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	634595	A. BUILDING _____ B. WING _____	5/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR REHAB CENTER OF NOVI INC	31215 NOVI ROAD NOVI, MI 48377

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F0000 SS=	INITIAL COMMENTS Maple Manor Rehab Center of Novi was surveyed for a Recertification survey on 5/11/23. Census=53	F0000		
F0558 SS= D	Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a call light was accessible for one (R22) of one resident reviewed for call light placement, resulting in the potential delay in services, unmet care needs, and isolation. Findings include: According to the facility's policy titled, "Call Lights: Accessibility and Timely Response" dated January 2023: "...Staff will ensure the call light is within reach of resident and secured, as needed...The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room..."	F0558	F558 – Accommodation of Needs. Call Light Not Within Reach. Element 1 The call light for resident #22 was placed within reach. Element 2 The facility has determined that all residents have the potential to be affected, but especially those residents who require extensive assistance and are unable to move or grasp a call light that is out of reach. Element 3 The facility's Accommodation of Needs Policy and Call Light: Accessibility and Timely Response Policy were reviewed and deemed appropriate. All direct care personnel received an in-service/education regarding these policies and procedures, as well as the facility's expectations of staff to ensure the accessibility of call lights in resident rooms at all times and to respond in a timely manner. Like residents were identified using the MDS 3.0 ADL Score Report to see which residents require extensive assistance. These residents (or guardians) will be educated on how to use call light and assessed for specific call light preferences or accommodations. Care plans will be updated accordingly. Element 4	6/20/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/02/2023

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

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	On 5/11/23 at 11:08 AM, R22's door was observed closed. Upon entering the resident's room, R22 was observed severely leaning to their left side with a pillow propped under their right shoulder. When asked if they needed help with repositioning, they reported they did and that their shoulder hurt and needed to be wrapped. At that time, an adaptive call light was observed on the floor near the head of the bed. When asked how they would contact staff if help was needed, R22 stated "That's ridiculous, been like that since yesterday!" R22 further reported there was no way for them to be able to reach the call light on the floor. On 5/11/23 at 11:11 AM, an interview was conducted Nurse 'R' who was assigned to R22. When asked who was R22's assigned Certified Nurse Assistant (CNA), they reported they weren't sure. When asked if there was an assignment sheet, Nurse 'R' deferred to the whiteboard at the nursing desk and indicated that had not been updated for today. At that time, Nurse 'R' was asked to accompany and observe R22's room. Upon entering the room, Nurse 'R' confirmed the resident's poor positioning and attempted to have the resident repositioned more on their left side. When asked about the call light on the floor, Nurse 'R' proceeded to pick up the call light and place on the table in front of the resident. Nurse 'R' reported the call light should be within reach.		For the like residents identified as requiring extensive assistance, the unit manager or designee will make rounds two times daily for one week, then once daily for one week. Random checks for one of the extensive assistance patients on each wing will be conducted three times weekly for two additional weeks to ensure compliance. The night shift supervisor or designee will provide checks of the same frequency and duration to ensure compliance 24/7. Results of this plan of correction will be monitored at the quarterly QAPI meeting until it is deemed that substantial compliance has been achieved. Results of this plan of correction, will also be discussed with the Resident Council. The facility administrator is responsible for sustained compliance.	

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	On 5/11/23 at 11:17 AM, an interview was conducted with R22's assigned Certified Nursing Assistant (CNA 'Q') who reported they did not come in to work until 9:00 AM and this was their first time working with R22. When asked about when they had last provided care to R22, CNA 'Q' reported they had been in to change and reposition R22 about an hour or hour and half ago and had just given the resident their breakfast tray about a half hour ago. CNA 'Q' reported they had been informed R22 usually leans to the side. When asked if they identified any concerns with the call light placement when they were in the room earlier, they reported they did not recall anything about the call light. CNA 'Q' was informed of the concern the call light had been on the floor and inaccessible and offered no further response. Review of the clinical record revealed R22 was admitted into the facility on 1/11/23 with diagnoses that included: diffuse traumatic brain injury without loss of consciousness, multiple sclerosis, person injured in unspecified motor-vehicle accident, acute respiratory failure with hypoxia, neuromuscular dysfunction of bladder, generalized anxiety disorder, and major depressive disorder, recurrent, moderate. According to the Minimum Data Set (MDS) assessment dated 1/17/23, R22 had no communication concerns, had intact cognition and required extensive assistance of two or more people for bed mobility and			

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	transfers.			
F0578 SS= D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.	F0578	POC F-578 Advanced Directive Element 1 The code status of R# 40 was verified and entered consistently into all relevant locations within the electronic medical record. Element 2 All residents have the potential to be affected. Element 3 The facility's Advanced Directive Policy was reviewed and updated (see attached Resident Rights Regarding Treatment and Advance Directives Policy). The Director of Nursing Services or designee provided an in-service to educate social services staff and licensed nurses regarding the Advance Directives/code status documentation procedures. An audit of all resident charts was completed on 5/16/2023. Audit findings were addressed immediately, and all needed actions were completed on 5/17/2023. Element 4 For a period of three months, the Director of Social Services or designee will perform weekly x (3) three months medical record audits of new admissions and those residents on the MDS assessment schedule for consistent documentation of the resident's Advance Directive/code status throughout the electronic medical record. After three months, the Director of Social Services will complete a random medical record audit of at least (5) five records per month for consistent documentation for the next (2) two months. Results of the audits will be discussed monthly with the QAA committee until such	6/20/2023

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	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident's code status was obtained and documented according to the resident's wishes for one (R40) of four residents reviewed for advance directives. Findings include: Review of the clinical record revealed R40 was admitted into the facility on 3/24/23 with diagnoses that included: diffuse traumatic brain injury, pneumonia and atrial fibrillation. According to the Minimum Data Set (MDS) assessment dated 3/30/23, R40 was cognitively intact and required the extensive assistance of staff for activities of daily living (ADL's). Further review of R40's clinical record revealed no documentation of code status. In addition, there was no document signed by R40 indicating his wishes for end of life measures. Review of an Social Work progress note dated 3/27/23 at 12:05 PM read in part, "...Advanced directive to be completed with patient and family per patient request..." On 5/10/23 at 1:35 PM, R40 was observed lying in bed. R40 was asked if anyone at the facility had talked to him about his wishes for		time it is determined that substantial compliance is maintained. The facility administrator is responsible for sustained compliance.	

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end of life decisions. R40 explained no one had talked to him about that. When asked what he would want done if his heart stopped, R40 explained he wanted them to "just let me go."

On 5/10/23 at 2:39 PM, Social Worker (SW) "H" was interviewed and asked about R40's code status. SW "H" explained when R40 was admitted, she had asked him about his wishes, but that he wanted his son involved in the decisions. When asked if she had followed up with R40 about his wishes, SW "H" explained she had not circled back to him. SW "H" was asked how long she usually waited to follow up. SW "H" explained she usually followed up in a few days or a week, but had not gotten back to R40.

Review of R40's progress notes revealed a note dated 5/10/23 at 3:36 PM that read in part, "SW met with the patient in his room to offer advanced directive choices. The patient stated, 'just let it end". SW confirmed the patient meant DNR (do-not- resuscitate)..."

Review of a facility policy titled, "Resident's Right Regarding Treatment and Advance Directive" revised 1/2023 read in part, "...It is the resident's right to formulate an Advance Directive, and to accept or refuse medical or surgical treatment... implement those Advance Directive formulated by the resident as evidenced by: a. A Resident completion of the Advance Directive while admitted to the facility. b. Physician signature on the Advance

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	Directive..."			
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 conduct an assessment prior to application of a seat belt restraint, ensure there was medical indication for use other than staff convenience, and attempt alternative interventions prior to using a restraint for one (R14) of one resident reviewed for physical restraints. Findings	F0604	POC F 604 - Rights to be Free from Physical Restraints Element 1 R#14 Medical Records were reviewed. PM&R recommendations were also reviewed for the appropriateness of the use of seatbelts. The most current MDS assessment was reviewed, and the care plan was modified to reflect restraints use on 05/11/2023. Physical Device Assessment was completed by Therapy. Updated Informed Consent for seatbelt was obtained from POA on 05/05/23. PM&R and attending physician noted clinical justification for the use of seatbelts. Order was also placed in the R#14 chart for Q Shift - Release seatbelt for 15 minutes every 2 hours and PRN for ADL and toileting Element 2 No other residents were identified on this deficient practice. Element 3 To ensure that this practice will not recur, the facility will assess new admissions regarding the use of physical device/restraint using the Physical Device Assessment Form. If physical restraint is deemed necessary, a physician order will be obtained stating how long the device will be used and how often the release from the device. A consent from the responsible party will also be obtained. Prior to application of the device □ the least restrictive measures will be implemented such as visits from activities staff, frequent checks, or if necessary 1:1 sitter. In services to nursing staff, activities staff, therapy staff as well as medical staff will be	6/20/2023

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	include: Review of a facility policy titled, "Restraint Free Environment", revised October 2020, revealed, in part, the following: "Each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints...A physical restraint is defined as any manual method of physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body...Physical restraints may include...using devices in conjunction with a chair, such as...belts, that the resident cannot remove and prevents the resident from rising...Behavioral interventions should be used and exhausted prior to the application of a physical restraint...A physician's order alone is not sufficient to warrant the use of a physical restraint...Before a resident is restrained, the facility will determine the presence of a specific medical symptoms that would require the use of restraints, and determine:...How the use of restraints would treat the medical symptom...The length of time the restraint is anticipated to be used to treat the medical symptoms, who may apply the restraint, and the time and frequency that the restraint will be released...The type of direct monitoring		provided when newly admitted residents are assessed to need restraints, and risks and benefits will be discussed and relayed to patients and /or responsible party. Restraint Committee will include nursing, social services, activities, therapist, resident/family will meet at least on quarterly basis or as necessary for review and reduction plan for the physical device used. Element 4 The facility will ensure that the above plan of corrections will be carried out. The Director of Nursing or designee will conduct a random audit of new admissions to ensure that the use of physical devices/restraints are minimized/reduced and that the least restrictive measures are implemented weekly x2 weeks and monthly x 2 months. These audits will be presented during the quarterly QAPI meeting, and the recommendations of the Restraints Committee will be followed until such a time consistent substantial compliance has been met. The facility administrator is responsible for sustained compliance.	

