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CHRISTIAN CARE NURSING CENTER	**2053 S SHERIDAN DRIVE MUSKEGON, MI 49442**

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F0000 SS=	INITIAL COMMENTS Chrisitan Care Nursing Center was surveyed for a Recertification survey on 4/20/23. Intakes: MI00134764, MI00135475, MI00135812, MI00135816 Census= 29	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and	F0550		

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

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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	reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to treat 2 of 12 residents (R23, and R24) with dignity and respect. Findings include: R23 A review of R23's Admission Record, dated 4/20/23, revealed R23 was a 91-year-old resident admitted to the facility on 1/27/23 with multiple diagnoses that included a cerebral infarction (stroke). A review of R23's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 2/2/23, revealed R23 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of "13" which revealed she was cognitively intact. In addition, R23's MDS revealed she needed extensive assistance (resident involved in activity, staff providing weight-bearing support) of two staff members for bed mobility (e.g., moving from side-to-side in bed) and toileting. In addition, R23's MDS revealed she needed extensive assistance of one staff member for personal hygiene and dressing. During an observation on 04/18/23 at 10:30 AM, certified nursing assistant (CNA) "E" was observed from the hallway changing R23's brief (the room door was open). R23 was turned towards the wall facing away from doorway.			

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	However, R23's naked bottom was clearly visible from hallway. During an observation on 04/18/23 from 10:50 AM to 11:10 AM, R23 could be heard down the hallway and from other residents' rooms yelling "help". Staff did not respond to R23's cries for help during this time. Licensed Practical Nurse (LPN) "C" was observed standing at the medication cart in the hallway less than three rooms from R23's. During an observation on 04/18/23 at 11:10 AM, R23 was still yelling for help. The surveyor walked past LPN "C" at the medication cart, went to R23's room, and saw the door was open and visitors were standing outside R23's room looking in. R23 was observed positioned halfway down the bed with her shirt pulled up below her breasts, no pants on, and her brief completely exposed to everyone who looked into R23's room. When the surveyor knocked on R23's door, asked permission to enter her room, and asked if she needed help, R23 tried to get out of bed. R23 stated, "I need to poop. Help me." The surveyor told R23 that they would get someone and R23 laid back down on the bed. The surveyor then went to LPN "C" at the medication cart and told LPN "C" that R23 needed to use the bathroom. LPN "C" called over the portable radio for an aide to help R23. It took approximately 10 more minutes for an aide to assist R23. During an interview on 04/20/23 at 09:10 AM, CNA "A" stated that when she is providing care to a resident (especially incontinence care, dressing, and bathing), she will close the room door. She stated she closes the door to provide privacy to the resident while she does the care. During an interview on 04/20/23 at 09:20 AM, LPN "B" stated she will close room doors and			

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window blinds when she provides personal care to residents. She stated she does these things to provide the residents with privacy and dignity during care. "So everyone does not see their business".

A review of the facility's Perineal Care Competency Procedure, dated 2014, revealed after staff introduce themselves, explain to the resident what they are going to do, get their equipment assembled and ready, wash their hands, and raise the resident's bed to the appropriate level for care, they are to provide the resident with privacy prior to starting the procedure (cleaning the resident).

R24

Review of R24's Minimum Data Set (MDS) dated 12/27/22 revealed she a 72-year-old female admitted on 10/7/20, had severely impaired cognition and had diagnoses that included: non traumatic brain dysfunction, Alzheimer's, dementia, and depression.

On 4/18/23 at 10:58 AM, R24 was sitting on the nursing unit in a high back wheelchair. R24 was not responding to her name and was not providing any verbal response to questions. Certified Nurse Aide (CNA) "H" was asked if this was R24. CNA "H" was coming up behind R24, she threw her hands in the air and said, "I have only been here 7 days". CNA "H" stood about 2 feet from R24s face and said she is "Mrs. pincher." The Surveyor said, "what" as this seemed very odd, and she was not sure she heard what she heard. CNA "H" again said, "Mrs. Pincher" and moved her hand in front of R24, she moved her thumb toward her fingers making a pinching motion and said that is because she pinches people.

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	During an interview with the facility Social Worker (SW) "J" on 4/19/23 at 12:30 PM, SW "J" confirmed she did the new employment dignity training and provided a posttest dated 3/30/23, that indicated CNA "H" had passed a test related to information on dignity. SW "J" was informed of CNA "H" calling R24 Mrs. Pincher and that she made a pinching motion in front of R24's face. SW "J" confirmed this was not dignified and unacceptable behavior.			
F0584 SS= E	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	F0584		

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	comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide comfortable room temperatures and shower room temperatures for two residents (R9 and R20), potentially affecting all facility residents, resulting in R20 experiencing pain and severe discomfort when his room got too hot and R9 having difficulty breathing when she gets a shower. Findings include: During the initial tour on 4/18/23 at 11:07 AM, R9 complained of difficulty breathing when taking a shower in the shower room. She wondered if ventilation could be added as the room gets stuffy. On 4/18/23 at 9:30 AM the Nursing Home Administrator (NHA) if informed the Survey team that his maintenance manager quit yesterday, and he would be getting some assistance from maintenance staff that worked at a different building. The NHA said one of the facility boilers were not working and he did not have a date or any documentation on what was needed to fix the boiler. Review of R20's face sheet dated 4/20/23 revealed he was a 74-year-old male admitted to the facility on 2/22/23, his diagnoses included: flaccid hemiplegia affecting left side (brain damaging causing loss of function of the left side of his body), neuralgia and neuritis (nerve damage), major depressive disorder and anxiety disorder. R20 was his			

