STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	234060	A. BUILDING _____ B. WING _____	3/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIMONDALE NURSING CARE CENTER	4000 N MICHIGAN ROAD DIMONDALE, MI 48821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Dimondale Nursing Care Center was surveyed for a Recertification survey on 3/16/2023. Intakes: MI00134682. Census: 119	F0000		
F0584 SS= D	Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as	F0584	F584 Safe, Clean, Comfortable, Homelike Environment S/S: D 1. The room for resident #4 was cleaned and sanitized. All residents have the potential to be affected. 2. A one-time audit was completed of resident rooms to ensure all were clean, comfortable, and homelike. Root Cause: Process of cleaning resident rooms daily was not followed. 3. The housekeeping staff were re-educated on ensuring all resident rooms are cleaned daily. System change: Resident rooms will be cleaned daily. 4. The administrator/Designee will audit 5 rooms to ensure they are clean and homelike weekly x 12 weeks. Any non-adherence will result in 1:1 education. All audits will be sent to the QA committee for review.	4/6/2023

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

Electronically Signed | 04/05/2023

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	evidenced by: Based on observation and interview, the facility failed to ensure a sanitary and clean environment for one Resident (Resident #4) resulting in a soiled room and dissatisfaction with their living conditions. Findings include: **Resident #4** **Review of an Admission Record revealed Resident #4 (R4) admitted to the facility on 11-11-2022 with pertinent diagnoses which included morbid obesity, cellulitis of the right and left leg, generalized anxiety disorder, and type 2 diabetes. The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/18/23, reflected R4 scored 15 of out 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The same MDS reflected R4 did not walk and required extensive to total assistance of one person to toilet.** **In an observation and interview on 03/13/23 at 07:24 AM, R4 reported that her room does not get cleaned in a timely manner. R4 stated that sometimes housekeeping staff does not come in for "days at a time" and even after requesting for her room to be cleaned, it does not always happen. R4 reported that there was a urine-soaked towel on her bathroom floor that had been there for three days, and no one ever makes the bed in the morning. An observation was made of the floor and room which was visibly dirty, soiled with crumbs and trash. The surface of R4's**			

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	bedside table was visibly dirty with several spots of residue. I observed a wad of Kleenex on floor, alcohol wipe wrapper, milk dud box, insulin strip, and the cap off a lancet used to perform a blood glucose test. In the bathroom was a towel on the ground and the bathroom trash was overflowing. In an observation on 3/13/23 at 1:02 PM, R4's room continued to be visibly soiled with crumbs and debris on the floor and the bed unmade. In an observation and interview on 03/14/23 at 11:01 AM, R4's room continued to be visibly soiled with crumbs and debris on the floor and the bed unmade. R4 denied having housekeeping in to clean the room over the weekend or yesterday. R4 reported the "bucket for the bedside commode would not fit under the bedside commode overnight so urine got in the floor three times, and it smelled horrible in here." Observed what appeared to be urine on the floor under bedside commode bucket and urine in the bedside commode bucket. R4 stated she is just terribly unhappy with the mess. In an observation on 3/14/23 at 3:14 PM, R4's room continued to be visibly soiled with crumbs and debris on the floors and the bed unmade. In an interview on 03/16/23 at 08:56 AM, Housekeeping Staff Member "N" reported that when Housekeeping enters a resident's room, the cleaning process is to collect visible trash, clean the bathrooms by disinfecting and cleaning the sink, mirror, toilet, and floor. Next, sweep and mop the main floor. When asked if R4 refused housekeeping services Staff Member "N"			

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	reported that R4 does not refuse any cleanings.			
F0604 SS= D	Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were free from physical restraints imposed for the purpose of convenience in 1 of 1 resident (Resident #102) reviewed for restraints, resulting in the restriction of mobility and a potential for decline in	F0604	F604 Physical Restraints S/S: D 1. Resident #102 was re-assessed and no longer has physical restraints in place. All residents have the potential to be affected. 2. A one-time audit of the current facility census was completed to ensure any resident with a restraint had appropriate physician orders, assessments and care plans as indicated. Root cause: clinical staff lacked understanding of the requirements that must be in place in order to implement a physical restraint. 3. Clinical staff were re-educated regarding physical restraints and related requirements, including physician orders, assessments, and care plans. System change: residents identified as possibly benefiting from a physical restraint will be referred to the therapy department to determine if there is a medical indication for a physical restraint. The facility will continue to monitor/assess quarterly for an ongoing need. 4. The DON/Designee will review 5 residents weekly to ensure if there is a physical restraint that all of the proper assessments and orders have been completed. Any non-adherence will result in 1:1 education. All audits will be sent to the QA committee for review	4/6/2023

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physical functioning and psychosocial wellbeing. **Findings Include:**

Resident #102

Review of an Admission Record revealed Resident #102 (R102) admitted to the facility on 01-24-2023 with pertinent diagnoses which included cerebral infarction (stroke), aphasia (a comprehension and communication disorder), muscle weakness, dysphagia (a condition with difficulty in swallowing food or liquid), history of falling, vascular dementia, hemiplegia and hemiparalysis following cerebral infarction affecting right dominant side, and unsteadiness on feet. The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/30/23, reflected R102 scored 0 of out 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The same MDS reflected R102 did not walk and required extensive to total assistance of one to two or more people to perform most activities of daily living.

In an observation on 03/14/23 at 11:11 AM, R102 was seen seated in her wheelchair in the hallway at the nurse's hub area. R102 was observed wearing standard socks and had a pillow placed behind her ankles and heels. A bedside table on wheels was in front of resident. R102 was awake and observing staff as they walked by.

In an observation and interview on 03/14/23 at 11:37 AM, R102 was seated in her wheelchair with a bedside table in front of her. I asked R102 if she was able to push the bedside table away from in front of her. R102

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	attempted to push the bedside table away but was unsuccessful in pushing the bedside table away from in front of her. In an interview on 03/14/23 at 12:14 PM, Certified Nursing Assistant (CNA) "I" reported the fall interventions for R102 included placing two mattresses on the floor beside her bed and giving R102 a "bedside table to rest on because she was trying to get up out of her wheelchair when she fell, so they put the table in front of her". In an observation and interview on 03/14/23 at 01:28 PM Certified Nursing Assistant (CNA) "K" reported that R102 was able to push the bedside table away from in front of her while she was seated in her wheelchair. When asked to demonstrate, R102 nor CNA "K" were able to push the bedside table away from in front of R102. CNA "K" reported that the bar that runs underneath the bedside table is behind the front wheels of R102's wheelchair, making it unable to be pushed away from in front of R102. In an observation on 03/14/23 at 03:13 PM, R102 was in her bed, awake and attempting to wiggle side to side. R102 reached towards the doorway and said "I want to... I want to...I need." The bed was in the lowest position on the floor and two bed mattresses were placed on the floor next to the bed. R102's right side of the bed was up against the wall and a body pillow that was the length of the bed was observed tucked under R102's fitted sheet on the left side of the bed. A second body pillow was observed in the room on the resident's bedside table. In an observation and interview on 03/15/23 at 08:18 AM, R102 was observed sleeping			

