Medical Care Facility is not in substantial compliance with 42 CFR, Part 483, Requirements for Long Term Care Facilities.	F0000		
F0656 SS= D	Develop/Implement Comprehensive Care Pla §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F0656	F656 DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN The Director of Nursing and the Restorative Director implemented corrective actions for resident #61 affected by this practice including: " On 3/15/23 resident #61 care plan was updated to reflect the posterior left ear pressure ulcer including staging, treatment plan and preventative measures in place. " On 3/23/23 all residents, who currently have a pressure ulcer, care plans were reviewed to ensure their care plan was up to date with the stage of the pressure ulcer, treatment plan and preventative measures in place. All residents have the potential to be affected by this process. The Director of Nursing and Restorative Director will implement measures to ensure this practice does not recur including: " The Restorative Director will educate the restorative wound nurses regarding care planning all residents with pressure ulcers.	4/15/2023

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

Electronically Signed | 03/30/2023

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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	rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement a comprehensive and person-centered care plan for one resident (Resident #61), resulting in Resident #61 developing a pressure ulcer with no subsequent care plan. Findings Include: Resident #61: On 2/28/2023 during initial tour, Resident #61 was observed resting in bed and behind his left ear was a bandage. At the time it did		Education will emphasis to include the stage of the pressure ulcer, the treatment plan in place and preventive measures to promote healing and prevent reoccurrence. Education will be completed no later than 4/15/23. The Restorative Director will monitor the corrective actions to ensure effectiveness by: " The Restorative Director, or designee, will do weekly chart audits on all residents with pressure ulcers to ensure staging, treatment plans and preventative measures are care planned. All results will be reported to the Quality Assurance and Process Improvement Committee quarterly until deemed no longer necessary.	

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not appear to be causing the resident any distress as he appeared to be content and comfortable.

On 2/28/2023 at 12:24 PM, a review was completed of Resident #61's medical record and it revealed the resident was admitted to the facility on 11/21/2018 with diagnoses that included Alzheimer's Disease, Dysphagia, Chronic Kidney Disease, Syncope and Collapse and Atrial Fibrillation. Resident #61 is dependent on staff for his Activities of Daily Living (ADL). Further review of Resident #61's records revealed the following:

Wound Notes:

1/27/2023 at 10:11: "Resident assessed d/t nurse concern. Unstageable pressure injury noted to lt (left) posterior ear, upper crease, measuring 0.5cm x0.4cm, 100% slough noted to wound bed ...Foam ear protectors places on oxygen per standard of care ..."

1/31/2023 at 11:38: "Previously noted unstageable pressure injury to L posterior ear, upper crease is now a Stage 3. Wound measuring 0.2cm x 0.1cm x0.1cm. Wound bed 100% beefy-red granulation tissue w/edges ...foam ear protections in place to 02 tubing per standard of care ..."

2/06/2023 at 13:30: " Stage 3 remains to posterior ear, upper crease, measuring 0.3cm x0.2cm, 100% epithelial skin noted, non-blanchable, surrounding skin pink and

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	blanchable, no tunneling or undermining noted, no drainage noted, no odor noted ...02 with foam ear protectors in place per standard of care ..." Pressure Injury Awareness From: " ...Site: lt (left) posterior ear, upper crease: Facility acquired: 1/27/2023 ...Unstageable pressure injury notes to it posterior ear, upper crease, measuring 0.5cm (centimeters) x 0.4cm , 100% slough notes to wound bed, wound edge well defined, surrounding skin red and blanchable, no tunneling or undermining noted, scant bloody drainage noted no odor noted. Lt posterior ear, upper crease: Soak with prophase wound wash for 5 minute, rinse with NS (normal saline), pat dry, apply sureprep skin barrier to surrounding skin, apply plurogel to wound bed, cover with optiform QOD and PRN ...avoidable ..." Care Plan: Problem: "Mobility: I need help to transfer and with my mobility due to having R (right)-sided weakness (r/t (related to) CVA in October 2017), contractures in both my legs (knees) and my left hand, dementia, and generalized weakness ... "Skin Management: I am at risk for skin breakdown r/t right-sided weakness following a stroke ...I have dry and fragile skin			

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	which places me at risk for skin tears and bruising. I have HX (history) of pressure areas to b/l (bilateral) heels, b/l hips, left elbow & right mid back. My left hip has an area of indentation which is scarring from previous pressure area and I sometimes get blisters on my left hip ...March March 2021: The toenails on my left great toe and right 2nd toe are lifting (left great toenail came off). 4/22/2022: I developed a Stage 1 pressure area on my left medial hand r/t brace (resolved 4/29/2022). 3/30/2022: I developed a Stage 2 pressure area on my left ear top of crease (resolved 4/15/2022). 4/29/2022: Dry, flaky growth on my right lower arm. 8/5/22: DTI proximal left thumb base and Stage 1 distal left thumb base, both resolved. breakdown, through next review." Resident #61's care plan did not address his posterior left ear pressure area. On 3/1/2023 at 3:50 PM, an interview was conducted with Wound Nurse "GG" and "FF," regarding Resident #61's facility acquired wound. The wound nurses reported Resident #61's left posterior ear wound opened on 1/27/2023 and they were informed by his nurse that he had a new skin issue. They went to his room to assess the area and found a facility acquired wound to his left ear from the resident not wearing 02 foam protectors. The wound nurses were queried if 02 foam protectors were readily available at the			

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	facility and nurse stated they are. They reported this was a preventable Stage 3 wound if his 02 foam protectors were in place. Nurse "GG" explained a facility nurse changed Resident #61's nasal cannula tubing the night prior and should have saw the wound. Nurse "GG" then completed an in-service with the nurse regarding the incident. Nurse "GG" and "FF" stated the wound was unstageable when it opened on 1/27/23 and on 1/31/2023 staged it at Stage III. On 3/1/2023 at 4:25 PM, a review was completed of Resident #61's skin care plan with Wound Nurse "FF." After review it was found Resident #61's posterior ear pressure ulcer was not added as a new skin issues within his care plan. Nurse "FF" was asked if they update residents skin care plans and they reported they do not. She expressed they complete their weekly rounds, wounds notes and monitoring but do not input their care plans related to new or continuing skin issues. On 3/8/2023 at 11:00 AM, a review was completed of the facility policy entitled, " Comprehensive Care Plan," reviewed 9/28/22. The policy stated, "It is the policy of this facility to develop and implement a comprehensive person centered care plan for each resident, consistent with the rights, that includes measures objectives and timeframe's to meet a resident's medical and psychosocial needs that are identified in the resident's comprehensive assessment...The			

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	comprehensive care plan will describe, at a minimum, the following. a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well being. f. Resident specific interventions that reflect the resident's needs and preferences...5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly assessment. Changes in a resident's condition often requires changes to the care plan either by change in individual approaches or by the addition of new problems to the Plan if Care...".			
F0657 SS= E	Care Plan Timing and Revisio §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after	F0657	F657 SS=D CARE PLAN TIMING AND REVISION The Director of Nursing and the In-service Department implemented corrective actions for residents #8, #13, #19, #28, #40, #42, #45, #56, #69, #75, #77, and #289 affected by this practice including: • There are no immediate corrective actions for the above residents as the symptoms have resolved. All residents have the potential to be affected by this practice. The Director of Nursing and the In-service Department will implement measures to ensure this practice does not recur including: • A process change will be implemented that when a resident is placed in precautions, a physician's order will be entered which then will prompt the nurse to care plan the precautions and ensures the physician is made aware. • Educational meetings with licensed staff are to be completed no later than 4/15/23.	4/15/2023

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	each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement care plans for droplet precautions for 12 residents (Residents #8, #13, #19, #28, #40, #42, #45, #56, #69, #75, #77, and #289) of 21 residents reviewed for care plans, resulting in the likelihood for non-interdisciplinary care and spreading of communicable disease, illness with possible hospitalization. Findings Include: Review of the Infection Control Gastrointestinal (GI) outbreak documentation dated 2/12/23 through 2/20/23, revealed a total of 12 resident's (Resident's #8, 13, 19, 28, 40, 42, 45, 56, 69, 75 and 289) who had been tracked after having signs/symptoms of GI distress (nausea, vomiting, loose stools and dry heaves). The residents were all put on droplet precautions between 2/12/23 through 2/20/23; most of them were on 1 East Hall. Review of the facility Infection Outbreak Response and Investigation Policy (not signed by any staff member, dated 2/27/23), revealed no documentation regarding who was responsible for up-dating or adding precaution care plans to involved resident's		Education provided will be on the above process change with emphasis on care planning the type of precaution the resident is placed in. Also, notification to the In-service Department when any resident is placed in precautions will be reviewed. The Inservice Department will monitor the corrective actions to ensure effectiveness by: • The In-service Department will monitor all residents placed in precautions to ensure the precautions are care planned. All results will be reported to the Quality Assurance and Process Improvement Committee quarterly until deemed no longer necessary.	

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records.

Review of the facility Comprehensive care plan policy dated 11/30/22, stated "The comprehensive care plan will be prepared by the interdisciplinary team, that includes, but not limited to: the attending physician, or non-physician practitioner designee involved in the resident's care, a registered nurse, a nurse aide, the resident and the resident's representative, other appropriate staff or professionals (MDS, social service, administration, discharge, mental health)."

Review of the facility resident Care Plans policy dated 2/21, stated "Change goals quarterly, annually if this is significant change in status or as needed (including an new GI communicable disease GI signs/symptoms).

Resident #8:

Review of the Face Sheet, physician orders dated 10/22, and care plans dated 10/22 through 2/23, revealed Resident #8 was 88 years old, had impaired cogitation and was admitted to the facility on 11/11/22 and discharged on 2/27/23. The resident's diagnosis included, surgical aftercare, chronic pain, dementia, kidney disease, and anemia with a history of colon cancer. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs

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monitoring.

Resident #13:

Review of the Face Sheet, physician orders dated 10/22, and care plans dated 4/21 through 2/23, revealed Resident #13 was 85 years old, was admitted to the facility on 4/29/21. The resident's diagnosis included, GI hemorrhage, vit D deficiency, back fractures, delayed healing, chronic pain, anemia, anxiety, and depression. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #19:

Review of the Face Sheet, physician orders dated 2/27/23, and care plans dated 2/23, revealed Resident #19 was 74 years old, had impaired cogitation and was admitted to the facility on 2/27/23. The resident's diagnosis included, respiratory failure, hemiplegia, diabetes, falls, mood disorder and vascular dementia. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #28:

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Review of the Face Sheet, physician orders dated 7/22 to 2/23, and care plans dated 7/22 through 2/23, revealed Resident #28 was 88 years old, had impaired cogitation and was admitted to the facility on 7/11/22. The resident's diagnosis included, dementia, chronic pulmonary disease, heart disease, emphysema, mood disorder and depression. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #40:

Review of the Face Sheet, physician orders dated 1/23 to 2/23, and care plans dated 1/23 through 2/23, revealed Resident #40 was 66 years old, had impaired cogitation and was admitted to the facility on 1/29/23. The resident's diagnosis included, chronic pain, chronic kidney and heart disease, anxiety disorder, depression colon cancer and falls. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #45:

Review of the Face Sheet, physician orders

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	dated 2/23, and care plans dated 2/23, revealed Resident #45 was 80 years old, had impaired cogitation and was admitted to the facility on 2/24/23. The resident's diagnosis included Barrett's esophagus with a cardiac pacemaker in place. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring. Resident #42: Review of the Face Sheet, physician orders dated 7/22 through 2/23, and care plans dated 7/22 through 2/23, revealed Resident #42 was 83 years old, had impaired cogitation and was admitted to the facility on 7/28/22. The resident's diagnosis included pulmonary disease, kidney disease, atrial fibrillation, pressure ulcer, metabolic alkalosis, dehydration, GI bleed, aspiration pneumonia and anxiety. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring. Resident #56: Review of the Face Sheet, physician orders dated 1/23 through 2/23, and care plans dated 1/23 through 2/23, revealed Resident #56 was 69 years old, and was admitted to			

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the facility on 1/31/23. The resident's diagnosis included lung cancer, metabolic encephalopathy, urinary tract infection, heart failure, chronic lung disease, myocardial infarction (heart attack) and anxiety. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #69:

Review of the Face Sheet, physician orders dated 2/23, and care plans dated 2/23, revealed Resident #69 was 55 years old, and was admitted to the facility on 2/1/23. The resident's diagnosis included, metabolic encephalopathy, heart failure, chronic lung disease, respiratory failure, kidney disease with renal dialysis, colostomy, and skin cellulitis with major depression and anxiety. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #75:

Review of the Face Sheet, physician orders dated 2/23, and care plans dated 2/23, revealed Resident #75 was 87 years old, had decreased cognition and was admitted to the

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BAY COUNTY MEDICAL CARE FACILITY	564 W HAMPTON ROAD ESSEXVILLE, MI 48732

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	facility on 2/24/23. The resident's diagnosis included absence of left leg above knee, bronchitis, muscle weakness, falls, dysphagia and dementia. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring. Resident #77: Review of the Face Sheet, physician orders dated 1/22 through 2/23, and care plans dated 1/22 through 2/23, revealed Resident #77 was 85 years old, had decreased cognition and was admitted to the facility on 11/24/22. The resident's diagnosis included Alzheimer's disease, muscle weakness, rotator cuff tear, spinal stenosis, kidney disease, bone density disorder, dementia, anxiety, and depression. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring. Resident #289: Review of the Face Sheet, physician orders dated 2/23, and care plans dated 2/23, revealed Resident #289 was 71 years old, had decreased cognition and was admitted to the facility on 2/25/23. The resident's diagnosis included pneumonia, bacteremia (infection in			

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	blood), heart failure, pulmonary disease, abdominal aortic aneurysm, kidney failure and depression Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring. During an interview done on 3/1/23 at 1:10 p.m., MDS (Minimum Data Set, resident assessment tool) Coordinator Nurse, RN "A" stated "The floor nurse and infection control nurses are responsible for up-dating care plans; we did not get a condition change, so we would not of known the resident's had a change." During an interview done on 3/1/23 at 1:33 p.m., Nurse, RN Supervisor "E" stated "Daily IDT (interdisciplinary team) huddle (from 2/17/23 through 3/1/23) we talked about the residents getting sick (with GI symptoms). The care plans are done by MDS when there are order (no orders are required for precautions to be put in place, nursing judgement). It should be the Nurse Manager who does the care plans." During an interview done on 3/1/23 at 2:21 p.m., Nurse, RN Manager "F" stated "If we get a new order, we add to care plans. I don't do that (add droplet precaution care plans), I wouldn't even know were to do that. I have never been instructed on how to do that."			

