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	824519	A. BUILDING _____ B. WING _____	5/10/2023

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OPTALIS HEALTH AND REHABILITATION OF CANTON	7025 LILLEY ROAD CANTON, MI 48187

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F0000 SS=	INITIAL COMMENTS Optalis Health and Rehabilitation of Canton was surveyed for a Recertification survey on 5/10/2023. Intakes: MI00133030, MI00134180, MI00134525, MI00134776, MI00134920, MI00135107, MI00135185, MI00135207, MI00135516, MI00135633, MI00135738, MI00136009, and MI00136152. Census= 99	F0000		
F0553 SS= D	Right to Participate in Planning Care §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of	F0553	Element I: Resident specific- The facility failed to conduct an initial are conference for one resident (R248) of two residents reviewed for choices, resulting in the missed opportunity for the resident and/or resident representative to participate in the care planning process and make choices about the residents daily life. Resident 248 was identified and no longer resides at the center. Element II: Like residents were identified as all new and current patients that require 72 hour, quarterly and annual care conferences. Initial sweep conducted for new admissions and current residents to ensure that care conferences completed timely. Element III: DON/Designee to complete education for therapy director, dietitian, social worker, therapeutic recreation, and nurse managers regarding policy for completion of timely care conferences. Element IV: DON/Designee to complete random weekly audits twice weekly, times four weeks on the timely completion of care conferences. The administrator will review results and submit to the QAPI committee for review and recommendation. Element V: The Administrator is responsible	6/8/2023

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

Electronically Signed | 06/02/2023

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	the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake MI00135738. Based on interview and record review, the facility failed to conduct an initial care conference for one resident (R248) of two residents reviewed for choices, resulting in the missed opportunity for the resident and/or resident representative to participate in the care planning process and make choices about the resident's daily life. Findings include: It was reported to the State Agency that the resident representative was not contacted to discuss plans and goals of care for the resident. A review of the clinical record for Resident #248 (R248) revealed an initial admission date of 2/24/2023 and readmission date of 3/22/2023 with diagnoses that included unspecified disease of the digestive system, depressive disorder, and anxiety disorder. A Minimum Data Set assessment dated 3/2/2023 documented severe cognitive impairment. A review of clinical progress notes for R248 revealed in part the following: - 2/24/2023 nursing: " ...Pt. is A&Ox3 (patient is alert and oriented to person, place, and time) and is able to make his needs known..." - 2/24/2023 at 2:07 PM nursing: " ...spoke with family who are at bedside ....Patient has not		for achieving and maintaining substantial compliance. The date of compliance is 6/8/2023	

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	communicated or answered any questions, just stares at you. Patient did shake his head no when asked about pain. Sister states this is patient's baseline. He answers in one or two words and hasn't been self in over 3 years..." - 2/28/2023 social service: "Social Services 5 day Assessment completed with Patient and Chart review. Patient presents as A & O x 1-2 and able to make some needs known ...The BIMS (Brief Interview for Mental Status) Assessment was administered with score of 01, indicating patient has a potential for severe cognitive impairments. Patient has periods of confusion..." - 3/2/2023 physician note: " ...Chief Complaint (s): Follow up visit ....He is not talking much, and does not (eat) much. Per family, he has been severely depressed..." - 3/8/2023 care conference note: " ...Care conference held. Those in attendance include Rehab Social Services Other Case Manager ...The discharge planning process is active at this time. Plans to discharge to private home/apartment with live in support. Was living home alone ... The care plan was developed and reviewed with the attending physician, registered nurse, nurse aide, and dietary staff prior to the care plan conference." An interview was conducted on 5/9/2023 at 12:23 PM, with the Director of Nursing (DON) and Unit Manager (UM) "G". UM "G" stated, "Residents are always invited to attend their 72-hour care conference if they are their own responsible party and capable of making their own medical decisions. (These residents) can determine if they want family there." UM "G" said if the resident is not capable of making medical decisions the resident representative/first emergency contact is always invited to the 72-			

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	hour care conference. During an interview on 5/9/2023 at 12:37 PM with Social Worker (SW) "D" and Therapy Director (TD) "E", SW "D" said it was standard for residents to have a 72-hour care conference. If residents are their own responsible party, we would like for them to attend their care conference, and we would document if the resident refused to attend. The emergency contact should be contacted if the resident had a BIMS score of 01 but no responsible party was designated. TD "E" said the purpose of a 72-hour care conference was to have an introductory meeting with the resident (and resident representative if in attendance) and facility disciplines, to make sure the resident's and facility's goals are aligned, to confirm discharge plans, equipment needs, and review any questions and concerns that may have occurred since admission. SW "D" and TD "E" confirmed R248 did not have a 72-hour care conference. The "care conference" conducted on 3/8/23 was a managed care meeting update held with the liaison for the building staff and the resident's insurance carrier. The residents do not attend the managed care meetings. During an interview on 5/10/2023 at 11:22 AM the DON said she was aware that R248 did not have a 72-hour care conference and that these conferences were important to touch base with the resident and first emergency contact and explain everything to them, get resident history, and start preparing for goals of discharge planning. On 5/10/2023 at 1:30 PM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.			

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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: This citation pertains to Intake MI00133152. Based on observation, interview, and record review, the facility failed to administer medications timely and per physician's orders for one resident (R59) of six residents reviewed for medication administration, resulting in the potential for less than therapeutic effect of the prescribed medication when medications were not taken properly. Findings include: In an observation and interview on 5/9/23 at 11:05 a.m., Licensed Practical Nurse (LPN) "O" prepared medication for Resident #59 (R59). The medication administration screen had red boxes on each medication. LPN "O" placed Amlodipine (treats high blood pressure), Aspirin, Plavix (prevents blood clots), Levetiracetam (anticonvulsant), Multivitamin-Minerals, and Senexon-S (prevents constipation) in a medication cup and poured MiraLAX (prevents constipation) in a cup. LPN "O" entered R59's room and administered the medication and exited the room. LPN "O" documented the medication administration. When asked if the medication was administered late, LPN "O" stated "Yes. I got behind this morning." In an interview on 5/10/23 at 8:21 a.m., LPN "P"	F0658	Element I: The facility failed to administer medications timely and per physician order for one resident of six reviewed for medication administration, resulting in the potential for less than therapeutic effect of the prescribed medication when medications were not taken properly. Resident 59 was not identified. There is not a resident 59 on the sample list provided to the center upon survey exit. Element II: Like residents were identified as all the residents currently residing at the facility. The facility performed an initial audit to determine id medications were passed timely. Element III: DON/designee will educate licensed nursing staff on medication administration policy, which covers the timely delivery of medication. Element IV: DON/designee will complete random weekly audits two-times weekly, times four weeks to validate medications are passed timely to ensure maximum therapeutic effect of prescribed medications. The administrator will review results and submit to the QAPI committee for review and recommendation. Element V: The Administrator is responsible for achieving and maintaining substantial compliance. The date of compliance is 6/8/2023	6/8/2023

