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F0000 SS=	INITIAL COMMENTS Medilodge of Westwood was surveyed for a combined Recertification and Abbrevated Survey from 5/8/23-5/18/2023. Intakes: MI00132440,MI00132561, MI00132573, MI00132540, MI00135353, MI00130620, MI00134506, MI00128951, MI00123014, MI00131761, MI00133629, MI00133638, MI00134146, MI00134227, MI00128902, MI00135634, MI00134804, MI00134769, MI00134254, MI00134428, MI00130764, MI00133919, MI00132304, MI00135661,MI00134949, MI00132056, MI00131068, MI00134655 and MI00136960 Census: 78	F0000		
F0550 SS= E	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The	F0550		

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

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

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	resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake # MI00130764. Based on observation, interview, and record review, the facility failed to ensure timely care and services to promote dignity, treat residents with dignity/respect, and ensure a dignified environment in 8 of 12 residents (Resident #4, #19, #9, #33, #62, #24, #17, & #16) reviewed for dignity/respect, resulting in long call light wait times, a cluttered, noisy environment, and the potential for feelings of diminished self-worth, sadness, and frustration. Findings include: Review of the policy/procedure "Resident Rights", dated 1/1/22, revealed "...Employees shall treat all residents with kindness, respect, and dignity...Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity..." Resident #4			

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	Review of a "Minimum Data Set" (MDS) assessment for Resident #4, with a reference date of 1/3/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. In an interview on 5/8/23 at 3:26 p.m., Resident #4 reported the "Certified Nursing Assistants" (CNA's) often wear ear phones while in the rooms providing care. Resident #4 reported CNA's will make calls while in the room and carry on phone conversations with other people in front of the residents. In an interview on 5/9/23 at 3:58 p.m., Resident #4 reported long wait times for care, with call light response times as long as 1-2 hours. Resident #4 described an incident where staff left her room before care was complete, leaving her naked in bed. Resident #4 stated "...It took so long for (staff) to come back I was getting cold..." Resident #19 Review of a "Minimum Data Set" (MDS) assessment for Resident #19, with a reference date of 2/19/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. In an interview on 5/10/23 at 9:49 a.m., Resident #19 described an instance where her schedule shower had not been provided. Resident #19 reported when she asked about it, the "Certified Nursing Assistant" (CNA) assigned to her "...came out yelling..." and told her (Resident #19) that because she (Resident #19) wasn't in her room, it was her fault she missed the shower. Resident #19 reported the CNA yelled at her in the hallway "...in front of everybody...(It) made			

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	me feel like I was doing something wrong..." Resident #19 reported many CNA's have "...bad attitudes..." when working with residents. Resident #9 Review of a "Minimum Data Set" (MDS) assessment for Resident #9, with a reference date of 3/4/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #9 was cognitively intact. Review of FRI (Facility Reported Incident) dated 5/17/23 at 2:31 PM revealed, "...Incident Summary (Resident #9) alleges that (NHA) (Nursing Home Administrator) threatened to discharge her to a hotel with no services, causing her mental anguish for that past 2 weeks." In an interview on 05/09/23 at 09:26 AM, Resident #9 reported that the NHA ("A") can be antagonizing. In an interview on 05/17/23 at 12:48 PM, Confidential Informant (CI) "DDDD" reported that the NHA ("A") is very mean, rude to everyone here, including the residents and staff. CI "DDDD" reported that NHA ("A") made Resident #9 cry and stated the NHA ("A") , "...told her that she had 30 days to get out and it didn't matter if she went to a hotel or a homeless shelter..." In an interview on 05/17/23 at 2:28 PM, Resident #9 reported that NHA ("A") told her that she needed to pay or be discharged and that she would send her to a hotel and stated, "...she was being rude and very matter of fact...like she always does...I am used to it..." Resident #9 reported that the Director of Nursing (DON "B") is worse.			

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Resident #33

Review of a Quarterly "Minimum Data Set" (MDS) assessment for Resident #33, with a reference date of 3/9/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 6, out of a total possible score of 15, which indicated Resident #33 was cognitively impaired. Section F "Preferences for Customary Routine and Activities" was not included on the assessment.