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	During an interview done on 3/2/23 at 9:45 a.m., the Director of Nursing/DON stated, "the nurse on the floor initiates the precautions, up-dates the care plans when there is an outbreak on the floor."			
F0684 SS= J	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed is placed in immediate jeopardy for its failure to provide every attempt to clear the airway for one resident (Resident #189) of 16 sampled residents, resulting in Resident #189 beginning to cough with some gurgling in the upper airway, respiratory distress and harm and/or death. Immediate Jeopardy: Immediate Jeopardy was begun on 6/6/2022. Immediately Jeopardy was identified on 3/3/2023. NHA was notified of the Immediate Jeopardy on 3/3/2023 at 11:35 AM. Immediate	F0684	F684 SS=J Quality of Care The Director of Nursing, Assistant Director of Nursing and the In-service Department implemented corrective actions for resident #189 affected by this practice including: " There is no immediate corrective action for resident #189 as she is deceased. " On 3/3/23 the nurse manager involved in the incident was educated on the facility□s CPR and choking episodes policy including response to the situation. " On 3/3/23 the In-service Department began facility wide training on the facility□s CPR and choking episodes policy. " On 3/7/23, the CNA involved in the incident was educated on the facility□s CPR and choking episode policy with emphasis on not leaving the resident, utilizing the staff emergency light or calling for help. " The LPN involved in the incident is no longer employed at the facility therefore could not be educated. All residents have the potential to be affected by this practice. The Director of Nursing, Assistant Director of Nursing and the In-service Department will implement measures to ensure this practice does not recur including: " Educational meetings with all staff are on-going and will be completed no later than 4/15/23. Education is on the facility□s CPR and choking episodes policy. " Educational meetings for licensed nursing staff are to be completed no later than 4/15/23. Education will include the above CPR	4/15/2023

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	Jeopardy was abated or removed on 3/3/2023. Immediate Jeopardy was identified on 3/3/2023. The Administrator and Director of Nursing were notified on 3/3/2023 at 10:35 AM of the Immediate Jeopardy that began on 6/6/2022 due to the facility's failure to make attempts or maneuvers to clear Resident #189's airway, implement an abdominal thrust or Heimlich maneuver during a choking event on 6/6/2022 at 5:58 PM. Immediate Jeopardy began on 6/6/2022 at 5:47 PM when, per record review and interview done on, 03/02/23 at 02:14 PM with the Nursing Home Administrator (NHA) of a record review of Resident #189's progress notes and code status and a record review of the facility-provided 'Aid to a Choking Victim: Conscious or Unconscious' policy. Record review of facility 'Aid to a Choking Victim: Conscious or Unconscious' policy reviewed date 3/23/2022, revealed the purpose: Choking is considered an acute emergency and regardless of code status every attempt to clear the airway must be made... The American Heart Association choking protocol will be initiated by Licensed Nursing staff for suspected obstructed airway. All nurses will be taught cooking techniques according to the American Heart Association procedures... In a conscious victim start abdominal thrust.... If victim		and choking episode policy with emphasis on getting the crash cart with each episode, not cancelling a 911 call if a resident begins to choke. " Educational meetings for nurse aides will be completed no later than 4/15/23. Education will include the above CPR and choking episodes policy with emphasis on not leaving the resident and either utilizing the staff emergency light or yelling for help. Proper positioning when feeding a resident is also included. The Director of Nursing and the In-service Department will monitor the corrective actions to ensure effectiveness by: " Random weekly interviews with all staff to ensure knowledge of the facility□s CPR and choking episodes policy. All results will be reported to the Quality Assurance and Process Improvement Committee quarterly until deemed no longer necessary.	

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becomes unconscious lower them to the floor and begin chest compressions.

Findings include:

Resident #189:

Record review of Resident #189 revealed an elderly female with a medical diagnosis of dementia and cognitive decline.

Record review of Resident #189's Care plans pages 1-18 revealed:
Cognitive/Communication: diagnosis of dementia with behavioral disturbance and cognitive social or emotional deficit...
Nutrition care plan: Biting/chewing (masticatory) difficulty related to partial edentulism, does not wear upper dentures with meals... Intervention of independent at meals after set-up. Activities of Daily Living (ADL) I require more assist daily care needs due to recent fall...

Record review of Resident #189's June 2022 Hospital record revealed that Resident had fall at the long-term care facility and fractured her left hip on 6/2/2022. Hospital records indicated the Resident #189 was stable for surgery and had surgical repair on 6/4/2022 prior to returning back to the facility on 6/6/2022.

Record review of Resident #189's electronic medical record noted resident #189 progress notes dated 6/6/2022 at 4:28 PM written by

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	Registered Nurse (RN) "HH" resident #189 returned from hospital via stretcher with 2 EMT's (Emergency Medical Technicians) at this time. EMT's stated that resident was given Norco (opioid analgesic- side effects of sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance... Nursing 2017 Drug Handbook, pg. 726-728.) before transfer. Resident is stable condition. Resident BBS (Bilateral breath sounds) clear, BS (bowel sounds) heard in all 4Q (four quads). Resident alert and talking during care. 1:1 Certified Nursing assistant (CNA) present. Resident made comfortable before leaving room... Record review of Resident #198's progress note dated 6/6/2022 at 5:56 PM written by Licensed Practical Nurse (LPN) "Y" revealed: Certified Nurse Assistant (CNA) called this nurse into resident's room. CNA stated that resident is coughing after drinking fluids at supper. CNA reported that resident needed assist with eating and starting coughing after taking a drink of water. Resident noted to be coughing with some gurgling in upper airway. Resident respirations suddenly became hiccup like and shallow. Color pale, this nurse instructed CNA to find nurse manager. Nurse manager in to assess resident. Record review of Resident #198's progress note dated 6/6/2022 at 5:58 PM written by Licensed Practical Nurse (LPN) "Y" revealed: Nurse Manager instructed this nurse to call			

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	911. 911 called at this time. EMS (Emergency Medical Services) canceled due to resident expired. Record review of Resident #198's progress note dated 6/6/2022 at 5:58 PM written by Registered Nurse (RN) "C" revealed: Called into resident's room due to resident's condition. Upon entering resident's room she's noted to be in bed in an elevated position with silent hiccup like cough, and a greyish-yellow waxy appearing skin. Resident's head of bed elevated higher. Instructed LPN to call 911. Resident with noted eyes fixed and non-reactive. Resident un-responsive to both verbal and tactile stimuli. BBS (Bilateral Breath Sounds) with no sound. Resident's O2 sat (Oxygen saturation) and pulse not reading on vital machine. Radial pulse attempted to be obtained and not able. No heart rate or respirations x 1 minute both. Time of death at 5:58 (PM). In an interview on 03/02/23 at 02:30 PM with Registered Nurse (RN) "C", who has worked at the facility of 9 years, stated that Resident #189, "she did not appear to be choking to me, she appeared short of breath. I elevated her head of her bed and instructed the Licensed Practical Nurse (LPN) "Y" to call 911, it was an emergency situation. Then Resident #189 stopped breathing, I listened to heart sounds, and she was a DNR, and I pronounced her deceased. Before this she was having her meal, it was between 5:30 and 6:00 PM dinner time, the Certified Nurse			

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	Assist (CNA) "Z" was in the room. The CNA "Z" came out of the room and told me that Resident #189 was coughing after she took a drink and could I come and see her. I asked if I needed to come immediately or if I could finish my progress note. CNA "Z" said no it could wait. Licensed Practical Nurse (LPN) "Y" said that she would go look at her (Resident #189) for me. LPN "Y" then came out and got me, and I finished my note and then went right away. I walked in Resident #189 was in the bed not elevated halfway or a little upward. Resident #189 had that silent hiccupping, chest was moving, she did not make eye contact. I instructed the LPN "Y" to go call 911 and to bring back the oxygen tank. Resident #189 stopped breathing, I listened to lung sounds and apical pulse for 1 minute and then I pronounced her deceased. She did have a meal tray at the bedside, but the meal tray was pushed aside on the bedside table. When I went into the room, she was not responding to calling her name, tactile touch to her hand. Yes, there was a meal tray in the room it was during the dinner time meal, I believe that she was eating prior. In an interview on 03/03/23 at 11:50 AM with Licensed Practical Nurse (LPN) "Y" of Resident #189's death at the facility revealed: That Resident #189 had just gotten back from the hospital after a fall. Resident #189 was having dinner at the time; she had a 1:1 (one to one) supervision Certified Nursing Assistant (CNA) "Z" when she came back from the hospital.			

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	The CNA "Z" came out of the room to report that she had to help (Resident #189) with eating by spooning food to her is what I heard at the nursing station. It was bite by bite per the CNA "Z" had to feed her. The CNA "Z" was helping her to eat. While she was lying in bed, the tray was set up. Resident #189 was not like herself when she came back from the hospital. Resident #189 was a lot weaker; she had only been back for a couple of hours. The CNA "Z" came out to the nurse's station and said that someone needed to go look at Resident #189. Resident #189 wasn't my resident, but I went to the room, I saw she was awake sitting up, but not enough in my opinion to be eating, she wasn't up high enough. The CNA "Z" said that she was feeding her, when Resident #189 started to have trouble swallowing her food and trouble with all over-eating. When I got in the room, we tried to get her to cough it up. She might have said a word or two, but she was clearly in distress. It all happened within a minute or two. No, no one tried the Heimlich maneuver, she was coughing and then she just stopped. LPN "Y" left the room to get a breathing treatment and to call 911. It happened during her meal; the CNA "Z" was feeding her. I went into the room and then went back out to get the RN "C" and call 911. and then the RN "C" said to cancel the 911 call because she expired. No, the crash cart wasn't brought in. In an interview on 03/07/23 at 09:38 AM with Certified Nursing Assistant (CNA) "Z" that			

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	Resident #189 had just came back from the hospital. CNA "Z" stated that she pickup an extra shift to be the 1:1 (one on one), supervision due to her dementia. CNA "Z" stated that Resident #189 came back really tired and lethargic, she had just had surgery, she was out of it, but she was talking to me. CNA "Z" stated that Resident #189 was just really tired, on and off sleeping. CNA "Z" stated that she got Resident #189 situated and took her off the gurney, slide across to the bed, I just made her comfortable. We chit chatted a little bit. I believe that she came back around 4 PM. Then it was dinner time, and CNA "Z" went to the dining room to get her water, pop and residents' meal. CNA "Z" stated that she did not remember what was on the meal tray or the texture. CNA "Z" took it (tray) back to Resident #189's room and set her up to eat. CNA "Z" stated that I don't believe I feed her, and then she took a drink of water and she started to cough, and I asked if she was OK. Resident #189 continued to cough; she thought it was phlem. Resident #189 continued to inter-mitten cough and then I went to get the nurse. I went to the nursing station; I asked if they could come and assess Resident #189 for the cough. Registered Nurse (RN) "C", she was the nurse manager, she said wait, 'I'll be right there'. CNA "Z" stated that she went back to the room with the vital signs machine, I got her vitals. She continued to cough and got a raspy gurgle, and she turned blue, she took her last breath and that was that. Registered Nurse (RN) "HH" came into room also. The			

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nurses assessed her and took her vitals and then her blood pressure went, we were going to get the crash cart, but she had already started the slow last couple of breaths. It all happened within 10 minutes it was so fast. The crash cart was mentioned but we didn't go get it. She just died".

In a phone interview on 03/07/23 at 10:32 AM with Registered Nurse (RN) "HH" revealed that she was on vacation. But the facility said to call the surveyor. RN "HH" stated that she remembered Resident #189, and was asked if she had been in the room the day Resident #189 died? RN "HH" stated: "That was so long ago, I don't believe I was. I was working that day she passes away, but I don't believe that I had anything to do with it. She wasn't my resident and I pretty sure I was not in her room. I don't have any notes to review here. That's all I can tell you".

On 3/3/2023 at 4:15 PM received Abatement plan from facility and was reviewed and sent to survey manager via email. On 3/3/2023 at 5:02 PM surveyor received phone call acceptance of the abatement plan from the surveyor manager.

Abatement:

The Immediate Jeopardy was abated on 3/3/2023, based on confirmation during interviews conducted on 3/3/2023 and 3/7/23 that the facility had implemented the following to remove the immediate jeopardy.

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1.) On 3/3/2023 the facility identified the nurse manager involved in the incident was educated on the facility's CPR and Choking episode policy including response to situation.

2.) On 3/3/2023 the In-service department began facility wide training on the facility's CPR and Choking policy. Training will be ongoing until all staff have been educated on the facility's CPR and choking policy.

3.) The Certified Nursing Assistant (CNA) involved in the incident will be educated immediately upon her first return to workday. The Licensed Practical Nurse (LPN) involved in the incident no longer employed at the facility.

Record review of the facility 'All Staff Mandatory Plan of Correction In-Service' documents revealed in-services on March 6th, 7th, 8th, 9th 2023 at 7 am, 10:30 am, 2:30 pm, 3 pm. Staff must attend one in-service. Location: In-service room. Will last approximately 15 minutes. Document attached to the in-service announcement stated: Notify your nurse if a resident is coughing or choking when eating. Nurses need to do assessment or resident, if choking start Heimlich maneuver and have someone call 911 immediately. Send resident out to hospital for evaluation even if you dislodge the food item. They need to be seen to make sure there is no injury to resident.

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	As of 3/7/2023, there were 115 out 279 staff members were educated on the 'Aid to a Choking Victim: Conscious or Unconscious' policy. Staff signature sheets were reviewed.			
F0686 SS= G	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent facility-acquired pressure ulcers for three residents (Resident #3, Resident #58, Resident #61) of 21 sampled residents, resulting in the worsening of pressure ulcers for Resident #3- the coccyx to open, Resident #58 to acquire pressure ulcers of the left heel and Resident #61 to have a facility-acquired Stage III pressure ulcer to the left ear with the likelihood for pain and discomfort and prolonged illness.	F0686	F686 SS=D TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE ULCER The Director of Nursing and the Restorative department implemented corrective actions for resident #3, #58 and #61 affected by this practice including: " There are no immediate corrective actions for residents #3, #58 and #61 as the corrective actions were implemented when the pressure injuries were identified. Resident #3 had an air mattress implemented after the pressure injury was identified. Resident #58 splint was immediately discontinued when the pressure injury was identified. Resident #61 had protective foam ear protectors applied immediately after the pressure injury was identified. All residents have the potential to be affected by this practice. The Director of Nursing and Restorative Department will implement measures to ensure this practice does not recur including: " The facility developed an assistive devices policy. " The transferring a resident to the Covid unit will be revised and updated to include: a skin check when arriving to the unit and daily skin checks while on the Covid unit. " Educational meetings with licensed nurses will be completed no later than 4/15/23. Education will include the updated transferring a resident to the Covid unit checklist, use of the facility□s O2 tubing which has foam protectors incorporated into the tubing on all residents requiring oxygen therapy. If tubing is	4/15/2023

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	Findings include: Record review of the facility 'pressure Ulcer Guidelines/Standards of Care' policy dated 9/28/2022, revealed the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. "Pressure Ulcer/Injury" refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. "Avoidable" means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.... 'Suspected deep tissue injury is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue form pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjunct tissue. 'Stage III' is a full thickness loss where subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss and undermining and tunneling		used which doesn□t have the foam protectors incorporated into the tubing, ensuring foam protectors are applied to the tubing, any resident receiving splints/braces must have an every two hour skin check order. The new facility assistive devices policy will be reviewed. The Restorative Department will monitor the corrective actions to ensure effectiveness by: " The restorative wound nurses will do weekly random chart audits on residents in the Covid unit to ensure the initial skin check and daily skin checks are completed. " The restorative wound nurses will do weekly random chart audits to ensure any resident with a splint/brace are receiving every two hour skin checks. " The restorative wound nurses will do weekly random visual checks of residents receiving oxygen therapy to ensure the foam ear protectors are in place. All results will be reported to the Quality Assurance and Process Improvement Committee quarterly until deemed no longer necessary.	

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can be present.

Resident #3:

Record review on 02/28/23 at 03:18 PM of Resident #3's electronic medical record revealed a Facility acquired Pressure Ulcer noted as Unstageable.