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	reported medication should be administered one hour before or after the scheduled time. In an interview on 5/10/23 at 8:31 a.m., The Director of Nursing (DON) reported one hour before or one hour after is the acceptable timeframe to pass medications before they are considered late. The DON then reported, if the nurse is late, the Physician should be notified to see if it is "ok" to administer the medication and a progress note should be made in the medical record. Review of a "Medication Administration Hours" policy with an issue date of 9/29/17 revealed, "Policy: Routine medication administration hours have been formulated to ensure appropriate and timely administration of medications in accordance with the physician's orders. The physician may specifically order certain medications to be administered at different hours then noted below ... Procedures: 1. Medications will be administered within one hour of the prescribed time for administration (60 minutes before or 60 minutes after the assigned time).... 2. If a nurse determines during her medication pass that the residents will not receive their medications according to this policy, he or she should contact the Nurse Manager and/or Supervisor for their assistance in medication administration ..."			
F0677 SS= E	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F0677	Element I: Resident specific - Facility failed to provide shaves, nail care, and scheduled showers for seven (R26, R73, R228, R248, R480, and R487) residents out of ten residents, reviewed for ADLs, resulting in unmet ADL needs, a feeling of frustration, and the potential for loss of dignity. Residents 487, 248, 228, and 480 were identified and no longer reside at the facility. Residents 26 and 73 were identified and offered showers at the	6/8/2023

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	This citation pertains to Intakes MI00134525, MI00134776, MI00135107, and MI00135738. **Based on observation, interview, and record review, the facility failed to provide shaves, nail care, and scheduled showers for seven residents (R26, R73, R228, R248, R429, R480, and R487) out of ten residents reviewed for Activities of Daily Living (ADLs), resulting in unmet ADL needs, a feeling of frustration, and the potential for loss of dignity.** **Findings include:** **R430** **On 5/2/2023 at 11:27 a.m., R430 was observed lying in bed alert and able to be interviewed. R430 was observed with long facial hairs. During an interview, R430 stated, "I would love to have a shave because I do not want all the hair on my face. My roommate gets shaved and got one yesterday, but he ended up putting his own shaving cream on and did his own shave. I always had a shave, and they only gave me one shower since I been here." R430 was asked does the staff ask to assist with shaves? R430 stated, "They never ask to help shave me, even when I got the one shower. My nails are long, and I never let them get this long." R430 fingernails was observed long and untrimmed.** **On 5/4/2023 at 3:29 p.m., R430 was observed lying in bed with long untrimmed fingernails and stated, "They haven't shaved me yet."** **According to the electronic medical record, R430 was admitted to the facility on 4/12/2023 with diagnoses of chronic kidney failure stage 3, major depressive disorder, anxiety, atrial fibrillation, seizure, Parkinson's disease,**		time of discovery. Element II: Like residents were identified as those who require assistance with ADL's. An initial sweep was conducted to validate shower days on the task list and that showers were offered appropriately. Element III: DON/Designee to educate nursing staff on ADL, shower, nail, shave documentation, as well as offering showers when applicable. Element IV: DON/Designee to conduct random weekly audits times four weeks, to validate showeres are being offered and documented appropriately. The administrator will review results and submit to the QAPI committee for review and recommendation. Element V: The Administrator is responsible for achieving and maintaining substantial compliance. The date of compliance is 6/8/2023	

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	hypertension, and history of falls. According to the admission Minimum Data Set (MDS) assessment dated 4/16/2023, R430 had moderate cognitive impairment with a BIMS (brief interview for mental status) score of 12/15, required extensive assistant of one person with bed mobility, toileting, bath/showers, require extensive assistance of one person with dressing, toileting, and incontinent of bowel and bladder. **Review of R430's "Activity Daily Living (ADL)" care plan with start date of 4/26/2023 documented, "ADL self-care deficit as evidence by ...chronic renal failure, mechanical fall, hypertension, Hyperlipidemia, a-fib (irregular heartbeat), MDD, (major depressive disorder), anxiety, gout, Parkinson, TIA (mini stroke), skin cancer, falls, BPH (benign hyperplasia (enlarge prostate) related to physical limitations.** **Interventions as following:** **-Assist to bathe/shower as needed.** **-Assist with daily hygiene, grooming, dressing ...** **Review of the "Shower/Bath/Bed Bath Task" on a look back scheduled for Wednesday and Saturday evenings for the month of April revealed, R430 received a shower on 4/22/2023 and received a bed bath on 4/12/2023 and 4/19/2023.** R487 In an observation and interview on 5/2/23 at 12:58 p.m., Resident #487 (R487) sat in a wheelchair in the room. R487 reported experiencing vaginal itching for the prior three to			

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four days. R487 reported they had one shower in the past three weeks.

Review of an admission record revealed, R487 admitted to the facility on 4/1/23 with pertinent diagnoses which included COVID-19, Hypertension and Congestive Heart Failure.

Review of a "Minimum Data Set" (MDS) assessment, with a reference date of 4/21/23 revealed R487 had mild cognitive impairment with a "Brief interview for Mental Status" (BIMS) score of 9 out of 15.

Review of a shower task as documented in the POC (Point of Care) revealed, R487 had scheduled showers on Wednesday and Saturday day shift. R487 did not have a documented shower on 4/5, 4/22, 4/26, or 4/29.

In an interview on 5/3/23 at 2:09 p.m., R487 reported she did not get a shower today.

In an interview on 5/8/23 at 12:34 p.m., the DON reported the staff should document showers in POC and the nurse should follow up.

In an interview on 5/8/23 at 2:44 p.m., Certified Nursing Assistant (CNA) "K" reported showers are documented in POC.

R26

During an interview on 5/2/2023 at 11:42 AM, Resident #26 (R26) expressed frustration because he had not been receiving his scheduled showers.

Review of the clinical record for R26 documented an admission date of 1/27/2022. R26's diagnoses included congestive heart failure. A MDS assessment dated 5/4/2023 documented intact cognition and independence with showers/baths

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with setup help only. Review of ADL self-care deficit care plan documented the following intervention: "Assist to bathe/shower as needed." Dated 4/27/2020.

During an interview and record review on 5/8/2023 at 3:57 PM with UM "G", R26 missed receiving a shower/bath on the following scheduled dates between 3/1/2023 to 5/8/2023: 3/14/23, 4/4/23, 4/14/23, 4/18/23, 4/25/23, and 5/2/23.

R73

During an interview on 5/2/2023 at 11:43 AM, Resident #73 (R73) indicated he had been missing his showers.

Review of the clinical record for R73 documented an admission date of 8/14/2020. R73's diagnoses included cerebral infarction and chronic obstructive pulmonary disease. A MDS assessment dated 2/2/2023 documented moderate cognitive impairment and that a bathing activity had not occurred during the seven-day look back period. R73 was scheduled for shower/baths twice weekly on Tuesdays and Fridays. Review of ADL self-care deficit care plan documented the following intervention: "Assist to bathe/shower as needed." Dated 8/19/2020.

During an interview and record review on 5/8/2023 at 3:52 PM with UM "G", R73 missed receiving a shower/bath on the following scheduled dates between 3/1/2023 to 5/8/2023: 3/7/23, 4/4/23, 4/14/23, 4/18/23, 4/25/23, and 5/2/23.