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	and supervision that will be provided during use of the restraint...Physician's order and consent must be obtained prior to use of the Restraint/Device...Medical symptoms warranting the use of restraints should be documented in the resident's medical record. The resident's record needs to include documentation that less restrictive alternatives were attempted to treat the medical symptom but were ineffective, ongoing reevaluation of the need for the restraint, and the effectiveness of the restraint in treating the medical symptoms. The care plan should be updated accordingly to include the development and implementation of interventions, to address any risks related to the use of the restraint..." On 5/9/23 at 10:00 AM, R14 was observed seated in a high back wheelchair with padded neck and trunk support in their room with a seat belt restraint fastened across their lap, an alarm attached to the wheelchair, and an alarm attached to the bed. At 10:25 AM, R14 was heard yelling out from their room and attempted to wheel their wheelchair toward the door. Activity Director 'S' entered R14's room and told them they had to stay in their room and watch television until lunch time. At 11:41 AM, R14 remained seated in a wheelchair in their room with a seat belt restraint fastened across their lap. An interview was attempted with R14. R14 appeared to be hard of hearing and did not want to answer any questions. R14 was seated upright in their wheelchair with no			

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apparent difficultly and no leaning forward or to the side.

On 5/10/23 at 9:03 AM, 10:25 AM, 12:05 PM, and 2:30 PM, R14 was observed in bed.

On 5/11/23 at 10:30 AM, R14 was observed seated in a high back wheelchair with padded neck and trunk support in their room with a seat belt restraint fastened across their lap. R14 was seated upright in the wheelchair with no difficulty. R14 requested to go to bed. When asked if they were able to remove the seat belt restraint, R14 did not understand and appeared to not realize they had a seat belt applied. At that time Certified Nursing Assistant (CNA) 'X' entered the room to assist R14 to bed. When queried about whether R14 was able to remove the seat belt restraint, CNA 'X' reported they were not able to unfasten it. CNA 'X' was observed to transfer R14 from the wheelchair to the bed. R14 sat on the side of the bed and moved themselves back further on the bed. R14 was not observed to fall forward or lean.

Review of R14's clinical record revealed R14 was admitted into the facility on 1/14/22 with diagnoses that included: epilepsy, muscle weakness, anemia, hypertension, traumatic brain injury, hearing loss right ear, and mild cognitive impairment. Review of a Minimum Data Set (MDS) assessment dated 4/23/23 revealed R14 had severely impaired cognition, no behaviors, and required extensive physical assistance with bed

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mobility and transfers, had one fall during the assessment period, and did not have a physical restraint.

On 5/11/23 at 8:35 AM, an interview was conducted with the Director of Nursing (DON). When queried about why R14 required a seat belt restraint, the DON reported she would look into it. At that time, an assessment for the use of the seat belt restraint was requested.

On 5/11/23 at 10:40 AM, an interview was conducted with Director of Rehab (DOR) 'Y'. When queried about any assessment completed for the use of R14's seat belt restraint, DOR 'Y' reviewed R14's records and reported R14 was assessed on 5/4/23. At that time, DOR 'Y' provided the assessment.

Review of a "Physical Device Assessment" for R14 dated 5/4/23 revealed R14 was assessed for a "Safety Seat Belt". The section to identify if the resident was able to "remove on command consistently" was left blank. The next section labeled "Device Restricts Freedom of Movement" indicated the device was a restraint and documented, "Reference on POC (plan of care) - Complete Restraint Protocol...If determined to be a restraint, describe how the restraint treats the medical symptom and assists in reaching the highest practicable level of functioning." The section for "Review and Assessment" indicated the "Factors/Symptoms/Medical Symptoms/Need" were "Attempts to get out

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of bed or w/c (wheelchair) r/t (related to) dementia", "Weakness/AEB (as evidenced by) disease process", "Unsteady gait r/t disease process", "Leaning and/or rigidity", "Visual deficit and/or Dementia", and "Decreased sitting balance, recurrent falls". The "Reason for Device Use" was documented as "Enable/Increase independence", "Provide tactile barrier", "Improves physical status", "Able to participate in activities", and "Decrease risk of falls, increased independence with wheelchair mobility around the facility". It was left blank in the section labeled "Restraint Alternatives Previously Used". The "Team Recommendation" was "Restraint as ordered".

Review of fall incidents for R14 since January 2023 revealed R14 was found on the floor after previously being in bed on 1/6/23 and was observed on the floor after previously being in bed on 3/22/23. There were no documented falls from the wheelchair in that time frame.

Review of a PM&R (Physical Medicine and Rehabilitation) progress note dated 5/10/23 revealed documentation that noted, "...In therapy she walked 150 ft (feet) with FWW (four wheeled walker), Min (minimal) to CGA (contact guard assist) with wc (wheelchair) follows. Her balance is good sitting and standing balance fair...Apply seatbelt while in wheelchair for safety, fall prevention, and optimal positioning due to poor truncal

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	control..." It should be noted that during observations of R14 on 5/9/23 and 5/11/23, R14 was seated upright in their wheelchair without difficulty. Further review of PM&R progress notes dating back to 5/3/22 (a year prior) consistently documented, "...Apply seatbelt while in wheelchair for safety, fall prevention, and optimal positioning due to poor truncal control..." However, there was no restraint assessment provided prior to 5/4/23 (a year later). Further review of R14's clinical record revealed no care plan for the use of the seat belt restraint. Review of R14's Physicians Orders revealed an active order with a start date of 5/5/23 to "Apply seat belt while in wheelchair for safety, fall prevention, and optimal positioning due to poor truncal control". It should be noted that it was documented for a year prior that R14 had been utilizing a seat belt restraint. There was no documentation in the Physicians Order, assessment, or plan of care that indicated the length of time the restraint was anticipated to be used, who may apply the restraint, where and how the restraint was to be applied and used, and the time and frequency the restraint was to be released. There was no documentation regarding direct monitoring and supervision provided			

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	634595	A. BUILDING _____ B. WING _____	5/11/2023

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	during the use of the restraint and no documentation of the monitoring. The MDS assessment conducted on 4/23/23 did not indicate R14 had a physical restraint despite documentation of the restraint dating back to 5/3/22. On 5/11/23 at 3:20 PM, an interview was conducted with the DON. When queried about why there was no care plan for R14's seat belt restraint, how often staff were supposed to release the restraint, what kind of monitoring was done to ensure safe use of the restraint, what less restrictive interventions were attempted prior to the seat belt restraint, and if a restraint should be used without an assessment, the DON reported there should be a physician's order with specific instructions for use of the restraint, a care plan should be in place, and the resident should be assessed before applying a physical restraint. No additional information was provided prior to the end of the survey.			
F0607 SS= C	Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the	F0607	F607 – Development/Implement Abuse/Neglect Policies Element 1 A thorough investigation was conducted by the Director of Nursing Services and the facility Administrator regarding the allegations made by resident #41 CRG. Results of the investigation for R#41 were reported to the State Survey Agency on 5/11/2023.	6/20/2023

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	QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement written policies and procedures for their Abuse policy in accordance with current regulatory standards. This deficient practice has the potential to affect all 53 residents that reside within the facility. Findings include: Review of the facility's abuse policy documentation dated 1/2/2018 failed to include/address the required CMS (Centers for Medicare & Medicaid Services) written polices and procedures that were effective 10/21/22, implemented on 10/24/22 as identified below: III. Prevention: The facility must have and implement written policies and procedures to prevent and		Element 2 The facility has determined that all residents have the potential to be affected. Element 3 The policy for reporting allegations of abuse/neglect/exploitation was reviewed and revised on 05/11/2023 (See attached REVISED Abuse Policy) to ensure compliance with current state and federal regulations. An in-service education program was conducted by the Director of Nursing Services and the Administrator with all direct care and ancillary staff regarding this new policy. Element 4 All residents in the facility will be questioned if they have any concerns regarding any instances of willful abuse, neglect, or mistreatment that may have occurred during their stay and have not been reported. All instances of abuse or alleged violations will be reported immediately, investigations will be conducted immediately, and findings will be reported to the appropriate agencies in accordance with current facility policy. Furthermore, the Director of Nursing, or designee, will interview five employees weekly for two consecutive weeks to verify understanding of the current policy for reporting allegations of abuse/neglect/exploitation. An in-service/re-education will be provided during the interview, if deemed necessary. A summary of investigations, interviews, and incidence of re-education, if required, will be discussed in the quarterly QAPI meeting until such time substantial compliance has been met.	

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	prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves (but is not limited to): -Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as the identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship; -Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur. This includes the implementation of policies that address the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms, if any; -Assuring that residents are free from neglect by having the structures and processes to provide needed care and services to all residents, which includes, but is not limited		The Administrator will be responsible for sustained compliance.	

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	to, the provision of a facility assessment to determine what resources are necessary to care for its residents competently; -The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as: *Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating; *Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects; *Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing; *Taking, touching, or rummaging through other's property; *Wandering into other's rooms/space; *Residents with a history of self-injurious behaviors; *Residents with communication disorders or who speak a different language; and *Residents that require extensive nursing care			

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	and/or are totally dependent on staff for the provision of care. -Ensuring the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions; VI. Protection: The facility must have written procedures that ensure that all residents are protected from physical and psychosocial harm during and after the investigation. This must include: -Responding immediately to protect the alleged victim and integrity of the investigation; -Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; -Increased supervision of the alleged victim and residents; -Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; -Protection from retaliation; and -Providing emotional support and counseling			

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	to the resident during and after the investigation, as needed. The facility must have written procedures that must include: -Immediately reporting all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes; -Assuring that reporters are free from retaliation or reprisal ... -Reporting to the State nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service ... -Defining how care provision will be changed and/or improved to protect residents receiving services; -Training of staff on changes made and demonstration of staff competency after training is implemented; -Identification of staff responsible for implementation of corrective actions; -The expected date for implementation; and -Identification of staff responsible for monitoring the implementation of the plan.			