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	on one of the floor mattresses adjacent to her bed. One of the body pillows was observed on the floor to the left of R102. When asked about the purpose of the body pillows, Certified Nursing Assistant "I" reported that they are to assist with preventing falls out of bed. In an interview on 03/15/23 at 12:48 PM, Certified Nursing Assistant (CNA) "L" reported that the body pillows are used to keep [R102] from "rolling out of bed. [R102] rolls out of bed all night long ... several times a night. [R102] rolls over the single body pillow so sometimes we double them up ... the other day I was down there we had the body pillows doubled up. [R102] can't roll out of bed when we double them up." Review of the Care Plan revealed that R102 had an at risk for falls section initiated on 1/20/23 related to diagnosis including but not limited to stroke with cognitive/communication deficits, right sided hemiparalysis, weakness, unsteadiness, need for assistance with care, vascular dementia, history of seizures, and incontinence. Some interventions included assess and treat pain, bilateral mattress on my side that I sometimes roll onto, call light accessible (touch pad), wearing nonskid footwear for transfers, orient to surrounds, observe for medication side effects, and provide with a bedside table while up in wheelchair to rest my head on. A Falls Assessment dated 3/7/23 revealed the Interdisciplinary Team reviewed the fall for root cause. R102 was "leaning forward in w/c (wheelchair) and fell over onto floor. Will offer resident bedside table while up in wheelchair to rest head on."			

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	In a phone interview on 03/15/23 at 01:16 PM, Certified Nursing Assistant (CNA) "J" reported she witnessed the fall that occurred on 3/7/23. CNA "" was walking down the hallway towards R102 and observed R102 reaching down toward her feet when she started tipping forward out of her wheelchair. **In an interview on 03/15/23 at 02:14 PM, Director of Nursing (DON) "B" reported that she was unaware that R102 had body pillows in use and that they body pillows were being utilized as a fall intervention. DON "B" reported that the use of the pillows would be acceptable for comfort or positioning, but that they should not be used for ensuring that R102 could not roll out of bed.** **Review of a "Restraint Policy", dated 7/1/08 provided by the facility revealed a policy statement: "Restraint's must be used only as a last resort ...restraints not to be used as ...convenience for staff or substitute for supervision ...restraints only to be used with a Physician Order."** **Review of the State Operations Manual Appendix PP, a "Physical restraint" is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: Is attached or adjacent to the resident's body; cannot be removed easily by the resident; and restricts the resident's freedom of movement or normal access to his/her body."**			
F0657 SS= D	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	F0657	F657 Care Plan Timing and Revision: S/S: D 1. Resident #23's care plans were reviewed by the IDT and updated as appropriate. All	4/6/2023

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	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 each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to review, revise, and update a comprehensive, individualized plan of care for one of five residents (Resident #23) reviewed for comprehensive care plans, resulting in the potential for impaired physical, mental, and psychosocial well-being. Findings include: Resident #23 (R23) Review of the medical record reflected R23 was an initial admission to the facility on		residents have the potential to be affected. 2. A one-time audit of care plans for the current census was completed to ensure care plans were reviewed and updated with interventions in place that meet the needs of each resident. Root cause: Facility staff did not update the care plans with new interventions timely. 3. The clinical staff was re-educated on updating care plans when events or changes occur for each resident. System Change: Care plans will be updated daily as indicated based on IDT discussion, 24-hour report review, orders review, etc. 4. DON/Designee will review 5 resident care plans weekly x 12 weeks to ensure that care plans are being updated timely with new or changed interventions. DON will be responsible for compliance. Any non-adherence will result in 1:1 in education. All audits will be taken to the QA committee for review.	

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	05/11/2022 with a re-admission on 01/10/23 with diagnoses of Crohn's disease, diabetes, unspecified dementia without behaviors, depression, anxiety and weakness. R23 was diagnosis with unspecified psychosis not due to a substance or known physiological condition on 02/23/23. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/17/2022, revealed R23 had a Brief Interview of Mental Status (BIMS) of 12 (moderately impaired) out of 15. Section F of the MDS under routine and activities revealed R23 rated making choices for herself was very important to her, including choosing her bedtime, doing her favorite activities and going outside for fresh air. According to the MDS assessment, the resident has been marked for falls. Record review of nursing notes dated 02/04/23 revealed R23 wheeled herself to the elevator, set off the alarm, got in the elevator and wanted to go home. R23 was upset, crying to go home. Staff were able to redirect her back to the unit. Record review of care plan did not reflect any updated or new interventions related to exit seeking or eloping. Initial intervention was dated 06/08/22. Record review of nursing notes dated 02/13/23 revealed R23 wheeled herself to the elevator a couple of times yelling she wanted to go home. R23 son and other visitors had			

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	been there earlier to visit, and she wanted to go home after their visit. Review of care plan did not reflect new interventions, non-pharmacological approaches to care, or revision to care plan as of this date. Record review of the physicians note dated 02/13/23 revealed nurse reported R23 had behavior issues at bedtime. Also revealed physician recommended to continue current medications for her anxiety and depression. Care plan revealed no intervention for her bedtime routine/sleeping pattern as identified on MDS activities as being very important to R23 to allow her the choose of her bedtime. Record review of social services note dated 02/20/23 revealed R23 was still on the same medication with no changes in dose. Stated R23 was an elopement risk and benefits from being on the memory care unit. Included she is alert and oriented 2-3 at times. Review of the care plan did not reflect any update to the elopement interventions after two episodes of R23 getting into the elevator. Initial intervention dated 06/29/22. Record review of social service note dated 02/23/23 revealed a discussion of medication changes with POA. Note failed to include what medications were being discussed or changed, or the POA's decision on medication changes. Also reflected the intervention of the black box warning was not updated to include new psychoactive			