R228

Review of the clinical record for Resident # 228 (R228) documented an admission date of

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	2/7/2023 and discharged date of 3/2/2023. R228's diagnoses included fusion of spine, cervical region. A MDS assessment dated 2/14/2023 documented intact cognition and no upper or lower extremity impairment, and one-person physical assistance for bathing. R228 was scheduled for shower/baths twice weekly on Wednesdays and Saturdays. Review of ADL self-care deficit care plan documented the following intervention: "Assist to bathe/shower as needed." Dated 2/8/2023. During an interview and record review on 5/8/2023 at 4:01 PM with the DON, R228 missed receiving a shower/bath on the following scheduled dates between 2/7/2023 and 3/2/2023: 2/8/23, 2/18/23, 2/22/23, and 3/1/23. The DON stated, "Showers lead to good hygiene and helps maintain good skin integrity. (Residents) might not feel very good about themselves if they don't get a shower." R248 Review of the clinical record for Resident #248 (R248) documented an initial admission date of 2/24/2023, discharge date of 3/16/23, readmission date of 3/22/2023, and final discharged date of 3/24/2023. R248's diagnoses included cerebral infarction and hemiplegia/hemiparesis affecting left dominant side. A MDS assessment dated 3/2/23 documented severe cognitive impairment and one-person physical assistance for part of bathing. Review of ADL self-care deficit care plan documented the following intervention: "Assist to bathe/shower as needed." Dated 2/27/23. A review of shower documentation revealed R248 missed receiving a shower/bath on the following scheduled dates: 3/7/23, 3/10/23, and 3/14/23. R429			

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	Review of the clinical record for Resident #429 (R429) documented an admission date of 1/13/2023 and discharged date of 2/27/2023. R429's diagnoses included cerebral infarction and hemiplegia/hemiparesis affecting left dominant side. A MDS assessment dated 1/18/2023 documented severe cognitive impairment, upper extremity and lower extremity impairments on one side, and a bathing activity had not occurred during the five-day look back period. Review of ADL self-care deficit care plan documented the following intervention: "Assist to bathe/shower as needed." Dated 1/16/2023. During an interview and record review on 5/8/2023 at 3:59 PM with UM "G", R429 missed receiving a shower/bath on the following scheduled dates between 1/13/2023 and 2/27/2023: 1/14/23, 1/18/23, 1/25/23, 1/28/23, 2/4/23, 2/11/23, 2/15/23, 2/18/23, 2/22/23, and 2/25/23. UM "G" indicated refusal should be documented and there were none. On 5/10/2023 at 1:30 PM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not. According to the facility's 4/1/2022 "Activity Daily Living (ADL)" policy," The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's ability in ADLs do not deteriorate unless deterioration is unavoidable. Resident needs for ADL care will be met according to resident specific care plan. Care and services will be provided for the following activities of daily living: -1. Bathing, dressing, grooming and oral care."			

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	824519	A. BUILDING _____ B. WING _____	5/10/2023

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F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: **This citation pertains to intake number MI00135633.** **Based on interview and record review, the facility failed to provide transportation for one resident (R431) scheduled for a follow up orthopedic appointment out of one resident reviewed for appointments, resulting in the potential for a delay and frustration in treatment due to multiple missed appointments by the facility.** **Findings include:** **Review of the Electronic Health Record (EHR) revealed Resident #431 was initially admitted to the facility on 3/2/2023 and re-admitted on 3/15/2023 with diagnoses of multiple fractures of ribs from a motor-vehicle accident and pain in left and right knees. R431's admission Minimum Data Set (MDS) with a reference date of 3/7/2023 indicated R431 had intact cognition with a BIMS (brief interview for mental status) score of 15/15, required extensive assistance of two persons with transfers and bed mobility, extensive assistance of one person for toileting, dressing**	F0684	Element I: Resident specific- Facility failed to provide transportation for one resident (R431) scheduled for a follow up orthopedic appointment out of one resident reviewed for appointments, resulting in the potential for a delay and frustration in treatment due to multiple missed appointments by the facility. Resident 431 was identified and no longer resides at the center. Element II: Like residents were identified as those with follow-up/ancillary/therapeutic appointments while staying at the center. Initial sweep was conducted that scheduled appointments had the appropriate transportation scheduled to coincide with each appointment. Element III: DON/Designee to educate medical record staff and licensed nursing staff LOA policy, therapeutic leave, and transportation scheduling to ensure transportation is offered and arranged as appropriate. Element IV: DON/Designee to complete random weekly audits times four weeks, on appointments scheduled in PCC, as well as new admission paperwork to ensure appointments are scheduled and transportation is offered as necessary. The administrator will review results and submit to the QAPI committee for review and recommendation. Element V: The Administrator is responsible for achieving and maintaining substantial compliance. The date of compliance is 6/8/2023	6/8/2023

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	and hygiene. **Review of the ADL care plan created on 3/3/2023 revealed, "ADL self-care deficit as evidence by significant need for assist related to trauma, physical limitations to bilateral knees with no weight bearing, multiples fractures."** **Review of Physician Orders dated 3/10/2023 documented," Please schedule appointments ASAP (As soon as possible) ...March 14th at 1:15 p.m. ortho Surgery Vascular and March 20th, 2023, at 1:30 p.m. one time only.** **Review of nursing progress note dated 3/14/2023 at 4:15 p.m. documented, "Patient was very upset stating she receive a phone call from the orthopedic Doctor stating the facility cancelled her appointment for tomorrow (referring to 3/14/2023 appointment). Patient states this is the third appointment she has missed since coming here due to rides not being scheduled (No documentation noted in the nurses progress notes of the previous missed appointments). Patient was tearful and visibly upset."** **Review of nursing progress note dated 3/14/2023 at 6:50 p.m. documented, "Resident express desire to transfer back to the hospital due to missed appointments after her accident. MD (Medical Doctor) made aware and order to transfer to be initiated. Ambulance to pick up this evening."** **Review of the nursing progress note dated 3/15/2023 at 10:13 a.m. documented, "Back on unit with new orders for Bactrim DS (antibiotic) BID (Twice a day) for 10 days."** **On 5/4/2023 at 11:18 a.m. during an interview,**			

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	the Director of Nursing (DON) reviewed R431's electronic medical record and confirmed that R431 did missed two ortho appointments but could not state the date of the first scheduled appointment. The DON stated, "It looks like we cancelled her appointment for March 14th and it's not documented why. I will have to get with the administrator to see why the appointment was cancelled. I don't know why because I wasn't here in March." The DON continued to read the nurse's progress notes for 3/14/2023 and said, "the appointment was cancelled because they did not make transportation three times. I will check around to see why and to see was there a follow up." The DON was asked to provide copies verifying R431 went out for the scheduled appointments. **On 5/4/2023 at 12:07 p.m., the DON presented a document verifying the resident had a post-op orthopedic appointment scheduled for March 14, 2023, at 1:15 p.m. The DON said, "We identified there was a transportation issue for the March 14th appointment, she needed to go to her appointment on a stretcher not wheelchair. She requested to go back to the hospital because she missed her March 14th appointment. The appointment was rescheduled for March 17th, 2023, and she still went out for that appointment after going back to the hospital." The DON was asked shouldn't the person scheduling appointments be informed about the manner of transportation needed already? The DON said, "Yes, this is something she should know before, checking to see what kind of transportation the residents will be needing."** **According to the facility's 8/2022 " ...therapeutic leave & Doctor appointment/Medical Visit" policy documented as following:**			