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	own responsible party. On 4/18/23 at 10:25 AM, R20 was in his room in bed and complained of being so hot last night he thought he would explode. R20 had a fan on in the room and his window open. He was happy with the room temperature at that time. He said they must keep the window open, so it doesn't get too hot but when his room door is open the air blows right through and the room gets freezing cold. R20 was very upset. On 4/18/23 at 3:30 PM R20 concern about his room temperature was shared with the NHA. The NHA said they did have to turn up the temperature on the one boiler because some residents were complaining their rooms were too cold. The NHA said he would investigate it and start monitoring the room temperatures. On 4/20 23 at 8:10 AM R20 was in bed in his room. His window was open, and a fan was blowing directly on him at head level. R20 was very upset. He said around 5:00 PM every night his room temperature starts to increase. R20 said at 8:30 PM last night he was so hot his face was burning so he put his call light on to have staff cool the room down and put his fan directly on him. R20 said staff did not respond to his call light until 10:20 PM and he was in a lot of pain due to the heat. On 4/20/23 at 8:21 AM, the Director of Nursing (DON) was on the nursing unit and was asked what the plan was to keep R20's room a comfortable temperature. The DON was not aware of any room temperature monitoring or a plan to keep R20's room comfortable.			

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	On 4/20/23 at 8:45 AM the NHA was in his office and the room temperature monitoring was requested. The NHA said some rooms were monitored and he would get the information. The monitoring document showed 8 room temperatures taken at unknown times on 4/18/23 and 4/19/23. There was not a room temperature taken in R20's room. The temperatures ranged from 71 to 76 degrees Fahrenheit. The NHA was asked if any of the room temperature were monitored at night and he reported, no. Review of R20's Social Work progress note dated 4/19/23 at 10:27 PM revealed, "This writer called R20's wife. This writer inquired about the resident's temperature preference while at home. R20's wife stated he likes his heat set at 68, while the coolness at 70." Later in this same note, the social worker had a conversation with R20 about his room temperatures and he replied, "sometimes it is so cold that I'm shivering and most of the time it is too hot in her (sp). SW validated his concern as the building was extremely cold when I arrived on Monday (4/17/23). I explained that we were having an issue with the boiler and "name of service provider" fixed it that morning." Review of R20's Social Work progress note dated 4/20/23 at 11:12 AM revealed that the Social Worker followed up with R20 about his room temperature concerns and R20 informed her he gets frequent onset of facial and neck flushing and sensation of increased body heat in which he feels as if the room temperature has increased, and this results in significant discomfort. He told the Social Worker his room preference is between 65-70 degrees.			

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	On 4/20/23 at 2:30 PM the Faith unit shower room was inspected with the NHA and temporary maintenance staff "K". The NHA said he was aware some residents felt the shower room was too hot, but the heat came from the floor and there was no adjustment for the heat. Upon walking into the shower room, the room was significantly hotter than the nursing unit. The room did not have a thermometer. The NHA and staff "K" denied taking any shower room temperatures and they were not sure what the current temperature was, but agreed some residents may be uncomfortable with the current temperature. The NHA was not aware of how many residents were not able to tolerate the shower room temperature.			
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	F0604		

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	amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record reviews, the facility failed to accurately assess 1 Resident (R3) for restraints, resulting in the potential for injury, agitation, and decline in mobility. Finding include: Review of R3's face sheet, dated 4/19/23 revealed he was an 85-year-old male last admission 4/10/19, and had diagnose that included: Dementia, muscle weakness (generalized), and peripheral vascular disease. He was not his own responsible party. R3 was observed on 4/18/23 at 10:52 AM sitting in a high back wheelchair looking out a window on the nursing unit. His feet were both on foot pedals and a padded board was placed between the foot pedals that prevented R3 from moving his feet off the foot pedals. R3's knees were about 6 to 8 inches higher than his hips while sitting in his wheelchair (places more force on his back and boney areas of his buttock, not a comfortable position) R3 complained of his wheelchair poking him in his back. There was a bar at went across the back rest. R3's back was pressed against the bar area of this back rest. R3 bent forward multiple times to relieve the poking sensation. R3 reached for a slipper that came off his left foot and he could not reach it. R3 yelled out for staff to help him. No staff were visible on the nursing unit. He became more agitated when no one			

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	came to assist him and eventually lifted his left leg over the padded board on the foot pedals and continued to try to get his slipper. In his attempts to get the slipper he bumped his left foot on the foot pedals and back board multiple time. Eventually he reached his slipper and put it on and moved his leg back onto the foot pedal. However, the board was only partially on when he got his foot back on the pedal. R3 was observed on 4/19/23 at 10:00 AM sitting in front of the same window he was sitting at on 4/18/23 in the same wheelchair with all the same equipment. R3 was observed receiving wound care in his room on 4/19/23 at 10:15 AM, Unit Manager (UM) "F" removed R3's foot pedals and padded board. R3 moved his wheelchair independently into the bathroom using both feet. He moved the wheelchair 6 to 8 feet. His movements were coordinated, and he did not drag either foot. UM "F" was questioned about the reason for the pedals and board being in place for extended periods of time of time as R3 was easily able to move his legs and wheelchair when they were removed. UM "F" stated she did not recall. UM "F" was asked if the facility did a restraint assessment for the foot pedals and padded board as they were restricting his movement. UM "F" said she would check. On 4/19/23 at 11:00 AM the Nursing Home Administrator (NHA) was asked for the facility restraint policy and the restraint assessment for R3's foot pedals/padded board. The NHA mailed a response on 4/19/23 at 3:56 PM that the facility did not have a restraint assessment for R3, and he was			

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having a wheelchair assessment and restraint assessment completed.