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	medication. Record review of an order note on 02/23/23 revealed Geodon oral capsule 20 mg, 1 capsule daily for new diagnosis of unspecified psychosis not due to a substance or known physiological condition. Also included a note stating this order was outside the recommended dose or frequency. Record review of behavioral note dated 03/08/23 revealed using her cell phone and facility phone to call 911 to come and get her, she had been kidnapped. Cell phone taken away. No changes to interventions were reflected on this date. During an interview and observation on 03/16/23 at 09:43 AM, POA "P" stated, facility wanted to change her medication due to behaviors. "P" stated she came here because she was sick and weak. Supposed to be here for therapy, but she was refusing. R23 was present during this interview and raised her legs up and down to show she has strength in her legs. During an interview on 03/16/23 at 10:06 AM Registered Nurse (RN) Unit manager (UM) "C" stated R23 had been having some behaviors, had family that came and visited often. When they go to leave, she would want to go with them. She wound cry. Now we distract her when anyone leaves. When asked if those behaviors could be related to her dementia. RN UM "C" stated, it's hard to say,			

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	part of it could be personality. Also stated R23 did not like being told what to do. She was very strong woman, quite a worker, very independent. During this same interview and observation, RN NM "C" stated, we had a behavioral meeting called complex, looking at what they could be missing something, looking to have an enjoyable life here. There were medication changes, sleep patterning, supplements, so far this is doing well. Didn't always know what triggered it. Upset, taking off her O2, looking to exit. Food didn't work, activities didn't work, family didn't work. Wants to sleep when she wants to. Family takes her outside for a walk, to get fresh air. Section F of the MDS under routine and activities revealed R23 rated making choices for herself was very important to her, including choosing her bedtime, doing her favorite activities and going outside for fresh air, were not implemented on the care plan. During an interview on 03/16/23 at 10:24 AM Social Worker (SW) "R", stated she had a follow up with R23 on 3/10/23. (SW note dated 03/10/23 did not include any context of conversation or discussion). SW "R" stated she had talked to R23 to see what was bothering her and could not identify anything. R23 is part of the complex program- behavioral management meetings. Team talked about R23 behaviors, in combination of being here and restricted to decisions of doing what she wants. Her			

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	234060	A. BUILDING _____ B. WING _____	3/16/2023

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	original goal was to go home, she refused therapy to strengthen her legs. Her son said if she can get stronger, she could go home. When asked what interventions had been put in place, SW "R" stated, she met with her one on one, R23 was going to a few activities. Both interventions were date Initiated: 06/08/2022. Record review of the care plan did not include any new non-pharmacological approaches to care. During an interview on 03/16/23 at 10:59 AM, Director of Nursing (DON) "B" stated, it looked like they did that based off behavioral services for diagnosis of psychosis. We did many things with R23, we talk to POA "P", sometimes it worked, we tried redirecting her, she loves Oreo's. DON "B" also stated R23 doesn't want to be here. When asked what interventions were in place for all those behaviors, DON "B" stated we tried a few different things, the approach, to not confront her, give her a busy blanket, diversional activity, change topic of conversation as distraction. R23 waxes and wanes, cannot identify a pattern with it. According to form titled ASSESSMENT AND INTERVENTIONS FOR MOOD AND BEHAVIOR SYMPTOMS, dated February 24, 2009, under purpose. To provide standards to assess and screen the resident with mood and behavior symptoms, following the OBRA 1987 requirements and informational clinical tools,			

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	MDS, and the resident assessment protocols. Individualized goals will be set by the resident's preferences and the interdisciplinary team .... VI. Evaluation and re-assessment of care plan and defined goals based on individual assessment			
F0684 SS= D	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 observation, interview and record review the facility failed to monitor and adequately document a skin assessment one of one residents (#74) reviewed for non-pressure skin related conditions. Resulting in the potential for worsening skin condition and continued itch and discomfort. Findings include: According to the clinical record including the Minimum Data Set (MDS) dated 2/27/23 , Resident 74 (R74) was admitted 1/30/23 with diagnoses that included pneumonia. R74 scored 13 out of 15 (cognitively intact) on the	F0684	F684 Quality of Care S/S: D 1. Resident #74's skin was re-assessed by the nurse manager. Orders and care plans were reviewed and updated as appropriate. All residents have the potential to be affected. 2. A one-time audit for all current residents was completed to identify any resident with a rash had documentation in place including description, treatment, and monitoring to determine progress. Root Cause: Licensed nurses were unaware of need to include detailed description of skin conditions to aid in monitoring progress in healing. 3. Licensed nurses were re-educated on detailed documentation of rash-related skin conditions. System change: charge nurses will write descriptive progress notes of skin conditions to include size, color, location, etc. and make note of progress in healing. 4. DON/Designee will review 5 charts weekly x 12 weeks for residents with skin conditions to ensure that documentation includes assessment/description and monitoring of progress. Any non-adherence will result in 1:1 in education. All audits will be taken to the QA committee for review.	4/6/2023

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	Brief Interview for Mental Status (BIMS). On 03/13/23 09:50 AM , during a bedside interview with R74, she reported she was observed resting in bed. When queried how she was doing, she reported terrible due to a rash that was on her back which caused her to be very itchy. Nurse Practitioner progress note dated 3/8/23 reflected R74's back was assessed by the Nurse Practitioner which was determined to be contact dermatitis and hydrocortisone cream was ordered to be applied daily. The 3/08/23 progress note did not reflect any type of description of the rash, size, color , open etc.. Further review of the clinical record including the skin assessment dated 3/8, nursing progress notes and skin care plan and treatment records did not include any type of assessment/description of the rash or any type of monitoring to determine if it was healing, worsening or if the treatment needed to be changed. On 03/14/23 02:25 PM during an interview with Registered Nurse / Unit Manager (RN/UM) "C" she also reviewed R74's clinical record and acknowledged she didn't find an assessment for contact dermatitis or any form of monitoring. When queried how the the Nurses would know if it were improving or worsening ? RN/UM "C" stated she would expect some type of documentation from the			

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	nurses giving a description and monitoring. On 03/14/23 02:36 PM, during an interview with RN/UM "D" she reported the facility skin assessments were normally used for open wounds and dressing changes. When queried how it is determined if R74's contact dermatitis is improving/worsening or the same without any type of assessment or monitoring. RN/UM "D" acknowledged the ability to free text on the skin assessment and it should have been captured there. When queried if she was aware that R74 is reporting the current treatment was not effective and she was still uncomfortable. RN/UM "D" stated she was not aware of R74's concern.			
F0687 SS= D	Foot Care §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide podiatry services for 1 of 1 resident reviewed for podiatry care (Resident #4), resulting in painful, thick, and long toenails.	F0687	F687 Foot Care S/S: D 1. Resident #4 was seen by an outside podiatrist on 3/24/23 and toe nails were trimmed. All residents have the potential to be affected. 2. All current residents were re-offered podiatry services by the social service department. Any residents who provided consent that were not seen by the podiatrist during the last visit to the facility were added to the visit list for the next scheduled visit. Root Cause: Resident who had previously declined podiatry were not re-offered services when a need was identified. 3. Clinical staff was re-educated on Podiatry services. System change: The Social Service Department will review new admits and upcoming quarterly admissions to ensure they have been recently seen by the Podiatrist. 4. The SW department/designee will review 5	4/6/2023