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	VIII. Coordination with QAPI (Quality Assurance Process Improvement): The facility must develop written policies and procedures that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program under §483.75. Cases of physical or sexual abuse, for example by facility staff or other residents, always require corrective action and tracking by the QAA (Quality Assurance Agency) Committee, at §483.75(g)(2). This coordinated effort would allow the QAA Committee to determine: *If a thorough investigation is conducted; *Whether the resident is protected; *Whether an analysis was conducted as to why the situation occurred; *Risk factors that contributed to the abuse (e.g., history of aggressive behaviors, environmental factors); and *Whether there is further need for systemic action such as: *Insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/misappropriation/exploitation,			

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	*Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about, *Efforts to educate residents and their families about how to report any alleged violations without fear of repercussions, *Measures to verify the implementation of corrective actions and timeframes, and *Tracking patterns of similar occurrences. Ensuring the reporting of a reasonable suspicion of a crime should by implementing the proper policies and procedures addressing the following actions, which should include, but are not limited to: -Orienting new and temporary/agency/contractor staff to the reporting requirements; -Assuring that covered individuals are annually notified of their responsibilities in a language that they understand; - Identifying barriers to reporting such as fear of retaliation or causing trouble for someone, and implementing interventions to remove barriers and promote a culture of transparency and reporting; - Identifying which cases of abuse, neglect, and exploitation may rise to the level of a reasonable suspicion of crime and			

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	recognizing the physical and psychosocial indicators of abuse/neglect/exploitation; -Working with law enforcement annually to determine which crimes are reported; -Assuring that covered individuals can identify what is reportable as a reasonable suspicion of a crime, with competency testing or knowledge checks; -Providing in-service training when covered individuals indicate that they do not understand their reporting responsibilities; and -Providing periodic drills across all levels of staff across all shifts to assure that covered individuals understand the reporting requirements. On 5/10/23 at 4:30 PM, an interview was conducted with the Administrator, who was also the facility's Abuse Coordinator. When asked about the reporting requirements for an abuse allegation, the Administrator reported if there was no harm they would have 24 hours to report. When queried about whether they were aware of the updates made to regulatory requirements for Abuse Prohibition on 10/21/22, the Administrator reported they were not. The Administrator was encouraged to review the regulation requirements and asked to provide any additional documentation. There was no further documentation provided by the end			

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	of the survey.			
F0656 SS= E	Develop/Implement Comprehensive Care Pla §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with	F0656	F 656 Develop/Implement Comprehensive Care Plans Element 1 Residents R#6, R#22, R#14, and R#33 comprehensive care plans were reviewed and updated. Care plan was developed and updated for R#33 for use of indwelling urinary catheter, and care plan was developed and updated for R#14 use of physical restraint/seatbelt, by the MDS coordinator. Updated activity assessments were completed for R#6, R#14, and R#22 by the Activities Director on 5/15/2023 and the Activity Care Plans were subsequently updated. MDS coordinator was informed regarding updated Activity Care plans for these residents. Element 2 All residents requiring or participating in activities, all residents with indwelling urinary catheters, and all residents with physical restraints have the potential to be affected by this deficiency. Element 3 The Activities Director was in-serviced regarding the updated Activities Policy. He was instructed to continue up-to-date Activity Assessments and Activity Care Plans for residents, as well as notify MDS of Activity Care Plans. The MDS Coordinator was in-serviced on policies for Indwelling Catheter Care and Physical Restraint Policy. All IDT Managers were in-serviced on the updated Comprehensive Care Plan Policy and encouraged to participate with developing individualized care plans for each resident.	6/20/2023

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	the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop comprehensive care plans which addressed activities, urinary catheters, and physical restraints for four (R6, R22, R14 and R33) of four residents reviewed for care planning. Findings include: According to the facility's policy titled, "Care Planning-Resident Participation" dated January 2023: "...The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care...If the participation of the resident and/or resident representative is determined not practicable for the development of the resident's care plan, an explanation will be documented in the resident's medical record." R6 Review of the clinical record revealed R6 was		Licensed nurses and CNAs also received in-service training on Indwelling Urinary Catheter and Physical Restraints. Element 4 All residents requiring/participating in Activities, all residents with indwelling urinary catheters, and all residents with physical restraints will be audited by DON or designee weekly x4 weeks and then monthly x2 months to ensure that activity assessments and care plans are updated. Any issues or deficiencies will be addressed immediately and rectified by Activities Director, MDS coordinator, and/or Director Nursing. Audit results will be reported at the quarterly QAPI meetings until it is determined that substantial compliance has been achieved. The Director of Nursing is responsible for sustained compliance.	

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	admitted into the facility on 8/25/22 with diagnoses that included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety disorder, Parkinson's disease, and depression. According to the MDS assessment dated 3/3/23, R6 sometimes was able to make themselves understood and usually understood others, had severely impaired cognition, and required extensive assist of one to two people for most aspects of care. Review of the MDS assessment dated 8/31/22 documented R6 had severe cognitive impairment. The section for activity preferences documented: "Very Important" for "How important is it to you to have books, newspapers, and magazines to read?". "Somewhat important" for "How important is it to you to listen to music you like?". "Somewhat important" for "How important is it to you to keep up with the news?". "Somewhat important" for "How important is it to you to do your favorite activities?". "Somewhat important" for "How important is it to you to go outside to get fresh air when the weather is good?".			

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	Review of R6's "Activity Assessments" revealed R6 was assessed for activities upon admission on 9/2/22. There were no additional activity assessments completed for R6. Review of this "Activity Assessment" revealed R6's activities of interest were cards/games, music, reading/audio books, spiritual/religious activities, traveling, outdoor activities, tv/radio, watching movies, gardening & plants, puzzles/word games. It was documented they preferred to do activities in their own room. Further review of R6's clinical record revealed there was no activity care plan developed for R6 as of this review, or that this information was available for direct care staff to utilize/incorporate into the resident's daily care/routine. R22 Review of the clinical record revealed R22 was admitted into the facility on 1/11/23 with diagnoses that included: diffuse traumatic brain injury without loss of consciousness, multiple sclerosis, person injured in unspecified motor-vehicle accident, acute respiratory failure with hypoxia, neuromuscular dysfunction of bladder, generalized anxiety disorder, major depressive disorder recurrent, moderate. According to the MDS assessment dated			

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	1/17/23, R22 had no communication concerns, had intact cognition and required extensive assistance two or more people for bed mobility and transfers. On 5/11/23 at 11:08 AM, an interview was conducted with R22 to discuss what kind of activities they liked to do. R22 reported they were given a coloring book and enjoyed the movies. When asked if there were any activities on the weekends, or more than one time a day (per the posted activity calendar) they reported there was not and they would like some more. R22 further reported they wanted to return to their former place (another rehab facility) and felt they were able to do more there like painting, exercises, more importantly be with their friends. Review of R22's "Activity Assessments" revealed R22 was assessed for activities upon admission on 1/12/23. There were no additional activity assessments completed for R22. Review of this "Activity Assessment" revealed R22's activities of interest were cards/games, crafts/arts/hobbies, exercise/physical activities, music, reading/audio books, writing, baking/cooking, computer, spiritual/religious activities, outdoor activities, tv/radio, watching movies, gardening & plants, and puzzles/word games. It was documented they preferred to do activities in their own room, day/activity			

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MAPLE MANOR REHAB CENTER OF NOVI INC	31215 NOVI ROAD NOVI, MI 48377

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	room, inside nursing home/off unit and outside facility. Further review of R22's clinical record revealed there was no activity care plan developed for R22 as of this review, or that this information was available for direct care staff to utilize/incorporate into the resident's daily care/routine. R14 On 5/9/23 at 10:25 AM, R14 was observed seated in a wheelchair in their room with a seatbelt restraint fastened across their lap. R14 was yelling out and attempted to wheel toward the door. Activity Director 'S' entered R14's room, moved R14 back over by the bed and instructed them to watch television until lunch time. On 5/9/23 at 11:41 AM, R14 was observed seated in their wheelchair in their room with a seatbelt restraint On 5/9/23 at approximately 3:30 PM, residents were observed in the common area of the second floor unit watching a movie and eating popcorn. R14 was observed lying in bed, awake. On 5/10/23 at approximately 10:20 AM, R14 remained in bed. At approximately 11:30 AM, R14 was observed eating with assistance while in bed. At approximately 2:30 PM, R14 remained in bed.			

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	On 5/11/23 at 10:30 AM, R14 was observed seated in a high back wheelchair with padded neck and trunk support in their room with a seat belt restraint fastened across their lap. R14 was seated upright in the wheelchair with no difficulty. R14 requested to go to bed. When asked if they were able to remove the seat belt restraint, R14 did not understand and appeared to not realize they had a seat belt applied. At that time Certified Nursing Assistant (CNA) 'X' entered the room to assist R14 to bed. When queried about whether R14 was able to remove the seat belt restraint, CNA 'X' reported they were not able to unfasten it. Review of R14's clinical record revealed R14 was admitted into the facility on 1/14/22 with diagnoses that included: epilepsy, traumatic brain injury, hearing loss, and mild cognitive impairment. Review of a MDS assessment dated 4/23/23 revealed R14 had severely impaired cognition and required extensive physical assistance for transfers. It was documented on the MDS that R14 felt it was very important to do things with groups of people, do their favorite activities, and participate in religious services. The MDS did not indicate R14 had a lap restraint. Review of a MDS assessment completed upon admission on 1/20/22 revealed R14 had intact cognition at that time and required limited assistance with transfers and walking. Review of R14's "Activity Assessments"			

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	revealed R14 was assessed for activities upon admission on 1/20/22. There were no additional activity assessments completed for R14. Review of the "Activity Assessment" conducted on 1/17/22 revealed R14 liked doing recreation on their own and in a group. Their current activities of interest at that time were cards/games, crafts/arts/hobbies, exercise/physical activities, music, reading/audio books, spiritual/religious activities, outdoor activities, TV/Radio, Watching Movies, and Puzzles/Word Games. It was documented that R14 preferred to participate in scheduled activities in the afternoon. It was documented it was very important for R14 to have books, newspapers, and magazines to read, very important to be around animals and/or pets, very important to do things with groups of people, very important to do their favorite activities, and very important to participate in religious services or practices. At that time, R14 was able to ambulate with assistance. Further review of R14's clinical record revealed there was no activity care plan developed for R14 as of 5/10/23, or that R14's information about person-centered activities was available for direct care staff to utilize/incorporate into the resident's daily care/routine. R14 did not have a care plan for the use of the seatbelt restraint. On 5/10/23 at 3:05 PM, an interview was			

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	conducted with the Activity Director (Staff 'S'). When asked about who develops and implements the activity care plans, Staff 'S' reported they did not do that and thought it was the MDS coordinator. When asked how the MDS coordinator would know about the specific activity preferences, Staff 'S' offered no further explanation. R33 On 5/9/23 at 9:30 AM, R33 was observed sleeping. A urinary catheter drainage bag was observed on the side of the bed. Review of R33's clinical record revealed R33 was admitted into the facility on 3/17/23 with diagnoses that included: chronic kidney disease and retention of urine. Review of a MDS assessment dated 3/23/23 revealed R33 had severely impaired cognition and had an indwelling urinary catheter. Review of R33's care plans revealed R33 did not have a care plan developed for the use of an indwelling urinary catheter. On 5/11/23 at 03:20 PM, the DON was interviewed. The DON reported that residents should have care plans developed for activities, physical restraints, and indwelling urinary catheters.			
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)	F0657	F-657 Care Plans Timing & Revision Element 1	6/20/2023