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	-1.0 This Facility shall allow residents to leave the facility, as appropriate, to ensure resident choice and continuity of care. **-2.0 The nurse will obtain an order from the practitioner specifying approval of a therapeutic leave or a follow up medical visit."**			
F0689 SS= G	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This citation has two deficient practices. Deficient Practice #1: Based on interview and record review, the facility failed to implement appropriate safety interventions for one resident (R71) out of eight residents reviewed for accidents, resulting in a fall with injury (femoral fracture), and an emergency hospital encounter. Findings include: During an interview on 5/3/2023 at 9:31 AM, a concerned family member of Resident #71 (R71) stated, R71 fell in his room "right in front of me. He fell hard and went to the hospital for surgery." A review of the Admission Record for R71 revealed an admission date of 10/10/2022 and	F0689	Element I: Facility Failed to implement appropriate safety interventions for one resident (R71), resulting in a fall with injury. Resident 71 was identified and transferred to the hospital and treated for a fractured right femur. Resident 71 returned and continues to reside at the center. The facility completed a fall review and modified care plans as needed. Facility failed to ensure assessments for the use of electronic cigarettes on the grounds of a non-smoking facility resulting in the potential for harm from the use of electronic cigarettes. Resident 128 and 230 and education was provided to each resident on the new smoking policy that now includes e-cigarettes and vapes. Facility submitted new policy to the QAPI committee for review and approved for adoption on 5/23/2023. Element II: Like residents were identified as residents with a fall risk as identified by the IDT and pertinent diagnoses as well as residents who smoke or vape as outlined by the smoking policy. Initial sweep conducted to ensure care plans, and Kardex were all accurate and current residents and new admissions were reviewed for smoking risk. Element III: DON/designee will educate licensed nursing staff on fall preventions, interventions, care plans, Kardex, and tasks, as well as the facility smoking policy and smoking cessation opportunities. Element IV: DON/designee will conduct random weekly audits two times weekly, times	6/8/2023

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	readmission date of 1/23/2023 with diagnoses that included right femur (thigh bone) fracture. A Minimum Data Set assessment dated 1/13/2023 and 5/1/2023 documented severe cognitive impairment. The MDS of 1/13/2023 documented no impairment of lower extremity and supervision with one-person physical assistance for transfer. The MDS of 5/1/2023 documented lower extremity impairment on one side and very limited bed transfers documented during the seven-day look back period. Further review of R71's clinical record and post-fall documents revealed in part the following: 1. Progress note date/time: 1/16/2023 at 5:55 AM: "Writer found patient on floor at 2:45am, patient was assessed physically and there is no known injuries. Patient denies hitting his head or being in any pain. Patient states he was trying to stand up to put his pants back on. Teaching was reinforced to use call lights when he feels he is in need or has wants, the bed light was put on, and bed is put in lowest position. Neuro-checks was (in place) and there is no change in mental status. Physician and patient's son has been notified of incident." 2. Radiology Report date/time of 1/16/2023 at 12:12 PM: Femur 1 View: Conclusion: Acute intertrochanteric right femoral fracture as noted. 3. Progress note date/time of 1/16/23 at 3:48 PM: Acute intertrochanteric right femoral fracture as noted. (Physician) updated. New order for patient to be sent to emergency room. 4. Staff Statement dated 1/16/23: Certified Nurse Aide (CNA) "R" changed R71's brief at 2:00 AM. 5. Post-Fall Assessment, dated 1/16/2023. Observations included: poor lighting, improper		four weeks on ten random residents to ensure environment, care plans, Kardex, and tasks are up to date as well as random weekly audits times four weeks on identified patient smokers to ensure facility policy is being followed and cessation program is offered where applicable. The administrator will review results and submit to the QAPI committee for review and recommendation. Element V: The Administrator is responsible for achieving and maintaining substantial compliance. The date of compliance is 6/8/2023	

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bed height, water spills, patient reaching for items. Comments: "Patient was trying to put on their pants."

6. Investigation Report dated 1/16/2023. Summary of alleged incident: "Patient got himself out of bed attempting to put his pants on and fell while holding onto the bed side table."

7. Progress note date/time of 1/17/2023 at 1:23 PM (created on 1/23/2023 at 1:24 PM): "IDT (interdisciplinary team) reviewed fall from 1/16/23. Patient fell attempting to get self dressed at (3:00 AM). Patient initially denied all pain. During the next shift patient began to complain of hip pain. X rays obtained and fx (fracture) noted. Patient sent out for treatment of fracture. Fall interventions in place at time of fall. Patient is cognitively impaired and unable to be educated on call light use ..."

8. Incident Report dated 1/17/23. Corrective Action: "Bed is back into lowest position, reinforced teaching on using the call light, and bed light is turned on."

9. Review of at risk for falls care plan documented the following intervention: "Bed in low position." Date initiated 10/11/2022.

During an interview on 5/8/23 at 2:22 PM, CNA "Q" said she had been a CNA for approximately two years. CNA "Q" said that when she changes a resident's brief, she brings the bed up to a decent height so she doesn't strain her back. After the brief is changed, she puts the resident's pants back on and lowers the bed back down just in case the resident rolls out of the bed, or they try to get out of the bed.

During an interview and record review on 5/8/2023 at 2:57 PM, the Director of Nursing

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(DON) said R71's fall was avoidable. The DON stated, "If we had the bed at the right level, better lighting, and water off the floor. (We need) to make sure spills are wiped up and have items within reach." The DON listed the following as contributing to R71's fall: poor lighting, water spill, and improper bed height.

The facility document titled, "Fall Management Guidelines", dated April 2022, was reviewed and revealed in part the following: "Fall reduction and injury prevention strategies that can be implemented upon admission may include, but are not limited to the following...Provide environmental modifications as indicated (use of appropriate height bed, removal of trip hazards, bedside commode) ..."

Deficient practice #2.

Based on observation, interview, and record review, the facility failed to ensure assessments for the use of electronic cigarettes were adequately completed for two residents (R128 and R230) observed using electronic cigarettes on the grounds of a non-smoking facility, resulting in the potential for harm from the use of electronic cigarettes.

Findings include:

During observations on 5/2/2023 at 8:30 AM, wall signage on the front entrance to the facility and on the front patio indicated: "THIS IS A SMOKE FREE CAMPUS."

During an observation on 5/4/2023 at 1:00 PM with Unit Manager (UM) "F", Resident #128 (R128) and Resident #230 (R230) were observed on the facility's front patio using electronic cigarettes.

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	R128 A review of the Admission Record for R128 documented an admission date of 4/13/2023 with diagnoses that included right fibula (calf bone) fracture, chronic pulmonary embolism, chronic obstructive pulmonary disease, and syncope (fainting) and collapse. A MDS assessment dated 4/20/2023 documented intact cognition and no upper extremity impairment. A Non-Smoking Facility Smoking Evaluation was initiated and completed on 5/4/2023 at 1:59 PM and 2:00 PM respectively. The smoking evaluation completed on R128 did not specifically address the use of electronic cigarettes. R230 A review of the admission record for R230 documented an admission date of 4/14/2023 with diagnoses that included peripheral vascular disease, chronic obstructive pulmonary disease and stage 3 chronic kidney disease. A MDS assessment dated 4/20/2023 documented intact cognition and no upper extremity impairment. Review of clinical record revealed R230 was offered education on risk of smoking and vaping. Patient offered smoking cessation and declined. Patient able to show safe vaping technique. Patient verbalized understanding to the sign out policy and that she needs to sign out and go outside independently. Progress note of 5/4/22 at 1:22 PM documented: "Resident signed out for LOA with the understanding that she is her own responsible person and responsible for herself when leaving the building. She states that she wants to vape and her vape were provided to her. She was able to navigate the hallway to the outside sitting area and safely vaped while at the table. She was approached by the unit manager who informed			