During an observation and interview on 05/18/23 at 07:53 AM in the main dining room Resident #33 ambulating himself into the dining room in his wheelchair. Dietary Aide (DA) "TT" spoke to Resident #33 with a firm loud voice stating, "Don't go over there for your coffee (Resident #33)!" and the resident responded submissively, "I won't, I am just waiting...", then DA "TT" stated, "You better!" DA "TT" went on passing breakfast trays to other residents in the dining room and Resident #33 waited anxiously and fidgeting in his chair. In an interview on 05/18/23 at 7:58 AM, Resident #33 reported that he was waiting for his coffee and that he like to have coffee first thing in the morning. At 8:00 AM, another male resident ambulated into the dining room and ask for a cup of coffee, and DA "TT" stopped prepping trays and got a cup of coffee for that resident, all awhile Resident #33 was watching and waiting for his coffee.

In an interview on 05/18/23 at 8:01 AM, DA "TT" reported that Resident #33 could not have a cup of coffee, that he had to wait for his tray to go to his hall and stated, "...he is on fluid restriction and he will just drink and drink if I give it to him..."

During an observation on 05/18/23 at 8:02 AM in the main dining room, the hall meal cart was

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wheeled out and into the hall. Resident #33 wheeled himself down to his room briskly.

In an interview on 05/18/23 at 3:30 PM, DA "TT" reported that she did not treat Resident #33 undignified, and thought that was what she had to do. DA "TT" reported that she could have offered him a cup of coffee to drink in the dining room instead of waiting for his trays (which had coffee on them) to go to his room. DA "TT" reported that she had been informed by the nurse that Resident #33 is not on a strict fluid restriction.

Review of Resident #33 "Physician Orders" revealed, "Regular diet, Regular texture, Regular fluid, thin consistency. If Diet Type is Other: (SPECIFY Diet) Fluid Restriction: YES...2,000 mls/24hours for CHF (congestive heart failure). Active 2/4/2023."

Resident #62:

Review of an "Admission Record" revealed Resident #62 was a female with pertinent diagnoses which included end stage heart failure, diabetes, COPD, high blood pressure, atrial fibrillation (an irregular, often rapid heart rate), depression, anxiety, and anemia.

Review of a "Minimum Data Set" (MDS) assessment for Resident #62, with a reference date of 1/9/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15 which indicated Resident #62 was cognitively intact.

In an interview on 05/15/23 at 08:53 AM, Resident #62 reported she had asked CNA "Z" to get her some water. Resident #62 reported she does get her own water at times but at this time she was hurting and felt like she had been "hit in the head with a baseball bat" and asked the CNA

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to get the water for her. Resident #62 reported she was told by CNA "Z" "you know where it is, get up and go get it yourself." Resident #62 reported was upset and reported she began to cry because of how she talked to her. Resident #62 reported the staff member never did go and get her some water, she had left her meal tray in her room on the table for hours and it was there still in the morning. Resident #62 reported you should never treat anyone with such disrespect at that. Resident #62 reported the staff won't change my sheets to my bed either, they have me do it myself, Resident #62 reported she was told this was "Because she can change the sheets yourself." Resident #62 reported she has a weak heart and only 10% of her heart was working.

In an interview on 05/17/23 at 02:09 PM, Resident #22 reported she was in the restroom, and she heard the whole exchange between Resident #62 and the aide. Resident #22 overheard the CNA ("Z") tell Resident #62 to get up and get her own water, shaking her head as she was telling this writer at the disbelief of what the aide said.

In an interview on 05/18/23 at 11:11 AM, Activities Director "I" reported it was not appropriate for a staff member to tell a resident to get up and get their own water, even if they were capable of doing so.

In an interview on 05/18/23 at 11:20 AM, LPN "VVV" reported it was inappropriate for a staff member to tell a resident to get up and go get their own water.

Resident #24

Review of a "Minimum Data Set" (MDS) assessment for Resident #24, with a reference date of 4/12/2023 revealed a "Brief Interview for

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Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #24 was cognitively intact.

In an interview on 5/8/2023 at 2:28 PM, Resident #24 reported that it can take 1 ½ hours for call lights to be answered. Resident #24 reported that this occurs a couple times a week.