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	Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure an interdisciplinary care plan was reviewed and/or revised by an interdisciplinary team in accordance with each Minimum Data Set (MDS) assessment for one (R6) of four residents reviewed for care plan review, resulting in the lack of opportunity for the resident and/or legal representative to participate in discussion of treatment options and decisions which pertain to all aspects of their plan of care. Findings include:		Resident R#6 was reassessed by the interdisplinary team (IDT) and resident care plans were updated as appropriate. R#6's PM&R physician re-ordered PT and OT evaluation. Activities director assessed R#6 on 5/15/2023 and Activities Plan was updated. MDS and Nursing continued its assessments. Resident #6 was encouraged to participate in her individualized care plan with the interdisciplinary team. Element 2 All residents have potential to be affected by this deficiency. Element 3 The facility's Comprehensive Care Plan Policy was reviewed and updated. See attached Comprehensive Care Plan policy. The MDS Coordinator, Director of Nursing, Director of Social Services, Activities Director, Director of Rehab and Dietary Manager received in-service/education regarding the updated Comprehensive Care Plan Policy, timeliness of updating care plans, and involvement of the resident and the interdisciplinary team in creating a resident-centered care plans as appropriate. Social Services was advised that care conference documentation must include meeting minutes and attendance list of the resident and interdisciplinary team members present during care planning conference. Element 4 The Director of Nursing or designee will conduct audits on 5 random resident charts to ensure that the resident and interdisciplinary team members are involved in developing up-to-date individualized, person-centered care plans. The audit tool will monitor the resident and IDT members attendance and	

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	Review of the facility's policy titled, "Care Planning-Resident Participation" dated January 2023, did not address the specific members of the interdisciplinary team to be present at the care planning review meetings. According to current regulations, the comprehensive care plans should be reviewed and revised by an interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments that include, but is not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Review of the clinical record revealed R6 was admitted into the facility on 8/25/22 with diagnoses that included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety disorder, Parkinson's disease, and depression. The clinical record identified that R6 was deemed incapacitated and had an activated power of attorney, which identified their son as the legal representative. Review of the Minimum Data Set (MDS) assessments since admission included an admission MDS assessment dated 8/31/22, a		participation in the care planning on 5 random resident charts each month x2 months. Audit results will be reported at the quarterly QAPI meetings until deemed compliant. Director of Nursing is responsible for sustained compliance.	

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	quarterly MDS assessment dated 12/1/22, and a quarterly MDS assessment dated 3/3/23. Review of the care conference documentation since admission for R6 revealed there were only two care plan review conferences conducted on 8/31/22 and 5/5/23. The documentation for the care planning review on 8/31/22 only included the son, daughter-in-law, Director of Rehab and Social Work Director (SW 'H'). There was no documentation that anyone from dietary, nursing (nurse and aide), activities, or physician was involved. The documentation for the care planning review on 5/5/23 only included SW 'H'. There was no documentation that anyone from dietary, nursing (nurse and aide), activities, or physician was involved. On 5/10/23 at 12:00 PM, an interview was conducted with SW 'H'. When asked about the facility's care planning review conferences, they reported they scheduled those with the residents/representatives and encouraged the interdisciplinary team to attend. When asked about R6's lack of care planning reviews and lack of required interdisciplinary team members, SW 'H' reported they did the best they could and sent out invitations to the team.			

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F0658 SS= D	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were administered per professional standards and resident wishes for one (R1) of two residents reviewed for medication administration. Findings include: Review of a facility provided Job Description for "Registered Nurses and License Practice Nurses Position: Geriatric (LTC - Long Term Care) Nurse" dated 1/2023 read in part, "...Geriatric Nurses provide direct and individualized nursing care to older patients based on the application of Scientific nursing principles. Responsibilities of Geriatric Nurses include (but are not limited to): ...Recognizes and manages geriatric syndromes common to older adults... Facilitates older adults' active participation in all aspects of their healthcare..." On 5/10/23 at 9:28 AM, Registered Nurse (RN) "D" was observed as part of the medication pass task. RN "D" prepared twelve medications: ten pills that were crushed and placed in individual dosage cups, including Memantine 10 mg (milligrams); two Docusate	F0658	F-658 Service Professional Standards Element 1 Resident R#1 continues to reside in the facility. R#1 has no adverse reaction related to the citation and receives all medication as prescribed by the physician. The resident□s clinical record has been reviewed, and the care plan has been updated, reflecting the current care plan for R#1. RN D Licensed nurse received a 1:1 in-service/education on Medication Administration Policy, Medication Safety, Medication Error, Resident Rights, Elderly and Dementia Care, Profesionalism and Customer Care, as well as following manufacture instructions on medication bottles. Element 2 All residents receiving medications given by RN "D"in the facility are at risk of this deficient practice. Element 3 All licensed nursing staff received in-service/education on the facility policies for Medication Administration, Resident's Rights, Medication Safety, Medication Error, Elderly and Dementia Care, and Professionalism and Customer Care. Licensed nurses will also review Medication Administration Policy, Medication Error Policy, and Medication Safety, and complete a Medication Administration Post-Test. Element 4 The Director of Nursing or designee will conduct chart audits/interviews with 5 random residents monthly x2 months to ensure that the resident nurses are following Medication Administration policy with Professional	6/20/2023

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	sodium 100 mg capsules; and ClearLAX powder that was mixed with water in a drinking cup. RN "D" was then observed to enter R1's room to administer the medications. As RN "D" was pouring the ten crushed medications into applesauce, R1 explained she did not want her "memory pill". RN "D" continued to pour crushed medications into the applesauce. R1 told RN "D" twice more that she did not want the memory pill, then R1 said, "You're not listening to me, I don't want my memory pill!" RN "D" put approximately half of the applesauce/crushed medication mixture, that included Memantine 10 mg, on a spoon, then place the two Docusate Sodium 100 mg capsules on top of the mixture and told R1, "See, this is just your bowel medication". R1 swallowed the spoonful of applesauce/medication mixture, then refused to take another spoonful of the other half of the mixture. Review of R1's May 2023 Medication Administration Record (MAR) revealed for all of the ten crushed medications RN "D" documented, "Not Administered: Refused; Comment: had 1/2 ameds [sic]". On 5/1/23 at 8:28 AM, the Director of Nursing (DON) was interviewed and asked if a resident could refuse a particular medication. The DON explained a resident could refuse medications and should not be tricked into taking them. The DON was asked what should happen if crushed medications		Standards, and abiding to Resident□s Rights policy. Any complaints or concerns will be addressed immediately with resident□s treating nursing staff. The audit results will be reported at the quarterly QAPI meetings until it is deemed that substantial compliance has been achieved. The Director of Nursing will be responsible for sustained compliance.	

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	were already mixed with applesauce. The DON explained, then the nurse should throw away the mixture and get new medications without the refused medication to give to the resident.			
F0679 SS= F	Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide ongoing meaningful resident activities based on their individual preferences, interests, and abilities for three (R14, R6, and R22) of three residents reviewed for activities and two anonymous residents who attended the resident council interview, resulting in residents feeling bored on the weekends and the potential for bed ridden and cognitively impaired residents to feel isolated and bored. This deficient practice has the potential to affect all 53 resident who reside in the facility. Findings include:	F0679	F 679 Structured Activities including Weekends and Holidays Element 1 Residents R#14, R#6, and R#22 were interviewed by Activities Staff to determine activity preferences. Structured activities were placed on the Activity Calendar and led by the Activities Director or designee, including two activities daily during the week (one in the morning and one in the afternoon), as well as activities daily on the weekend days and holidays. Attendance and participation were documented and maintained in the Activities Office, to be filed with the resident's medical record at the end of each month. Activity assessments and care plans for residents R#14, R#6 and R#22 were reviewed and updated. Element 2 The facility has determined that all residents have the potential to be affected. The Activity Director reviewed all residents' activity attendance and participation records for trends regarding activities daily, on weekends, and on holidays. Follow-up interviews and assessments were conducted on residents R#14, R#6, and R#22 and completed on 05/15/2023. Element 3 The Activities Director received in-service/education on the updated Activities	6/20/2023

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	On 5/9/23 at 10:25 AM, R14 was observed seated in a wheelchair in their room with a seatbelt restraint fastened across their lap. R14 was yelling out and attempted to wheel toward the door. Activity Director 'S' entered R14's room, moved R14 back over by the bed and instructed them to watch television until lunch time. On 5/9/23 at approximately 10:30 AM, a form titled, "May 2023 Activity Calendar" was observed hung inside of the elevator. Review of the calendar revealed the following: Monday through Thursday of each week, one activity was scheduled per day at either 3:00 PM or 6:00 PM, including activities such as "cards and board games", popcorn and a movie, karaoke, and Bingo. There was no indication that there were any scheduled or structured activities before 3:00 PM on Monday through Thursday. There were no structured or scheduled activities on Fridays, Saturdays, and Sundays. Friday through Sunday, the documented activity was "Independent leisure/Activity cart *Items on cart/shelf*. On 5/9/23 at 11:41 AM, R14 was observed seated in their wheelchair in their room with a seatbelt restraint. On 5/9/23 at approximately 3:30 PM, residents were observed in the common area of the second floor unit watching a movie		Policy on 5/25/2023. (See attached Updated Activities Policy). Activity staff will provide structured activities twice a day during week days (one in the morning and one in the afternoon), as well as activities daily on the weekend days and holidays. Attendance and participation will be documented and maintained in the Activities Office monthly. Records will be filed in each resident□s medical record at the end of the month. Element 4 The Activities Director will review activity attendance, preference, and participation records monthly for trends regarding weekend activities. Activities Staff will interview five residents weekly to determine weekend activity preferences and to guide activity planning. Findings will be discussed with the Resident Council and at the monthly Quality Assurance meeting until satisfaction is reported by the Resident Council. The Administrator or designee will review and approve the activities calendar monthly until sustained compliance. The monthly activities calendar will be discussed at the resident council meeting for any suggestions and updates from the residents□ council. All monthly activities calendar and resident council meeting minutes will be reported at the QAPI meeting quarterly until sustained compliance. The administrator is responsible for sustained compliance.	

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and eating popcorn. R14 was observed lying in bed, awake.

On 5/10/23 at 9:07 AM, and observation of the activity shelf on the second floor was conducted. The shelf contained multiple puzzles with a large amount of pieces, board games, a stack of fashion magazines, some books and word puzzles, and a stack of history and nature magazines.

On 5/10/23 at approximately 9:15 AM, R14 was observed receiving care from the staff.

On 5/10/23 at approximately 10:20 AM, R14 remained in bed. At approximately 11:30 AM, R14 was observed eating with assistance while in bed. At approximately 2:30 PM, R14 remained in bed.

Review of R14's clinical record revealed R14 was admitted into the facility on 1/14/22 with diagnoses that included: epilepsy, traumatic brain injury, hearing loss, and mild cognitive impairment. Review of a Minimum Data Set (MDS) assessment dated 4/23/23 revealed R14 had severely impaired cognition and required extensive physical assistance for transfers. It was documented on the MDS that R14 felt it was very important to to things with groups of people, do their favorite activities, and participate in religious services. Review of a MDS assessment completed upon admission on 1/20/22 revealed R14 had intact cognition at that time and required limited assistance with

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transfers and walking.