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	her that we are a non-smoking facility and smoking must be 150' from the building to which the resident explained that she was not smoking and she was in fact vaping. The resident then stated that she would move to the city sidewalk. She was able to navigate the parking lot onto the city sidewalk off of (the facility's) property and safely vape. The resident understands the potential negative effects of smoking and vaping and declines smoking/nicotine cessation." During an interview and record review on 5/8/2023 at 2:48 PM with the DON, the Non-Smoking Facility Smoking Evaluation completed for R230 on 5/1/2023 was reviewed. The DON stated, "A care plan has been done. Everything else is blank. (R230) does not have a completed smoking assessment." The areas left blank on the smoking evaluation were cognitive function, visual function, communication function, physical function, non-smoking facility, and patient observation. The DON said the purpose of the smoking assessment was to ensure the resident's safety when they go out to smoke and acknowledged the potential for harm is there with vaping. On 5/10/2023 at 1:30 PM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.			
F0694 SS= D	Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as	F0694	Element I: Resident specific- The facility failed to provide timely PICC (peripheral inserted central catheter) line/dressing changes, label and IV (intravenous, therapy that delivers liquid substances directly into a vein) bag, date an IV tubing, and obtain physicians order for PICC line maintenance for two residents (R43 and R485) reviewed for IV Parenteral	6/8/2023

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	evidenced by: Based on observation, interview, and record review, the facility failed to provide timely PICC (peripheral inserted central catheter) line/dressing changes, label an IV (Intravenous, therapy that delivers liquid substances directly into a vein) bag, date an IV tubing, and obtain physician's order for PICC line maintenance for two residents (R43 and R485) reviewed for IV Parenteral fluid resulting in the potential for medication delay and error and a bacterial infection originating at the PICC line site. Findings include: R43 On 5/3/2023 at 1:10 p.m., a bag of IV solution was observed hanging at R43's bedside with no label on the bag and no date on the IV tubing. R43 was observed with a right arm PICC dressing dated 4/23/2023 which appeared soiled and not adhered to the skin. On 5/3/2023 at 4:30 p.m., the Director of Nursing (DON) was interviewed in R43's room while observing the unlabeled IV bag, undated IV tubing, and the 4/23/2023 dated PICC dressing. The DON was asked about the frequency of a PICC line dressing change, should the IV bag be labeled, and the tubing dated. The DON stated, "The PICC line dressing should be change every seven days I think, for infection reasons, and afterwards they should put a date on the dressing. The IV line should be dated, and the bag should have the resident's name, date, room number, medication name, and the time it went up." The DON verified the PICC line was not changed within the seven days, and the IV bag had not been labeled and the IV tubing was not dated.		fluid resulting in the potential for medication delay and error and a bacterial infection originating at the PICC line site. Residents 43 and 485 were identified and no longer reside at the center. Element II: Like residents were identified as those with IV treatment. An initial sweep was completed to audit orders dressing changes, flushing, and tubing and valve changes are in place. Element III: DON/Designee to educate licensed nursing staff on IV/Central/Peripheral policies and PCC batch order procedures to ensure infusion orders are in place and followed as prescribed. Element IV: DON/Designee to complete twice weekly random audits, times four weeks of batch orders, IV tubing/dating, care planning, flush maintenance and dressing changes. The administrator will review results and submit to the QAPI committee for review and recommendation. Element V: The Administrator is responsible for achieving and maintaining substantial compliance. The date of compliance is 6/8/2023	

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During the interview, R43 stated, "The dressing was wet, and it started to itch after getting it wet from a shower. We try to keep it dry with tape and a plastic bag, but it's hard. A nurse came by today about an hour ago taped it up after I asked her to change the dressing. The nurse said, since you are being discharged tomorrow (5/4/23), I will just tape it instead." A concern family member (CFM) in the room at this time verified the nurse did not change the PICC line dressing after R43 requested it to be changed.

According to the electronic medical record, R43 was admitted into the facility 2/17/2023 with diagnoses of cellulitis of left lower limbs and discitis of lumbosacral region (an infection of the intervertebral disc space). R43's admission Minimum Data Set (MDS) with a reference date of 2/24/2023 indicated R43 was cognitively intact with a BIMS (brief interview for mental status) score of 14/15.

Review of R43's physician's order dated 2/19/2023 revealed, "Change PICC line dressing every night shift every Sunday." Review of the April 2023 and May 2023 Medication Administration Records did not reveal documentation that the PICC line dressing had been changed.

R485

In an observation on 5/2/23 at 11:33 a.m., Resident #485 (R485) sat in a wheelchair and had a PICC line in the right upper arm.

Review of an admission record revealed, R485 admitted to the facility on 4/13/23 with pertinent diagnosis which included Infection and Inflammatory Reaction due to Internal Right Hip Prothesis.

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	Review of a MDS assessment, with a reference date of 4/18/23 revealed R485 had no cognitive impairment with a "Brief interview for Mental Status" (BIMS) score of 14 out of 15. Review of Physician orders revealed R485 did not have a current order for a PICC line or management of the PICC line. R485 had an order to receive "cefTRIAXone Sodium (treats infections) Intravenous Solution Reconstituted 2 GM (Ceftriaxone Sodium) Use 2 gram intravenously at bedtime for antibiotic until 05/17/2023" with a start date of 4/19/23. In an observation on 5/8/23 at 10:45 a.m., R485 had a PICC line in right upper arm with a date of 5/8/23. In an interview on 5/08/23 at 10:47 a.m., Registered Nurse (RN) "H" reported "everyone" usually has an order for PICC line flushes. RN "H" then reported there are no orders pertaining to a PICC line for R485 in the EHR (Electronic Health Record). RN "H" reported the PICC line should be flushed before and after medication administration and the dressing should be changed weekly and as needed. In an interview on 5/8/23 at 10:50 a.m., Unit Manager "G" stated, "Anybody with a PICC line should have maintenance orders, that's policy." Unit Manager "G" reviewed R485's Physician orders and stated, "She has none." In an interview on 5/8/23 at 10:57 a.m., The Director of Nursing (DON) reported every resident with a PICC line should have orders to maintain it. The DON then reported Physician orders should include dressing change every seven days and flush orders. A review of the facility policy titled, "IV-			

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	Dressing Changes for Central Lines", dated 9/26/2017, revealed the following: -The catheter insertion site is a potential entry for bacteria that may cause a catheter-related infection. Dressing change procedure for central line catheters and midline catheters: -1. Vigorously cleanse around catheter insertion site with antimicrobial solution, according to the manufacturer's instructions. Allow to air dry. -2. Apply securement device if not integral to the transparent dressing. -20. Label dressing with date, time of dressing change. -21. Documentation in the medical record includes, but is not limited to: (a) date and time (b) site assessment (c) reason for dressing change (d)patient response to procedure ... -Transparent dressing changes: 24-hour post insertion or on admission, then every week and as needed."			
F0756 SS= D	Drug Regimen Review, Report Irregular, Act O §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to,	F0756	Element I: Resident specific- The facility failed to ensure a physician responded to a pharmacy recommendation for one resident (R26) out of five residents reviewed for pharmacy recommendations resulting in a missed opportunity for collaboration on a medication recommendation and the potential for unmet medical care needs. Resident 26 was identified and continues to reside at the center, patient's physician was at the center at time of discovery and reviewed medications. Element II: Like residents were identified as	6/8/2023