Review of R3's "Device/Equipment/Material Use Evaluation" dated 4/19/23 at 1:14 PM revealed, "Purpose of the Evaluation: For purpose of this evaluation "Device" applies to any device/equipment or material attached or adjacent to the resident's body. The evaluation has been developed to adequately assess all aspects of the resident's well-being (physical, mental, emotional, environmental, and social considerations) PRIOR to the use of physical devices in order to identify the least restrictive intervention. It is to be completed by the IDT (interdisciplinary team). 1. Devices (s) being assessed: Foot Buddy to w/c (wheelchair). 2. Medical symptom(s) for which the device is being recommended: Fall & safety risk; proper LE (lower extremity) alignment while seated in w/c (wheelchair). J. Evaluation. 1. Can the resident independently remove the recommended device. No. K. Summary. Freedom of Movement. This device WILL NOT restrict the resident's freedom of movement or normal access to his/her body and therefor WILL NOT function as a restraint for this resident. (See observation on 4/19/23 at 10:15 AM, when these devices were removed R3 could move both feet to move his wheelchair). The information in section K did not accurately document the restriction of movement these devices cause.

On 4/20/23 at 10:00 AM R3 was observed in his room with the foot pedals and padded board in place.

Review of R3 physician orders dated 4/20/23 revealed, "Foot buddy to be on at all times

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	when up in w/c (wheelchair) to support upright positioning and LE (lower extremity) alignment. Consult therapy if concerns/problems arise regarding r/t foot buddy use with BLE (both lower extremities) positing during w/c propulsion every shift. There was no indication these devices were a restraint and there was no instruction for removal to allow R3 unrestricted movement.			
F0610 SS= D	Investigate/Prevent/Correct Alleged Violatio §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate and document an injury of unknown origin resulting in an incomplete investigation for one resident (R30) and the potential for further injury and potential abuse or accidents to occur. Findings include: Review of facility provided policy "Abuse,	F0610		

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CHRISTIAN CARE NURSING CENTER	2053 S SHERIDAN DRIVE MUSKEGON, MI 49442

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	Neglect and Exploitation" with a last revised date of 12/29/22 revealed: "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property." Definitions include: " 'Alleged Violation' is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property." Under the section: "Identification of Abuse, Neglect and Exploitattion:" "Possible indicators of abuse include, but are not limited to ... Physical injury of a resident, of unknown source..." Review of R30's face sheet printed 4/20/23 and electronic medical record revealed she initially admitted to the facility on 3/25/2020 and most recently readmitted to the facility on 3/17/23 with diagnoses that included: Chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus type 2, nonthrombocytopenic pupura (red or purple discolored skin due to altered platelet function), and visual hallucinations. R30 reentered the facility on 3/17/23 on hospice care after a short hospital discharge and was deceased as of 3/27/23. R30 was listed as their own responsible party. Review of R30's progress notes revealed a note on 3/18/23: "Cena called this nurse to resident room to show me resident has a skin tear right knee. Skin tear involves whole knee area across the knee. Tried putting edges of skin together, area cleansed and dressing applied per provider orders. DON notified. Cena was transferring resident from toilet to her w/c (wheelchair),			

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	noticed resident skin on right knee had rolled, thought resident had a clear dressing on her knee. Resident skin is a little dry, also asked for muscle rub on knees for knee pain applied gently, also moisture cream. Resident has bilateral edema knee and lower legs. Resident is on hospice care, resident has a very large bruise above right knee." There were no further progress notes describing the injury or follow up. There was no skin assessment where a measurement of the bruise or skin tear was documented. A request was made to the NHA (Nursing Home Administrator) for any incident report or additional information related to this injury. An email was received on 4/19/23 at 10:32 AM from the NHA: "I do not have a reportable with this event. Attached is an incident report regarding her skin. I will ask our clinical team if they have any further information." Review of the incident report dated 3/18/23 revealed: "Cena called this nurse to resident room to show me resident had a skin tear right knee area. Resident has a large skin tear across right knee, tried putting edges of skin together, bright red blood mad (sp?) amount, area cleansed with normal saline and dressed after order from provider. Resident description: Resident does not know how it happened." It is noted the resident is oriented to person and place, but not situation or time. It was marked under predisposing situation factors "during transfer" and "other." Under "Other Info:" "resident skin is a little dry, also has edema bilateral legs, resident is on Hospice." No witnesses were listed, the DON (Director of Nursing) and the physician were listed as notified. There were no notes or other narrative on the incident report. No conclusion, further description of the injuries or investigation information was listed regarding the injury of unknown origin. A bruise was not mentioned in the incident report.			