Review of R14's "Activity Assessments" revealed R14 was assessed for activities upon admission on 1/20/22. There were no additional activity assessments completed for R14.

Review of the "Activity Assessment" conducted on 1/17/22 revealed R14 liked doing recreation on their own and in a group. Their current activities of interest at that time were cards/games, crafts/arts/hobbies, exercise/physical activities, music, reading/audio books, spiritual/religious activities, outdoor activities, TV/Radio, Watching Movies, and Puzzles/Word Games. It was documented that R14 preferred to participate in scheduled activities in the afternoon. It was documented it was very important for R14 to have books, newspapers, and magazines to read, very important to be around animals and/or pets, very important to do things with groups of people, very important to do their favorite activities, and very important to participate in religious services or practices. At that time, R14 was able to ambulate with assistance.

Further review of R14's clinical record revealed no progress notes or documentation about activities.

On 5/10/23 at 10:40 AM, an interview was conducted with members of the resident council. When queried about their stay in the

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	facility and the activities program. One resident reported there was a scheduled activity each day that was fun, but that the weekends were "very quiet". The residents reported they wished there was something to do on Fridays because it makes the weekend very long and boring. The resident explained they had less visitors recently and it would be nice to have something to do on the weekends. The other resident in attendance reported the same. On 5/10/23 at 3:16 PM, an interview was conducted with Activity Director 'S'. Activity Director 'S' reported they were the only activity staff in the facility and worked Monday through Friday. When queried about the activity program in the facility and how they developed and implemented person centered activities for each resident, Activity Director 'S' reported they conducted an activity assessment for each resident upon admission to get their interests and preferences, made a list of activities, and made a schedule for each month. Activity Director 'S' reported there were a lot of short term residents in the facility and therefore they made the calendar "based off general interests" and offered specific activities if they were requested. When queried about how they developed an activity program for residents who were cognitively impaired or bed ridden, Activity Director 'S' reported they went to their room "once a week to check on them". When queried about why there were no scheduled activities on the weekends,			

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	Activity Director 'S' reported there was a shelf on the second floor and a cart on the first floor with activities that residents could use during the weekends. Activity Director 'S' reported there was no activity staff in the facility on Saturdays and Sundays and on Fridays they were in the building, but used that day to "catch up". When queried about what residents like R14, who was cognitively impaired, did on the weekends, Activity Director 'S' reported they did not know. When queried about how often activities assessments were conducted, Activity Director 'S' reported they were only done upon admission. It was explained that the MDS coordinator was responsible for developing activities care plans. Activity Director 'S' was unsure how the comprehensive MDS assessment was conducted and where the information was received from. Activity Director 'S' was not aware that R14 did not have an activities care plan. On 5/10/23 at 4:45 PM, the Administrator was interviewed. When queried about the facility's activities program and why there was only one scheduled activity per day and no scheduled activities on Fridays, Saturdays, and Sundays, the Administrator reported Activity Director 'S' was the only activity staff and reported they needed to "spice up the program" and figure out how to make activities more accessible to all residents on the weekend.			

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	R6 Multiple observations of R6 at various times from 5/9/23 to 5/11/23 revealed R6 was often in their room laying either in bed, or in their gerichair recliner. Staff interactions included feeding assistance and responding to the resident's activated chair alarm. Review of the clinical record revealed R6 was admitted into the facility on 8/25/22 with diagnoses that included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, anxiety disorder, Parkinson's disease, and depression. According to the MDS assessment dated 3/3/23, R6 sometimes was able to make themselves understood and usually understood others, had severely impaired cognition, and required extensive assist of one to two people for most aspects of care. Review of the MDS assessment dated 8/31/22 documented R6 had severe cognitive impairment. The section for activity preferences documented: "Very Important" for "How important is it to you to have books, newspapers, and magazines to read?". "Somewhat important" for "How important is it to you to listen to music you like?".			

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"Somewhat important" for "How important is it to you to keep up with the news?".

"Somewhat important" for "How important is it to you to do your favorite activities?".

"Somewhat important" for "How important is it to you to go outside to get fresh air when the weather is good?".

Review of R6's "Activity Assessments" revealed R6 was assessed for activities upon admission on 9/2/22. There were no additional activity assessments completed for R6.

Review of this "Activity Assessment" revealed R6's activities of interest were cards/games, music, reading/audio books, spiritual/religious activities, traveling, outdoor activities, tv/radio, watching movies, gardening & plants, puzzles/word games. It was documented they preferred to do activities in their own room.

Further review of R6's clinical record revealed no progress notes, care plan, or documentation about activities.

R22

Review of the clinical record revealed R22 was admitted into the facility on 1/11/23 with diagnoses that included: diffuse traumatic brain injury without loss of consciousness,

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multiple sclerosis, person injured in unspecified motor-vehicle accident, acute respiratory failure with hypoxia, neuromuscular dysfunction of bladder, generalized anxiety disorder, major depressive disorder recurrent, moderate.

According to the MDS assessment dated 1/17/23, R22 had no communication concerns, had intact cognition and required extensive assistance two or more people for bed mobility and transfers.

On 5/11/23 at 11:08 AM, an interview was conducted with R22 to discuss what kind of activities they liked to do. R22 reported they were given a coloring book and enjoyed the movies. When asked if there were any activities on the weekends, or more than one time a day (per the posted activity calendar) they reported there was not and they would like some more. R22 further reported they wanted to return to their former place (another rehab facility) and felt they were able to do more there like painting, exercises, more importantly be with their friends.

Review of R22's "Activity Assessments" revealed R6 was assessed for activities upon admission on 1/12/23. There were no additional activity assessments completed for R6.

Review of this "Activity Assessment" revealed R22's activities of interest were cards/games, crafts/arts/hobbies, exercise/physical

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	activities, music, reading/audio books, writing, baking/cooking, computer, spiritual/religious activities, outdoor activities, tv/radio, watching movies, gardening & plants, and puzzles/word games. It was documented they preferred to do activities in their own room, day/activity room, inside nursing home/off unit and outside facility. Further review of R22's clinical record revealed no progress notes, care plan, or documentation about activities.			
F0755 SS= E	Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F0755	F-755 Pharmacy Services Element 1 There was no specific resident identified for this deficient practice. At the end of the investigation, it was concluded that there were no missing drugs. The controlled substance medication counts were tallied, and no discrepancies were noted. Element 2 It was determined that this deficient practice could affect all residents residing in the facility who are prescribed controlled substances. Element 3 The Facility reviewed the Controlled Medications Shift Change Sign-out Sheet and made revisions to facilitate accurate narcotic and controlled medications count. Licensed nurses received an in-service/education on medication administration, and the revised "Controlled Medications Shift Changed Sign-	6/20/2023

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	reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to utilize an effective system to account for accurate reconciliation of controlled substances (medications tightly controlled by the government because they may cause addiction or be misused) for two of four medication carts reviewed. Findings include: On 5/9/23 at 12:00 PM, an observation of the medication cart located on the 1 South Unit was conducted with Nurse 'C'. Review of a form titled, "CONTOLLED <sic> MEDICATIONS SHIFT CHANGE SIGN OUT SHEET" for May 2023, 1 South cart revealed instructions that noted, "Accountable drugs are to be counted at each change of shift. The last person whose name appears on this sheet is responsible for the drugs. Nurse 'C' signed the form on 5/9/23 at 7:00 AM as the oncoming nurse, as well as the outgoing nurse, Nurse 'AA' and indicated there were "8" containers of controlled substances in that medication cart. On the next line, Nurse 'C' documented 5/9/23 at 7:00 PM and signed their initials as the outgoing nurse before a count was completed with the oncoming nurse.		out" Form. All licensed nursing staff were in-serviced on the facility policies - Medication Administration Policy, Medication Error Policy, and Medication Administration Competency. All licensed nursing staff were required to complete the Medication Administration Post-Test. Element 4 The revised form, Controlled Medications Shift Change Sign-out Sheet, will be reviewed weekly by the DON/designee to ensure that controlled medications are accurately accounted for every shift weekly x4 weeks and then monthly x2 months. Any inconsistencies or count discrepancy will be reported immediately to the DON/ charge nurse for verification and reconciliation. QA audit results will be discussed during the weekly IDT meeting. All reports will be discussed at the quarterly QAPI meeting until sustained compliance is deemed. The director of Nursing will be responsible for sustained compliance.	

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	When queried about why they signed their name before the count was completed, Nurse 'C' reported it was "a mistake". Further review of the "Shift Change Sign out Sheet" revealed the following: The nurses were to enter the date and time of the count, the "number of full containers" plus the "number of partial containers" plus the "number of containers received from pharmacy" and the "total number of containers". Then there was an entry for the "number of empty or d/c (discontinued) containers returned to the DON (Director of Nursing)". That count would then be signed by the outgoing nurse and the oncoming nurse. On 5/1/23 at 7:00 AM, it was documented that there were "02" full containers and "04" partial containers which equaled "06" total containers in the cart. It was documented that no containers were received from pharmacy and no containers were emptied or discontinued and returned to the DON. On 5/1/23 at 7:00 PM, it was documented that there were "3" full containers and "4" partial containers" which equaled "7" total containers. However, it was not documented that any containers were received by the pharmacy to account for the increase of full containers from 2 to 3. On 5/2/23 at 7:00 AM, it was documented			

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	that there were "3" full containers, "3" partial containers", "1" container was received from pharmacy, and "1" container was emptied or discontinued and returned to the DON. On 5/2/23 at 7:00 PM, it was documented that there were "2" full containers and "5" partial containers" and none were received from pharmacy or returned to the DON. The total number of containers at 7:00 AM and 7:00 PM was documented as "7". However, if one container was removed and one was received, the count would have been six. On 5/4/23 at 7:00 AM, it was documented that there were "2" full containers and "5" partial containers. . No containers were received from the pharmacy or returned to the DON. The total number of containers documented was "7". On 5/4/23 at 7:00 PM, it was documented that there were "2" full containers, "6" partial containers, and "1" containers was received from the pharmacy. The documented total was "8". However, based on the calculations on the form, the total number would have been "9" which was two more containers that the 7:00 AM shift and only one container was documented as received from pharmacy. On 5/8/23 at 7:00 AM, it was documented that there were "2" full containers and "5" partial containers. The total number of containers was "7". No containers were received from the pharmacy or returned to the DON. On 5/8/23 at 7:00 PM, it was			

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	documented that there were "3" full containers and "5" partial containers and one container was received from the pharmacy which equaled "8" total containers. However, based on the calculation formula on the form, the count would have been nine. On 5/9/23 at approximately 12:30 PM, Nurse 'C' counted the number of controlled substance containers in the 1 South medication cart. There were "8" containers in the cart. When queried about how the number of total containers were counted and documented on the "Shift Change Sign Out Sheet", Nurse 'C' reported the form was "confusing" and that if a full container was received it was added to the full container section and the number received from the pharmacy, but the count in the cart was accurate to what was documented on the form. On 5/11/23 at 8:35 AM, an interview was conducted with the DON. The DON reported the nurses should not sign the "Shift Change Sign Out Sheet" until the count was completed. The DON reviewed the "Shift Change Sign Out Sheet" for the 1 South Medication Cart and reported the counts were not done correctly and reported the form was confusing to use. When queried about when the containers received and the containers removed were supposed to be calculated into the count, the DON did not offer a response.			