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	any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a physician responded to a pharmacy recommendation for one resident (R26) out of five residents reviewed for pharmacy recommendations resulting in a missed opportunity for collaboration on a medication recommendation and the potential for unmet medical care needs. Findings include: A review of the clinical record revealed Resident #26 (R26) was admitted into the facility on		those having pharmacy consultant monthly medication reviews. Initial sweep completed to identify and ensure MMRs have been reviewed timely by the physician. Element III: DON/Designee to educate physicians and nurse managers on MMR policies and procedures to ensure the timely review of medication recommendations. Element IV: DON/Designee to complete random weekly audits, twice weekly, times four weeks on timely MMR physician review to ensure medical care needs are meant. The administrator will review results and submit to the QAPI committee for review and recommendation. Element V: The Administrator is responsible for achieving and maintaining substantial compliance. The date of compliance is 6/8/2023	

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1/27/2022. R26's diagnoses included congestive heart failure, atrial fibrillation, and anxiety disorder. A Minimum Data Set assessment dated 5/4/2023 documented intact cognition.

A review of a Medication Regimen Review (MRR) for R26 dated 1/9/2023 revealed the following recommendation: "The National Osteoporosis Foundation recommends an intake of 800 - 1000 units of vitamin D per day for adults age 50 and older. Please consider Vitamin D 1000 units daily."

During an interview and record review on 5/8/2023 at 1:45 PM, Unit Manager (UM) "F" revealed that R26 did not receive supplemental Vitamin D and the multivitamin with mineral supplement that R26 received contained 400 units of Vitamin D. During a review of R26's medical record, UM "F" was unable to confirm that R26 had been prescribed supplemental Vitamin D since 1/9/2023 or that the physician addressed the pharmacist's 1/9/2023 recommendation.

During an interview on 5/8/2023 at 2:42 PM, the Director of Nursing, (DON) said it was a concern that the physician had not responded to the pharmacist's recommendation. The DON stated, "The pharmacists recommends something for the patient's well-being. The doctor needs to review (the recommendation) and say if it is a suggestion that needs to be followed up."

A review of the facility policy titled, "Medication Regimen Reviews (MRR) - Pharmacy Services", dated 10/8/2018, revealed in part the following:

- "Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR, and the Director of Nursing, to act upon the recommendations contained in the MRR. For those issue that require Physician/Prescriber

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	intervention Facility should encourage Physician/Prescriber to either, accept and act upon the recommendations contained within the MRR, or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected....If the attending physician has decided to make no change in the medication, the attending physician should document the rationale in the resident's health record." - "The attending physician should address the consultant pharmacist's usual MRR recommendation no later than their next scheduled visit to the facility to assess the resident, either 30 or 60 days per applicable regulation." - "If the attending physician has not yet responded to the resident's MRR report by their next scheduled visit, the Director of Nursing will notify the Medical Director to review and respond to the pending MMR reports." On 5/10/2023 at 1:30 PM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.			
F0804 SS= E	Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F0804	Element #1 It is the practice of the facility to ensure that food is being given to the resident at a palatable temperature, prepared by methods that conserve nutritive value, flavor and appearance. Resident 65 was identified and in substitution for her meal tray, provided a freshly made hamburger at a palatable temperature. Element #2	6/8/2023

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	This citation pertains to Intake MI00134180. Based on observation, interview, and record review, the facility failed to ensure meals were served at palatable temperatures for multiple residents on the Medbridge Unit, Resident #65, an unidentified resident, and four out of seven anonymous residents attending a Resident Council Meeting, resulting in resident hunger, dissatisfaction with the meal experience, and the potential for unmet nutritional needs. Findings include: A complainant reported to the State Agency that the facility failed to serve palatable food. In an interview during the resident council meeting on 5/3/2023 at 3:00 PM, four out of seven residents reported the food was not warm when trays arrived for meals. During an observation and interview on 5/4/2023 at 8:21 AM, the last tray on the Medbridge Unit meal cart was obtained and used as a test tray. The Minimum Data Set (MDS) Coordinator "A" was present during the testing of food temperatures on the breakfast tray. The following temperatures were obtained using a metal stem thermometer: Sausage link #1: 113 ºF (Fahrenheit) Sausage link#2: 115.8ºF Carton of milk: 55 ºF Yogurt: 52 ºF		Residents who reside at the facility have the potential to be affected by this citation and the components listed above. Audits for the following were completed: " Food Service Director/designee audited meal trays as they were taken to residents rooms, for meal experience satisfaction and palatable temperature. Element #3 Policy # 5010 was reviewed by the IDT and deemed appropriate. Dining and nursing staff will be educated on the importance of serving trays at a safe and palatable temperature. All parties educated acknowledged an understanding. Element #4 The Food Service Director/designee will conduct random weekly audits, 4 times per week, for a duration of four weeks, on resident meal satisfaction and tray temperatures to ensure that the food is palatable when delivered to the room. The administrator will review the findings and submit them to the QAPI Committee for further review and recommendation. Element #5 The Administrator is responsible for achieving and maintaining substantial compliance. The date of compliance is 6/8/2023	

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Apple juice: 55 ºF

The temperature of the toast was not taken. MDS Coordinator "A" agreed that when a pat of soft butter/margarine was spread on the toast it did not melt.

During an observation and interview on 5/4/2023 at 12:28 PM, Resident #65 (R65) was observed with her lunch tray in front of her. A dome lid covered her plate. When queried if she ate her lunch, R65 stated she was hungry but could not eat her food because it was cold. R65 granted the State Surveyor permission to remove the dome lid and R65's lunch appeared to be untouched. The plate in front of R65's roommate was observed and also appeared untouched. R65's roommate stated, "I'm not going to eat it. I can't eat cold things."

During an interview on 5/9/2023 at 8:16 AM, Food Service Director (FSD) "B" stated her expectations for point of service food temperatures were hot food "should be 135 or above and cold food should be 41 or below." FSD "B" added. "The cold temps (obtained from the test tray) for sure bother me because those are dairy products. They are coming out of the cooler and shouldn't be that high."

During an interview on 5/10/2023 at 9:21 AM, Corporate Registered Dietitian (RD) "C" stated her expectations for point of service food temperatures was "that food is served safe and without bacterial growth." RD "C" agreed that it was important to serve palatable food and stated, "People need to eat. We need to heal them. Clinically speaking we count on (food acceptance) to avoid significant weight loss."