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	An interview was completed with the DON on 4/19/23 at approximately 2:30 PM. The DON stated she was immediately notified about the injury, but could not recall the details of the event, and thought the injury occurred during a transfer in the shower. The DON was informed per the progress notes and the incident report, there was no clear conclusion on how the injury was sustained and appeared to be an injury of unknown origin. The DON stated the resident had a history of skin tears so there was not a concern regarding abuse. The DON stated Unit Manager (UM) "F" would have completed an investigation and the notes should be in the incident report. The DON was questioned if the injury occurred during a transfer, why no witnesses were listed and why what appeared to be quite a large injury was not noticed and she reiterated the resident had fragile skin and that UM "F" would have more information. An interview was completed with UM "F" on 4/19/23 at 3:04 PM. UM "F" stated she did an investigation after R30 sustained an injury. UM "F" stated she did not believe the injury occurred during a transfer and after doing a reenactment, she believed it happened during toileting when the resident's pants were pulled down. UM "F" confirmed R30 required assistance with her care and was questioned why this was not noticed by staff if this is how it occurred when the injury was so large. UM "F" stated R30's skin was so fragile that "if you put a notebook on her lap, her skin could bruise or tear." It was discussed with UM "F" that R30's skin assessments did not support her statement that R30's skin was so fragile that if touched it would tear or bruise, as the skin assessments did not indicate an immense number of injuries. UM "F" stated R30 "had so many injuries, that if you walked into her room, she would immediately say 'no one hurt me.'" UM "F" confirmed she did not have a direct statement documented from the R30 on this injury other			

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	than the incident report, which indicated the resident did not know how the injury occurred. UM "F" stated that R30 was cognitively intact. UM "F" was questioned if there was any decline in cognition due to her recent decline in medical status and placement on hospice a few days prior to the injury and she stated R30 was still making her own medical decisions, but could not be sure if her cognitive status vacillated due to her end of life process. UM "F" provided a statement from the aide that was caring for R30 and helping her into bed when the injury was noted. UM "F" was questioned that the statement seemed to indicate that the aide felt the injury occurred during the transfer to bed. The statement from CNA (certified nurse aide) "P" revealed: "helping [R30] into bed I was trying to be careful. I honestly have no idea how it (the skin tear) happened." UM "F" stated the aide was not sure if this was how it happened, but that is when it was noticed. UM "F" stated her reenactment revealed the injury was more likely from the action of removing the resident's pants during care. UM "F" was asked if she had more information regarding how the reenactment was completed and how she came to that conclusion and she stated "they are really just scribbles in a notebook and some of it in my short hand, it really wouldn't make sense." UM "F" stated she does have an incident report checklist that include documenting measurements, completing interviews, documenting findings and completing a conclusion, but not everything that is checked occurred. UM "F" stated at this time she added more notes to the incident report and they should have been completed at the time. UM "F" stated she does not know why measurements were not completed and documented. UM "F" stated she is responsible for ensuring all the elements of the investigation and incident report were completed. A follow up interview was completed with UM			

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	"F" on 4/19/23 at 4:05 PM and she stated again she was "surprised measurements were not in the incident report" since it was marked as completed on the checklist. She again confirmed she should have ensured all elements of the investigation were complete. UM "F" stated she believed this incident occurred when they first opened up an additional resident unit and it must have been overlooked due to all of her duties at the time. UM "F" indicated that R30's diagnosis of nonthrombocytopenic pupura was indicative that her skin would tear frequently. Medical News Today reveals: "Purpura, also known as skin hemorrhages or blood spots" and ...Nonthrombocytopenic purpura happens when platelet levels are normal, suggesting another cause." There are no symptoms related to skin tears. Retrieved on 4/21/23 from https://www.medicalnewstoday.com/articles/311725 The facility provided "Incident Report Checklist" for R30 and the injury found on 3/18/23 revealed an injury "skin tear R (right) knee" was the injury, no mention of the bruising. Under the section "what occurred" the handwritten response was "with transfer." On the checklist "For injury of unkow (sp) cause, what were the circumstances surrounding this injury and DON or UM may be able to help you determine cause" was NOT checked as being completed. "Injury noted and description of injury, appearance and measurements" was checked as being completed. An edited version of the incident report was provided on 4/20/21 at 7:30 AM by email from the NHA. The incident report included more notes added by UM "F." UM "F" had added that on 3/19/23 (time not noted) "wound assessed. No Sx of infection noted. Large bruise noted around her knee and lower thigh. Resident denies pain r/t			

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	(related to) this injury. Resident stated she is not being hurt by anyone at Facility, she is not afraid of anyone at the facility. Reviewed events of the night before, with re-enactment and noting her history of skin tears r/t clothing management. Causation consistent doffing her pants when sitting on the commode for HS care. Resident is on Hospice and will be wearing a hospital gown for the duration of her time at this facility."			
F0623 SS= D	Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under	F0623		

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	paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility			

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	must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the resident and/or the resident's representative of the transfer and the reasons for the move in writing and in a language and manner they understand for one resident (R6), resulting in the potential for the resident and/or resident's representative not being fully informed of the reason and circumstances for the transfer. Findings include: A review of R6's Admission Record, dated 4/19/23, revealed R6 was an 88-year-old resident admitted to the facility on 2/16/23 and re-admitted on 3/21/23. In addition, R6's Admission Record revealed multiple diagnoses that included a fracture around the prosthetic hip joint, a fracture of the left femur (leg bone), falls, dementia with agitation, and a history of strokes (transient ischemic attacks and cerebral infarctions). In addition, R6's Admission Record revealed she had a responsible party for making care decisions. A review of R6's Minimum Data Set (MDS) (a			

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tool used for assessing a resident's care needs), dated 2/22/23, revealed R6 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of "3" which revealed she was severely cognitively impaired.