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	Findings Include: Resident #4 Review of an Admission Record revealed Resident #4 (R4) admitted to the facility on 11-11-2022 with pertinent diagnoses which included morbid obesity, cellulitis of the right and left leg, generalized anxiety disorder, and type 2 diabetes. The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/18/23, reflected R4 scored 15 of out 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The same MDS reflected R4 did not walk and required extensive to total assistance of one person to toilet. In an observation and interview on 03/13/23 at 07:24 AM, R4 was seated in her wheelchair wearing a purple nightgown. R4 did not have socks on at the time and an observation of her toenails was made. R4's toenails appeared to be roughly a half inch in length. When queried the last time she had her toenails trimmed, R4 reported they were trimmed at the last facility she lived at, back in November. R4 reported that her toenails were causing her pain and were ripping her bedsheets. R4 stated that she has been "asking to see a foot doctor because my toenails are so long. I requested with social work several times in the four months I've been here, they just tell me you're on the list, but I don't get seen (by podiatry) or get an update." Review of the Kardex (computer program that states resident's care needs) revealed R4 had an intervention in place for daily feet checks.		charts weekly x 12 weeks to ensure a podiatry consent/consult was completed timely if needed. Any non-adherence will result in 1:1 education. All audits will be taken to the QA committee for review.	

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	In an interview 03/16/23 at 8:42 AM, Certified Nursing Assistant (CNA) "L" reported she checks R4's feet on shower days which are twice a week. CNA "L" reported that she had noticed R4's toenails have appeared longer and thicker. In an interview on 03/16/23 at 09:27 AM, Licensed Practical Nurse (LPN) "O" reported the CNA duties for feet checks for residents included keeping an eye out for sores, or anything out of the ordinary such as dry skin and to report the irregularities to nursing. Regarding toenail length, "it is a concern to diabetic's and something that should be reported to nursing staff. I've had to educate staff over the years about toenail length and diabetics. It can be subjective but it's something that does need to be monitored and reported." In an interview on 03/16/23 at 08:40 AM, Unit Manager "D" reported that consents are signed for Podiatry services upon admission and faxed over to podiatry. Weekly skin checks are conducted and the CNA's should be checking the resident's feet and reporting any concerns to nursing.			
F0689 SS= D	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:	F0689	F689 Incident/Accidents: S/S D 1. Resident #102 was reassessed by the nurse manager and care plans were updated as needed. All residents have the potential to be affected. 2. A one-time audit of nurses notes and incident reports were reviewed for the previous 14 days to ensure incidents were recorded appropriately with new interventions added as indicated.	4/6/2023

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	Based on observation, interview and record review failed to prevent falls for one (Resident #102) of four reviewed for falls, resulting Resident #102 sustaining falls and a hospital transfer. Findings Include: **Resident #102** **Review of an Admission Record revealed Resident #102 (R102) admitted to the facility on 01-24-2023 with pertinent diagnoses which included cerebral infarction (stroke), aphasia (a comprehension and communication disorder), muscle weakness, dysphagia (a condition with difficulty in swallowing food or liquid), history of falling, vascular dementia, hemiplegia and hemiparalysis following cerebral infarction affecting right dominant side, and unsteadiness on feet. The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/30/23, reflected R102 scored 0 of out 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The same MDS reflected R102 did not walk and required extensive to total assistance of one to two or more people to perform most activities of daily living.** **In an observation on 03/14/23 at 11:11 AM, R102 was seen seated in her wheelchair in the hallway at nurse's hub area. R102 was observed wearing standard socks and had a pillow placed behind her ankles and heels. A bedside table on wheels was in front of resident. R102 was awake and observing staff as they walked by.**		Root Cause: Nurse was unaware of documentation requirements when a fall occurs and the need for an immediate intervention. 3. Licensed nurses were re-educated on facility's Accident/Incident Policy and required documentation for fall events, including adding an immediate intervention. System Change: Nurse managers will review progress notes and incident reports the next business day to ensure documentation was completed appropriately, as well as new safety interventions were implemented and care planned. 4. DON/Designee will audit 5 charts weekly x 12 weeks to ensure new safety interventions are initiated after a fall and all related documentation was completed per policy. Any non-adherence will result in 1:1 education. All audits will be taken to the QA committee for review.	

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	In an observation on 03/14/23 at 03:13 PM, R102 was in her bed, awake and attempting to wiggle side to side. R102 reached towards the doorway and said "I want to... I want to...I need." The bed was in the lowest position on the floor and two bed mattresses were placed on the floor next to the bed. R102's right side of the bed was up against the wall and a body pillow that was the length of the bed was observed tucked under R102's fitted sheet on the left side of the bed. A second body pillow was observed in the room on the resident's bedside table. In an observation and interview on 03/15/23 at 08:18 AM, R102 was observed sleeping on one of the floor mattresses adjacent to her bed. One of the body pillows was observed on the floor to the left of R102. When asked about the purpose of the body pillows, Certified Nursing Assistant "I" reported that they are to assist with preventing falls out of bed. Review of the Care Plan revealed that R102 had an at risk for falls section initiated on 1/20/23 related to diagnosis including but not limited to stroke with cognitive/communication deficits, right sided hemiparalysis, weakness, unsteadiness, need for assistance with care, vascular dementia, history of seizures, and incontinence. Some interventions included assess and treat pain, bilateral mattress on my side that I sometimes roll onto, call light accessible (touch pad), wearing nonskid footwear for transfers, orient to surrounds, observe for medication side effects, and provide with a bedside table while up in wheelchair to rest my head on.			