In an interview on 5/15/2023 at 9:45 AM, Resident #24 reported she turned her call light on Friday after lunch because she had a bowel movement in her brief. Resident #24 reported an aide came in, turned her call light off and left the room, stating that she would return. Resident #24 reported that staff did not return until 5:00 PM to change her, leaving her soiled in her brief for several hours. Resident #24 reported this made her feel neglected, left out, and invisible.

Dining Observation

In an observation in the Grand Oak Dining Room on 5/8/2023 at 12:46 PM, a bed frame was pushed against a wall, along with two rolling stools on wheels, a large empty cardboard box, and a disheveled stack of mattresses.

In an interview on 5/25/2023 at 12:16 PM, Resident #18 reported it bothered him that the resident dining hall was being used for storage. Resident #18 reported this makes him feel disrespected.

Resident #17

Review of an "Admission Record" dated 7/1/21 for Resident #17 revealed pertinent diagnoses that included: Alzheimer's Disease (progressive disease resulting in memory loss of loss of functional abilities), Major Depressive Disorder, Anxiety Disorder and Psychotic Disorder with

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delusions (mental disorder characterized by disconnection with reality).

Review of a Minimum Data Set (MDS) assessment for Resident #17dated 5/8/23 revealed the Resident could hear adequately without a device, was usually able to make self-understood and usually understood verbal content. Resident #17 had no current indications of psychosis.

Review of a care plan for Resident #17, revised on 2/8/23, revealed a focus: "Resident needs activities of daily living assistance ..." With interventions of: "wears briefs, check and change with rounds and PRN (as needed)." A focus that was last revised on 10/14/22 stated: "(Resident #17) is dependent on staff for meeting her psychosocial wellbeing."

During on observation on 5/16/23, Resident #17 was in the hallway, self-propelling her specialty wheelchair with 2 other residents and a visitor nearby. Social Services Director(SSD) "F" approached the group and asked Resident #17 if she "got changed yet". Resident #17 did not respond but a Certified Nursing Assistant was overheard saying Resident #17 was going to be assisted next. SSD "F" then said to Resident #17, in a loud tone of voice: "(Resident #17) let's go. We've got to get your butt changed. You're wet and I told you to wait in your room!" Resident #17 then cast her eyes to the floor, hung her head and stopped moving her chair. SSD "F" began walking away and was heard referring to Resident #17 "stinking up the hall".

Resident #16

Review of Resident #16 "Admission Record" revealed Resident #16 was originally admitted to the facility on 4/28/2020 with pertinent diagnoses which included: major depressive disorder and

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	heart failure. Review of a "Minimum Data Set" (MDS) assessment for Resident #16 with a reference date of 2/25/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #16 was cognitively intact. During an interview on 5/09/23 at 09:07 AM, Resident #16 was observed lying on his back in bed without a shirt on and wearing a brief. Resident #16 did not have a sheet covering his lower body. Resident #16's room door was open and his body was in view of anyone that walked past his room. Resident #16 reported that he was upset about how he was left, and that he had turned his call light on to get help, but it would be a long time before anyone came to assist him because it always took a long time. Resident #16 reported that he hated living at the facility because staff acted like they did not care about him and he felt like a secondary citizen. Resident #16 reported that staff frequently walked by his room when his call light was on but would not stop and check on him. Resident #16 pointed down at his toe and reported that his big toe nail was falling off and that the nurse had recently put a band aid over it and just left his toe dirty. Resident #16 reported "This is the kind of care I get all the time, you see what I mean?". Resident #16's right foot was observed as covered with a sock that was visibly soiled with blood. During an interview on 5/9/2023 at 9:15 AM, Licensed Practical Nurse (LPN) "X" reported that she was aware that Resident #16's toe was bleeding and that she had already addressed it by looking at it and messaging the provider on call about it. LPN "X" reported that the she was aware that the sock on Resident #16's right foot was soiled because that was the same sock he had on earlier.			