During an interview on 04/18/23 at 10:40 AM, R6 appeared to be alert and oriented. R6 was responding appropriately to questions about her care and stay at the facility. R6 stated one night she had decided to get up go to the bathroom without using her call light, tripped over something, and fell. She stated she knew she was supposed to call for assistance, but decided to do it on her own. R6 stated this happened several months ago, she went to the hospital, and they found she had fractured a small area of her hip.

A review of R6's progress notes, dated 1/18/23 to 4/18/23, revealed the following:

- Incident Note, dated 3/19/23, revealed, "Heard calling out for help and entered residents room and observed resident sitting on floor in front of recliner off to left side with w/c (wheelchair) facing bed but closer to bathroom. Resident stated she went to sit down and w/c moved. Resident assessed and ROM (range of motion) unchanged. Did state that she was having some discomfort in left hip and left knee. Left knee laceration present 2 cm (centimeters) long. Area cleanse with NS (normal saline) and Tegaderm (a type of adhesive dressing) applied..."

- Health Status note, dated 3/19/23, revealed R6 was complaining of severe pain (10 of 10) on the left side from her lower back to her toes. R6 could not wiggle her toes due to numbness. The on-call provider was called and a message was left.

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	- Health Status note, dated 3/19/23, revealed the on-call provider returned the facility's phone call and ordered R6 sent to the emergency room for an evaluation. - Admission Note, dated 3/21/23, revealed, "Resident returned to facility after short stay at a local hospital r/t (related to) post fall hairline Fx (fracture) of her left hip. No surgical intervention was needed... Resident is A/O (alert and oriented) to self and place." - Health Status note, dated 4/1/23, revealed R6 was alert and oriented to person, place, and time. A review of R6's electronic medical record failed to reveal a facility transfer form for transfer to hospital on 3/19/23 or documentation that R6 and/or their responsible party were given a written explanation for transfer to hospital on (or soon after) 3/19/23. During an interview on 04/19/23 at 02:40 PM, the Director of Nursing (DON) stated transfer forms are printed from the computer system and sent with the resident when they go to the hospital. She stated the facility does not keep copy of the transfer forms in the resident's medical records or anywhere at the facility. The DON stated she would look to see if she can locate any documentation that the resident and/or responsible party were given the reason for R6's transfer to the hospital in writing. However, the DON stated she doubted that the resident and/or responsible party were ever given in writing the reason for R6's transfer to the hospital, but she would look anyway. A copy of any documentation that the DON may find that revealed R6 and/or their responsible party were given, in writing, the reason for R6's transfer to the hospital on 3/19/23 were requested from the DON.			

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	On 04/19/23 at 02:51 PM, a copy of any documentation that R6 and/or their responsible party were given in writing the reason for R6's transfer to the hospital on 3/19/23 was requested from the NHA. During an interview on 04/20/23 at 07:50 AM, the NHA stated he was still trying to locate documentation that R6 and/or their responsible party were given, in writing, the reason for the transfer to the hospital on 3/19/23. He stated he would provide to the surveyor the facility's policy on hospital transfers. However, the NHA stated he doubted he had any more information to provide regarding R6's transfer to the hospital on 3/19/23. Copies of any documentation that can be located was requested from the NHA (second request). As of the time of the completion of the survey and exit from the facility, the facility failed to provide any documentation that R6 and/or their responsible party were provided with the reason for R6's transfer to the hospital in writing on 3/19/23 or soon thereafter.			
F0625 SS= D	Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph	F0625		

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(e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to provide the notice of the facility's bed hold policy to the resident and/or their responsible party for one resident (R6), resulting in the potential for R6 and/or their responsible party not being aware of the choice to hold a bed or decline to hold a bed when R6 was admitted to the hospital.

Findings include:

A review of R6's Admission Record, dated 4/19/23, revealed R6 was an 88-year-old resident admitted to the facility on 2/16/23 and re-admitted on 3/21/23. In addition, R6's Admission Record revealed multiple diagnoses that included a fracture around the prosthetic hip joint, a fracture of the left femur (leg bone), falls, dementia with agitation, and a history of strokes (transient ischemic attacks and cerebral infarctions). In addition, R6's Admission Record revealed she had a responsible party for making care decisions.

A review of R6's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 2/22/23, revealed R6 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of "3" which revealed she was severely cognitively

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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
	impaired. During an interview on 04/18/23 at 10:40 AM, R6 appeared to be alert and oriented. R6 was responding appropriately to questions about her care and stay at the facility. R6 stated one night she had decided to get up to the bathroom without using her call light, tripped over something, and fell. She stated she knew she was supposed to call for assistance, but decided to do it on her own. R6 stated this happened several months ago, she went to the hospital, and they found she had fractured a small area of her hip. A review of R6's progress notes, dated 1/18/23 to 4/18/23, revealed the following: - Incident Note, dated 3/19/23, revealed, "Heard calling out for help and entered residents room and observed resident sitting on floor in front of recliner off to left side with w/c (wheelchair) facing bed but closer to bathroom. Resident stated she went to sit down and w/c moved. Resident assessed and ROM (range of motion) unchanged. Did state that she was having some discomfort in left hip and left knee. Left knee laceration present 2 cm (centimeters) long. Area cleanse with NS (normal saline) and Tegaderm (a type of adhesive dressing) applied..." - Health Status note, dated 3/19/23, revealed R6 was complaining of severe pain (10 of 10) on the left side from her lower back to her toes. R6 could not wiggle her toes due to numbness. The on-call provider was called and a message was left. - Health Status note, dated 3/19/23, revealed the on-call provider returned the facility's phone call and ordered R6 sent to the emergency room for an evaluation.			