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	An Unusual Circumstance note on 1/25/2023 at 05:00 AM revealed R102 was observed on the floor in her room and appeared to have rolled out of bed. R102 was "found on floor of her room, facing the door to her room. Floor mattress in place for safety." A Falls Assessment dated 1/27/23 revealed the Interdisciplinary Team reviewed the fall to determine a root cause. The Falls Assessment revealed that R102 was a new admission in an unfamiliar environment ... R102 had severe aphasia and was not able to describe fall. It was perceived by staff that R102 rolled off the bed and as an intervention, a mattress was placed next to right side of the bed to prevent her from injury. A Nurses Note dated 2/4/2023 at 2:23 PM revealed R102 "was observed laying [sic] face down on the floor in the hallway. [R102] repositioned into a supine position. [R102] has facial bruising, is more lethargic than baseline, and is hypotensive. Pupils are slow to react. BS 196. [R102] states she is in pain. On call NP (Nurse Practitioner) contacted and ordered to send resident to ER (Emergency Room) for a CT (computed tomography scan) scan. 911 called and instructed staff to leave resident in supine position on the floor until EMS (Emergency Medical Services) arrives. EMS arrived at 1425. Ombudsman paperwork and bed hold policy sent with resident". The facility was unable to locate an Incident Report regarding the fall that occurred on 2/4/23. No fall intervention was added for the fall. A Nurses Note dated 2/18/2023 at 11:05 AM			

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	revealed R102 "had a witnessed fall while in wheelchair after breakfast. No injuries noted ...transferred back to bed". The facility was unable to locate an Incident Report regarding the fall that occurred on 2/18/23. No fall intervention was added for the fall. A Nurse's Note dated 3/7/2023 at 2:08 PM revealed R102 fell "forward out of wheelchair in hallway ... [R102] was laying her right side with right arm underneath her body ... [R102] was ...transferred into her bed. [R102] has abrasion on right cheek bone, on lateral corner of right eye, and small open area between nose and upper lip ...". A Falls Assessment dated 3/7/23 revealed the Interdisciplinary Team reviewed the fall for root cause. R102 was "leaning forward in w/c (wheelchair) and fell over onto floor. Will offer resident bedside table while up in wheelchair to rest head on." In a phone interview on 03/15/23 at 01:16 PM, Certified Nursing Assistant (CNA) "J" reported she witnessed the fall that occurred on 3/7/23. CNA "" was walking down the hallway towards R102 and observed R102 reaching down toward her feet when she started tipping forward out of her wheelchair. In an interview on 03/16/23 at 11:06 AM, Unit Manager "D" was unable to locate Fall assessments or Incident reports for the falls R102 sustained on 2/4/23 and 2/18/23. In an interview on 03/16/23 at 11:11 AM Director of Nursing "B" reported she was only aware of the two falls that R102 sustained.			

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	Typically, after a fall, the nursing staff was supposed to notify the unit manager and complete the appropriate forms. The Interdisciplinary Team gathers to discuss the fall and implement an intervention. Falls are then reviewed for three days to ensure the interventions are successful.			
F0698 SS= D	Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to provide ongoing communication and collaboration with the contracted dialysis facility regarding dialysis care and continued assessment for one resident (#80) of one resident reviewed resulting in the potential of unmet care needs and possible complications for residents receiving dialysis services. Findings include: **Resident #80** According to the clinical record, including the Minimum Data Set (MDS) dated 2/20/23, Resident 80 (R80) was 67 years old, admitted to the facility on 2/14/23 with diagnosis that included end stage renal disease, (ESRD).	F0698	F698 Dialysis S/S:D 1. Resident #80 no longer resides in the facility. All residents receiving dialysis have the potential to be affected. 2. A one-time audit of dialysis forms completed in the last 14 days was completed to verify accuracy and completion. Root Cause: Nurses were not ensuring dialysis forms were received from the dialysis center post-treatment. 3. The Licensed nurses were re-educated on the dialysis communication forms. System change: the licensed nurses will be responsible for contacting dialysis centers to obtain treatment documentation if the resident does not return to the facility with the completed form. 4. DON/Designee will review 5 dialysis communication forms weekly x 12 weeks to ensure the forms are completed as designed. Any non-adherence will result in 1:1 education. All audits will be taken to the QA committee for review. DON will be responsible for sustained compliance.	4/6/2023

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	Review of R80's clinical record, Physician orders reflected R80 was scheduled for dialysis on Tuesdays, Thursdays and Saturdays and the dialysis center was to flush R80's dialysis catheter. Further review of the clinical record on 3/14/23 reflected dialysis communication sheets were located in the clinical record for the following dates 2/16, 2/18, 2/23 and 2/25. During an interview on 3/14/23 at 10:30 am with Registered Nurse / Unit Manager (RN/UM) "C" she reported the Unit Manager for R80's unit was on leave, therefore was not able offer any explanation for the missing communication. RN/UM "C" reported she would check with medical records staff, offering the documents may be in the facility, but not uploaded to R80's medical record yet. On 3/14/23 at 10:40 during an interview with R80's Nurse, Licensed Practical Nurse (LPN) "E" reported, upon R80's return from dialysis he was to give the paper work to nursing, nursing staff then reviews it and from there it goes into a basket where medical records staff picks up the contents of the basket and uploads paperwork to residents medical records. LPN "E" offered no explanation for the 7 separate dates of missing communication forms from dialysis.			

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	234060	A. BUILDING _____ B. WING _____	3/16/2023

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	On 03/14/23 at 02:17 PM, a follow up interview with RN/UM "C", she reported medical records staff found 4 dialysis communication sheets and was looking for the rest. On 03/14/23 02:48 PM during an interview with Medical Records staff "F" she explained the process form dialysis communication just as LPN "E" did. Medical Records staff "F" reported she received some of the dialysis communication forms from the dialysis via fax within the last 15 minutes. When queried why they were faxed and not previously uploaded, Medical Records staff "F" stated she was not behind in her work and the missing dialysis communication forms were not uploaded to the medical record because they were never made available to her.			
F0758 SS= D	Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use	F0758	F758 Unnecessary Psychotropic Medication S/S: D 1. Resident #23 was reviewed by the IDT and updates to medical record were made as needed. All residents have the potential to be affected. 2. A one-time audit of all residents receiving psychotropic medications was completed by the IDT to ensure that all medications were necessary and had an appropriate diagnosis. Root cause: Adequate supporting documentation was not present in the chart prior to initiating a new psychotropic medication. 3. Nurses and social workers were re-educated on the requirements for use of	4/6/2023

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	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 ensure one of five residents (Resident #23) was free from unnecessary medications, did not follow the indicated purpose for use without justification of use, resulting in the potential for resident and/or family representatives being ill informed of the purpose. Findings Included: Resident #23 (R23)		psychotropic medications. System change: The SW department will review new psychotropic medications Monday-Friday to ensure there is an appropriate diagnosis and supporting documentation for use of the medication. Social work will recommend review by the Medical Director and/or psych services as appropriate. 4. The SW department/designee will review 5 charts weekly x 12 weeks to ensure psychotropic medications have the correct diagnosis and documentation needed to support use. Any non-adherence will result in 1:1 education. All audits will be taken to the QA committee for review. The ED will be responsible for sustained compliance.	