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	During an interview on 5/09/23 at 02:30 PM, Registered Nurse/Unit Manager (RN/UM) "P" reported that he he looked at the bandage on Resident #16's toe. RN/UM "P" observed the sock on Resident #16's right foot which was soiled with blood and reported that he felt that the sock should be changed and the bandage should be cleaned up.			
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 call lights were within resident reach in 2 of 2 residents (Resident #32 & Resident #39) reviewed for call light placement, resulting in the inability to call staff for assistance and the potential for unmet care needs. Findings include: Resident #32 Review of an "Admission Record" revealed Resident #32 was a male, with pertinent diagnoses which included stroke, diabetes, high blood pressure, aphasia (difficulty with speech expression), chronic pain, depression, arthritis, and muscle weakness, and a history of falls. Review of a "Minimum Data Set" (MDS) assessment for Resident #32, with a reference	F0558		

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date of 1/2/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 11, out of a total possible score of 15, which indicated moderate cognitive impairment.

Review of a current "Care Plan" for Resident #32 revealed the focus "...The resident is at risk for falls related to: Bil. (bilateral) LE (lower extremity) amputation and impaired thought processes..." initiated 8/5/22, with interventions which included "...Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed..." initiated 8/16/22.

In an observation on 5/9/23 at 11:48 a.m., Resident #32 was noted in bed in his room, leaning to the far left side of his bed. Observed a paddle-style call light hanging off the right side of his bed, out of reach.

In an interview on 5/16/23 at 9:47 a.m., "Director of Nursing" (DON) "B" reported Resident #32 has a history of falls at the facility. DON "B" reported Resident #32 is able to understand the need for and utilize his call light for assistance.

Resident #39

Review of Resident #39's "Admission Record" revealed Resident #39, was originally admitted to the facility on 3/3/2023 with pertinent diagnoses which included: dysphagia (difficulty swallowing), cognitive communication deficit, muscle weakness, repeated falls, and difficulty in walking.

Review of a "Minimum Data Set" (MDS) assessment for Resident #39, with a reference date of 3/9/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 6/15 which indicated Resident #39 was severely cognitively impaired.

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In an observation on 5/09/23 at 9:20 AM, Resident #39 was observed lying on his back in bed. Resident #39's call light was observed hanging on the floor underneath the bed and out of reach.

During an interview on 5/09/23 at 12:28 PM, Family Member (FM) "YYY" reported that Resident #39's call light is frequently observed on the floor and out of reach.

In an observation on 5/10/23 at 09:05 AM, Resident #39 was observed lying in bed on his back. Resident #39's call light was on the floor under the bed and out of reach. Resident #39 reported that he needed to be cleaned up and had been waiting for 1.5 hours for someone to come in and check on him.

During an interview on 5/9/23 at 9:10 AM, Registered Nurse (RN) "XX" reported that Resident #39 does use his call light when he needs help.

In an observation on 5/15/23 at 09:01 AM, Resident #39 was observed lying in bed on his back. Resident #39's call light was clipped to his bed, but hanging down towards the floor out of reach.

In an observation on 5/16/23 at 09:54 AM, Resident #39's roommate, Resident #47 was observed yelling out for staff assistance in the hallway outside of Resident #39's room. Resident #47 reported there was a man on the floor. Resident #39 was observed kneeling on the floor next to his bed, using his arms to hold onto his bed. The call light was observed lying on the ground under Resident #39's bed. Resident #39 stated loudly, "My knees are killing me. I have been waiting 45 minutes for someone to come help me." Regional Clinical Care Coordinator

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(RCCC) " M", Licensed Practical Nurse (LPN-UM) Unit Manager "O" and RN "E" entered Resident #39's room and assisted Resident #39 back to bed using a hoyer lift (assistive device used to transfer residents).Resident #39 reported he was trying to get out of bed. LPN-UM "O" clipped Resident #39's call light to his bed near his right shoulder and then LPN-UM "O" and RN "XX" left the room.

During an interview on 5/16/23 at 11:00 AM, Resident #39 asked this surveyor for assistance in finding his call light. Resident #39 was unable to see or grab his call light which was clipped to his bed near his right shoulder. RN "XX" entered Resident #39's room and confirmed that Resident #39 could not reach the call light.