A facility policy titled, "Trayline Food Temperatures", dated April 2023, was reviewed

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	and revealed in part the following: "It is the policy of this facility to serve food at acceptable temperatures that are safe and palatable." On 5/10/2023 at 1:30 PM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: **Based on observation, interview, and record review, the facility failed to maintain a sanitary kitchen, plumbing, and an accessible hand sink, resulting in the potential contamination of food and equipment, and potential for discouragement of hand hygiene, affecting all residents who consume food from the kitchen.**	F0812	Element #1 It is the facility practice to ensure that all residents are served food that has been procured from sources approved or considered satisfactory by federal, state or local authorities. It is the practice of the facility to store, prepare, distribute, and serve food according to professional standards for food safety. No specific residents were affected by these practices. Element #2 Residents who reside at the facility have the potential to be affected by this citation and the components listed above. • The FSD/Designee will ensure that food is labeled and dated according to policy in the food service department as well as in the nourishment rooms. • The FSD/Designee will ensure that all noted areas of food storage, prep areas and shelving are kept clean and orderly, free of crumbs and debris, including the floors and walls. • The FSD/Designee will ensure that all hand sinks are not blocked and are for the sole purpose of handwashing. • The FSD will ensure that mops are stored in a position that allows them to dry according to standard operating procedures. • The FSD will ensure that all food delivery	6/8/2023

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	Findings include: **On 5/02/23 at 10:29 AM, a dried spill and food splatter was observed in the dry storage room at the wall/floor juncture near the can shelf. An unknown substance was observed to have a solidified drip hanging from the wire rack at the same location.** **According to the 2017 FDA Food Code Section 6-501.12 Cleaning, Frequency and Restrictions.** **"(A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.** **(B)Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of FOOD is exposed such as after closing."** **On 5/02/23 at 10:31 AM, food debris and grease were observed to be accumulating in the top and bottom drawer of the three-tier drawer near the preparation sink, where utensils were stored.** **According to the 2017 FDA Food Code Section** **4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.** **"(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. Pf** **(B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations.**		carts are washed and sanitized after each use. Element #3 Policy # 5016, was reviewed by the IDT and deemed appropriate. Dietary staff will be educated on the importance of appropriate use of date marking and effective methods of cleaning in all areas. All parties educated acknowledged an understanding. Element #4 The FSD/designee will randomly audit all refrigeration, 3 times per week, times 4 weeks to ensure labeling and dating compliance, as well as kitchen cleanliness compliance. The results will be reviewed by the administrator and submitted to the QAPI Committee for review and recommendation. Element #5 The Administrator is responsible for achieving and maintaining substantial compliance. The date of compliance is 6/8/2023	

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	(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." On 5/02/23 at 10:34 AM, water was observed to be accumulating under the coffee maker shelving. At this time, Food Service Director "B" stated that the leak may be a result of the newly installed coffee maker and juice machine. According to the 2017 FDA Food Code Section 5-205.15 System Maintained in Good Repair. "A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; P and (B) Maintained in good repair." On 5/02/23 at 10:36 AM, food debris and soil, beyond daily operational spills/messes, were observed to be accumulating on the floor near the preparation sink, cookline, hand sink, and dish machine area. At this time, Food Service Director "B" stated that they just hired a floor cleaner who will be starting to clean floors today. On 5/02/23 at 10:38 AM, the hand sink by the cookline was observed to be blocked by three large rolling carts. At this time, Food Service Director "B" moved the carts to provide access to the hand sink. According to the 2017 FDA Food Code Section 5-205.11 Using a Handwashing Sink. "(A) A HANDWASHING SINK shall be			

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	maintained so that it is accessible at all times for EMPLOYEE use. Pf (B) A HANDWASHING SINK may not be used for purposes other than handwashing. Pf (C) An automatic handwashing facility shall be used in accordance with manufacturer's instructions. Pf " On 5/02/23 at 10:43 AM, a mop was observed to be left in a mop bucket, in the janitorial closet, not hung up in a position to air dry. According to the 2017 FDA Food Code Section 6-501.16Drying Mops. "After use, mops shall be placed in a position that allows them to air-dry without soiling walls, EQUIPMENT, or supplies." On 5/02/23 at 11:48 AM, the nourishment refrigerator, located near the 100 hall, was observed to contain a quinoa salad with no date label to identify the discard date. According to the 2017 FDA Food Code Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. "(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24			

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	hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Pf' **On 5/02/23 at 3:28 PM, three of the accessible rolling tray carts, used to distribute meal trays to residents, were observed to be soiled with dried food splatter, grease, and wrappers. At this time, Food Service Director "B" was queried on the frequency of cleaning the carts and stated that they are cleaned in between each meal and have been cleaned at this time. Food Service Director "B" commented on the condition of the rolling carts, not having been adequately cleaned.**			
F0880 SS= F	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national	F0880	Element #1 Not resident specific, facility failed to ensure staff adhered to contact precautions during meal pass and ensure meal cart was properly cleaned and sanitized for meal distribution to the residents. Resident specific facility failed to educate the residents on the risk of sharing electronic cigarettes. These deficient practices resulted in the potential for the spread of harmful pathogens among the residents in the building. Resident 128 was identified and no longer resides at the center. Resident was 230 was identified and educated on the facility smoking policy and not sharing vaping materials with others. Element #2 Initial sweep conducted, and like patients were identified as any resident in isolation precautions, as well as any smoking/e-cigarette/vaping residents.	6/8/2023

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	standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to: 1. Ensure staff adhered to contact precautions during meal pass;		Residents in isolation were ensured to receive disposable trays and proper PPE used during pass. The residents that were smoking or sharing vapes/cigarettes/e-cigarettes were educated for the potential risk for the spread of infection. Element #3 DON/Designee will educate licensed staff on Donning/Doffing PPE, hand washing, and isolation precautions and tray pass procedures. DON/Designee will educate licensed nursing staff on completing education about sharing smoking materials. Food Service Director/Designee will educate dietary staff on isolation tray requirements to ensure patients in isolation receive disposable dishware. Element #4 DON/designee will conduct random audits twice weekly, times four weeks on donning, doffing, handwashing, isolation precautions, and tray pass to those rooms. The FSD will audit the tray line in dietary twice weekly, times four weeks to ensure isolation rooms receive disposable dishware. The administrator will review the results and submit to QAPI committing for review and recommendation. Element #5 The Administrator is responsible for achieving and maintaining substantial compliance. The date of compliance is 6/8/2023	

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	2. Ensure a meal cart was properly cleaned and sanitized for meal distribution to the residents; and, 3. Educate residents on the risks of sharing electronic cigarettes. These deficient practices resulted in the potential for the spread of harmful pathogens among the residents in the building. Findings include: - Isolation precautions and meal cart On 5/2/2023 at 12:21 PM, a meal tray was observed removed from the room of a resident on contact precautions (transmission-based measures implemented to a resident known or suspected to be infected with a microorganism that can be transmitted by direct contact with other residents or indirect contact with environmental surfaces) for Clostridium difficile (C-diff: symptomatic infection due to the spore forming bacteria causing watery diarrhea). Certified Nurse Aide (CNA) "M" donned personal protection equipment (PPE) upon entering the isolation room to retrieve the tray which included a regular cup, plate, eating utensils, plate warmer, and dome lid. CNA "M" was wearing gloves when she opened the resident's door and handed the tray to CNA "L" who was not wearing gloves. CNA "L" placed the meal tray from the isolation room on the rolling meal cart with the rest of the used meal trays. During an interview on 5/2/23 at 12:22 PM, CNA "M" said she donned a gown and gloves because the resident had C-diff. When queried about passing the isolation tray to CNA "L", CNA "M" stated, "Why did I have on gloves and she didn't?" CNA "M" offered no answer to her question/statement. During an interview on 5/2/23 at 12:25 PM, Registered Nurse (RN) "N" was informed about			

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the way the isolation tray for a resident on contact precautions was handled. RN "N" said the resident was on contact precautions and anyone on isolation should have disposable eating containers and utensils. RN "N" stated the resident's tray on isolation was on the meal cart and can "potentially contaminate everything else." RN "N" said she wondered if the kitchen was aware this resident was on isolation for C-diff.