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	On 5/9/23 at 10:00 AM, review of the 2 north controlled substance binder was conducted with Nurse 'P'. Nurse 'P' confirmed they had taken over the medication cart from the Director of Nursing (DON) and upon review of the "CONTOLLED <sic> MEDICATIONS SHIFT CHANGE SIGN OUT SHEET" for "Cart: 2 North May 2023" there were several discrepancies and concerns identified. The instructions on the form read, "ACCOUNTABLE DRUGS ARE TO BE COUNTED AT EACH CHANGE OF SHIFT. THE LAST PERSON WHOSE NAME APPEARS ON THIS SHEET IS RESPONSIBLE FOR THE DRUGS." The most recent documented nurse to sign as an oncoming nurse was the DON on 5/8/23 at 7:00 PM. On 5/3/23 at 7:00 AM, it was documented that there were "7" full containers and "14" partial containers, three containers were received from pharmacy, there were two empty or discontinued containers returned to DON, and there were "22" total containers. On 5/3/23 at 7:00 PM, it was documented that there were "10" full containers, "12" partial containers, one container was received from pharmacy, there were no empty of discontinued containers returned to the DON, and there were "22" total containers. On 5/4/23 at 7:00 AM, it was documented that there were "7" full containers, "15" partial containers, there were no containers			

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	received from the pharmacy or empty or discontinued containers returned to the DON, and there were "23" total containers. There was no signature of an oncoming nurse (only the outgoing). On 5/4/23 at 7:00 AM (second entry for same date and time), it was documented that there were "7" full containers, "15" partial containers, there was one container received from pharmacy and the section for number of empty or discontinued containers returned to the DON had illegible print which looked like a zero with a line through it and either a negative one or seven. There was no signature of an outgoing nurse (only the oncoming). On 5/5/23 at 7:00 AM, it was documented that there were "7" full containers, "15" partial containers, there were no containers received from the pharmacy, or empty or discontinued containers returned to the DON, and there were "22" total containers. On 5/5/23 at 7:00 PM, it was documented that there were "7" full containers, "15" partial containers, there were no containers received from the pharmacy, and there were a total of 22 containers. The section for number of empty or discontinued containers returned to the DON had conflicting documentation and was noted with "+1" and "-5". On 5/6/23 at 7:00 AM, it was documented			

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	that there were "5" full containers, "13" partial containers, there were no containers received from the pharmacy and no empty or discontinued containers returned to the DON, and there were "18" total containers. On 5/6/23 at 7:00 PM, it was documented that there were "5" full containers, "13" partial containers, there were no containers received from the pharmacy, there was one container empty or discontinued container returned to the DON, and there were "18" total containers. On 5/7/23 at 7:00 AM, it was documented that there were "5" full containers, "12" partial containers, there were two containers received from the pharmacy, there were no empty or discontinued containers returned to the DON, and there were "17" total containers. On 5/7/23 at 7:00 PM, it was documented that there were "5" full containers, "14" partial containers, there were no containers received from the pharmacy, there was one empty or discontinued container returned to the DON, and there were "19" total containers. On 5/8/23 at 7:00 AM, it was documented that there were "5" full containers and "13" partial containers which equaled "18" total containers in the cart. It was documented that no containers were received from the pharmacy and the section for number of			

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	empty or discontinued containers returned to the DON was left blank. On 5/8/23 at 7:00 PM, it was documented that there were "8" full containers and "13". It was documented there were three containers received from pharmacy. The section of this document to identify the total number of containers and number of empty or discontinued containers returned to the DON were left blank. On 5/8/23 at (time illegible) it was documented that there were "8" full containers and "13" partial containers. The section of this document to identify the number of containers received from pharmacy, total number of containers and number of empty or discontinued containers returned to the DON were left blank. There was no signature of the outgoing nurse or the oncoming nurse. There was no documentation available as to the inaccurate accounting for the above discrepancies with number of full/partial containers and those removed to give to the DON or received from pharmacy. On 5/9/23 at 10:05 AM, Nurse 'P' was asked to count the current partial and full containers of narcotics/controlled substances and verified there were a total count of "16" containers. Nurse 'P' reported the DON had removed several of the containers earlier but confirmed that had not been documented.			

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	When asked how many were removed, Nurse 'P' reported they were not sure and began to document on the controlled medication shift change form. Nurse 'P' began to document on the 5/8/23 11:00 PM section that there were "17" total cards and "-1" empty or discontinued containers returned to DON, and added on 5/9/23 at 10:00 AM there were "5" full containers and "11" partial containers. Nurse 'P' was asked about why they were filling in other empty areas on the form and they offered no further response. Nurse 'P' was asked to provide a copy of the document before they continued any further. On 5/9/23 at 10:20 AM, review of a second 2 north controlled substance binder for the medication cart used on the 2 north and 2 south "split" assignment revealed similar discrepancies and concerns identified. On 5/2/23 at 7:00 AM, it was documented that there were "2" full containers, "7" partial containers, there were no containers received from pharmacy, or empty or discontinued containers returned to the DON, and there were "9" total containers. On 5/2/23 at 7:00 PM, it was documented that there were "3" full containers, "7" partial containers, there was one container received from pharmacy, there were no empty or discontinued containers returned to DON, and there were "9" total containers. On 5/3/23 at 7:00 AM, it was documented			

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	that there were "3" full containers, "7" partial containers, there were none received from pharmacy and there were no empty or discontinued containers returned to DON, and there were "10" total containers. On 5/4/23 at 7:00 PM, it was documented that there was "1" full container, "7" partial containers, there were none received from pharmacy, there were two empty or discontinued containers returned to DON, and there were "8" total containers. On 5/5/23 at 7:00 AM, it was documented that there was "1" full container, "7" partial containers, there were none received from pharmacy, there were no empty or discontinued containers returned to DON, and there were "8" total containers. On 5/7/23 at 7:00 PM, it was documented that there was "1" full container, "7" partial containers, there were none received from pharmacy, there were no empty or discontinued containers returned to DON, and there were "8" total containers. On 5/8/23 at 7:00 AM, it was documented that there was "1" full container, "7" partial containers, and there were "8" total containers. The section for number of containers received from pharmacy and number of empty or discontinued containers returned to DON were left blank. On 5/8/23 at 7:00 PM, it was documented			

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	that there was "1" full container, "7" partial containers, and the sections for total number of containers, number of containers received from pharmacy and number of empty or discontinued containers returned to DON were left blank. On 5/8/23 at 11:00 PM, the sections for number of partial, full, containers received from pharmacy, total number of container and number of empty or discontinued containers returned to DON were left blank. There was only a signature from the outgoing nurse, and none for the oncoming nurse. On 5/9/23 at 7:00 AM, the sections for number of partial, full, containers received from pharmacy, total number of container and number of empty or discontinued containers returned to DON were left blank. There was only a signature from the outgoing nurse, and none for the oncoming nurse. On 5/9/23 at approximately 11:00 AM, the DON was asked about the concern and discrepancies with the accounting of the narcotic/controlled substances and they reported they had been working as the nurse last night and this morning prior to the survey starting. On 5/10/23 at 1:40 PM, an interview was conducted with the DON. In reviewing the controlled substance shift change sheets, the DON acknowledged similar concerns and further reported the documents contained			

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	illegible documentation and was unable to offer any further explanation as to the multiple discrepancies.			
F0759 SS= D	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a medication error rate less than five percent when four medication errors out of 28 opportunities for error were observed for one (R1) out of two residents reviewed during the medication administration observation, resulting in a 14.29% error rate. Findings include: Review of a facility policy titled, "Medication Administration" revised 1/2022 read in part, "...Medications are administered by licensed nurses... as ordered by the physician and in accordance with professional standards of practice... Administer medication as ordered in accordance with manufacturer specifications..." On 5/10/23 at 9:28 AM, Registered Nurse (RN) "D" was observed as part of the medication pass task. RN "D" prepared twelve medications, including ClearLAX polyethylene glycol 3350. RN "D" explained the dose for	F0759	F 759 Med Error Greater Than 5% Element 1 Nurse D received in-service education regarding resident R#1□s medication orders and was counseled on the appropriate administration R#1 medications to ensure that they are within ordered parameters and according to the manufacturer□s direction. Nurse D was also in-serviced on Medication Administration Policy, Medication Safety Education (includes the 9 Rights of Medication Administration), and Medication Error Policy. Element 2 All residents receiving medications have the potential to be affected by this practice. Element 3 Licensed nurses were in-serviced on Medication Administration Policy, Medication Errors Policy, and Medication Safety Education (including Nine Rights of Medication Administration) on 5/26/2023 by Director of Nursing and /or designee. The DON and/or designee will conduct a Prevention Medication Error audit to all nurses individually by 5/29/2023. Element 4 The medication administration audits will be conducted randomly for one nurse daily on each shift for (2) weeks, then two nurses weekly per shift for (2) months, then one nurse monthly on-going to ensure compliance with facility guidelines.	6/20/2023

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	the ClearLAX was 17 g (grams), so she filled a 30 ml (milliliters) dosage cup to to top (30 ml) with the ClearLAX. RN "D" then poured the 30 ml of ClearLAX into a drinking cup. RN "D" was then observed to enter R1's room, pour water into the drinking cup, stir and administer the ClearLAX. After RN "D" exited R1's room, she was asked if all medication that were due at that time were administered. RN "D" agreed that they were. Review of the manufacturers directions on the bottle of ClearLAX read in part, "...the bottle top is a measuring cap marked to contain 17 grams of powder when filled to the indicated line (white section in cap)... fill to top of white section in cap which is marked to indicate the correct dose (17 g)..." On 5/10/23 at 10:28 AM, R1's physician orders were reconciled (compared) against the medications observed prepared by RN "D". During the reconciliation, it was noted R1 had an orders for Calcium Carbonate-Vitamin D 500 mg (milligrams)-200 unit, scheduled for 9:00 AM; Flonase Allergy Relief spray 50 mcg (micrograms), scheduled at 9:00 AM; and Olopatidine eye drops 0.1%, scheduled at 9:00 AM. These three medications were not observed as prepared or offered and/or administered by RN "D", all were marked off on the Medication Administration Record (MAR) as "Refused". On 5/11/23 at 8:28 AM, an interview was conducted with the Director of Nursing		The findings of the audits will be reported at the quarterly QAPI meeting until it has been determined that substantial compliance has been achieved. The Director of Nursing will be responsible for sustained compliance.	