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	- Admission Note, dated 3/21/23, revealed, "Resident returned to facility after short stay at a local hospital r/t (related to) post fall hairline Fx (fracture) of her left hip. No surgical intervention was needed... Resident is A/O (alert and oriented) to self and place." - Health Status note, dated 4/1/23, revealed R6 was alert and oriented to person, place, and time. A review of R6's electronic medical record failed to reveal if the facility's bed hold policy was presented to R6 and/or their responsible party prior to, or soon thereafter, their transfer to the hospital on 3/19/23. During an interview on 04/19/23 at 02:40 PM, the Director of Nursing (DON) stated she would look to see if she could locate any documentation that R6 and/or responsible party were given a copy of the facility's bed hold policy prior to, or soon, after R6 transferred to the hospital on 3/19/23. However, the DON stated she doubted that the resident and/or responsible party were ever the facility's bed hold policy. A copy of any documentation that the DON may find that revealed R6 and/or their responsible party were given a copy of the facility's bed hold policy on, or soon after, their transfer to the hospital on 3/19/23 was requested. On 04/19/23 at 02:51 PM, a copy of the facility's bed hold policy that was presented to R6 and/or their responsible party prior to, or soon after, her transfer to the hospital on 3/19/23 was requested from the NHA. During an interview on 04/20/23 at 07:50 AM, the NHA stated he was still trying to locate documentation that the facility's bed hold policy was presented to R6 and/or their responsible party prior to, or soon after, her transfer to the hospital			

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	on 3/19/23. He stated he would also provide to the surveyor the facility's policy on hospital transfers. However, the NHA stated he doubted he had any more information to provide regarding R6's transfer to the hospital on 3/19/23. Copies of any of this documentation were requested, if the NHA was able to locate them. As of the time of the completion of the survey and exit from the facility, the facility failed to provide any documentation that R6 and/or their responsible party were provided with the facility's bed hold policy on 3/19/23 or soon thereafter.			
F0686 SS= D	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 observations, interview, and record reviews, the facility failed to prevent, heal and provide adequate pressure relief for 1 Resident (R3) of 1 Resident reviewed for pressure ulcers, resulting in R3 developing a stage 2 pressure ulcer on his buttock and the potential for delayed healing or worsening of this ulcer.	F0686		

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	Finding include: Review of R3's face sheet, dated 4/19/23, revealed he was an 85-year-old male last admission 4/10/19, and had diagnoses that included: Dementia, muscle weakness (generalized), and peripheral vascular disease. He was not his own responsible party. R3 was observed on 4/18/23 at 10:52 AM sitting in a high back wheelchair looking out a window on the nursing unit. His feet were both on foot pedals and a padded board was placed between the foot pedals that prevented R3 from moving his feet off the foot pedals. R3's knees were about 6 to 8 inches higher than his hips while sitting in his wheelchair (places more force on his back and boney areas of his buttock, not a comfortable position). R3 was observed on 4/19/23 at 10:00 AM sitting in front of the same window he was sitting at on 4/18/23. He was sitting in the same wheelchair with all the same equipment as the day before. On 4/19/23 at 10:00 AM, Unit Manager (UM) "F" assisted R3 to his room for a skin check and care. Certified Nurse Aide (CNA) "G" assisted UM "F" to stand R3 in his bathroom. R3 held the grab bars on the wall as UM "F" provided wound care. R3 had a round discolored area on his left buttock about 1-1/2" in diameter. There were 2 small open areas in his skin within the discolored area. On 4/19/23 at 10:15 AM, CNA "G" was asked about the care R3 had received today. CNA "G" said she and CNA "O" got R3 out of bed around 6:30 to 7:00 AM and she had not			

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	provided any care since. CNA "O" entered the room during this time and confirmed she had assisted at that time getting R3 out of bed and said she had not provided care since. They were both asked if R3 required assistance with pressure relief and they both denied any need to assist R3 with pressure relief. They both indicated he only got care when he requested it, and he normally will request to use the bathroom. Review of R3's Kardex (nurse aide care guide) on 4/19/23 revealed, the Pressure Prevention area did not indicate staff needed to assist R3 with any pressure relief. On 4/19/23 at 11:00 AM the Nursing Home Administrator (NHA) was asked for R3's wheelchair assessment and responded later they did not have one. He also stated he was having Occupational Therapy evaluate his wheelchair. Review of R3's, "Occupational Therapy Evaluation", dated 4/19/23, revealed, "STG (short term goal) #1. Patient will increase ability to achieve and maintain correct anatomical alignment to Supervision or Touching Assistance with seating in W/C using specialized cushion, leg rests and adaptive equipment/devices in order to facilitate intact skin integrity, achieve proper joint alignment, enhance comfort, facilitate participation in activities of interest and facilitate weight distribution." The Posture/Position/Assessment section revealed, "Pt's hip/knee/ankle alignment is @90 degrees = No (pt knees above hip level in w/c, posterior pelvic tilt), Pt has recent fall or hx of falling out of chair = no; Current W/C = Reclining wheelchair; Method of Propulsion = Bilateral upper extremities; Adaptive			