During an interview on 5/16/23 at 10:25 AM, Certified Nursing Assistant (CNA) " BBB" reported that Resident #39 had been telling staff all morning that he wanted to go home, and he was attempting to get out bed earlier to go home. CNA "BBB" reported that the last time she checked on Resident #39 was around 9:00 AM, and she had helped place his legs back in his bed and told him to stay in bed. CNA "BBB" reported she did not know if Resident #39's call light had a clip to prevent the call light from falling to the floor.

During an interview on 5/16/23 at 10:59 AM, Resident #47 reported that he had observed Resident #39 attempting to get out of bed earlier in the morning and that staff assisted Resident #39 back into bed. Resident #47 reported that he heard Resident #39 asking for help and saying he was on the floor. Resident #47 reported he checked on Resident #39 and witnessed him on the floor and immediately went into the hallway to yell for help. Review of Resident #47 Brief Interview for Mental Status" (BIMS) score

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	revealed a score of of 15/15 which indicated Resident #47 was cognitively intact. Review of Resident #39's "Care Plan" revealed, "... At risk for falls related to deconditioning. Date initiated 3/3/2023. Goal: The resident will be free of falls. Interventions: ...Anticipate resident's needs based on nursing assessments. Date initiated 3/6/2023. Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed. Dated initiated 3/3/2023..." Review of the policy/procedure "Call Lights: Accessibility and Timely Response", dated 1/1/22, revealed "...The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance...All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light...All residents will be educated on how to call for help by using the resident call system...Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system..."			
F0561 SS= D	Self-Determinatio §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and	F0561		

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	other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to honor resident choice in regard to activities and schedules that are significant to the resident in 2 of 5 residents (Resident #19 & Resident #33) reviewed for choices, resulting in dissatisfaction with care provided and the potential for frustration. Findings include: Review of the policy/procedure "Resident Rights", dated 1/1/22, revealed "...Employees shall treat all residents with kindness, respect, and dignity...Residents are entitled to exercise their rights and privileges to the fullest extent possible...Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity..." Resident #19 Review of an "Admission Record" revealed Resident #19 was a female, with pertinent diagnoses which included heart failure,			

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obstructive lung disease, heart disease, kidney disease, diabetes, depression, arthritis, muscle weakness, and reduced mobility.

Review of a "Minimum Data Set" (MDS) assessment for Resident #19, with a reference date of 2/19/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. Further review of this MDS assessment, with a reference date of 2/19/23, revealed Resident #19 was totally dependent on staff for bathing.

In an interview on 5/10/23 at 9:49 a.m., Resident #19 reported her showers are scheduled on second shift on Monday and Friday. Resident #19 reported second shift "Certified Nursing Assistants" (CNA's) often wait until everyone else is in bed before offering her shower. Resident #19 reported at times she wouldn't get her shower until 9:30 p.m. to 10:00 p.m. at night. Resident #19 reported her showers are scheduled the day before her dialysis appointments, and stated she would "...prefer to not be up that late..." Resident #19 reported she would like her scheduled shower sometime between lunch and dinner, and does not want a late night shower.

Resident #33

Review of an "Admission Record" revealed Resident #33 was originally admitted to the facility on 12/1/22.

Review of a Quarterly "Minimum Data Set" (MDS) assessment for Resident #33, with a reference date of 3/9/23 revealed Section F "Preferences for Customary Routine and Activities" was not included on the assessment.

During an observation and interview on 05/18/23

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	at 07:53 AM in the main dining room Resident #33 ambulating himself into the dining room in his wheelchair. Dietary Aide (DA) "TT" told Resident #33 that he could not have a cup of coffee and continued passing prepping meal trays and passing breakfast to other residents. In an interview on 05/18/23 at 7:58 AM, Resident #33 reported that he was waiting for his coffee and that he liked to have coffee first thing in the morning. In an interview on 05/18/23 at 8:01 AM, DA "TT" reported that Resident #33 could not have a cup of coffee, that he had to wait for his tray to go to his hall and stated, "...he is on fluid restriction and he will just drink and drink if I give it to him..." In a follow up interview on 05/18/23 at 3:30 PM, DA "TT" reported that she could have offerred Resident #33 a cup of coffee to drink in the dining room instead of waiting for his trays to go to his room. DA "TT" reported that she had been informed by the nurse that Resident #33 is not on a strict fluid restriction. Review of Resident #33 "Physician Orders" revealed, "Regular diet, Regular texture, Regular fluid, thin consistency. If Diet Type is Other: (SPECIFY Diet) Fluid Restriction: YES...2,000 mls/24hours for CHF. Active 2/4/2023."			
F0580 SS= D	Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F0580		