During an observation and interview on 5/2/2023 at 3:28 PM, the rolling tray carts in the kitchen were observed to be soiled with dried food splatter, wrappers, grease and crumbs on the interior surface and rails. At this time, Food Service Director (FSD) "B" said the carts are cleaned in between each meal and have been cleaned already post lunch.

On 5/3/2023 beginning at 8:38 AM during dining observations of residents on isolation for COVID-19, resident meals were served on regular trays, using regular cups, plates, eating utensils, plate warmers, and dome lids as follows:

- Isolation Room 314's meal service included regular utensils, dome lid, plate, charger, and tray. The meal ticket for this resident was reviewed and did not specify "isolation".

- Registered Nurse (RN) "H" was observed exiting isolation Room 315 with a regular cup. When queried, RN "H" said this resident should not have a regular cup since they were on isolation.

- Isolation Room 313's meal service included a regular tray, plate, plate warmer, dome, cup, and eating utensils.

- Isolation Room 316's meal service included

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disposable eating wear but was served on a regular tray.

On 5/3/2023 at 8:52 AM during an observation, the used trays from the isolation rooms were placed on the same meal cart as the used trays from non-isolation rooms.

On 5/8/2023 at 2:37 PM, the Director of Nursing (DON) said that the resident on isolation for C-diff should have been serve meals using disposable items which should have been disposed of in their room. The DON stated, "Everything should have been disposable and discarded in the room. There must be a break in communication between the kitchen and the floor staff. This was an infection control violation and could have potentially cause the spread of C-diff spores."

During an interview on 5/9/2023 at 8:12 AM, FSD "B" said she was unaware that some residents were on isolation and had concerns because her staff could be exposed to whatever the patient has when they were breaking the trays down in the kitchen. FSD "B" agreed that disposable items were to be used for residents on isolation.

A review of the policy titled, "Tray Pass / Food Acceptance Policy", dated February 2018, revealed in part the following: "All residents on isolation precautions (all types) should have their meals served on disposable trays. All content should be disposed of within the room when the meal is completed. All trash should be removed per regulations of contaminated waste removal. Reusable products (i.e. plastic trays) should not be used in the rooms for isolated residents."

- Sharing electronic cigarettes

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	During an observation on 5/4/2023 at 1:00 PM with Unit Manager (UM) "F", Resident #128 (R128) and Resident #230 (R230) were observed on the facility's front patio using electronic cigarettes. During an interview on 5/4/2023 at 2:20 PM, UM "G" said that R230 had four vapor pens and these vapor pens were shared with R128. During an interview on 5/4/2023 at 2:49 PM, R230 said she used her vapor pens today and on Sunday (4/30/2023) and she allowed R128 to "hit it once or twice." R230 stated, "We didn't think about infection control" when queried about sharing vapor pens. During an interview on 5/4/2023 at 2:58 PM, R128 stated, "My friend vapes. She has some different flavors, so I hit it a couple of times. I've been out twice with her." A review of the medical record for R128 revealed an admission date of 4/13/2023 with diagnoses that included fracture of right fibula, atherosclerotic heart disease, and chronic pulmonary embolism. A Minimum Data Set (MDS) assessment dated 4/20/2023 documented intact cognition and no upper extremity impairment. A review of the medical record for R230 revealed an admission date of 4/14/2023 with diagnoses that included infection of amputated stump, peripheral vascular disease, and chronic obstructive pulmonary disease. A MDS assessment dated 4/20/2023 documented intact cognition and no upper extremity impairment. During an interview on 5/8/2023 at 1:42 PM, Unit Manager "F" said residents should not share electronic cigarettes because "medically,			

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	depending upon what the other person has, things can be transferred via saliva and that could put the residents at risk." During an interview on 5/8/2023 at 2:48 PM, the Director of Nursing (DON) stated she had concerns with residents sharing electronic cigarettes because of "germ swapping." During an interview on 5/10/2023 at 11:52 AM, UM "F" said she was unaware if R128 or R230 had received education regarding the potential risks of sharing electronic cigarettes. UM "F" stated, "If they were educated, it would be documented." UM "F" was requested to provide documentation of this education. Proof of resident education regarding sharing electronic cigarettes was not provided by the end of the survey. A review of the facility policy titled, "Smoking Guidelines", dated November 2013, revealed the following: "Instruct patients, family members and visitors not to share lighted cigarettes, lighters, or other smoking accessories with other patients." On 5/10/2023 at 1:30 PM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey and they reported there was not.			
F0926 SS= D	Smoking Policies §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. This REQUIREMENT is not met as evidenced by:	F0926	Element I: The facility failed to develop and implement a smoking policy that addressed the use of electronic cigarettes. Element II: Like residents were identified as any resident that smokes cigars, cigarettes, pipes, e-cigarettes and vapes. Residents that smoke were educated on the facility policy. Residents 128 and 230 were identified, resident 128 no longer resides at the center and resident continues to reside at the center	6/8/2023

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	Based on observation, interview, and record review, the facility failed to develop and implement a smoking policy that addressed the use of electronic cigarettes (e-cigs) for residents of the facility. This deficient practice resulted in two residents (R128 and R230) using e-cigs on the property of a non-smoking facility and staff not being adequately educated about the use of e-cigs. Findings include: During an observation and interview on 5/4/2023 at 1:00 PM with Unit Manager (UM) "F", Resident #128 (R128) and Resident #230 (R230) were observed on the facility's front patio using electronic cigarettes. Registered Nurse (RN) "H" was sitting on the front patio with the two residents. UM "F" stated, "They are not allowed to use those within 150 feet of the building." During an interview on 5/4/2023 at 2:12 PM, RN "H" said when R230 wanted to vape (use her e-cigs), he got her vapor pens from the unit manager. R230, her friend (R128), and RN "H" went out on the front patio. According to RN "H", he informed R230 that they were not allowed to smoke within 150 feet of the property. R230 told RN "H" that she was not smoking she was "vaping." RN "H" said this was his first time being with R230 while she used an e-cig. RN "H" stated, "If they are only vaping, they don't need a smoking assessment." During an interview on 5/4/2023 at 4:10 PM, the Director of Nursing (DON) said their current policy on smoking does not address the use of electronic cigarettes. The DON stated, "We're treating vaping under general smoking guidelines. They did not follow the guidelines today because they were smoking on the front patio."		and was educated on the facility's new smoking policy. Element III: DON/Designee to educate staff on the newly adopted smoking policy, as well as identifying smoking patients. The administrator will review results and submit to the QAPI committee for review and recommendation. Element IV: DON/Designee will conduct random weekly audits, times four-weeks on residents who have been identified as smokers to ensure facility policy is being followed Element V: The administrator is responsible for achieving and maintaing compliance. The compliance date is 6/8/2023	

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	On 5/8/2023 at 2:48 PM during an interview and review of a facility document titled, "Smoking Guidelines", dated November 2013, the DON said the facility's current smoking guidelines do not address the safe use of electronic cigarettes. On 5/10/2023 at 1:30 PM during the exit conference, the Nursing Home Administrator, DON, and Regional Clinical Services Director (RCSD) "I" were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey. The DON said that a policy that addressed the use of e-cigs was currently undergoing the Quality Assurance process but had not been implemented in the facility. The DON added that staff are educated once new policies have been implemented.			