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	Equipment/Devices: pt has 2-inch cushion in place, leg buddy positioned on elevating footrests, non-slip webbing under cushion." The treatment section revealed, "Pt noted to be sitting with bilateral knees above hip level. OTR (Registered Occupational Therapist) trialed 2-inch-thick w/c cushions to increase seat to floor height to allow knees to be positioned closer to hip height. Pt reporting increased comfort with thicker cushion in place. Pt also observed to have footrest of differing height. Pt may benefit from order of slightly higher profile cushion for additional seat to floor height. R3 was observed in his room in his wheelchair on 4/20/23 at 10:00 AM. His feet were on foot pedals and his knees were 3-4 inches above his hips, placing increased pressure on his buttocks where his stage 2 pressure ulcer was located. Review of R3's "Weekly Wound Assessment", dated 4/12/23 at 5:07 PM, revealed R3 had a wound on his left lateral Proximal buttock that was 5 cm x 3 cm and 0.1 cm deep, no stage was provided. Review of R3's "Weekly Wound Assessment", dated 4/18/23 at 7:27 PM, revealed R3 had a wound on his left lateral Proximal buttock that was 5 cm x 3 cm and 0.1 cm deep, no stage was provided. On 4/19/23 at 10:30 AM, UM "F" was asked for a history of R3's wounds for the last year, wound measurement, assessments, treatments, and physician notes for the last two months. On 4/20/23 at 10:20 AM a 2nd request for wound documents was made to the Director			

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	of Nursing (DON). On 4/20/23 at 10:28 AM the Nursing Home Administrator (NHA) was asked for any information regarding the root cause of R3's wounds and physician assessments of his wounds. On 4/20/23 at 11:00 AM, UM "F" provided a typed timeline of R3's wounds and nursing assessments. The timeline did not provide any measurements or root cause. The only supporting documents provided were nursing assessments and they did not have any information on treatment or root cause of the wounds. Upon exit the facility did not provide any root cause analysis of the wounds, physician assessments, verification of treatment orders and/or that treatments were being done as ordered for R3's wounds.			
F0761 SS= D	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive	F0761		

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	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 properly label medications for 2 of 2 medication rooms, potentially affecting all 30 facility residents, resulting in the potential for expired Tuberculin Protein Derivative being administered and the potential for inaccurate tuberculin test results from possible oxidation and degradation of the solution. Findings include: During an observation on 04/18/23 at 04:20 PM, the Love's Garden medication room was inspected with Registered Nurse (RN) "D". The following observation and interview were made: - A vial of [brand name] Tuberculin (TB) Purified Protein Derivative (PPD) was observed open and undated in the medication room refrigerator. - RN "D" stated she did not know when the vial was opened. She stated the vials are good for 30 days after they are opened. - RN "D" stated if she opens a TB PPD vial, she labels it with the open date. She stated she labels it so other staff know when it was opened and when to discard it. During an interview on 04/19/23 at 10:40 AM, Licensed Practical Nurse (LPN) "B" stated when			

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	she opens a new TB PPD vial, she labels it with the open date. She stated she does this so she knows when it was opened and so she can know when to dispose of it after it has been open for too long. LPN "B" stated she did not know how long a TB PPD vial can be open until it needs to be discarded, but she would find out. During an observation on 04/19/23 01:00 PM, the Faith's Terrace medication room was inspected with LPN "C". The following observation and interview were made: - A vial of [brand name] Tuberculin (TB) Purified Protein Derivative (PPD) was observed open and undated in the medication room refrigerator. - LPN "C" stated, "Your guess is as good as fine" when asked when the TB PPD vial was opened. She stated if she had opened the vial, she would have dated it. - LPN "C" stated she dates vials when they are opened so she knows when to discard it. She stated the TB PPD vials are only good for 30 days after they are opened. The undated TB PPD vial was then placed back into the medication room refrigerator. During an interview on 4/19/23 at 1:30 PM, LPN "B" stated the TB PPD vials are good for 30 days after they are opened. She stated this information was printed on the vial's label. LPN "B" then showed the surveyor where the information was printed on the label. A review of the manufacturer's instructions for the TB PPD vial, dated 3/16, revealed, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency."			

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F0921 SS= D	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 keep the environment free from hazardous chemical gases, resulting in possible respiratory distress, discomfort and hazardous conditions for residents residing on the Love's Garden unit. Findings Include: On 04/18/23 at approximately 10:25 AM, when entering the Love's Garden unit, a very strong bleach odor was noted, within a few minutes on the unit, this surveyor's throat was burning and felt sore even when breathing through a KN95 mask. On 04/18/23 at approximately 10:29 AM, a family visitor in a resident's room, "N" remarked during an interview "the smell of the chemicals is quite strong today, very bleachy." On 04/18/23 at 10:38 AM housekeeping employee, "M" was approached and they were mopping the floor in the dining area on the unit. As Housekeeper "M" was approached, the chemical smell became extremely strong where the floor was wet. Housekeeper "M" was asked what they were using to clean the floor and they stated, "water and a little bit of bleach and a green cleanser." Housekeeper "M" was asked to show what exactly was being used and this surveyor followed to the housekeeping closet on the Faith's Garden unit. Housekeeper "M" pointed to a bottle	F0921		