In an interview on 03/02/23 at 08:30 AM with both Registered Nurse (RN) "FF" and Licensed Practical Nurse (LPN) "GG" both are wound care nurses for the facility. They do wound rounds one time weekly. Doctors do not round with wound care nurses. Review of Resident #3: He was in the COVID unit and that's where his facility acquired pressure ulcer started, at first it was unstageable, but now it is open, and we are packing the wound (Stage III).

Resident #58 also has a facility acquired Deep tissue injury; it started here when she had a left foot splint from therapy that rubbed on her heel. It did open (Stage II), and we had to do treatments to it. Now, it is closed with a protective dressing.

Observation on 03/02/23 at 10:05 AM of Resident #3's coccyx wound dressing change observation with LPN "GG" and RN "FF" to hold the resident in position on his side, revealed an old dressing dated 3/1/23, remove of old dressing revealed a packed wound with AG material. Observed an open wound, RN "FF" stated that it was smaller and

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became larger. Wound cleanser with Prophase for 5 minutes held to the wound. The wound to the coccyx started in May 2022 while he was in the COVID unit. Measurement of length 0.7 cm x 0.9 cm in width (there was no depth measurement taken). Area cleansed and packed with pluragel via Q tip, and then packed with Opticel material with Q tip.

Resident #58:

In an interview on 02/28/23 at 01:57 PM with Resident #58 revealed that the wounds to her heel on the left foot started here and so did her butt areas. They are healing here, and yes, they do the treatments.

Observation and interview on 03/02/23 at 10:25 AM of Resident #58's left heel wound area with Registered Nurse (RN) "FF" revealed that the residents wound started at the facility on 3/4/2022 as a Deep Tissue Injury and progressed to an open wound. Observed dressing dated 3/1/23. Observation revealed a closed deep tissue injury, slow to blanch around the wound site. RN "FF" stated that the wound started from a left leg splint that went from the calf and down under the heel and foot, the heel rubbed on the leg splint. Observation of epithelial measuring 0.7 cm X 1.20 cm intact. Resident complained of pain rated at a level of 5.

Resident #61:

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	On 2/28/2023 during initial tour, Resident #61 was observed resting in bed and behind his left ear was a bandage. At the time it did not appear to be causing the resident any distress as he appeared to be content and comfortable. On 2/28/2023 at 12:24 PM, a review was completed of Resident #61's medical record and it revealed the resident was admitted to the facility on 11/21/2018 with diagnoses that included Alzheimer's Disease, Dysphagia, Chronic Kidney Disease, Syncope and Collapse and Atrial Fibrillation. Resident #61 is dependent on staff for his Activities of Daily Living (ADL). Further review of Resident #61's records revealed the following: Physician Notes: 2/6/2023: " ...patient is noted to have Stage III left posterior ear pressure injury ...Patient is being closely followed by the facility wound care nurse. Patient's appetite is poor at times so the recommendation is for protein supplementation twice daily to help with skin integrity and wound healing ..." Pressure Injury Awareness From: " ...Site: lt (left) posterior ear, upper crease: Facility acquired: 1/27/2023 ...Unstageable pressure injury notes to it posterior ear, upper crease, measuring 0.5cm (centimeters) x 0.4cm , 100% slough notes to wound bed, wound edge well defined, surrounding skin			

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	red and blanchable, no tunneling or undermining noted, scant bloody drainage noted no odor noted. Lt posterior ear, upper crease: Soak with prophase wound wash for 5 minute, rinse with NS (normal saline), pat dry, apply sureprep skin barrier to surrounding skin, apply plurogel to wound bed, cover with optiform QOD and PRN ...avoidable ..." Care Plan: Problem: "Mobility: I need help to transfer and with my mobility due to having R (right)-sided weakness (r/t (related to) CVA in October 2017), contractures in both my legs (knees) and my left hand, dementia, and generalized weakness ... "ADLS: "I need assistance with bathing, dressing, and grooming due to having generalized weakness, dementia ..." "Skin Management: I am at risk for skin breakdown r/t right-sided weakness following a stroke ...I have dry and fragile skin which places me at risk for skin tears and bruising. I have HX (history) of pressure areas to b/l (bilateral) heels, b/l hips, left elbow & right mid back. My left hip has an area of indentation which is scarring from previous pressure area and I sometimes get blisters on my left hip ...March March 2021: The toenails on my left great toe and right 2nd toe are lifting (left great toenail came off). 4/22/2022:			

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	I developed a Stage 1 pressure area on my left medial hand r/t brace (resolved 4/29/2022). 3/30/2022: I developed a Stage 2 pressure area on my left ear top of crease (resolved 4/15/2022). 4/29/2022: Dry, flaky growth on my right lower arm. 8/5/22: DTI proximal left thumb base and Stage 1 distal left thumb base, both resolved. breakdown, through next review." Approach: "I am dependent to turn and reposition in bed at routine intervals of every 2 hours, going from back to right side ..." "I am dependent for shaving and combing hair and for bathing and dressing ...I receive a complete bed bath with shampoo weekly." Resident #61's care plan did not address his posterior left ear pressure area. On 3/1/2023 at 3:50 PM, an interview was conducted with Wound Nurse "GG" and "FF," regarding Resident #61's facility acquired wound. The wound nurses reported Resident #61's left posterior ear wound opened on 1/27/2023 and they were informed by his nurse that he had a new skin issue. They went to his room to assess the area and found a facility acquired wound to his left ear from the resident not wearing 02 foam protectors. The wound nurses were queried if 02 foam			

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protectors were readily available at the facility and nurse stated they are. They reported this was a preventable Stage 3 wound if his 02 foam protectors were in place. Nurse "GG" explained a facility nurse changed Resident #61's nasal cannula tubing the night prior and should have saw the wound. Nurse "GG" then completed an in-service with the nurse regarding the incident. Nurse "GG" and "FF" stated the wound was unstageable when it opened on 1/27/23 and on 1/31/2023 staged it at Stage III.

Further review was completed of Resident #61's medical records:

Wound Notes:

1/27/2023 at 10:11: "Resident assessed d/t nurse concern. Unstageable pressure injury noted to lt (left) posterior ear, upper crease, measuring 0.5cm x0.4cm, 100% slough noted to wound bed ...Foam ear protectors places on oxygen per standard of care ..."

1/31/2023 at 11:38: "Previously noted unstageable pressure injury to L posterior ear, upper crease is now a Stage 3. Wound measuring 0.2cm x 0.1cm x0.1cm. Wound bed 100% beefy-red granulation tissue w/edges ...foam ear protections in place to 02 tubing per standard of care ..."

2/06/2023 at 13:30: " Stage 3 remains to posterior ear, upper crease, measuring 0.3cm x0.2cm, 100% epithelial skin noted, non-

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	blanchable, surrounding skin pink and blanchable, no tunneling or undermining noted, no drainage noted, no odor noted ...02 with foam ear protectors in place per standard of care ..." 2/14/2023 at 10:00: "Lt posterior ear, upper crease remains with stage 3, measuring 0.4cm x 0.3cm, 100% epithelial skin noted slow to blanch, surrounding skin and blanchable, no tunneling or undermining noted, no drainage noted, no odor noted ..." 2/22/2023 at 13:20: Stage 3 remains to left posterior ear, upper crease, measuring 0.4cm x 0.3cm, 100% epithelial skin noted, slow to blanch, surrounding skin pink and blanchable no drainage noted, no odor noted ..." Respiratory Supply and Equipment for Resident #61: January 27, 2023: Log indicated Resident #61's 02 concentrator and cannula tubing were changed by Nurse "MM" on 1/27/2023. On 3/2/2023 at 11:30 AM, Nurse "FF" and "GG" preformed wound care on Resident #61's wound. The wound was located at the crease, at the top of his ear. Nurse "FF" reported the wound was slow to blanch, 100% epithelial with no odor or drainage. Nurse "FF" stated the wound has been stagnant and looks the same as wound rounds last week.			

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	On 3/2/2023 at 11:55 AM, an interview was held with Nurse "BB" regarding 02 form protectors' availability in the facility. Nurse "BB" showed this writer the oxygen room and the multiple 02 protectors that were accessible in the storage room The nurse reported they recently received nasal cannula tubing that already have the 02 ear protectors attached to them. Nurse "BB" reported 02 protectors are always accessible and available for residents.			
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. §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 interview and record review, the facility failed to offer restorative nursing therapy per care plan for one resident (Resident #49), resulting in feelings of	F0688	F 688 SS=D INCREASE/PREVENT DECREASE IN ROM/MOBILITY The Restorative Director implemented corrective actions for resident #49 affected by this practice including: " On 3/1/23 the Restorative Director was made aware of resident□s request for therapy services. A PT referral was completed. " On 3/23/23 the Restorative Director met with resident #49 and reviewed current restorative plan. Resident requested a change in her program so a therapy referral was completed. All residents receiving restorative services have the potential to be affected by this practice. The Director of Nursing and the Restorative Director will implement measures to ensure this practice does not recur: " The Restorative Director will educate the restorative staff on the correct process if a resident refuses their treatment plan including documentation of refusals, offering all residents on restorative services their restorative program and notifying restorative nursing if staff are unable to provide the restorative program for any reason. Education will be completed no later than 4/15/23.	4/15/2023

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	frustration with the likelihood of decreased mobility and weakness. Findings include: Resident #49: On 2/28/23, at 11:30 AM, Resident #49 was sitting in their wheelchair and complained that the restorative aides get pulled to the floor and don't always assist them with their scheduled ambulation therapy. Resident #49 stated that if they don't walk regularly, they get weak. Resident #49 further offered that their neurologist wants her to walk as much as she can. Resident #49 sadly explained that if you "pee or poop" yourself at least if the staff could help you walk so you could feel better emotionally and physically. On 3/1/23, at 7:45 AM, a record review of Resident #49's electronic medical record revealed an admission on 1/19/2022 with diagnoses that included Parkinson's disease, Osteoarthritis and weakness. Resident #49 required assistance with Activities of Daily Living and had intact cognition. A review of the "MOBILITY" care plan revealed "I have Parkinson's disease with tremors & involuntary movements of my extremities & body ... Goal ... I want to be able to continue to ambulate with restorative nursing with 2 assist and walker through next review ... Approach Start Date: 02/09/2022 I am receiving the follow restorative program:		" The Restorative Director will create a High Priority Resident List so staff are aware of the most critical restorative services that must be provided first. " Restorative services will only be cancelled in an emergent situation. Before any restorative services are cancelled, the Restorative Director will correlate with activities and administrative staff to provide group restorative therapy rather than cancelling restorative services. Activities and administrative staff will be educated on this new process no later than 4/15/23. The Restorative Director will monitor the corrective actions to ensure effectiveness by: " The Restorative Director or designee will audit random restorative treatment sheets weekly to ensure completeness. " The Restorative Director or designee will interview random High Priority Residents weekly to ensure continued satisfaction with their restorative program.	

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	Ambulate up to 150 feet with 2 assist ... 5-7 days wkly ... " On 3/01/23, at 11:24 AM, Restorative Nurse "II" was asked where the facility documented restorative therapy/ambulation for Resident #49 and Nurse "II" offered on the restorative sheets. Restorative Nurse "II" offered that they have had staffing issues and have been pulled to the floor when asked if the aides were ever pulled to floor for a different assignment. On 3/01/23, at 11:30 AM, a record review along with Restorative Nurse "II" of Resident #49's restorative nursing calendar revealed the following: " ... Problems/Precautions: 2 assist with transfers Goals: Maintain current functional mobility within facility Interventions: Ambulate up to 150 feet with 2 assist, GB, (gait belt) personal FWW (front wheeled walker) (Ustep) w/c (wheelchair) to follow 5-7 x (times) weekly ... Month: December 2022 ... COMMENTS ... Ambulates up to 178 ft (feet), participates well, cont (continue) as above ..." The resident received restorative therapy as ordered. " ... Month: January 2023 ... " From January 15 through 21st, the resident only received restorative therapy four times and from January 22 through 28th, the resident only received therapy three times. COMMENTS ... No declines noted, continue program as			

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above ... "

" ... Month: February 2023 ... " From February 8 through 14th, the resident only received therapy three times. From February 15 through 21st, the resident only received therapy only four times. From February 22 through 28th, the resident only received therapy only three times.

Restorative Nurse "II" was asked to explain why the resident did not receive her restorative therapy as ordered and Restorative Nurse "II" offered that they are trying to hire more staff. Restorative Nurse "II" offered that they work from a short list when they are working short.

On 3/1/23, at 11:40 AM, A record review along with Restorative Nurse "II" of the short list and long list for restorative therapy revealed only 14 residents (Resident #49 was on the short list) and the long list revealed 28 residents in total. Restorative Nurse "II" was asked if Resident #49 was on the short list why wasn't she getting restorative therapy then and Restorative Nurse "II" stated, she complained about not getting walked so she was added to the short list.

On 3/01/23, at 12:42 PM, Resident #49 was in their wheelchair and was asked to explain to Restorative Nurse "II" how they were feeling about not getting restorative nursing regularly and Resident #49 stated "like a piece of shit right now." Restorative Nurse "II"

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BAY COUNTY MEDICAL CARE FACILITY	564 W HAMPTON ROAD ESSEXVILLE, MI 48732

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	reassured the resident that they could go to the therapy gym and complete restorative nursing exercised along with the restorative aides and that they would ensure she gets her walking. A review of the facility provided "RESTORATIVE NURSING SERVICE POLICY Revised: 7/27/22" revealed " ... to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level ...			
F0689 SS= G	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent fractures for two residents (Resident #2, Resident #189) of three residents reviewed for accidents and falls, resulting in a left tibia fracture, a hospital stay with surgery for Resident #2 and two left femur fractures with a hospital stay for surgical repair for Resident #189, pain, hospitalization and decreased mobility. Findings include:	F0689	F689 SS=G Free of Accident Hazards/Supervision/Devices The Director of Nursing, the Restorative Department and the In-Service Department implemented corrective actions for residents #2 and #189 affected by this practice including: There are no immediate corrective actions for resident #2 as her fracture has healed and resident #189 is deceased. All residents have the potential to be affected by this practice. The Director of Nursing, the Restorative Department and the In-Service Department will implement measures to ensure this practice does not recur including: " Educational meetings with licensed nurses and certified nursing assistants will be completed no later than 4/15/23. Education will include the following: " The therapy department will do an educational review of the types of weight bearing transfers, i.e.: 1 assist, 2 assist with emphasis on proper placement of the resident□s feet and body mechanics to avoid twisting motions to ensure safe transferring.	4/15/2023

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	Resident #2: On 2/28/23, at 2:30 PM, a record review of the facility reported incident revealed "Resident ... has a diagnosis of Traumatic Brain Injury ... On 5/15/22 at 2104 (9:04 PM) a bruise was identified on her left outer knee ... measured approximately 4.5 cm (centimeters) in diameter and was with dark, pink in center ... the cause of the bruise was unknown ... On 5/16/22 at 0600, the nurse aide reported the bruise was enlarging ... to be 10 cm x (by) 1 cm and dark purple in color ... At 0840, the nurse noted the resident o be more anxious and starting to display symptoms of pain. The knee and leg were now swollen ... At 1:21 PM ... received notification of a fracture of the proximal left tibia ... On 5/20/22, resident underwent an ORIF of the left Tibia ... Resident can be easily upset with any changes in her routine and will yell out loudly at times. She will grab and flail arms and legs when she is either upset, changes in her routine, in pain or over stimulated ... The fracture is described as a comminuted acute fracture. Due to the type of fracture and her Osteoporosis, the medical director did state it may have happened spontaneous or pathological in nature, perhaps with transferring or turning in bed ... " On 3/01/23, at 08:00 AM, CNA "SS" was interviewed regarding Resident #2 injury of unknown origin. CNA "SS" stated they were told she had a bruise to her knee but when		" A review of the facility□s fall policy and program will be presented. Items included are residents who require increased supervision are provided with an orange tag or star, residents who show any declines or improvements are placed on 3 day monitoring with restorative notification, utilizing the "hey therapy form with any decline or improvement so therapy is aware and all new admissions and re-admissions are placed on 3 day monitoring for self-transferring. " All licensed nursing staff and certified nurse aides are required to complete the Healthcare Academy assignment Fall Management by 4/15/23. The Restorative Director and the Restorative Department will monitor the corrective actions to ensure effectiveness by: " The Restorative Department will do random visual observations of the types weight bearing transfers listed above weekly. " The Restorative Department will review all residents with improvements or declines in the fall meeting weekly to ensure all monitoring is in place as stated above. " The Restorative Department will do random weekly chart audits to ensure all self-transferring monitoring is completed as stated above. All results will be reported to the Quality Assurance and Process Improvement Committee quarterly until deemed no longer necessary.	