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	Review of the medical record reflected R23 was an initial admission to the facility on 05/11/2022 with a re-admission on 01/10/23 with diagnoses of Crohn's disease, diabetes, unspecified dementia without behaviors, depression, anxiety and weakness. R23 was diagnosis with unspecified psychosis not due to a substance or known physiological condition on 02/23/23. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/17/2022, revealed R23 had a Brief Interview of Mental Status (BIMS) of 12 (moderately impaired) out of 15. Section F of the MDS under routine and activities revealed R23 rated making choices for herself was very important to her, including choosing her bedtime, doing her favorite activities and going outside for fresh air. According to the MDS assessment, the resident has been marked for falls. Quarterly MDS dated 02/17/23, section E under behaviors, reveals R23 did not have any behaviors exhibited. Section I of the MDS, under section active diagnosis included dementia, depression and anxiety. Section N of the MDS, under section medications received included medication for anxiety, depression and dementia. R23 was not receiving any antipsychotic medication. Record review of nursing notes dated 02/04/23 revealed R23 wheeled herself to the elevator, set off the alarm, got in the elevator			

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	and wanted to go home. R23 was upset, crying to go home. Staff were able to redirect her back to the unit. Record review of care plan did not reflect any updated or new interventions related to exit seeking or eloping. Initial intervention was dated 06/08/22. During a record review of behavioral health services revealed a risk vs benefit dated 02/09/23, for Trazadone for depression and a sedative, Cymbalta for depression and Xanax for anxiety. Record review of nursing notes dated 02/13/23 revealed R23 wheeled herself to the elevator a couple of times yelling she wanted to go home. R23 son and other visitors had been there earlier to visit, and she wanted to go home after their visit. Review of care plan did not reflect new interventions, non-pharmacological approaches to care, or revision to care plan as of this date. Record review of the physicians note dated 02/13/23 revealed nurse reported R23 had behavior issues at bedtime. Also revealed physician recommended to continue current medications for her anxiety and depression. Care plan revealed no intervention for her bedtime routine/sleeping pattern as identified on MDS activities as being very important to R23 to allow her the choose of her bedtime. Record review of psychiatric evaluation dated			

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	02/15/23 revealed R23 current medications of Xanax 0.25 mg tablet, duloxetine 40 mg capsule, delayed release and trazodone 50 mg tablet. Gradual Dose Reduction (GDR) dated 02/15/23 stated these medications were ineffective in controlling symptoms and not R23 was not a candidate for GRD at this time. Record review did not reflect any doses changes in these medications to evaluate effectiveness. Record review of social services note dated 02/20/23 revealed R23 was still on the same medication with no changes in dose. Stated R23 was an elopement risk and benefits from being on the memory care unit. Included she is alert and oriented 2-3 at times. Review of the care plan did not reflect any update to the elopement interventions after two episodes of R23 getting into the elevator. Initial intervention dated 06/29/22. Record review of social service note dated 02/23/23 revealed a discussion of medication changes with POA. Note failed to include what medications were being discussed or changed, or the POA's decision on medication changes. Also reflected the intervention of the black box warning was not updated to include new psychoactive medication. Record review of an order note on 02/23/23 revealed Geodon oral capsule 20 mg, 1			

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	capsule daily for new diagnosis of unspecified psychosis not due to a substance or known physiological condition. Also included a note stating this order was outside the recommended dose or frequency. ...Administering a psychotropic medication(s), which the resident has not previously received, when it is not necessary to treat a specific condition that has been diagnosed and documented in the clinical record; or Failure to attempt non-pharmacological approaches, unless clinically contraindicated, in efforts to discontinue psychotropic medications .... Record review of Psychotherapeutic medication information sheet dated 02/23/23 revealed a black box warning that this medication was not indicated for behavioral problems associated with Dementia and the use has been associated with increased mortality in the elderly population ... Record review of Geodon on manufacture website reveals ... Geodon is an antipsychotic medication to treat schizophrenia and bi-polar. Also stated Geodon is not approved for use of elderly adults with dementia related psychosis. Record review also revealed the care plan interventions were not updated to reflect Potential for serious or even life-threatening adverse effects r/t taking medications.			

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	with black box warning on the new antipsychotic medication Geodon. Resident/family educated on black box warnings. Date Initiated: 06/10/2022. Record review of behavioral note dated 03/08/23 revealed using her cell phone and facility phone to call 911 to come and get her, she had been kidnapped. Cell phone taken away. No changes to interventions were reflected on this date. Record review of behavioral note dated 03/12/23 revealed wanted to leave the facility to get a new cell phone, POA stated to give R23 her cell phone back. During an interview and observation on 03/16/23 at 09:43 AM, POA "P" stated, facility wanted to change her medication due to behaviors. He was not aware that the medication they ordered was not for her current diagnosis. Reviewed Psychotherapeutic medication information sheet dated 02/23/23 revealing this medication is for schizophrenia and bi-polar. "P" stated she came here because she was sick and weak. Supposed to be here for therapy, but she was refusing. R23 was present during this interview and raised her legs up and down to show she has strength in her legs. During an interview on 03/16/23 at 10:06 AM Registered Nurse (RN) Unit manager (UM) "C" stated R23 had been having some			

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	behaviors, had family that came and visited often. When they go to leave, she would want to go with them. She wound cry. Now we distract her when anyone leaves. When asked if those behaviors could be related to her dementia. RN UM "C" stated, it's hard to say, part of it could be personality. Also stated R23 did not like being told what to do. She was very strong woman, quite a worker, very independent. I don't believe she has had any medication changes prior to the one recommendation from behavioral health. During this same interview and observation, RN NM "C" stated, we had a behavioral meeting called complex, looking at what they could be missing something, looking to have an enjoyable life here. There were medication changes, sleep patterning, supplements, so far this is doing well. Didn't always know what triggered it. Upset, taking off her O2, looking to exit. Food didn't work, activities didn't work, family didn't work. Wants to sleep when she wants to. Family takes her outside for a walk, to get fresh air. Section F of the MDS under routine and activities revealed R23 rated making choices for herself was very important to her, including choosing her bedtime, doing her favorite activities and going outside for fresh air, were not implemented on the care plan. During an interview on 03/16/23 at 10:24 AM Social Worker (SW) "R", stated she had a follow up with R23 on 3/10/23. (SW note dated 03/10/23 did not include any context			

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	of conversation or discussion). SW "R" stated she had talked to R23 to see what was bothering her and could not identify anything. R23 is part of the complex program- behavioral management meetings. Team talked about R23 behaviors, in combination of being here and restricted to decisions of doing what she wants. Her original goal was to go home, she refused therapy to strengthen her legs. Her son said if she can get stronger, she could go home. When asked what interventions had been put in place, SW "R" stated, she met with her one on one, R23 was going to a few activities. Both interventions were date Initiated: 06/08/2022. Record review of the care plan did not include any new non-pharmacological approaches to care. During an interview on 03/16/23 at 10:59 AM, Director of Nursing (DON) "B" stated, it looked like they did that based off behavioral services for diagnosis of psychosis. We did many things with R23, we talk to POA "P", sometimes it worked, we tried redirecting her, she loves Oreo's. DON "B" also stated R23 doesn't want to be here. When asked what interventions were in place for all those behaviors, DON "B" stated we tried a few different things, the approach, to not confront her, give her a busy blanket, diversional activity, change topic of conversation as distraction. R23 waxes and wanes, cannot identify a pattern with it.			