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	of bright greenish yellow cleanser and stated the cleaner automatically is mixed with water when filling the mop bucket at the set ratio and then bleach is added to the mixture. Housekeeper "M" showed a clear plastic cup with red lines on it and pointed to a line that appeared to be approximately a cup and stated, "I add this much bleach." Housekeeper "M" stated they had worked for the facility about 2 months and this was the cleaning procedure they had been trained to do and they had been using this mixture on the floor every day. The bottle of the greenish yellow liquid was viewed to be "Mr. Clean Professional Finished Floor Cleaner." On 04/18/23 at approximately 11:12 AM, an interview was completed with the Nursing Home Administrator regarding the mixing of cleaning chemicals. The NHA stated "I don't think any cleaning chemicals should be mixed." They stated they would follow up with housekeeping staff and provide the safety data sheets for the cleansers. Review of the Safety Data Sheet for "Mr. Clean Professional Finished Floor Cleaner" revealed the active ingredients included: "Alcohols, C9-11, ethoxylated" and "Sodium carbonate." Per the International Association for Chemical Safety: "Mixing chemicals is never a good idea, unless you know what you're doing and are fully prepared for the reaction you will get ...did you know that mixing bleach with alcohol will create chloroform? In fact, any chlorinated compound that is reacted with any one of a wide range of organic molecules will create chloroform ... Something as simple as mixing two different generic cleaning substances could create any number of hazardous substances, including chloroform ... Chloroform is very hazardous to humans and can cause any or all of the following health problems:			

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	*Irritation of the eyes, *almost instantaneous unconsciousness, *irritation of the respiratory system, *skin rashes and irritation, *severe damage to the nervous system and several organs including the lungs, liver and kidneys, *cancer, *fatal cardiac arrhythmia." Retrieved on 4/21/23 from https://www.thechemicalsafetyassociation.org/post/dangers-of-mixing-bleach-alcohol			
F0943 SS= D	Abuse, Neglect, and Exploitation Training §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to take immediate corrective actions for 1 employee that had inappropriate behavior with a	F0943		

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resident, resulting in ongoing inappropriate behavior that could have negative psychological outcomes for residents.

Findings include:

Review of R24's Minimum Data Set (MDS) dated 12/27/22 revealed she a 72-year-old female admitted on 10/7/20, had severely impaired cognition and had diagnoses that included: non traumatic brain dysfunction, Alzheimer's, dementia, and depression.

On 4/18/23 at 10:58 AM, R24 was sitting on the nursing unit in a high back wheelchair. R24 was not responding to her name and was not providing any verbal response to questions. Certified Nurse Aide (CNA) "H" was asked if this was R24. CNA "H" was coming up behind R24, she threw her hands in the air and said, "I have only been here 7 days". CNA "H" stood about 2 feet from R24s face and said she is "Mrs. pincher." The Surveyor said, "what" as this seemed very odd, and she was not sure she heard what she heard. CNA "H" again said, "Mrs. Pincher" and moved her hand in front of R24, she moved her thumb toward her fingers making a pinching motion and said that is because she pinches people.

During an interview with the facility Social Worker (SW) "J" on 4/19/23 at 12:30 PM, SW "J" confirmed she did the new employment dignity training and provide a posttest dated 3/30/23, that indicated CNA "H" had passed a test related to information on dignity. When asked if she remembered CNA "H" she responded, yes, the Director of Nursing (DON) and I both had some concerns about her. SW "J" was informed of CNA "H" calling R24 Mrs. Pincher and that she made a

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	614010	A. BUILDING _____ B. WING _____	4/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE NURSING CENTER	2053 S SHERIDAN DRIVE MUSKEGON, MI 49442

(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

pinching motion in front of R24's face. SW "J" confirmed this was not dignified and unacceptable behavior. SW "J" said, human resources was responsible for discipline when something like this occurred.

During an interview with the Human Resources (HR) Director, "I" on 4/19/23 at 12:55 PM, "I" was asked if CNA "H" had any discipline, write ups or new educational opportunities after completing her orientation as there was nothing in CNA "I's employee folder. HR "I" said she had received and email on Monday 4/15/23 that CNA "I" had inappropriate behavior at work last Thursday 4/11/23 (4 days prior to HR notification). HR "I" was not sure what the behavior was or if it had been addressed by anyone. A policy was requested to see how Human Resources manages staff discipline or reeducation. HR "I" said she did not have one.

On 4/19/23 at 1:40 PM, the Nursing Home Administrator (NHA) confirmed he had received and email about CNA "H" related to a behavioral issue. He could not recall what the issue was and was not sure if the issue had been addressed. The NHA was informed of CNA "H" referring to R24 as Mrs. Pincher on 4/18/23 (7 days after the facility was aware CNA "H" had some kind of behavioral issue.)

During an interview with the Director of Nursing (DON) on 4/19/23 at 2:20 PM she confirmed CNA "H" worked on 3rd Shift on 4/10/23 into the morning of 4/11/23. During that time a resident said, she wanted to die and CNA "H" responded to that resident that she wanted to die too. The DON said, when she met with CNA "H" at the end of her shift on 4/18/23 (7 days after the inappropriate

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	behavior), CNA "H" acknowledged her response was not appropriate and admitted she told the resident she wanted to die. The DON denied any disciplinary action at that time and said she types up the information later. The DON did not have any paperwork at the time that indicated what happened on 4/11/23 and her discussion with CNA "H" on 4/18/23. The DON said she became aware of the situation the happened on 4/11/23 the morning of 4/17/23 when staff that witnessed the inappropriate conversation reported it to her. The staff that reported it to her said they had informed the charge nurse. The DON confirmed the staff are to follow the abuse policy for behavioral issue like this and the charge nurse should have immediately notified her when she became aware of the situation. The DON said she had not followed up with the charge nurse yet. The DON was informed at this time about CNA "H's" Mrs. Pincher comment the morning of 4/18/23 (7 days after having inappropriate behavior related to a different resident.)			