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they pulled the blanket back, there was more than a bruise. There was swelling and her foot was rotating inward, so they went to get the nurse. CNA "SS" stated that they had worked three days prior and no bruising or swelling was seen. CNA "SS" was asked if they thought Resident #2 had gotten up on their own and CNA "SS" stated, no, she can't get up on her own. CNA "SS" stated that Resident #2 was only able to twist with their transfers from bed to chair and did not take any steps at all back then.

On 3/01/23, at 8:17 AM, assistant director of nursing (ADON) "OO" was interviewed regarding Resident #2's type of fracture and ADON "OO" offered that they thought the fracture happened during a transfer. ADON "OO" was asked if Resident #2 was ever combative during care for example receiving an enema and ADON "OO" offered that they day it happened the only thing that came up was the bruise so we thought maybe she hit her knee on the heater cover as the staff did state she would could come close to hitting it at times

On 3/01/23, at 8:39 AM, an observation of Resident #2 was conducted along with CNA "QQ" and "RR." Resident #2 was lying on their back in bed with there legs crossed over and squeezed together. Resident #2 was grabbing at the headboard and smiling. CNA "QQ" touched Resident #2's left leg and said please let me help you and at that time Resident #2 released the squeeze on her legs

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and CNA "QQ" was able to perform care. Both CNA "QQ" and "RR" assisted Resident #2 to their chair. Resident #2 did not bear weight on either leg and was transferred completely by the staff. CNA "QQ" and "RR" were both asked if Resident #2 ever kicks at them and CNA"QQ" stated, no she is unable to move her legs much but will grab at the head board with her arms like she is doing now. CNA "QQ" and "RR" were asked if they felt a Hoyer would work better for her transfers seems she doesn't put her feet on the floor and CNA "QQ" stated, she is easy and doesn't weigh much so we can lift her.

On 3/1/23, at 10:00 AM, a record review of Resident #2's electronic medical record revealed an admission on 6/17/2005 with diagnoses of Osteoporosis, Osteoarthritis and dementia. Resident #2 is non-verbal and is dependent for all Activities of Daily Living.

A review of the "MOBILITY Problem Start Date: 05/22/2008" revealed "(the resident) has impaired mobility r/t (related to) muscle weakness/atrophy, spastic extremity movements, bilateral ankle contractures ... She is non-ambulatory ... she was recently hospitalized on 5/18-5/23 for Left Tibia Fracture resulting in ORIF (open reduction and Internal Fixation/surgical procedure)

On 3/01/23, at 2:07 PM, CNA "PP" was interviewed regarding Resident #2's fracture and CNA "PP" stated they do remember getting the resident but the odd thing was

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	that she had her pants on which she never did while in bed. CNA "PP" stated, that they did not see the bruised knee until later in the shift about 7:30 PM when they assisted Resident #2 to bed. CNA "PP" stated, that Resident #2 was a one person transfer at the time. CNA "PP" stated that they removed her pants and observed the bruise to be green and yellow, swollen and was "huge." CNA "PP" offered that they thought maybe they could have hit her knee on her wheelchair but don't remember hearing anything or noticing the resident in any type of pain that day. CNA "PP" was asked how they though she had got the fracture and CNA "PP" stated that a new person had put her to bed earlier that day and that she also had an enema prior as well. CNA "PP" also offered that maybe they had rolled her into the heater cover and bumped her knee but did not think they did. On 3/01/23, at 2:43 PM, CNA "TT" was interviewed regarding the day they worked with Resident #2 when the bruise/fracture showed up. CNA "TT" stated they normally work restorative and when they get pulled to floor for an assignment they work in pairs. CNA "TT" stated that they worked alongside CNA "SS" during all cares for Resident #2 that day. CNA "TT" stated both of them assisted the resident into the chair using the gait belt. Later that day, CNA "TT" offered that when they lied her down they did remove her pants and did not see a bruise. CNA "TT" was asked if they had transferred the resident or did any			

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care with her alone that day and CNA "TT" stated, no and that CNA "SS" was with her. CNA "TT" stated, there was nothing out of the ordinary that day. CNA "TT" was further questioned regarding Resident #2 receiving an enema that day and CNA "TT" stated, oh yes "I did have to give her a fleets." CNA "TT" stated, that there was nothing out of the ordinary and both her and CNA "SS" gave the enema because "we know how she flails." CNA TT " stated at the end of the shift they checked on the resident as well as the nurse for bowel movement results and that the resident did not have pants on.

On 3/02/23, at 8:39 AM, CNA "UU" was interviewed regarding Resident #2's fracture/bruising and CNA "UU" stated, that they helped CNA "UU" with dressing for the morning and into her chair. CNA "UU" further offered that in the afternoon they were headed towards the linen room and heard (Resident #2) yelling out so "I opened the door a little bit and asked if (CNA "TT") needed help." CNA "UU" further stated that Resident #2 will yell out and that she does keep her legs squeezed together at times and that they don't open up that much. CNA "UU" stated, that they did not help CNA "TT" assist Resident #2 back into bed, with the enema and any other cares that day.

On 3/02/23, at 12:33 PM, The Director of Nursing (DON) was interviewed regarding Resident #2's fracture and the DON stated, that Resident #2 is very vocal especially if

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anything is different from her normal routine. The DON was asked what their hypothesis was, and the DON offered that after speaking with the physician that felt with the history of her osteoporosis and the twisting motion with the transfer that is how it happened. The DON was alerted that CNA "TT" and CNA "UU" interviews don't match up and could they get CNA "TT" on the phone.

On 3/02/23, at 1:31 PM, An interview was conducted with the DON, CNA "UU" and along with CNA "TT" on the phone in the DON's office. CNA "TT" was asked again what they remembered and CNA "TT" stated, they got her washed up by themselves and CNA "UU" spoke up and offered, that they assisted with morning cares and then CNA "TT" stated, oh yeah. CNA "TT" was asked if they had help with Resident #2 for the remainder of the day and CNA "TT" stated, oh "I did give her enema by myself." CNA "TT" denied ever transferring Resident #2 by themselves but did agree that CNA "UU" was not in there helping for the remainder of the shift.

On 3/02/23, at 1:40 PM, The DON again stated, the only thing I can think of is with the transfer when asked how they thought Resident #2 got the fracture.

Resident #189:

Record review of facility report incident on 4/21/2022 at 3:30PM revealed a dietary server alerted nurse that Resident #189 was

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	on the floor. Nurse responded to resident room to find resident lying on her back, feet towards the door. Resident #189 was noted to state she lost her balance when standing up from wheelchair. Resident #189 was noted to have her own slippers on which did not have good grips. Nurse noted 1cm X 1cm elevated area to left top of head and left foot inward and shortened. Resident #189 sent to the hospital for fracture of left femur. Record review of Resident #189's 'Event History' document dated 3/1/2023, revealed that in 2021 Resident #189 sustained five (5) falls while residing in the facility. On 4/21/2022 Resident #189 sustained a fall and a dietary staff member responded to Resident #189's call for help and was found on the floor in her room. Record review of Resident #189's April 26, 2022, hospital record revealed that on 4/22/2022 the resident had a surgical repair of left hip fracture and returned to the long-term care facility on 4/26/2022 at 4:25 pm. Record review of Resident #189's June 2, 2022, at 7:40 pm facility report incident form revealed that the nurse heard Resident 3189 calling out for help and responded. Resident #189 was yelling out "My hip, my hip. I think it's broke." Resident #189 was noted to state that she broke her hip, and her pain was ten (10) out of ten (10). Resident #189 was sent to the hospital and admitted with left hip fracture.			

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Record review of resident #189's June 6, 2022, hospital record revealed 'admitted from extended care facility (EFC) with recurrent left hip fracture around the hip replacement which was just last month...'

In an interview on 03/01/23 at 11:29 AM with Licensed Practical Nurse "II" Restorative nurse, reviewed Resident #189's falls. The fall on April 21, 2022, was in her room, she was found by the dietary aide on the floor. Resident #189 had Fractured left femur and was sent to the hospital. It was at change of shift when she fell from days to afternoons shift. The resident did go to the hospital for hip repair surgery and came back. LPN "II" acknowledged Resident #189 did have a diagnosis of dementia. LPN "II" stated that so on June 2, 2022, she was work with therapy and we had her on 1:1 supervision from 7 am to 7 pm, at 7:40 PM the LPN found her on the floor at the foot of the bed. We had a one to one from 7 AM to 7 PM and then we start a 15-minute checks on her, Resident #189 was found on the floor at 7:40 PM. The surveyor asked if the falls preventable. LPN "II" stated that well the 1st fall she was independent and unexpected, but the June 2022 fall we thought that she had adjusted and was working with therapy, but still had a history of falls.

In an interview on 3/2/23 at 11:27 AM with the Assistant Director of Nursing ADON "OO" reviewed Resident #189's falls: April 2022 her

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	BIMS was 11 and she had a history of self-transfer and falls prior to the fall with her fracture hip. Resident #189 was found on the floor, we sent her to the hospital for repair of hip and she came back. Then Resident #189 had therapy and in June 2022 she was found on the floor again by staff and fractured the same hip again. Resident #189 did have the history of falls, we had her on one-to-one supervision from 7 AM to 7 PM and then 15-minute checks after 7 PM. She fell at 7:40 PM after the one to one was stopped for the day and the 15 minutes checks were in place. That didn't work because she fell anyways. In an interview on 03/02/23 at 1:29 PM with Certified Nurse Assistant (CNA) "PP" revealed that she was Resident #189's CNA when she fell in April 2022, she was my resident and during report I was told to check on her first, because of her history of falls and self-transfers. CNA "PP" stated that she put color crayons and a book in reach of Resident #189. CNA "PP" stated that within 20 minutes someone found Resident #189 on the floor. Resident #189 was alert, and she would self-transfer, she would get up and straighten items in her room. CNA "PP" acknowledged that Resident #189 had a fall history.			
F0690 SS= G	Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain	F0690	F690 SS=G BOWEL/BLADDER INCONTINENCE, CATHETER, UTI The Director of Nursing and the Infection Prevention Department implemented corrective actions for resident #44 as follows:	4/15/2023

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	continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent recurrent Urinary Tract Infection (UTI) for 1 (#44) of 16 sampled residents, resulting in Resident #44 sustaining recurrent urinary tract infections with prolonged illness and bacteremia with hospitalization and antibiotic therapy. Findings include:		" Resident #44 plan of care has been updated to reflect this resident□s abdominal pain may be a symptom of a UTI. All residents have the potential to be affected by this practice. The Director of Nursing and the Infection Prevention Department will implement measures to ensure this practice does not recur including: " Educational meetings with licensed nurses will be completed no later than 4/15/23. Education will include use of the SBAR, including head to toe assessments, when notifying the physician with condition changes. Also, when placing residents on UTI monitoring implement increasing fluids. Review s/sx of UTI including the UTI monitoring checklist. " Educational meetings with nurse aides will be completed no later than 4/15/23. Education will include residents exhibiting UTI symptoms with emphasis on proper peri care for a female and a male resident. The Director of Nursing and the Infection Prevention Department will monitor the corrective actions to ensure effectiveness by: " The In-service Department will monitor random SBAR assessments/progress notes weekly on residents with UTI signs and symptoms to ensure a thorough assessment of the resident is being completed. " The In-service Department will do random weekly visual observations of female and male peri-care. All results will be reported to the Quality Assurance and Process Improvement Committee quarterly until deemed no longer necessary.	

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	Record review of the facility provided staff education/skills fair stations documents dated for June 2022, revealed that Peri-Care and Catheter Care were covered. Bullet point 'Providing Catheter Care' Procedure and 'Standards of Care Delivery for CNA's- Peri and Cath Care' were part of the skills fair packet. Staff signature sign-in sheets noted June 22 and 23 at 7am, 2pm and 3pm were reviewed. Resident #44: Record review of Resident #44's electronic medical record revealed an elderly male resident with noted times of confusion. Record review of Resident #44's care plan for Cognitive loss/dementia: hallucinations/psychosis related to diagnosis of Parkinson's disease... Care plan for Continence: continence of urine; occasional incontinence of bowel movements. My incontinence may vary in times of increased confusion... In an interview on 02/28/23 at 02:11 PM with Resident #44 revealed that the resident had a urinary tract infection (UTI) and was sent out to the hospital in late August or early September 2022. Resident #44 stated that he came back to the facility on antibiotic for UTI. Resident #44 stated then a couple of weeks later he felt the same way again, Resident #44 stated that he told them (nurses) that he didn't feel good, the nurses said that his urine smelled bad, but nothing was done.			

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	Resident #44 Then started to feel really sick and asked to go back to the hospital and that's when the infection was found in my blood from another UTI. Resident #44 had antibiotic for that and was sent back here. You need to look into that, look at my records, it's all got to be in there. Urine was smelly and the nurses didn't do anything different for him, he went out to the hospital for stomach cramps and the hospital found a UTI and it went to his blood (sepsis). Record review of Resident #44's August progress notes: 8/12/22 at 7:12am blood draw for labs in right hand. Record review of Resident #44's August progress notes: 8/12/22 at 2:53pm dietary noted Resident #44 had complaints of upset stomach and refusing meals. Record review of Resident #44's August progress notes: 8/13/22 at 8:56pm Resident #44 complained of nausea, had a poor appetite and Zofran medication (Zoran: antiemetics to prevent nausea and vomiting, adverse reaction: urine retention. Nursing 2017 Drug Handbook, pg. 1084-1087.), was given. Record review of Resident #44's August progress notes: 8/14/22 at 8:35am Resident #44 complained of upset stomach, Zofran (medication) given. Record review of Resident #44's August			

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	progress notes: 8/15/22 at 4:32am Resident #44 complained of upset stomach and Zofran (medication) given. Record review of Resident #44's August progress notes: 8/16/22 at 12:31pm Resident #44 complained of nausea and Zofran (medication) given. Record review of Resident #44's August progress notes: 8/18/22 at 1:50pm Resident #44 complained of upset stomach and stomach pains. Resident #44 was noted to request Zofran, medication given. Record review of Resident #44's August progress notes: 8/18/22 at 2:08pm dietary noted resident had meal intake as poor and feeling queasy... Record review of Resident #44's August progress notes: 8/19/22 at 10:51am Nurse Practioner noted new order to send to hospital for abnormal labs and abdominal pain. Record review of Resident #44's August progress notes: 8/19/22 at 4:22pm Nurse Practioner noted: long-term resident at this facility had labs drawn due to complaint of fatigues and malaise. Resident white blood cells elevated... has had significant nausea and vomiting over the last 24-48 hours and the nausea is not responding to Zofran. No noted hematemesis. All other systems reviewed and negative.			