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	According to form titled ASSESSMENT AND INTERVENTIONS FOR MOOD AND BEHAVIOR SYMPTOMS, dated February 24, 2009, under purpose. To provide standards to assess and screen the resident with mood and behavior symptoms, following the OBRA 1987 requirements and informational clinical tools, MDS, and the resident assessment protocols. Individualized goals will be set by the resident's preferences and the interdisciplinary team .... VI. Evaluation and re-assessment of care plan and defined goals based on individual assessment			
F0810 SS= D	Assistive Devices - Eating Equipment/Utensils §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide care planned special eating equipment for one of one Resident (Resident #102) reviewed for assistive devices, resulting in the potential for difficulty with self-feeding and weight loss.	F0810	F810 Assistive Devices S/S: D 1. Resident #102 was re-assessed and continues to require a divided plate for meals. The need for a divided plate was added to her dietary ticket prior to survey exit and remains in place. The care plan and diet order were also reviewed to verify need for divided plate was identified appropriately. All residents needing assistive devices for eating and drinking have the potential to be affected. 2. A one-time audit of residents needing assistive devices for eating and drinking was completed to ensure physician orders, care plans, and dietary meal tickets were updated if needed. Root cause: Dietician did not add the need for a divided plate to the meal tickets for resident #102 when the physician's order was initiated. 3. Dietician was re-educated on	4/6/2023

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	Findings Include: Resident #102 (R102) Review of an Admission Record revealed Resident #102 (R102) admitted to the facility on 01-24-2023 with pertinent diagnoses which included cerebral infarction (stroke), aphasia (a comprehension and communication disorder), muscle weakness, dysphagia (a condition with difficulty in swallowing food or liquid), history of falling, vascular dementia, hemiplegia and hemiparalysis following cerebral infarction affecting right dominant side, and unsteadiness on feet. The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/30/23, reflected R102 scored 0 of out 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The same MDS reflected R102 did not walk and required extensive to total assistance of one to two or more people to perform most activities of daily living. In an observation on 03/14/23 at 11:11 AM, R102 was seen seated in her wheelchair in the hallway at the nurse's hub area. R102 was observed wearing standard socks and had a pillow placed behind her ankles and heels. A bedside table on wheels was in front of resident. R102 was awake and observing staff as they walked by. In an observation on 03/15/23 at 12:30 PM,		updating/adding information on resident meal tickets when new assistive devices are added to a diet order. All staff was re-educated regarding assistive devices for eating and drinking and where to find the information. System change: Dietician will update dietary meal ticket with assistive devices upon admission and with new orders to ensure tickets match the physician's order and care plan. 4. The RD/Designee will review 5 residents with assistive devices weekly x 12 weeks to ensure the physician's order, care plan, and dietary meal tickets match and devices are provided as indicated. Any non-adherence will result in 1:1 education. All audits will be sent to the QA committee for review. The DON will be responsible for sustained compliance.	

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	R102 was eating lunch in the hallway. R102's lunch consisted of carrots, broccoli, mashed potatoes, and small amounts of Salisbury steak. R102's lunch was served on a standard, flat plate. In an interview on 03/15/23 at12:41 PM, Certified Nursinf Assistant (CNA) "I" verified that R102 had no adaptive equipment that was being utilized for mealtime, specifically, no divided plate. In an interview on 03/16/23 at 08:48 AM Unit Manager "D" reported R102 required a divided plate for meals. "I believe it is on the meal ticket, theres a thing on the bottom that tells CNA's what the residents diet is... and special tidbits to help the CNA's." Review of R102's Kardex revealed that R102 "Food and Nutrition Preferences" section indicated R102's "food and fluid consistency is regular/mechanical soft texture, thin liquids with divided plate ...". Review of R102's dietary meal ticket revealed that the "Adaptive Equipment" section of R102's Dietary information section was blank.			
F0919 SS= E	Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing	F0919	F919 Call lights within reach S/S: E 1. Residents #44, #8, #61, #39 and #64 were re-assessed by the IDT and no acute changes were noted related to being unable to reach the call light. All residents have the potential to be affected. 2. A one-time audit of all current residents	4/6/2023

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	facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure call lights were within reach for five out of 25 residents (Resident #8, 39, 44, 61, and 64) resulting in the potential for resident needs to go unmet. Findings Included: Resident #8 (R8): In an observation on 3/13/2023 at 9:40 AM, R8 was observed in his room asleep. R8's call light was observed to be hanging over the headboard of his bed not accessible to R8. In another observation on 3/14/2023 at 3:03 PM, R8 was observed to be asleep in his bed, with his call light observed to be on the floor at head of R8's bed, which was not accessible to R8. . Record review of a care plan in place for R8 dated 2/24/2021, that addressed falls and safety, revealed an intervention to make sure R8's call light was accessible. In an interview on 3/15/2023 at 9:22 AM, Certified Nurse Aid (CNA) "G" stated that R8 would press on his call light for assistance. Resident #39 (R39): In an observation on 3/14/2023 at 1:57 PM, R39 was observed lying in his bed with a blanket over head, and his call light out of reach hanging on wall at the foot of his bed, and out reach.		was completed to ensure that all call lights were within reach. Root cause: Staff were not monitoring to ensure call lights remain in reach of residents. 3. All staff were re-educated to ensure that call lights are within reach. System change: all staff members are responsible to ensure that call lights are within reach before exiting the room. 4. DON/Designee will review 5 resident rooms per unit weekly x 12 weeks to ensure that call lights are within reach. Any non-adherence will result in 1:1 education. All audits will be sent to the QA committee for review.	