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	mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00133629. Based on interview and record review, the facility failed to inform the resident's physician and			

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	family/guardian of a change in condition for 2 of 2 residents (Resident #331 and #44) reviewed for notifications, resulting in the physician and family/guardian not being notified of resident change in condition and the potential for delayed medical intervention and care. Findings include: Resident #331 Review of an "Admission Record" revealed Resident #331 admitted to the facility on 9/2/2016 with pertinent diagnoses which included Alzheimer's Disease, cognitive communication deficit, and bipolar disorder. Review of a "Minimum Data Set" (MDS) assessment for Resident #331, with a reference date of 3/3/2023 revealed a "Staff Assessment for Mental Status" score of 3, which indicated Resident #331 was severely cognitively impaired. Review of a current dementia and anxiety "Care Plan" intervention for Resident #331, initiated 8/27/2018, directing staff to observe Resident #331 for symptoms of an acute physical/psychiatric condition and notify the medical provider as indicated. Further review revealed a current altered cardiovascular status "Care Plan" intervention, initiated 1/27/2023, directing staff to monitor, document, and report to the medical provider as needed any symptoms of coronary artery disease including shortness of breath. In an interview on 5/11/2023 at 8:46 AM, CNA "C" reported the morning before Resident #331 went to the hospital he noticed she was hardly talking, was breathing different, and she was gasping for breath. CNA "C" stated "she (Resident #331) just seemed really different."			

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	CNA "C" reported he notified the nurse of Resident #331's change in condition. In an interview on 5/10/2023 at 2:19 PM, RN "QQ" reported he was Resident #331's nurse the day that she was sent to the hospital and the prior day. RN "QQ" reported he was notified by CNA "C" that Resident #331 was not acting like herself the day before she was transferred to the hospital. RN "QQ" reported Resident #331 was lethargic, not yelling out like she normally would, and was slumped over in her chair more than normal In an interview on 5/10/2023 at 2:48 PM, RN "QQ" reported he did not notify the medical provider or family of Resident #331's change of condition when he was first aware the day prior to her hospitalization. RN "QQ" reported he did not notify the medical provider of the change in condition until the following day when Family Member of Resident #331 "GGG" requested she be sent to the local emergency department. In an interview on 5/15/2023 at 8:35 AM, Medical Doctor "RRR" reported he expects to be contacted by nursing staff for new open wounds, fevers, abnormal vital signs, patient complaints, new admissions, history and physicals, discharges, and changes in resident condition. Review of facility policy/procedure "Notification of Changes", reviewed 1/1/2022, revealed " ...The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification ... Circumstances requiring notification include: Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: life-threatening			

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	conditions, or clinical complications ... Circumstances that require a need to alter treatment ..." Resident #44: Review of an "Admission Record" revealed Resident #44 was a female with pertinent diagnoses which included kidney disease, arthritis, anemia, GERD, cognitive communication deficit, history of falling, heart failure, chronic embolism (piece of the blood clot becomes stuck in a blood vessel) and thrombosis (blood clot develops in the vein) of the femoral vein both legs, cardiac murmur, enlarged heart, nephrotic syndrome (damage to blood vessels in kidneys, excrete too much protein in the urine), low blood sugar, metabolic encephalopathy (caused by chemical imbalance in the blood affecting the brain) and immunodeficiency (the immune system was unable to mount an adequate immune response). Review of a "Minimum Data Set" (MDS) assessment for Resident #44, with a reference date of 4/12/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 10 out of 15 which indicated Resident #44 was moderately cognitively impaired. Review of current "Care Plan" for Resident #44, revised on 4/26/23, revealed the focus, " ...Self-determination related to advanced directive full code status ..." with the interventions " ...Implement resident decisions ..." Review of "Orders" for Resident #44 revealed, " ...Full Resuscitate ...Active ...Dated: 4/30/23 ..." Review of "Do Not Resuscitate" (DNR) document in the purple code status book at the nurse's station on 05/17/23 at 4:27 PM, revealed			

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the document had not been signed by the provider. The DNR had been signed by Resident #44 and two staff members on 5/3/2023.