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Record review of progress notes dated on 8/25/2022 at 10:07am resident #44 was re-admitted after hospitalization and treatment for UTI (Urinary Tract Infection) ... Keflex antibiotic therapy was noted in other progress notes.

Record review of Resident #44's hospital history & physical medical record dated 8/20/2022 noted resident was admitted to hospital for leukocytosis and urinary tract infection with IV antibiotic therapy.

Record review of progress notes dated on 9/12/22 at 4:56 PM noted Resident #44 complained of shortness of breath and abdominal pain. Resident #44 requested to go to the hospital...

Record review of Resident #44's progress note dated 9/21/2022 revealed the resident was re-admitted from hospital setting.

Record review of Resident #44's Hospital discharge note dated 9/21/2022 noted acute urinary tract infection with E. Coli and blood cultures done on 9/12/22 were positive for E. Coli...

In an interview and records review on 03/03/23 at 10:43 AM with Registered Nurse/Infection Control Preventionist (RN/ICP) "K" of Resident #44's record review of the August and September antibiotic use logs revealed Resident #44 on 8/25/2022 the

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	resident was re-admitted from the hospital setting on cephalexin 500mg every 8 hours for urinary tract infection. Review of Resident #44's August 'Infection Control Surveillance' log noted that on 8/25/2022. Resident #44 tested positive for greater than 100,000 E. coli (Escherichia coli) and gram-negative bacilli organisms. Record review of the September 2022 'Infection Control Surveillance' antibiotic log revealed that the Resident #44 was noted on 9/21/2022. Resident #44 teste positive for urinalysis with E. coli (Escherichia coli) in the urine and blood cultures with E. coli in the blood system. Resident #44 was re-admitted from the hospital with antibiotic of Bactrim 800/160mg twice daily for Bacteremia (infection of blood) and urinary tract infection. Review of progress notes that the resident complained of abdominal discomforts and requested to go to the hospital.			
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F0695	F695 SS=D RESPIRATORY/TRACHEOSTOMY CARE The Director of Nursing and the Infection Prevention Department implemented corrective actions for resident #47 affected by this practice including: " The nurse involved was educated on the correct process for removing the CPAP mask in the am and washing with soap and water. " Resident #47 care plan was updated on 3/24/23 to reflect the resident has a history of removing his CPAP mask himself. An order was placed in the resident□s treatment record to wash the mask with soap and water daily. " All residents receiving CPAP/BIPAP therapy	4/15/2023

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	Based on observation, interview and record review, the facility failed to ensure proper cleaning and storage of a Continuous Positive Pressure (CPAP) mask for Resident #47, resulting in the CPAP mask lying face down on dirty surfaces, no documented cleaning with Resident's own cleaning machine with the likelihood of cross contamination and respiratory illness. Findings include. On 3/01/23, at 8:34 AM, Resident #47 sitting up in bed. CPAP mask is lying face down on top of the machine on the bedside nightstand. Resident #47 stated that they usually take it off themselves in the morning and will place it in the cleaning machine once the staff has assisted them up to the wheelchair. Resident #47 stated the entire mask goes inside the cleaning machine but was unsure if the cleaning machine had been serviced or was working properly. A record review of Resident #47's electronic medical record revealed an admission on 6/5/2021 with diagnoses that included Spinal stenosis, muscle weakness and Obstructive sleep apnea. Resident #47 required assistance with Activities of Daily Living and relied on staff to get out of the bed. A Review of the "CARDIAC/RESPIRATORY" care plan revealed " ... I have obstructive sleep apnea and wear a CPAP ... Approach ... Nursing to apply my CPAP at bedtime & remove in the AM. May wear my CPAP when		will have a nursing order entered into their chart to wash the mask with soap and water daily. All residents receiving CPAP/BIPAP therapy have the potential to be affected by this practice. The Director of Nursing and Infection Prevention Department will implement measures to ensure this practice does not recur including: " Educational meetings with Licensed nurses will be completed no later than 4/15/23. Education will include review of the facility□s BIPAP/CPAP policy with emphasis on cleaning the mask with soap and water daily. Education will also include importance of including the nursing order for residents with CPAP/BIPAP masks to be cleaned daily with soap and water to ensure all masks are cleaned per facility policy. The Director of Nursing and Infection Prevention Department will monitor the corrective actions to ensure effectiveness by: " The Infection Prevention Department will do weekly random visual audits of residents receiving CPAP/BIPAP therapy with emphasis on ensuring the masks are cleaned and stored properly after use. All results will be reported to the Quality Assurance and Process Improvement Committee quarterly until deemed no longer necessary.	

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	taking a nap ... " There was no mention the resident takes his own CPAP mask off and that they may lie in mask in the bed or on the nightstand. On 3/01/23, at 1:29 PM, Resident #47 was sitting in their wheelchair. Nurse "AA" was asked who assisted Resident #47 with their CPAP mask and Nurse "AA" stated that he usually takes it off himself. On 3/02/23, at 9:20 AM, Resident #47 was sitting up in bed with their CPAP mask lying on their lap on top of the blanket. The resident was eating their breakfast meal over top of the mask. A review of the facility provided "Care of C-PAP and BI-PAP Equipment Reviewed: 12/21/22" revealed " ... To provide guidelines for the proper care and maintenance of the C-PAP ... Inspect the face mask and head strap each morning and if soiled, use a soft cloth with mild soap and water. Wipe with a wet cloth to remove soap and air dry ... Allow to air dry ... "			
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	F0758	F758 SS=D FREE FROM UNECESSARY PSYCHOTROPIC MEDS/PRN USE The Director of Nursing and the Social Services Director implemented corrective actions for resident #43 affected by this practice including: " The Social Services Director reviewed resident #43 care plan and behavior tracking sheet to ensure nonpharmacological interventions in place were up to date and	4/15/2023

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	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 resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to respond when monitoring of Resident #43's multiple psychotropic (drug that affects brain activities associated with mental processes and behavior) medications indicated a lack of progress toward the therapeutic goal. Resulting in Resident #43 exhibiting a		appropriate for this resident. " The Social Services Director educated the licensed staff on reviewing resident #43 behavior tracking sheet for nonpharmalogical interventions to be used prior to administering any PRN psychotropic medication which must be documented in the medical record. " The Social Services Director placed resident #43 on the doctor□s book requesting a neurology consult to rule out any underlying conditions. All residents receiving PRN psychotropic medications who exhibit behavioral symptoms have the potential to be affected by this practice. The Director of Nursing and the Social Services Director will implement measures to ensure this practice does not recur including: " Educational meetings with licensed staff will be completed no later than 4/15/23. Education will include review of the behavior tracking book, referring to the behavior book for nonpharmalogical interventions to be used prior to giving a PRN antipsychotic medication and documenting what interventions were used in the medical record. " Educational meetings with certified nursing assistants will be completed no later than 4/15/23. Education will include review of the behavior tracking book, utilizing the behavior book for interventions when a resident is having behaviors, reporting to the nurse on effectiveness of the interventions utilized. The Social Service Director and the Social workers will monitor corrective actions to ensure effectiveness by: " The Social Service Director and the Social workers will do random weekly audits of PRN psychotropic med use to ensure nonpharmalogical are used prior to administering a PRN medication. " The Social Services Director will complete a	

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	plethora of distressing behaviors (paranoia, auditory hallucinations, delusions, physical/verbal aggression and suicidal ideations) directly related to his decompensating mental health with no meaningful interventions that in turn created an unsafe environment for facility staff and residents. Findings include: On 2/28/2023 during initial tour, Resident #43 was observed sleeping in his room and this writer was unable to arouse him. On 03/01/2023 at approximately 8:15 AM, a review was completed of Resident #43's medical records and it revealed the resident was admitted to the facility on 04/05/2016 with diagnoses that included Dementia, Kidney Disease, Delusional Disorder, Visual Hallucinations, Anxiety Disorder and Bipolar Disorder. Resident #43 required assistance with his Activities of Daily Living (ADL's). Further review of Resident #43's recorded yielded the following: Physician Orders: Buspirone Tablet- 5mg (milligrams) twice a day Buspirone Tablet 5mg- once a day Haloperidol Lactate Solution- 5mg/mL (milliliter) 0.4 ml injection as needed three		referral for an advanced psychologic evaluation on any resident in which all other interventions have been exhausted.	

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	times a day Klonopin Tablet- 0.5mg at bedtime Klonopin Tablet-0.5mg once a day Seroquel XR Tablet-300mg amt (amount): 2 tabs (tablets) =600mg Topomax Tablet- 25mg twice a day Zoloft Tablet- 25mg once a day Resident Number #43 is currently prescribed six psychotropic medications with two being Antipsychotics (a class of psychotropic medication primarily used to manage psychosis (including delusions, hallucinations, paranoia or disordered thought) at an attempt to stabilize his mental health and associated behaviors. Care Plan: Problem: "Mood/Behavior: "I have some difficulty w/ my mood/behavior at times. I have a dx (diagnosis) Bipolar disorder, visual hallucinations & delusional disorders in addition to Unspecified dementia, mild, with agitation ...I am Rx (prescribed) psychotropic medication. I have a hx (history) of mood disorder w/depressive features & Anxiety ...I have a hx of being combative w/care ...I use loud/foul language often, and occasionally			

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	threaten others when I believe someone has wronged me/stolen my things... I often use offensive language which is how I communicated prior to my illness/admission. I present with some unrelated/off the wall conversation & hallucinations/delusions at times which can be distressing to me ..." Approach: "Encourage distractions that are meaningful to me ie: I get upset/agitated with too much stimuli. I enjoy listening to Mexican, country, oldies music, socializing, news, socials coffee hour, small groups, restorative exercise and occasionally Catholic Church services. I enjoy watching sports and funny shows." On 3/1/2023 at 8:53 AM, an interview was conducted with Social Worker "N" regarding Resident #43's prn (as needed) Haldol order. Social Worker "N" explained the resident has a prn Haldol and Buspar order due to his behaviors. She reported last year they attempted a GDR (Gradual Dose Reduction) on his Seroquel in March 2022 and Resident #43's behaviors increased significantly. Since then, they have been unable to stabilize his behaviors and have struggled to find a medication regime that is effective for him. Social Worker "N" stated they did increase his Seroquel back to the original dosage, and it was still ineffective. They completed Genesight testing and attempted those recommendations but they were still unsuccessful in their ability to manage his			

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	mental health needs. Social Worker "N" was asked to provide a timeline of events related to his medication changes, behavior tracking, consents for his psychotropic medication usage and other interventions utilized to stabilize the resident. Social Worker "N" provided a timeline of Resident #43's medication changes since March 2022. Resident #43's had numerous medication changes over the course. There was no true stabilization period for the resident over the last year as they medications changes occurred at least monthly. March 2022: Seroquel 100 mg qhs (every night at bedtime) 3/11/22 GDR to 75 mg qhs- failed- increased agitation, vulgar language aggression 3/23/22 Seroquel increased back to 100 mg qhs April 2022: 4/8/22-4/20/22 Ativan 0.5 mg BID (twice a day) PRN (as needed) ordered 4/22/22 Seroquel increased to 50 mg qam/100 mg qhs- d/t increased agitation and irritability as well as distressing delusions			

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	May 2022: 5/6/22-5/20/22 Ativan 0.5 mg q6h (every 6 hours) PRN ordered 5/13/22 Seroquel changed to 25 mg qam/25 mgat qhs-continuing with increased agitation and loud outbursts. Delusional/distressed-changed to address increased periods of agitation during the afternoon. 5/21/22-5/30/22 Ativan 0.5 mg q6h PRN ordered Genesight testing done 5/23/22 5/30/22-6/12/22 Ativan 0.5 mg BID PRN ordered June 2022: 6/10/22 Seroquel increased to 50 mg qam/50 mg q12:00/100 mg qhs d/t continued agitation, irritability, anxiety, and delusions, The alteration from 5/13/22 did not appear sufficient 6/13/22-6/18/22 Ativan 0.5 mg BID PRN ordered Genesight test done shows Xanax may have more of an effect than Ativan for this particular patient Ativan changed to Xanax 6/18/22-6/28/22 Xanax 0.25mg q8h PRN ordered			

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	6/28/22-7/7/22 Xanax 0.25 q8h PRN ordered July 2022: 7/2/22 Seroquel increased to 75 mg qam/50 mg @14:00/1 mg qhs d/t continues to exhibit increased agitation, irritability, delusions and related anxiety 7/7/22-7/13/22 Xanax 0.25 mg BID PRN ordered 7/18/22-7/31/22 Xanax 0.25 mg q8h PRN ordered August 2022: 8/1/22-8/14/22 Xanax 0.25 mg q8h PRN ordered 8/13/22-8/20/22 Seroquel changed to Risperdal 1 mg qam/O.5 mg q12:OO/1 mg qhs ordered d/t increased agitation, irritability and distressing delusions, along with poor sleep. Risperdal d/c by facility PA d/t apparent allergic reaction 8/15/22-8/26/22 Xanax 0.25 mg q8h ordered 8/26/22 Restart Seroquel, XR 300 mg to treat distressing hallucinations and delusions; Topamax reduced to 15 mg BID September 2022: 9/2/22-9/15/22 Xanax 0.25 mg q8h PRN			

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	ordered 9/15/22-10/2/22 Xanax 0.25 mg TID PRN ordered October 2022: 10/7/22 Increased Seroquel XR to 400 mg qhs d/t increased depression, anxiety, agitation, irritability, hallucinations, delusions along with decreased sleep 10/21/22-10/22/22 Haldol 2 mg q6h PRN ordered 10/22/22-11/2/22 Haldol 1 mg q6h PRN ordered November 2022: 11/7/22-11/8/22 Haldol 1 mg QID PRN ordered 11/8/22-11/9/22 Haldol 2 mg ordered q6h PRN ordered 11/11/22-11/18/22 Haldol 1 mg QID ordered PRN ordered 11/25/22-12/1/22 Haldol 2 mg q6h PRN December 2022: 12/2/22-12/3/22 Haldol 2 mg q6h PRN ordered 12/3/22-12/3/22 Haldol 1 mg QID PRN ordered			

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	12/3/22-12/16/22 Haldol 1 mg QID PRN ordered 12/18/22-15/25/22 Haldol 2 mg q6h PRN ordered 12/23/22 Increase Seroquel XR to 600 mg qhs d/t continued hallucinations at times as well as delusions with accompanying anxiety, agitation and irritability- frequent Haldol use noted January 2022: 1/7/23-1/20/23 Haldol 2 mg TID PRN ordered 1/14/23 Klonopin increased am dose to 1 mg qam/O.5 mg qhs d/t PRN Haldol being used 4x during prior 3 days, 3 of which were in the morning 1/20/23 Topamax 25 mg qam/17:OO started-continues with agitation, hallucinations and delusions as well as anxiety r/t delusions, sleep improved 1/21/23-1/27/23 Haldol 2 mg TID PRN ordered 1/30/23-2/23/23 Haldol 2 mg TID PRN ordered Resident #43 had a plethora of changes to his psychotropic medications that occurred monthly and yet his target behaviors were			

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	still distressing, and medication management did not appear to be effective. Resident #43 received multiple doses of Haldol in combination with other medications since October 2022. There was no documented effort by the facility to rule out other underlying causes of his symptoms. Resident #43 was never evaluated for psychiatric placement when geriatric and neuro-behavioral facilities are available in the surrounding areas. Contracted Psychiatric Group Progress Notes: From October 2023 to January 2022 the facility's contracted psychiatric service documented agitation, hallucinations, delusions, suicidal ideations, yelling and swearing in all of their notes. It did not appear from the medication regime being trialed was effective for him, there were no other efforts/interventions listed. 10/6/2022: " ...patient states I'm dying of that thing in my head. Staff report patient has been depressed, as evidenced by statements that he want to kill himself, as well as anxiety and increased agitation and irritability. Patient is said to have increased hallucinations and delusions recently ..." 10/21/2022: " ...Patient is said to have recently hit a CNA in the face leading to initiation of Haldol ...Patient has just been given a dose of Haldol for agitation. Patient is lethargic but happy ..."			