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	234060	A. BUILDING _____ B. WING _____	3/16/2023

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	In an interview on 3/15/2023 at 9:22 AM, CNA "G" stated that R39 did generally use his call light, but stated his call light was supposed to be within his reach anyway. Review of a care plan that was in place for R39 dated 9/9/2022 and last revised on 12/14/2022, revealed R39 was at, "Risk for falls r/t (related to) poor safety awareness, history of falls, cognitive deficits, delirium, strength/balance deficits, failure to thrive, OA (osteoarthritis), incontinence, anemia, vision/hearing loss, terminal illness, potential side effects of cardiac medication. Combative with care at times, declines care at times, impulsive, self TF (transfer)/ambulates - difficult to re-direct.", and included an interview to ensure R39's, "Call light accessible", dated 9/19/2022. Resident #44 (R44): During an observation and interview on 3/13/2023 at 8:02 AM, R44 was visited in her room, and upon entering R44 was yelling out that she was hungry, and calling for the nurse. R44 was asked where her call light was located, which R44 stated she did not know. R44's call light was observed to be clipped onto the room divider curtain, and R44 stated she was not able to reach it. In an observation and interview on 3/14/2023 at 11:20 AM, R44 room door was closed, and upon entrance R44 was observed in her bed. R44 was asked if she knew where her call light was located in which R44 stated no. R44's call light was observed to be clipped to the room divider curtain. Review of a care plan for activities of daily living (ADLs), dated 4/30/2014 and last revised on 11/16/2022, revealed the following intervention			

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	dated 4/15/2021, was in place for R44, "I (R44) often times throw my call light on the floor and I like the call light on the top of my bed by my pillow on my left side." In an interview on 3/15/2023 at 9:22 AM, CNA "G" stated that R44 would use her call light sometimes. CNA "G" also stated that resident call lights were to be within reach, and when CNAs would leave a resident's room the CNA was to assure that the resident's call light was in place and within reach. Resident #61 (R61): In an observation and interview on 3/13/2023 at 9:44 AM, R61 was observed lying in her bed with her call light at the head of her bed. R61 stated that she did not know where her call light was located. In another observation and interview on 3/14/2023 at 2:59 PM, R61 was observed while lying in bed. R61 stated she did not know where her call light was located. R61's call light was observed to be at the head of her bed on her right side, R61 was asked if she could reach her call light, and was observed to attempt to reach it once told where it was located, but was not able to reach for it. Record Review of R61's care plans revealed she had care plan in place related to falls that was dated 5/12/2021, and also included an intervention, dated 5/21/2021 to assure R61's call light was accessible to R61. In an interview on 3/15/2023 at 9:22 AM, CNA "G" stated that R61 did use her call light to call for assistance. Resident #64 (R64):			

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In an observation on 3/13/2023 at 9:34 AM, Resident R64 was observed in bed, and her call light was on the floor underneath the head of her bed.

In another observation on 3/14/2023 2:56 PM, R64 was asleep, and her call light was observed to be hanging over the head of her bed, which was not accessible.

In an observation and interview on 3/15/2023 at 8:59 AM, R64 was again observed to be in bed. R64 was asked if she knew where her call light was located, in which R64 stated no. R64 also stated that she knew how to use her call light, but could not if she did not know where it is was located. R64 stated that sometimes the staff would put her call light where she could reach it, but usually did not.

R64's call light was observed to be on the floor on the right side of R64's bed lying on a mattress that was on the floor, and not accessible to R64.

Record review of R64's care plans revealed a care plan in place for "Safety: At risk for falls..." dated 1/22/2021. The care plan revealed an intervention dated 1/22/2021, that was in place, "Call light accessible."

In an interview on 3/15/2023 at 9:22 AM, CNA "G" stated that R64 loved to use her call light, and was always turning it on for random reasons.

In an interview on 3/15/2023, at 9:42 AM, Registered Nurse (RN) "C", who was the manager of the second floor, stated that all residents were to have their call lights accessible to them, and that her expectations were that all residents had access to their call lights all the time.

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	In an interview on 3/15/2023 at 2:13 PM, Director of Nursing (DON) "B" stated that her expectation was that call lights were within reach for all residents. DON "B" also stated that even if a resident could not, or did not use their call light, the call light was to still be within reach for the resident just in case the resident did use it. Record review of the facility's policy and procedure titled, "CALL LIGHT POLICY", dated 5/17/2017 and revised on 7/1/2008, revealed under, "PROCEDURE: 1. Call lights will be placed within reach of the resident."			
F0921 SS= F	Safe/Functional/Sanitary/Comfortable Enviro §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to properly store supplies, maintain plumbing in good repair, and prevent plumbing cross connections, resulting in potential contamination of supplies, and the domestic water supply, affecting all residents in the facility. Findings include: On 3/13/23 at 9:45 AM, the trough drain, located at the dish machine drain board, was observed to have a significant leak at the drain connection, resulting in water accumulation on the floor underneath the drain board. At 10:20 AM, Dietary Manager "S" stated that she will notify maintenance of	F0921	F921 Safe/Functional/Sanitary/Comfortable Environment S/S: F 1. No specific resident was identified in this citation. All residents have the potential to be affected. The trough drain for the dish machine drain board was corrected. The boxes of face masks were removed from the floor. The backflow preventer was added to the salon sink. 2. A one-time audit was completed in the building to ensure there were no other backflow preventers missing, no boxes were stored on the floor, and no other similar issues were noted affecting the trough drain. Root Cause: Maintenance was not aware of the necessary requirements for facility compliance with noted areas. 3. The maintenance director was educated regarding the requirements. Central Supply clerk was educated on not storing boxes on the floor. System Change: Preventative maintenance program updated to include inspection of trough drain and back-flow preventers. 4. ED/Designee will audit 5 storage rooms weekly x 12 weeks to ensure no boxes are	4/6/2023

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	the leak. On 3/14/23 at 9:43 AM, three boxes of face masks were observed to be stored on the floor in the Emergency Supply room. At this time, Maintenance Director "T" said that they will get a new shelf arrangement in the Emergency Supply room to accommodate the boxes stored on the floor. On 3/14/23 at 9:57 AM, the Salon hair sink was observed to have a hose sprayer that was long enough to sit inside the sink, creating a potential cross connection from the water supply to the drain line. At this time, no backflow prevention device was observed to prevent the potential for backflow of solid, liquid, or gas contaminants. At this time, Maintenance Director "T" said that he will equip a backflow prevention device to the hair sink hose sprayer. According to the Michigan Plumbing Code, Incorporating the 2015 edition of the International Plumbing Code, SECTION 608 PROTECTION OF POTABLE WATER SUPPLY "608.1 General. A potable water supply system shall be designed, installed and maintained in such a manner so as to prevent contamination from nonpotable liquids, solids or gases being introduced into the potable water supply through cross connections or any other piping connections to the system. Backflow preventer applications shall conform to Table 608.1, except as specifically stated in Sections 608.2 through 608.16.10."		stored on the floor. ED/Designee will audit 5 sinks requiring a backflow preventer weekly x 12 weeks to ensure device is in place. ED/Designee will audit kitchen drains weekly x 12 weeks to ensure there are no leaks. Any non-adherence will result in 1:1 education. All audits will be sent to the QA committee for review. The ED will be responsible for sustained compliance.	