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	(DON) and she acknowledged concern with the omitted medications. When asked how 17 g of ClearLAX should be measured, the DON explained the cap of the ClearLAX bottle should be used as it is calibrated for the correct dose.			
F0761 SS= E	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure appropriate storage and/or labeling of medications and treatments/biologicals in	F0761	F 761 Medication Label/Storage of Drugs and Biologicals Element 1 The broken narcotic box was replaced with a secured metal storage box that locks appropriately. It is located inside medication cart #2 on the second-floor north wing. New glucose testing strips were provided and with an opening date of 5/9/2023. Element 2 15 residents on the second-floor north wing could have been affected by this citation, however, there were no missing medications and no narcotic count discrepancies found. Element 3 All licensed nurses received an in-service/education regarding Medication Storage Policy and Labeling of Medications and Biologicals Policy. Specifically, nurses were instructed that all controlled substances must be stored under double-lock and key, blood glucose testing strips must be dated when opened, and all medication and treatment carts housings drugs or biologicals must be locked. The facility added Labeling of Medications and Biologicals Policy to its Policy and Procedures Handbook. Both facility policies of Medication Storage and Labeling of Medications and Biologicals were reviewed and deemed appropriate.	6/20/2023

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	two of four medication carts and two of two treatment carts reviewed, resulting in the potential for unauthorized entry, misuse, contamination, and diversion of narcotics and controlled substances. This deficient practice has the potential to affect multiple residents in the facility. Findings include: According to the facility's policy titled, "Medication Storage" dated January 2020: "...It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security...All drugs and biologicals will be stored in locked compartments...Only authorized personnel will have access to the keys to locked compartments...Narcotics and Controlled Substances...are stored under double-lock and key...Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area...Any discrepancies which cannot be resolved must be reported immediately..." On 5/9/23 at 11:07 AM, an observation of "cart two" on 2 north was conducted with Nurse 'P'. When asked to observe the portion		Element 4 The medication storage audits will be conducted randomly weekly, then two nurses weekly for 2 weeks then monthly x2 to ensure compliance with facility policy. The findings of these audits will be reported to the quarterly QAPI meeting until it is determined that substantial compliance has been achieved. The Director of Nursing will be responsible for sustained compliance.	

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	of the medication cart that contained the controlled substances (CS), the lock was not secured and able to be opened without a key. The lid to this CS section was observed to have several pieces of tape and when asked if that was broken, Nurse 'P' reported they weren't sure. Nurse 'P' proceeded to open the CS section without using a key and when asked if they had administered any CS medication to any residents this morning, they reported they had to for one resident. When asked if they identified any concern with the locking mechanism for the CS section, Nurse 'P' reported they did not. Nurse 'P' proceeded to attempt to lock the CS section and was unable to. Additional observation of a container of blood glucose testing strips was observed opened without any date of when it had been opened. Nurse 'P' was asked if they had opened them during their shift and they reported they did not, it had already been opened when they came onto their shift. When asked if the blood glucose testing strips should be dated when opened, Nurse 'P' reported they were not sure. According to the manufacturer's insert for the blood glucose testing strips, "...Write date opened on test strip vial label when removing the first test strip. Discard all unused test strips in vial after either date printed next to EXP on the test strip vial label or 4 months after date opened, whichever comes first..."			

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	On 5/10/23 at 8:20 AM, observation of the 2 north treatment cart revealed the cart was unattended and unlocked. The drawers were able to be opened and further observations included the following contents: revealed there were multiple lotions, antifungal ointments, antibiotic creams, safety blood collection set (needle), tweezers, bottles of iodine and ultrasound gel and hot compresses. Continued observations from 8:20 AM to 9:24 AM revealed multiple staff (nursing and non-nursing) and residents passing my the unsecured treatment cart. On 5/10/23 at 8:58 AM, Nurse 'O' was asked if they had provided any wound care/treatments to residents today and they reported they did not but knew that the midnight nurse had done some treatments. When asked if they had noticed the treatment cart was unlocked (as they had walked by earlier when the surveyors were observing what items where in the unsecured cart) and Nurse 'O' reported they did not and that the cart should be locked when not in use. At that time, Nurse 'N' was observed to go to the treatment cart and without unlocking, opened to retrieve treatment supplies. On 5/10/23 at 1:29 PM, the treatment cart on 2 south was observed to have several items stored on top of the cart which included a large box of covid-19 tests, a box of			

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	"MTSPANDAGE MULTI-PURPOSE TUBULAR RETAINER NET" and a small roll of clear trash bags. On 5/10/23 at 1:33 PM, the treatment cart on 2 north was observed to have several items stored on top of the cart which included a box of "MTSPANDAGE MULTI-PURPOSE TUBULAR RETAINER NET" and a box of compression medigrip elastic tubular bandages. On 5/10/23 at 1:40 PM, the Director of Nursing (DON) was asked to observe the 2 south treatment cart and confirmed the items stored on top. When asked if there should be any treatments or testing supplies stored on top of the cart in the hallway, the DON reported those should not and proceeded to remove the items.			
F0805 SS= D	Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to serve the correct, prescribed mechanically altered diet to one (R14) resident, resulting in the resident having a choking incident. Findings include: Review of a facility policy titled, "Therapeutic	F0805	F 805 Food in Form to Meet Individual Needs Element 1 Resident R#14 still resides in the facility. Speech Therapy and Medical team have evaluated patient and continue to recommend regular pureed diet. Dietary department, Nursing, and CNAs who provide care to R#14 have been updated regarding physician diet order. Resident R#14 receives 1:1 feeding. The resident is being weighed weekly and weights are documented in the clinical record. There have been no significant changes in her weight. The resident's care plans have been reviewed and updated regarding her diet.	6/20/2023

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	Diet Orders" revised January 2023, revealed, in part, the following: "The facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care...Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed..." On 5/10/23 at approximately 12:00 PM, R14 was observed in bed. Staff was observed providing feeding assistance to the resident. Review of R14's clinical record revealed R14 was admitted into the facility on 1/14/22 with diagnoses that included: epilepsy, traumatic brain injury, and mild cognitive impairment. Review of a Minimum Data Set (MDS) assessment dated 4/23/23 revealed R14 had severely impaired cognition. Review of R14's progress notes revealed a note written by the physician on 4/18/23 that read, "...(R14) had a choking episode this morning that resolved..." Review of a progress note written by the speech therapist on 4/18/23 read, "Patient seen 2/2 (secondary to) episode of choking this morning. Patient seen sitting up in chair, mildly lethargic however cooperative. Patient is currently on pureed with thin liquids. Per nursing patient had dysphagia episode when		Element 2 All similar residents who require pureed diet were identified and reassessed to ensure the diet per physician order is followed, and weights were recorded as indicated in the clinical record. Care plans were reviewed and updated where deemed necessary for appropriateness. Element 3 Nursing staff, Dietary staff, and Speech Therapy were in-serviced on the Therapeutic Diet Orders policy. Nursing staff were in-serviced on providing therapeutic diets according to the Therapeutic Diet Orders policy. Element 4 An audit tool was initiated to monitor residents' diets performed by the Charge Nurse or designee. Audits will be done in all shifts to ensure pureed diet is followed according to the physician's order daily x2 weeks, then weekly x2 months. Audit results will be discussed during quarterly QAPI meetings until it is determined that substantial compliance is achieved. The Director of Nursing & Registered Dietician will be responsible for sustained compliance.	

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	eating yogurt with small pieces of fruit. Assessed with pureed and thin liquids by straw. Patient tolerating both consistencies without any overt s/s (signs and symptoms) of airway compromise. No vocal changes or coughing displayed. Recommend continuing with current diet in place. RD (Registered Dietitian) and dietary department notified regarding yogurt consistency with plans to only allow nonfruit added yogurt to patient's menu. Will monitor as needed." Review of a nursing progress note dated 4/18/23 read, "... Patient had a choking episode this morning on pt (patient's) yogurt. .." Review of a dietician note dated 4/19/23 read, "...Reported to writer that res (resident) had choking episode yesterday morning at breakfast. Noted yogurt had small pieces of fruit. SLP (speech language pathologist) observed res at lunch with no issues with puree diet diet. Review of R14's Physicians Orders revealed an order dated 4/22/22 for "Regular, pureed, 1:1 supervision during meals..." On 5/11/23 at 1:33 PM, an interview was conducted with assistance dietary manager (DM) 'J'. DM 'J' explained that the kitchen was responsible to ensure items on residents' meal trays were consistent with their prescribed diets. DM 'J' reported they utilized color coded diet tickets to indicate			

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	therapeutic diets. When queried about R14 who received yogurt with fruit pieced when prescribed a pureed diet, DM 'J' reported it should not have happened and now it is documented that R14 only received plain yogurt. On 5/11/23 at 2:13 PM, a phone interview was conducted with Certified Nursing Assistant (CNA) 'W', the CNA who was assigned to R14 on 4/18/23. CNA 'W' recalled the incident with R14 and reported they were feeding R14 yogurt and the yogurt had "fruit pieces" in it and R14 "choked". CNA 'W' explained R14 did not get that type of yogurt anymore and reported R14 "chokes easily and quickly". On 5/11/23 at 2:30 PM, a phone interview was conducted with Registered Dietician (RD) 'Z'. RD 'Z' reported yogurt with fruit pieces was not appropriate for R14 or residents who required a pureed diet and R14 should not have received that on their tray.			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and	F0812	F812 Food Storage/Sanitation Element 1 No resident was identified and affected by this citation. Brand new ice scooper and receptacle was installed in the kitchen. 1 box of croissants and 1 box of French baguette were thrown out. Frequency of walk in freezer maintenance check was increased to weekly instead of once every two weeks. Vendor to fix ice-build up in the freezer was contacted and contracted with to repair the deficiency.	6/20/2023

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	food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the ice scoop was maintained adequately and contaminated food items were removed/discarded to maintain sanitary conditions in the kitchen. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 5/9/23 at 8:34 AM, an initial tour for the kitchen was conducted with Dietary Manager (DM 'J'). The following observations were made with Dietary Manager (DM 'J'): The metal ice scoop was stored inside a blue plastic container which was secured to the wall next to the ice machine. There was drainage in the bottom of the ice scoop holder and a white substance was visible in the bottom. The walk-in freezer was observed to have a heavy build-up of icicles on the internal ceiling fan unit, surrounding ceiling and an		Element 2 All residents can potentially be affected by improper food storage and sanitation. The Dietary Manager J and dietary staff have been in-serviced on Proper Food Storage and Sanitation Policy. Element 3 Food in the kitchen was inspected for proper storage, labeling, dating, and possible expiration. Any food found to be stored improperly was discarded immediately. Staff was in-serviced on food storage, cleaning and sanitizing. The Dietary staff received education/in-service on sanitation of utensils including ice scoopers and the receptacle that holds the ice scoopers. Element 4 The Dietary Manager will audit 3x/week x4 weeks to ensure proper food safety and sanitation. Registered Dietician will audit the findings weekly x4weeks then monthly x2 months. Reports of the audit will be reported to QAPI committee quarterly until deemed compliance is achieved. The Registered Dietician or designee will be responsible for sustained compliance.	