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11/4/2022:" ...patient is quit delusional, stating, I'm trying to get rid of weed from my house. I asked the devil and he said he would help. I don't want my kids on it. Staff report patient has recent extreme agitation for which PRN Haldol was restated by PCP ..."

11/25/2022: " ...Patient last seen on 11/4/22, at time which Seroquel was increased ...Patient was unable to be aroused by this writer ... agitation is said to be somewhat improved and anxiety related to delusions continues ...".

12/23/2022: " ...patient is delusional, stating that he is "fighting off biting bugs from trolls" ... staff report patient exhibits anxiety, agitation, and irritability, as well as hallucinations at times and delusions ..."

1/20/2023: " ...patient is delusional talking about being in the miliary and "if we get attacked ...." Staff report patient exhibits agitation, to include throwing food on the floor, swearing and yelling ...Hallucinations are noted in form of seeing bugs, as well as delusions regarding his belief that people are stealing from him ..."

Behavior Management Notes:

Resident #43 exhibited multiple behaviors including, auditory hallucinations, delusions, physical/verbal aggression, falls, at risk for resident-to-resident incidents, agitation,

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suicidal ideation, anxiety and depression over the last years. His notes indicated he never returned to his baseline prior to GDR of Seroquel in March 2022, Resident #43 continued to have erratic behavior that endangered the safety of staff and residents. Even with his documented mental health decompensation the facility only efforts were continued medication changes with hopes of stabilization.

2/2/23-3/21/22:

"(Resident #43) continues with periods of agitation and irritability d/t distressing hallucinations/delusions at times. Juan can become agitated when overstimulated and his environment is simplified as needed which is times he will present with distressing hallucinations/delusions. 6 documentations in behavior fracking sheets (3 during I st shift; 3 during 2nd) regarding (5) yelling out, (3 talking loudly, (6) cursing at others, (6) verbal aggression and (2) at risk for resident to resident incidents. 5 documentations in progress notes regarding the above mentioned. Staff report increased agitation, aggression and yelling following GDR in Seroquel.

03/22/22-4/21/22:

"(Resident #43) continues with periods of agitation and irritability d/t distressing hallucinations/delusions at times. He has exhibited an increase in agitation following a

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	GDR from 3/11/22. Med was increased back to prior dose on 3/23/22 though his agitation has not retuned to his baseline... 10 documentations in behavior tracking sheets 5 during 1 st shift; 4 during 2nd shift/ 1 during 3 rd shift regarding (9) yelling out, (3) talking loudly, (l) singing loudly, (7) cursing at others, (3) auditory hallucinations/delusional statements, (3) verbal aggression, (1) attempting to stand/self-transfer and (3) at risk for resident to resident incidents. 7 documentations in progress notes regarding the above mentioned ..." 04/22/22-5/21/22: "(Resident #43) continues with periods of agitation and irritability d/t distressing hallucinations/delusions at times. He has exhibited an increase in agitation following a GDR from 3/11/22. 24 documentations in behavior tracking sheets 6 during 1 st shift; 1 during 2nd shift, 7 during 3rd shift regarding (22) yelling out, (14) talking loudly, (2) singing loudly, (10) cursing at others, (3) auditory hallucinations/delusional statements, (12) verbal aggression, (7) attempting to stand/self-transfer and (10) physical aggression towards others. Numerous documentations in progress notes regarding the above mentioned. Seroquel was increased back to prior dose on 3/23/22 though his agitation has not returned to his baseline. PRNx14 days has been ordered and reordered d/t increased agitation (yelling, swearing, threatening, kicking etc). Klonopin			

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was started on 5/6/22, Seroquel was increased on 4/23/22 and again on 5/13/22. D/t continued agitation and aggression Topamax was started on 5/13/22. Genesight testing has also been ordered ..."

5/22/22-6/21/22:

"(Resident #43) continues with periods of agitation and initability, at times d/t distressing hallucinations/delusions. He has exhibited an increase in agitation following a GDR from 3/11/22. 19 documentations in behavior tracking sheets 7 during 1st shift; 8 during 2nd shift, 4 during 3 rd shift regarding (16) yelling out, (13) talking loudly, (10) singing loudly, (12) cursing at others, (8) verbal aggression, (l) attempting to stand/self-transfer, (4) throwing things, (5) physical aggression towards others and (l) entering other residents rooms uninvited... Seroquel was increased back to prior dose on 3/23/22 though his agitation did not returned to his baseline. Seroquel was increased again to Seroquel 50 mg BID and 100 mg HS on 6/10/22, Facility physician added Buspar on 6/18/22 d/t continued anxiety/agitation and changed PRN Ativan to PRN Xanax as Ativan was only somewhat effective ..."

06/22/22-7/21/22:

" (Resident #43) continues with periods of agitation and irritability, at times d/t distressing hallucinations/delusions. He has

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	exhibited an increase in agitation following a GDR from 3/11/22. 1 documentations in behavior tracking sheets down from 19 last month. Behaviors included 2 during 1 st shift; 9 during 2nd shift (10) yelling out, (9) talking loudly, (7) singing loudly, (7) cursing at others, (2) auditory hallucinations/delusions, (2) verbal aggression, (3) attempting to stand/self-transfer, (6) physical aggression towards others ...Seroquel was increased back to prior dose on 3/23/22 though his agitation did not returned to his baseline. Seroquel was increased again to Seroquel 50 mg BID and 100 mg HS on 6/10/22. Increased again to his current dose of 75/50/100. Facility physician added Buspar on 6/18/22 d/t continued anxiety/agitation and changed PRN Ativan to PRN Xanax as Ativan was only somewhat effective ..." 7/22/22-8/21/22: Analysis: Juan continues with periods of agitation and üTitability, at times d/t distressing hallucinations/delusions. He has exhibited an increase in agitation following a GDR from 3/11/22. 10 documentations in behavior tracking sheets down from 11 last month. Behaviors included 5 during 1 5t shift; 2 during 2nd shift 3 during 3rd shift (10) yelling out, (7) talking loudly, (2) singing loudly, (7) cursing at others, (1) auditory hallucinations/delusions, (4) verbal aggression, (3) attempting to stand/self-			

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transfer, (5) physical aggression towards others (lx) throwing things, (2) at risk for resident to resident incidents. Numerous documentations in progress notes regarding the above mentioned. Juan has also had attempts to self-transfer and several falls. Seroquel was changed to Risperdal on 8/12/22 following several increases of Seroquel without improvement Juan is followed closely by the SWGM for psychotropic medication management. Genesight testing was done and results were reviewed by physician.

8/22/2022-9/21/2022:

"(Resident #43) continues with periods of agitation and irritability ...distressing hallucinations/delusions. He has exhibited an increase in agitation following a GDR from 3/11/22. 13 documentations in behavior tracking sheets up from 10 last month. Behaviors included 1 during 1 shift; 9 during 2nd shift 3 during 3 rd shift (12) yelling out/talking loudly, (2) singing loudly, (10) cursing at others, (3) auditory hallucinations/delusions, (8) verbal aggression, (1) attempting to stand/self-transfer, (3) physical aggression towards others (2x) throwing things ...(Resident #43) has also had attempts to self-transfer and several falls ..."

9/22/22-10/21/22:

" (Resident #43) continues with periods of

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	agitation and irritability, at times d/t distressing hallucinations/delusions. He has exhibited an increase in agitation following a GDR from 3/11/22. 20 documentations in behavior tracking sheets up from 13 last month. Behaviors during 1 st shift 5; 12 during 2nd shift, 3 during 3rd shift (19) yelling out/talking loudly, (7) singing loudly, (12) cursing at others, (9) auditory hallucinations/delusions, (8) verbal aggression, (3) attempting to stand/self-fransfer, (3) physical aggression towards others, (1) at risk for resident to resident incident, (3) eneting other resident rooms uninvited, (4) stating that he wants to shoot himself/someone else ..." 10/22/22-11/21/22: " (Resident #43) continues with periods of agitation and initability, at times d/t distressing hallucinations/delusions. He has exhibited an increase in agitation following a GDR from 3/11/22. 3 documentations in behavior fracking sheets down from 20 last month. Behaviors included (3) yelling out/talking loudly, (2) cursing at others, (2) auditory hallucinations/delusions, (3) verbal aggression, (l) physical aggression towards others, (1) throwing things, (1) at risk for resident to resident incident ..." 11/22/22-12/21/22: "(Resident #43) continues with periods of agitation and irritability, at times d/t			

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	distressing hallucinations/delusions. He has exhibited an increase in agitation following a GDR from 3/11/22. 7 documentations in behavior tracking sheets. Behaviors included (7) yelling out/talking loudly, (7) cursing at others, (1) auditory hallucinations/delusions, (7) verbal aggression, (2) physical aggression towards others, Q) at risk for resident to resident incident... Haldol PRN was ordered and used during periods of significant agitation. 1 mg was not effective when used and was followed by additional does before effectiveness was noted. Haldol 2mg was SE when used ..." 12/22/22-01/21/23: "(Resident #43) continues with periods of agitation and irritability, at times d/t distressing hallucinations/delusions. He has exhibited an increase in agitation following a GDR from 3/11/22 ...agitation, aggression ...Haldol PRN was ordered and used during periods of significant agitation..." On 3/2/2023 at 1:10 PM, an interview was conducted with Social Worker "N" regarding Resident #43. She reported the resident was stable for some time on his medication regime and in March 2022 his Seroquel was decreased from 100 mg to 75 mg and this in turn led to him spiraling. Prior to the GDR he had intermittent outbursts but nothing that arose to his current level. In October 2022, with increased dosages of Seroquel, Resident #43 was still quite agitated, delusional, and			

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	combative. Social Worker "N" reported facility nurses would administer Xanax and it was not very effective and was switched to IM Haldol as needed. Social Worker "N" stated Resident #43 has been distressed, agitated, paranoid, yelling, swearing, and has destroyed his heater and broken a window. There have been no precipitating factors and/or triggers indicate. Social Worker "N" explained that managing his medication to illicit a positive response has been challenging and they still have not garnered the stabilization they would like from him or return to his baseline prior to the Seroquel GDR. Social Worker "N" was queried if any other interventions outside of medication management have been attempted to rule out underlined medical conditions, was he assessed for inpatient psychiatric unit that specializes in geriatrics or a neurobehavioral unit or other community referrals completed at an attempt to meet his needs. Social Worker "N" responded they did not. A conversation was held with Social Worker "N" that while they did attempt to manage Resident #43's persistent behaviors they were not effective and her posed a threat to staff/residents and more should have been attempted to stabilize the resident who was distressed and mentally decompensating. Social Worker "N" expressed understanding of this writer's concerns. It can be noted the facility monitored and documented the			

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multiple behavioral concerns and still failed to act and identify other options to assist him in mental health stability other.

On 3/9/2023 at 9:00 AM, a review was completed of the facility policy entitled, "Use of Psychotropic Drugs & Gradual Dose Reduction of Psychotropic Drugs," date: 12/4/2018. The policy stated, " ...The indications for initiating, withdrawing, or withholding medications(s), as well as the use of non-pharmacological approaches, will be determined by a. Assessing the resident's underlying condition, current signs, symptoms, expressions and preferences and goals for treatment b. Identification of underlying causes ...For psychotropic medications shall be initiated only after medical, physical, functional, psychosocial, and environment causes have been identified and addressed ...An evaluation shall be documented to determine that the residents' expressions or indications of distress are: 1. Not due to a medical condition or problems that can be expected to improve or resolve as the underlying condition is treated ..."

According to SOM (State Operations Manual), " ...Antipsychotic medications (both first and second generation) have serious side effects and can be especially dangerous for elderly residents. When antipsychotic medications are used without an adequate rationale, or for the sole purpose of limiting or controlling expressions or indications of distress without first identifying the cause,

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	there is little chance that they will be effective, and they commonly cause complications such as movement disorders, falls with injury, cerebrovascular adverse events (cerebrovascular accidents (CVA, commonly referred to as stroke), and transient ischemic events) and increased risk of death ..."			
F0761 SS= E	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, 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 ensure proper	F0761	F761 SS=E Label/Store Drugs and Biologicals The Director of Nursing, Assistant Director of Nursing and the In-service Department implemented corrective actions as follows: • Resident #63 Pataday drops were discarded and reordered from the pharmacy. • Resident #71 Ferrous sulfate medication was discarded and reordered from the pharmacy. • Resident #80 and #52 remaining Ipart-Albuterol ampules were discarded. • Resident #57 Promet/Codeine was corrected with an open date per the narcotic record. • Resident #58 Roxanol was corrected with an open date per the narcotic record. • All the medication carts in the facility have been cleaned and free of any loose medications. • The epinephrine injections on all the units have been moved from the crash carts to the locked medication carts on the units. • The crash cart check was immediately completed, locked, and the documentation corrected. The crash cart checkoff list has been updated with the epinephrine injection removed from the list. All residents have the potential to be affected by this practice. The Director of Nursing, Assistant Director of Nursing and the In-service Department will implement measures to ensure this practice	4/15/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	labeling of medications for 4 of 5 medication carts reviewed for proper labeling of medications and expired medications, and to properly secure a medication cart with medical supplies and prescription medications resulting in the opened and undated medications, potential for a resident to receive medications with decreased efficacy, and drug diversion or ingestion of unlocked medication. Record review of facility 'Storing Medications' policy provided by the facility (Undated) page 39-40, revealed medications and biologicals will be stored in a safe, secure, and orderly manner, at proper temperatures and accessible only to licensed nursing and pharmacy personnel or others authorized by law to administer medications... When not attended by a person permitted access, all medication storage areas must be kept locked. Record review of the facility pharmacy services policy 'Storage and Stability of Selected Medications' table dated May 2016, revealed that oral inhalation solutions (includes ipratropium bromide, albuterol sulfate, normal saline, cromolyn sodium, DuoNeb and generic DuoNeb) date when opened are stored at room temperature, protected from light (foil packet) keep in manufacture pouch for 90 days. Oral liquid medications date when opened in manufacturer containers- expire by manufacture date or 1 year from date		does not recur including: • The Director of Nursing revised and updated the facility's Glucoscan monitoring policy. • Educational meetings for licensed staff will be completed no later than 4/15/23. Education provided will include review of the medication storage policy, with emphasis on medications which require an open date and loose pills in medication carts. Review of the proper procedure and policy for glucose testing will be reviewed. Staff will be reminded it is third shift's responsibility for completing the crash cart audit nightly. The Director of Nursing, Assistant Director of Nursing and the In-service Department will monitor the corrective actions to ensure effectiveness by: • The in-service department will do random weekly inspections of medication carts to ensure medications which require an open date are dated per policy and medications carts are free of any loose pills. Medication audits will include ensuring the epinephrine injection is locked in the medication cart. • The in-service department will do random weekly audits of the crash cart checkoff lists to ensure completeness. Random weekly visual inspections will be completed to ensure the crash cart is locked when not in use. All results will be reported to the Quality Assurance and Process Improvement Committee quarterly until deemed no longer necessary.	

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	opened which comes first. Ophthalmic medications date when opened- all other multi-dose ophthalmic expire in 90 days. Medication Storage and Labeling: Observation and interview on 03/01/23 at 07:55AM Review of the 1 East medication cart with Registered Nurse (RN) "F" review of all drawers: Observed Resident #63 to have bottle of PATADAY 0.2% daily, eye drops, and the bottle does not have an open date, seal on bottle is broken. Review of the Narcotic box on 1 East med caret pulled meds and they matched the narcotic count in the narc sign out book. Review of the 1 East med room with refrigerator within normal temp, has an alarm when open too long or temp rises. Review of the (Pixis) "EMMA" dispensing machine in the other med room on the unit revealed a mid-size pixis machine with a narcotic dispensing machine on top. Reviewed the process to retrieve pixis meds with RN. Record review of destruction logs and Drug Buster system is used with two people to sign off on medications. Observation and interview on 03/01/23 at 08:20 AM of the 2 West medication cart reviewed on the south side of the unit with Registered Nurse (RN) "AA" review of all drawers: Resident #71 observed to have a large bottle of Ferrous Sulfate 300mg/5ML bottle was dispensed with 300ML, bottle was observed to be less than 200ml in bottle per RN "AA", seal is broken and there is no open			

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	date noted on the bottle or bag it was stored in. Observation of Resident #71 to have Glycerin suppositories noted to be open seal broken under lid, with no open date noted. Observation of the medication cart drawers revealed a loose white tablet found in the second drawer, RN "AA" did not know what the tablet was or whom/resident it belonged too. Observation and interview on 3/1/23 at around 8;30 AM with Licensed Practical Nurse (LPN) "BB" of the 2 West North medication cart, review of narcotic medication drawer revealed resident #57 medication of Promet/Codeine 6.25mg/10ml, dispensed with 400ml bottle, observed with estimated 88ml per LPN observation, there is no open date noted. Med cart review on 1 West unit (only has one med cart at this time in use) with Licensed Practical nurse (LPN) "CC", revealed Resident #80 inhalation medication of Ipart-Albuteral foil packet to be open, with no open date, and two missing ampules, comes with 5 ampules per packet. Observation of Resident #52 inhalation medication of Ipart-Albuteral foil packet to be open, with no open date, and two missing ampules, comes with 5 ampules per packet. Observed only 3 in the packet. Review of the narcotic drawer revealed Resident #58 had Roxinal 0.25mg, 20mg/ml, bottle dispensed with 30 ml resident received			

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	the last dose on 2/28/23 at 10:40PM there is no open date found by LPN "CC" on the bottle or box. Observation of Emergency Crash Cart: Observation was made on 2/28/23 at 10:15 a.m., on East Unit of the Emergency Crash Cart. The crash cart was left open; this surveyor opened it up and found a epinephrine injection pen (used in an emergency) in the second drawer. Review of the Emergency Cart Daily Checklist in the second drawer of the crash cart (on East Unit) revealed no documentation on 2/28/23 at the start of shift; the cart contents check had not been done. During an Interview done on 2/28/23 at 10:15 a.m., Nurse RN, "L" stated "I am new I don't know who is supposed to check it (the crash cart contents at start of shift)." During an interview done on 2/28/23 at 10:20 a.m., Nurse RN, "M" Manger stated "It (the crash cart check list) should be filled out and locked (the crash cart should be locked)" During an interview done on 3/1/23 at 12:00 p.m., Social Service "O" stated there were "24 residents who were confused on East Unit)."			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)	F0812	F812 – Food Procurement, Store/Prepare/Serve-Sanitary – failed to Ensure that food preparation and kitchen	4/15/2023

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	(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 1) Ensure that food preparation and kitchen equipment were maintained in a sanitary manner and in good working condition, and 2) Ensure that kitchen refrigerators' temperatures were properly done, resulting in an increased potential for food borne illness with possible hospitalization and with the potential to affect the census of 89 residents who consume nutrition from the facility kitchen. Review of the U.S. Health Service 2012 Food Code, as adopted by Michigan effective 10/12, directs that equipment cleaning frequency is to be "throughout the day at frequency necessary to prevent recontamination of equipment and utensils. The Food Code also directs no food		equipment were maintained in a sanitary manner and in good working condition, and ensure that kitchen refrigerators' temperatures were properly done, resulting in an increased potential for food borne illness with possible hospitalization and with the potential to affect the census of 89 residents who consume nutrition from the facility kitchen. Corrective Action for residents affected: • Maintenance repainted the floor mixer March 1, 2023. • Silver metal pan was pulled and rewashed, dried immediately February 28, 2023. • Wet Robot Coupe was immediately pulled and rewashed February 28, 2023; stored on drying rack until dry. • Pan and clear plastic cover was immediately washed to remove dust February 28, 2023. • Refrigeration Temperature Log missing was acknowledged and staff was immediately in-serviced on policy (Policy B003) of recording temperatures timely February 28, 2023. • Counter blender was immediately rewashed to ensure no food particles present February 28, 2023. • Juice machine with dried juice was deep-cleaned and sanitized immediately February 28, 2023. Identification of Residents with Potential to be affected: • All residents have the potential to be affected by the issues cited in the statement of deficiencies. Action Taken to Prevent Recurrence: • Establish routine equipment checks for defects or other physical contaminants. These to be performed monthly by manager. • Pans will be rotated to ensure debris and dust will not build up, in-service will be performed for staff. • In-service to be performed for storing dishes and equipment, ensuring items are properly	

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	equipment be stacked inside each other until completely (to decreased bacterial growth) dry, and potentially hazardous food shall be maintained at a safe temperature (time/temperature control for food safety). Review of the facility Cold Storage Temperatures policy dated 1/20, stated "Temperatures of food storage areas and cold food vendors are monitored, and action is taken to maintain temperatures within ranges recommended by licensing and surveying agencies. Each morning at opening and evening at closing, record temperatures of each storage unit (each refrigerator)." Findings Include: During the initial tour of the facility done on 2/28/23 at 9:20 a.m., accompanied by the Director of Dietary "Q" the following was observed: -At 9:20 a.m., the clean and ready for use floor mixer had silver paint chipping off the attachment area directly over the large bowel. -At 9:25 a.m., one clean and ready for use silver metal pan was observed to have dried white substance on the inside bottom. -At 9:29 a.m., the clean and ready for use Robot Coupe was found wet inside with the top on it. 2 Robot Coupe bowels in total were found wet inside.		cleaned, sanitized, and completely dried for storage. Assign designated personnel to monitor equipment during closing inspections to ensure it is stored away clean and sanitized before the next use. • In-service to be performed for filling in temperature logs timely for all staff for refrigeration. Refrigerator and Freezers remain under 24-hour electronic monitoring for temperatures falling out of range. • Staff will perform cleaning procedures on juice machine weekly (previously monthly deep cleaning) to ensure equipment and areas are cleaned in accordance with the weekly kitchenette cleaning list: “Individual Area Cleaning Schedule and Checklist”. Schedule will be initialed by personnel weekly. • All in-services to be completed by April 15, 2023. • Dining Services management will monitor for sanitary conditions on an on-going basis. Monitoring Corrective Action and Responsibility: • Executive Chef, Dietary Manager or designee will conduct Food Safety and Sanitation Audit 2 times a week for 4 weeks and then monthly thereafter. This audit includes equipment, storage, preparation & production, and cleaning & sanitizing. • Dining Service Manager will report the results of the sanitation audits to Bay County Medical Care Facility QA committee quarterly or until QA committee deems no longer necessary.	

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During an interview done on 2/28/23 at 9:29 a.m., Prep Cook "T" stated "It should be cry inside."

-At 9:30 a.m., a pan covered with a clear plastic cover was observed with the cover having several pieces of dried food particles on it and some dust.

-At 9:35 a.m., refrigerator #8's temperature log had no documentation for 2/27/23, nor for 2/28/23 am.

Review done on 2/28/23 during initial tour of the kitchen revealed the facility Refrigeration Temperature Record dated 2/23, revealed no data recorded of a temperature done on "2/27/23" and no morning temperature recorded on "2/28/23."

During an interview done on 2/28/23 at 9:35 a.m., Dietary Director "Q" stated "It (Refrigerator #8's temp. log) should be filled in (for 2/27/23 and for 2/28/23 am)."

-At 9:46 a.m., the clean and ready for use counter blender had dried food particles inside.

Observations made of the East Wing Kitchenette observations done on 2/28/23 at 10:00 a.m. accompanied by Dietary Director "Q":

-Observations done at 10:12 a.m. and at

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	10:40 a.m., revealed the juice machine was found to have an excessive amount of dried juice around all the spigots. During an interview done on 2/28/23 at 10:40 a.m., Dietary Aide "S" said she had "wiped it (the juice machine) down."			
F0880 SS= D	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation	F0880	F880 SS=D Infection Prevention & Control The Director of Nursing, Assistant Director of Nursing and the In-service department implemented corrective actions for this practice including: • The Infection Prevention Department was educated on importance of complete documentation in the infection control monthly data collection book including importance of staff education when warranted. • The licensed nurse involved was educated on proper use of PPE on the Covid unit. • There are no immediate corrective actions for the 12 residents and 10 staff members involved in the GI outbreak as symptoms have resolved. • The licensed nurse involved in the glucose testing for resident #49 has been educated on the proper procedure for glucose testing. All residents/employees have the potential to be affected by this practice. The Director of Nurses and the In-service Department will implement measures to ensure this practice does not recur including: • The Infection Prevention Director has completed the Infection Surveillance through the CDC. Modules included: Surveillance and its purpose, types of surveillance measures and methods, recommended practices for developing a surveillance plan and identify resources for collecting, managing, analyzing, and reporting surveillance data.	4/15/2023

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	should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to 1) ensure resident monthly infection data was analyzed for 1/23 through 2/23, 2) ensure personal protective equipment (PPE) was worn appropriately on the COVID unit, 3) promptly investigate an outbreak of gastrointestinal (GI) infections for 12 resident's (Resident's #8, 13, 19, 28, 40, 42, 45, 56, 69, 75, 77, and 289) and 10 staff members, and 4)ensure contact isolation precautions were followed for R#49 for their blood glucose test of a sample of 21 residents reviewed for infection control,		• 2 types of the same infection on one nursing unit will require staff education by the Infection Prevention Department. • The Director of Nursing and the Infection Director developed a facility Outbreak Policy. • Signage has been placed on the Covid unit indicating wear PPE is no longer required such as the break room. • Educational meetings with licensed staff will be completed no later than 4/15/23. Education included is proper PPE use emphasis on the Covid unit, facility glucose monitoring policy with demonstration of proper procedure and early detection of residents with GI symptoms including interventions to put in places such as hydration, monitoring of labs etc. The new Outbreak policy will be included in the education. • An outbreak investigation form has been developed and will be utilized with any out break situation to ensure the investigation is thoroughly investigated. The Director of Nurses and the In-service Department will monitor the corrective actions to ensure effectiveness by: • The In-service Department will do weekly random observations of glucose monitoring. • The In-service Department will do weekly random visual observations of proper PPE use including on the Covid unit when in use. • The Director of Nursing, Assistant Director of Nursing and the Infection Prevention Department will meet weekly to review the monthly infection control book to ensure complete documentation, staff education and proper analyzation of infections is being done. • An outbreak committee has been developed and they will meet immediately with any outbreak investigation to ensure all pieces of the outbreak are completed such as staff education, proper notifications, precautions in place etc.	

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	resulting in the likelihood for cross contamination, resident and staff illness with possible hospitalization, increased risk for the spread of COVID, and a facility wide gastrointestinal (GI) outbreak. Findings Include: Analyzing of Infection Control Data: Review of the facility resident infection control monthly data collection dated 1/23 and 2/23, revealed blank analyzing areas and incomplete analyzing of monthly data, no plan for staff education and no staff education done regarding resident infections. During an interview done on 3/1/23 at approximately 8:15 a.m., Infection Control Nurse, RN "K," said she did not do any analyzing of the monthly resident infection data for 1/23, or 2/23. Review of the facility General Infection Prevention and Control Policy dated 5/21 and per Michigan Infection Control Society 2001, revealed a facility infection control program collects data, investigates data (includes analyzing data) and make recommendations for staff education based on data analyzes. GI Investigation: Resident #8: Review of the Face Sheet, physician orders dated 10/22, and care plans dated 10/22		All results will be reported to the Quality Assurance and Process Improvement Committee until deemed no longer necessary.	

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through 2/23, revealed Resident #8 was 88 years old, had impaired cogitation and was admitted to the facility on 11/11/22 and discharged on 2/27/23. The resident's diagnosis included, surgical aftercare, chronic pain, dementia, kidney disease, and anemia with a history of colon cancer. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #13:

Review of the Face Sheet, physician orders dated 10/22, and care plans dated 4/21 through 2/23, revealed Resident #13 was 85 years old, was admitted to the facility on 4/29/21. The resident's diagnosis included, GI hemorrhage, vit D deficiency, back fractures, delayed healing, chronic pain, anemia, anxiety, and depression. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #19:

Review of the Face Sheet, physician orders dated 2/27/23, and care plans dated 2/23, revealed Resident #19 was 74 years old, had

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impaired cogitation and was admitted to the facility on 2/27/23. The resident's diagnosis included, respiratory failure, hemiplegia, diabetes, falls, mood disorder and vascular dementia. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #28:

Review of the Face Sheet, physician orders dated 7/22 to 2/23, and care plans dated 7/22 through 2/23, revealed Resident #28 was 88 years old, had impaired cogitation and was admitted to the facility on 7/11/22. The resident's diagnosis included, dementia, chronic pulmonary disease, heart disease, emphysema, mood disorder and depression. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #40:

Review of the Face Sheet, physician orders dated 1/23 to 2/23, and care plans dated 1/23 through 2/23, revealed Resident #40 was 66 years old, had impaired cogitation and was admitted to the facility on 1/29/23. The resident's diagnosis included, chronic

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pain, chronic kidney and heart disease, anxiety disorder, depression colon cancer and falls. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #42:

Review of the Face Sheet, physician orders dated 7/22 through 2/23, and care plans dated 7/22 through 2/23, revealed Resident #42 was 83 years old, had impaired cogitation and was admitted to the facility on 7/28/22. The resident's diagnosis included pulmonary disease, kidney disease, atrial fibrillation, pressure ulcer, metabolic alkalosis, dehydration, GI bleed, aspiration pneumonia and anxiety. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #45:

Review of the Face Sheet, physician orders dated 2/23, and care plans dated 2/23, revealed Resident #45 was 80 years old, had impaired cogitation and was admitted to the facility on 2/24/23. The resident's diagnosis included Barrett's esophagus with a cardiac pacemaker in place. Review of the resident's

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	facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring. Resident #56: Review of the Face Sheet, physician orders dated 1/23 through 2/23, and care plans dated 1/23 through 2/23, revealed Resident #56 was 69 years old, and was admitted to the facility on 1/31/23. The resident's diagnosis included lung cancer, metabolic encephalopathy, urinary tract infection, heart failure, chronic lung disease, myocardial infarction (heart attack) and anxiety. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring. Resident #69: Review of the Face Sheet, physician orders dated 2/23, and care plans dated 2/23, revealed Resident #69 was 55 years old, and was admitted to the facility on 2/1/23. The resident's diagnosis included, metabolic encephalopathy, heart failure, chronic lung disease, respiratory failure, kidney disease with renal dialysis, colostomy, and skin cellulitis with major depression and anxiety. Review of the resident's facility care plans			

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and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #75:

Review of the Face Sheet, physician orders dated 2/23, and care plans dated 2/23, revealed Resident #75 was 87 years old, had decreased cognition and was admitted to the facility on 2/24/23. The resident's diagnosis included absence of left leg above knee, bronchitis, muscle weakness, falls, dysphagia and dementia. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #77:

Review of the Face Sheet, physician orders dated 1/22 through 2/23, and care plans dated 1/22 through 2/23, revealed Resident #77 was 85 years old, had decreased cognition and was admitted to the facility on 11/24/22. The resident's diagnosis included Alzheimer's disease, muscle weakness, rotator cuff tear, spinal stenosis, kidney disease, bone density disorder, dementia, anxiety, and depression. Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet

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precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Resident #289:

Review of the Face Sheet, physician orders dated 2/23, and care plans dated 2/23, revealed Resident #289 was 71 years old, had decreased cognition and was admitted to the facility on 2/25/23. The resident's diagnosis included pneumonia, bacteremia (infection in blood), heart failure, pulmonary disease, abdominal aortic aneurysm, kidney failure and depression Review of the resident's facility care plans and room daily care plan dated 2/23 through 3/23, revealed no droplet precaution care plan with interventions regarding precautions put in place or GI symptom's, hydration, or labs monitoring.