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	accumulation of icicles on top of the two boxes of food stored directly below the fan. There was one large box of french baguettes and one large box of croissants. DM 'J' was asked about the heavy ice build-up and reported their maintenance worker comes every two weeks to deal with the build-up of ice in the walk in freezer. When asked about the food items stored underneath that were contaminated, DM 'J' reported they would have the maintenance worker come. On 5/9/23 at 4:09 PM, DM 'J' was leaving the facility and asked to follow up with a second observation of the facility's walk-in freezer. Observations revealed the same contaminated two boxes were stored underneath the fan and some of the ice build-up from earlier had been removed, but some ice remained. Additional ice accumulation was visible on one of the lines above the food racks on the right side of the freezer and a bag which contained Udi's multigrain bread was also observed to have ice build-up on the plastic packaging. DM 'J' reported the maintenance man been in and scraped away a lot of the ice. When asked why the contaminated food items were still available for use, they only responded that they would remove those items. When asked if any of those items were on the menu for the week, they reported there was for 5/10/23.			

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	According to the Food & Drug administration (FDA) 2017 Model Food Code, Section 3-304.12 In-Use Utensils, Between-Use Storage, "During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: ...(E) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous (time/temperature control for safety food)..." 3-305.11 Food Storage. 1. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: 1. (1) In a clean, dry location; 2. (2) Where it is not exposed to splash, dust, or other contamination; and 3. (3) At least 15 cm (6 inches) above the floor. "3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306."			
F0867 SS= F	QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures	F0867	F-867 QAPI Element 1 There was no specific resident identified on	6/20/2023

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	for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems		this deficient practice. Element 2 It was determined that all 53 residents residing in the facility could be affected by the substandard quality of care related to activities. The Activities director was instructed to increase activities such that there are two activities during the weekdays (one in the morning and one in the afternoon), as well as activities daily on the weekend days and holidays. The Activities calendar, activity attendance, and the participation records of all residents were reviewed to identify trends regarding participation in activities after the first weekend of scheduled activities. Residents were interviewed to follow up on participation and preferences for weekday, weekend, and holiday structured activities. Element 3 A review of the QAPI Policy and the Activities Policy was performed and the policies were deemed appropriate. All Managers including Activities Director were in-serviced regarding QAPI policy and Activities Policy. In addition, a QAPI Monitoring and QAPI PIP- Tool was developed. The Activities Director or designee will provide structured activities twice a day during the weekdays, and daily during the weekend days and holidays. Assigned activities staff will be scheduled to work at least four additional hours each weekend day and holiday to lead structured activities for the residents. During the current month, attendance and participation in activities will be documented and maintained in the Activities Office and filed in each resident□s medical record at the end of the month. All staff in-service/education will be conducted to emphasize the importance of encouraging	

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	impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities,		participation in structured activities on the weekdays, weekends, and holidays per resident preference. Element 4 The Activities Director will review activity attendance and participation records monthly for trends regarding participation in activities. Activities Staff will interview five residents weekly to determine activity preferences and to guide activity planning. Findings will be discussed with the monthly Resident Council and at the quarterly QAPI meetings until the Resident Council reports consistent satisfaction. The facility administrator will be responsible for sustained compliance.	

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	including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement an effective Quality Assurance & Performance Improvement (QAPI) program that identified quality issues and implemented appropriate plans of action to correct quality deficiencies, resulting in substandard quality of care related to activities. This had the potential to affect all 53 residents who resided in the facility. Findings include: Review of a facility policy titled, "Quality Assurance Performance Improvement (QAPI) Plan" dated 2023 read in part, "...designed to establish and maintain an organized facility-wide program that is data-driven and utilizes a proactive approach to improving quality of care and services throughout the facility..." An annual recertification survey was conducted from 5/9/23 through 5/11/23 and the widespread deficiency of the facility not providing directed activities daily for residents was identified through observation,			

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	interview and record review. On 5/11/23 at 3:54 PM, the Administrator was interviewed regarding the facility's QAPI program. The Administrator explained the QAPI committee met quarterly to discuss any quality deficiencies and/or action plans. When asked whether concerns related to activities were identified as a concern through the QAPI process, the Administrator explained activities had been a concerns since the COVID-19 restrictions, but had not implemented any specific plan to ensure residents were provided with directed activities on a daily basis.			
F0881 SS= E	Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain an effective Antibiotic Stewardship program that included consistent implementation of protocols for appropriate antibiotic administration and ensured that infection criteria were met for four (R51, R14 and R251 and R15) residents resulting in the potential for unnecessary	F0881	F-881 Antibiotic Stewardship Program Element 1 Residents: R#51, R#15, and R#251 no longer reside in the facility. Resident R#14, who currently resides at the facility who was prescribed antibiotic treatment, was assessed and reviewed for clinical signs and symptoms of infection but did not meet McGeer□s criteria for UTI. These findings were discussed with R#14□s attending physician to educate the physician on appropriate evaluation for infection and appropriate use of antibiotics. Furthermore, R#14 physician was instructed that for symptomatic UTI, a urine culture and sensitivity must be ordered before initiation of antibiotics. Element 2: All residents prescribed antibiotics are at risk. Element 3:	6/20/2023

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	antibiotic usage and the development of multiple drug resistant organisms. Findings include: On 5/11/23 at 1:01 PM, review of the facility's infection control program was conducted with Licensed Practical Nurse (LPN) "B", who served as the Infection Control Nurse (ICN) and revealed the following: R51 was documented in January 2023 as having a urinary tract infection (UTI) treated with an antibiotic with only a urinalysis (UA). No documentation of a positive culture and sensitivity (C&S) along with symptoms to justify antibiotics. R14 was documented in January 2023 as having a UTI and treated with an antibiotic with no diagnostic testing to justify the appropriate use of antibiotics. ICN "D" explained R14 was sent to the hospital for weakness and confusion, and the hospital put R14 on antibiotics for a UTI. ICN "D" was asked if the facility had documentation of a C&S from the hospital. ICN "D" explained they usually did not get C&S documentation from the hospital, but they would give the resident the antibiotic. According to R14's January 2023 Medication Administration Record (MAR), cephalexin 500 mg (milligrams) three times a day was given from 1/7/23 through 1/14/23. R251 was documented in January 2023 as having a UTI and treated with an antibiotic		The facility Infection Control Audit Report was completed by the Infection Control Nurse specifying the signs and symptoms of infection for every resident on the antibiotic, whether the condition meets Mcgeer□s criteria for antibiotic use, and if attending MD was notified. Laboratory results and findings will be monitored for residents prescribed antibiotics, including culture and sensitivity (C & S). Infections were mapped in the facility, separating community-acquired from nosocomial infections. Call-off log was collected from every department to identify infections among staff. An analysis of the infection control data was done, comparing infection control rates every month, specifying locations and types of infection, and determining trends and patterns. The Director of Nursing (DON) and unit managers made rounds in all units and departments, including dietary, activities, maintenance, and therapy for infection control surveillance and departmental infection control surveillance report. Infection control concerns identified during rounds were corrected and discussed with the infection control committee and interdisciplinary team (IDT) meeting. Facility Policy on Infection Prevention and Control and the Antibiotic Stewardship Program was reviewed and deemed appropriate. Licensed Nurses received in-service/training regarding the Mcgeer□s criteria, identifying signs and symptoms of infection of residents, notifying the attending physician if it meets the Mcgeer's criteria and the importance of proper documentation. All physicians were in-serviced regarding McGreer's criteria, Infection Control Policy, and Antibiotic Stewardship Policy, and were notified that for any symptomatic UTI, a urine culture and sensitivity must be ordered prior to initiation of antibiotics. Other IDT Department	

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	with only a UA. ICN "D" explained she had marked on the line listing that this antibiotic did not meet McGeer's criteria. Review of R251's progress notes revealed a physician noted dated 1/10/23 that read in part, "...Although his UA is positive, he denies any issues with urinating... Acute UTI... I ordered Cephalexin 500mg BID (two times a day) x 5 days..." According to R251's January 2023 MAR, the cephalexin was given 1/11/23 through 1/14/23. R15 was documented in April 2023 as having a suspected UTI and treated with an intravenous (IV) antibiotic with a negative C&S. ICN "D " explained R15 was confused and was put on an IV antibiotic for a suspected UTI, but it was stopped when the C&S came back negative. Review of R15 ' s progress notes revealed a physician note dated 4/26/23 at 10:21 that read in part, " ...The patient was seen today due to his nurse reporting to me he was having hallucinations and showing signs of confusion... He reports hesitancy with urination (it should be noted, hesitancy is not a symptom of UTI)... Differential Dx (diagnosis): UTI vs (verse) BPH (benign prostatic hyperplasia - enlarged prostate)... I have ordered for IV to be placed and Ceftriaxone 1 g (gram) x 7 days... ". According to R15 ' s April 2023 MAR, the ceftriaxone was given by IV on 4/26/23. ICN " D " was asked about the risks of inappropriate antibiotic use, and the starting and stopping of antibiotics. ICN " D "		managers received in-service on identifying conditions among their staff, reporting any contagious or infectious illness, and completing the Call-off Log. All department managers will then submit the Call-off Log to the Infection Control Nurse monthly for analysis. The Infection Control Nurse received a one-on-one in-service on completing the infection control report, gathering, and analyzing data, identifying trends and patterns, and presenting it monthly to the infection control committee. The Consultant Pharmacist received an in-service to review and document indications of antibiotic use in the facility. Element 4: Audits will be maintained and reviewed by the Infection Control Nurse monthly x3 months. The Infection Control Committee will meet monthly and the Quality Assurance QAPI Committee will meet quarterly to discuss the results of audits until it is determined that substantial compliance has been achieved. The Director of Nursing is responsible for sustained compliance.	

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	explained all contribute to antibiotic resistance. Review of a facility policy titled, " Antibiotic Stewardship Program " revised 9/2019 read in part, " ...It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility ' s overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use...			