Review of the facility Transmission Based Precautions policy dated 9/22, revealed for droplet precautions staff were to use masks, gloves and gowns and residents were to be placed in private rooms is infection control deemed necessary.

Review of the facility General Infection Prevention and Control Policy dated 5/21, stated "A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable disease for all residents, staff, volunteers, visitors and other individuals providing services."

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Review of the facility Infection Control Response and Investigation Policy dated 2/27/23 (after the GI outbreak started) stated "The facility promptly responds to outbreaks of infectious diseases within the facility to stop transmission of pathogens and prevent infections. Staff will be educated on the mode of transmission of the organism, symptoms of infection, and isolation or other special procedures. Surveillance activities will increase to daily for the duration of the outbreak. The Infection Control Preventionist (Nurse "H") will be responsible for coordinating all investigation activities." No documentation of daily investigations of outbreak chain of contraction from staff to residents and residents to residents was found.

During an interview done on 2/28/23 at 11:18 a.m., Infection Control Nurse's "H" (RN), "I" (LPN) and "J" (LPN) along with the Director of Nursing reviewed the facility documentation of the GI outbreak which was documented as starting on 2/14/23 and ending on 2/25/23. During the interview, it was concluded per facility documentation there was a total of 12 residents and 10 staff members who had GI signs/symptom's between 2/15/23 and 2/25/23.

Review of the facility Infection Control documentation of the GI outbreak revealed the following:

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	-On 2/14/23 2 staff members called in with GI sign's/symptoms (S/S's) and Residents #28 and #42 had GI symptoms (one resident resided on 1 West and other on 1 East Unit). -On 2/15/23, Resident #13 had symptoms (resided on 1 East). -On 2/17/23, 3 Nursing Assistant's/CNA's called in sick with GI S/S's. -On 2/18/23, resident's #69 and #289 from 1 East had GI S/S's. -On 2/19/23, resident #75 from 1 East had GI S/S's. -On 2/20/23, resident's #19, #56, and #77 from 1 East had GI S/S's. -On 2/22/23, resident #8 from 1 East had GI S/S's. -On 2/24/23, resident's #40 and #45 from 1 East and 3 staff members had GI S/S's. -On 2/25/23, 2 staff members had GI S/S's. A total documented of 12 resident's and 10 staff members had GI S/S's. During an interview done on 3/1/23 at approximately 8:15 a.m., the Infection Control Coordinator, RN "K" said the facility had not documented a GI outbreak investigation including the 12 residents and 10 staff			

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members documented as having GI symptoms of an outbreak. Nurse "K" confirmed no additional staff/visitor education regarding staff call-in illnesses or droplet precautions had been done until 2/28/23.

During an interview done on 2/28/23 at 4:00 p.m., Medical Director, MD "G" said extra staff education could have been done at the start of the outbreak (prior to 2/24/23) regarding the GI outbreak. No documentation was given to this surveyor per request of any staff education regarding the GI outbreak until 8 days after the start of the resident S/S's had been reported to infection control.

Review of facility staff education dated 2/24/23, revealed staff were informed of residents with nausea, vomiting and diarrhea; however, no resident names or room numbers were given.

Improper Use of PPE on COVID Unit:

Review of the postings on the wall at the entrance to the COVID unit and in the staff PPE room revealed, instructions on what kind of PPE (including mask and hood/PAPR) and how to properly put them on and take them off.

Observation was made of the COVID unit on 3/2/23 at 11:36 a.m., accompanied by infection control coordinator "K." During the observation, Nurse, LPN "P" was observed at

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	the end of a hall with her protective hood pulled completely off her face. Nurse "K" informed Nurse "P" she should be taking her break in the break room and her hood had to be completely pulled down over her face while on the unit. Review of Nurse "P's" facility orientation dated 9/28/22, revealed she had been instructed on basic infection control procedures (including proper use of PPE). On 3/02/23, at 2:02 PM, Nurse "NN" was at the medication cart and had gathered supplies to check Resident #49's blood sugar at the bedside. Nurse "NN" placed the bottle of blood strips in a plastic cup along with the other supplies. Nurse "NN" walked to Resident #49's room set the cup down, donned a gown and gloves and then picked up the cup with the blood strips. Nurse "NN" set the cup down on the over bed table. Nurse "NN" prepared Resident #49 's finger, then opened the multi-use bottle of strips and grabbed a blood test strip with their gloved hand. Nurse "NN" completed the task, doffed their PPE and walked towards the medication cart. Nurse "NN" was asked if they had cleaned and disinfected the bottle of test strips and Nurse "NN" stated, no. Nurse "NN" was asked why they didn't take just a few of the strips inside the contact isolation room and Nurse "NN" stated, yeah, I should have. Nurse "NN" was asked why Resident #49 was in contact isolation and the resident in bed 1 had tested positive for			

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	COVID-19 a few days prior. On 3/03/23, at 10:43 AM, Infection Control (IC) Nurse "K" was alerted that Nurse "NN" took the multi-use bottle of blood test strips into a contact isolation room and IC Nurse "NN" stated, they shouldn't do that. A review of the facility provided "BLOOD GLUCOSE MONITORING POLICY Reviewed: 12/21/22" revealed "Obtain equipment and supplies: Gloves, glucometer, alcohol pads, lancets, blood glucose testing strips ... Insert glucoscan strip into glucometer ... remove strip and dispose of properly ... Clean glucometer with a bleach based wipe after each use ... "			
F0909 SS= E	Resident Bed §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to conduct consistent enabler bar safety inspections for five ((#16, #17, #23, #39 and #51) residents of 53 residents who utilize enabler bars to enhance their bed mobility. Resulting in, residents	F0909	F909 SS=E Resident Bed- Assist Bars Maintenance Staff failed to upload documentation that proved they checked each resident bed with enabler bars in the facility. During the period of June -August 2022 the bed rail safety checks were not completed. The Plant Operations Director implemented corrective action(s) is as follows: • A new rule was implemented within out Tels work order system for this specific reoccurring work order. We will now require a document of completion to be uploaded before the work order will be allowed to be marked as complete within the system. This will ensure that the checks are being completed and that we will not be missing any future paperwork. • We will also be conducting an initial facility wide assessment of assist rails on resident beds. All residents have the potential to be affected	4/15/2023

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	assist bars not being regularly inspected by maintenance for secure placement, supporting documentation being completed for safety inspections and the possibility of entrapment. Findings Include: On 2/28/2023 during initial tour, multiple residents (#16, #17, #23, #39 and #51) were observed to have bilateral assist bars affixed to their beds. - Resident #16 was observed in his wheelchair in his room, he reported he recently admitted at the facility and the bedrails were already on his bed upon admission. - Resident #39 was observed to be resting in bed and bilateral assist bars were affixed to his bed. - Resident #51 was observed in his room and was in a pleasant mood. He reported he utilized the bilateral assist bars to reposition in bed. On 2/28/2023 at approximately 4:00 PM, a review was completed of Resident #16's medical records and it showed the resident was admitted to the facility on 1/16/2023 with diagnoses that included Nontraumatic subarachnoid hemorrhage, Diabetes, Anxiety and Major Depressive Disorder. According to facility documentation Resident #16's		by this practice. The Plant Operations Director will implement measures to ensure this practice does not recur by: • Educating our maintenance team during our POC training regarding work order changes and make it clear to all staff performing these checks that the documentation needs to be completed thoroughly and within the correct specifications. The Plant Operations Director will monitor the corrective actions to ensure effectiveness by: • Reviewing the reoccurring Tels work orders and making sure that they are being done as specified. All results will be reported to the Quality Assurance and Process Improvement Committee until deemed no longer necessary.	

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	bilateral assist bars were placed on 1/7/2023 which is consistent with the statement he provided to this writer. On 2/28/2023 at approximately 4:05 PM, a review was completed of Resident #17's medical records and it indicated the resident was initially admitted to the facility on 9/8/2021 with diagnoses that included: Parkinson's Disease, Dementia, Congestive Heart Failure, Peripheral Vascular Disease and Major Depressive Disorder. Resident #17's bilateral enabler bars were placed on 9/9/2021. On 2/28/2023 at approximately 4:10 PM, a review was completed of Resident #23's medical records and it indicated Resident #23 was admitted to the facility on 6/8/2021 with diagnoses the included: Congestive Heart Failure, Atrial Fibrillation, Dementia and Bipolar Disorder. Resident #23's bilateral enabler bars were placed on 6/10/2021. On 2/28/2023 at approximately 4:15 PM, a review was completed of Resident #39's medical records and it showed the resident was admitted to the facility on 11/17/2018 with diagnoses that included Heart Disease, Diabetes, Atrial Fibrillation, Dementia, Anxiety and Kidney Disease. Resident #23's bilateral enabler bars were placed on 11/9/2020. On 2/28/2023 at approximately 4:20 PM, a review was completed of Resident #51's medical record and it revealed the resident			

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	was admitted to the facility on 12/15/2022 with diagnoses that included: Chronic Obstructive Pulmonary Disease, Heart Disease, Myocardial Infarction and Spinal Stenosis. Resident #51's bilateral enabler bars were placed on 12/27/2022. On 3/1/2023 at 8:56 AM, an interview was conducted with Maintenance Crew Member "U" regarding safety monitoring of residents assist bars. Crew Member "U" reported he did not believe there were any additional checks being completed on the bilateral assist bars as they are secured to the bed. On 3/1/2023 at 11:58 AM, Therapy Manager "V" was interviewed regarding enabler bar assessments. Manager "V" explained they (therapy department) completed an assessment for each resident prior to assist bars being installed. Manager "V" stated if they met criteria based on their assessment they explain to the resident (or their responsible party) the risk versus benefits associated with usage of assist rails and obtain verbal consent. A request is placed through their maintenance system and a staff from that department will place the rails on the residents' bed. Manager "V" stated they complete quarterly assessments of the residents to assess their continued need for the assist bars. On 3/1/2023 at 1:25 PM, an interview was conducted with Restorative Nurse "W" regarding their role in residents assist bars.			

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	Nurse "W" explained every three months assessment/measurements are completed on the side rails to ensure entrapment does not occur. Nurse "W" stated their list is reconciled with the therapy department to ensure accuracy. Nurse "W" was queried if maintenance completed safety checks on the bedrails and she explained their department has asked them for a list of residents with rails but it unsure as to their process. On 3/1/2023 at approximately 2:30 PM, a review was completed of TELLS (electric maintenance request system) "Work History Report" for bed rail safety inspections. TELLS generates a monthly tasks list for maintenance with one of those task being "Beds & Mattresses: Inspect bed Rails." Their task description does not indicate which facility residents have bed rails, they have to manually upload the "Assist Bar List" which shows each resident with enabler bars, the staff who completed the inspection and when. Of the eight months of documentation provided, three months (April 2022, September 2022 and December 2022) maintenance staff failed to upload documentation that proved they checked each resident with enabler bars in the facility. In June 2022, July 2022, and August 2022 the bed rail safety checks were not completed. The documents showed the following: 4/2022: Safety checks completed assist bar list was not uploaded.			

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	6/2022: Assist bar safety checks was not completed. 7/2022: Assist bar safety checks was not completed. 8/2022: Assist bar safety checks was not completed. 9/2022: Safety checks completed assist bar list was not uploaded. 12/2022: Safety checks completed assist bar list was not uploaded. It can be noted there are 53 facility residents that utilize enabler bars at the time of survey. On 3/1/2023 at 2:46 PM, an interview was conducted with Maintenance Crew Member "R" regarding safety checks on facility resident assist bars. He explained TELLS prompts their department to complete the safety checks and the receive a list from Restorative Nurse "W" of all residents with enabler bars. During the inspection they ensure the enabler bars are secure and check to make sure the enabler bar cover is not ripped. Upon completion of the task, they upload their documentation into TELLS and mark it as completed. Crew Member "R" at some point they switched to completing the safety checks every quarter instead of every month, but he cannot recall when that was. Crew Member "R", "X" and this writer reviewed TELLS "Work History Report," and			

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subsequent attached documentation. Crew Member "R", reported he will request a list from Restorative and then upload it into TELLS once the safety checks have been completed. Maintenance Crew Member "X" explained he pulled the reports that are being reviewed and there were only two, assist bar list's attached to the tasks in TELLS. They did not have another way to show this writer which residents were reviewed during the enabler bar inspections as the task was marked off and the documentation was not uploaded.

On 3/2/2023 at 2:30 PM, Maintenance Crew Member "R" reported he searched for hard copies of the Assist Bar Lists for and was not able to locate them. He stated going forward they will not be able to mark the bed rail safety checks as completed until they attach the document to the task.

On 3/7/2023 at 3:20 PM, a review was completed of the policy entitled, "Assist Bar Policy and Procedure," revised 8/31/22. The policy stated, " ...Occupational Therapy will complete the resident's comprehensive assessment ...The facility shall: a. Assess the resident for risks of entrapment, and other risks associated with the use of assist bars ...b. Document the condition, symptom, or functional reason for the use of the side/bed rail ...Checking bars regularly to make sure they are still installed correctly, and have not shifted or loosened over time ...d. The maintenance director, or designee, is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	098510	A. BUILDING _____ B. WING _____	**3/7/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY COUNTY MEDICAL CARE FACILITY	**564 W HAMPTON ROAD ESSEXVILLE, MI 48732**

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	responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses and rails."			