In an interview on 05/18/23 at 11:06 AM, MDS Coordinator "U" reported the facility changed providers at the end of March/April and with the new providers the facility would fax over the document to the provider for signature.

In an interview on 05/18/23 at 11:12 AM, Licensed Practical Nurse (LPN) "X" reported the document would be scanned and sent to the provider via the printer/scanner which had a saved email for the DNR to be sent to the provider for their review and signature. During an observation on 05/18/23 at 11:13 AM, the wall by the printer/scanner also had the emails listed for certain documents to be sent to certain emails. This writer observed the email for DNRs to be sent to for review.

In an interview on 05/18/23 at 11:18 AM, Registered Nurse (RN) "E" reported they would obtain the required signatures for completion and the document would be placed in the physician's bin at the nurse's station for their review and signature. RN "E" reported once signed by the provider, it was recorded in the medical record and then scanned in.

In an interview on 05/18/23 at 11:18 AM, LPN "VVV" reported if the provider was in the building the staff would have the provider review and sign, if not, it would be faxed over to the provider for review. LPN "VVV" reported they would follow up with the provider to ensure the document was completed and "it doesn't get lost." LPN "VVV" reported if the change was a no code to a full code they would be able to change the code status right away but if it was a change to a DNR, the facility would contact the doctor right a

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	way for that change. In an interview on 05/18/23 at 11:25 AM, Nursing Home Administrator (NHA) "A" reported the nurses would fax over the completed DNR for physician signature to the designated email address for the provider for review and signature. The staff once the document has been faxed over would save the fax cover sheets for proof of the document being faxed to the provider. Note: Review of Resident #44s record showed no designation to a DNR nor any scanned documents in the document section in the record.			
F0584 SS= D	Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a	F0584		

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temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

This cite pertains to intake MI00134949.

Based on observation, interview, and record review the facility failed to maintain an environment with comfortable sound levels for 1 of 24 residents (Resident #22) reviewed for noice levels, resulting in the loss of a comfortable home like environment affecting the resident's quality of life.

Findings include:

Review of an "Admission Record" revealed Resident #22 was a female with pertinent diagnoses which included fractured left acetabulum (hip fracture), cancer, anemia, high blood pressure, GERD, kidney disease, arthritis, stroke, and difficulty walking.

Review of a "Minimum Data Set" (MDS) assessment for Resident #22, with a reference date of 3/22/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 14 out of 15 which indicated Resident #22 was cognitively intact.

In an interview on 05/09/23 at 09:14 AM, Resident #22 reported the call light alert buzzer on the wall outside of her room was very annoying. Resident #22 reported it beeps all day and night, it was "very irritating and like Chinese water torture." Resident #22 reported the only time she gets any peace from the noise was when she was asleep, the beeping was an alert for staff that a call light was activated. Resident #22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

reported the service hallway entrance was across the hall and she would hear the alarm for the door going off because staff did not enter the code or entered incorrectly and entered the hallway. Resident #22 reported the TV across the hallway was very loud well after 10:00 PM sometimes all night long. Resident #22 reported the staff on the night shift were so loud in the hallways and the nurse's station and this was when residents were trying to sleep. Resident #22 reported she was interested in moving facilities and discussed this with the social worker. Resident #22 reported she had lived by herself for many years and any noise made in the house was by her and she had a hard time with all the noise all day and night.

This writer attempted to follow up with the Social Worker in regard to her discussion with the resident, but she was no longer employed at the facility.

In an interview on 05/15/23 at 2:40 PM, Resident #22 reported she does try to shut the door to her room but then there was no air circulation and with the temperature rising she would need to leave her door open due to the temperature in the room rises and would need to pull in the air conditioning from the hallway.

This writer had multiple observations of the call light alert system beeping during the duration of the survey 5/8/23 to 5/18/23. This alert system was on the wall outside the room opposite of where the resident's bed was located. The call light alert system has a standard beep with a hesitation and a fast beep for when a resident was in the restroom and needed assistance. The call light alert system was placed on all halls located by the soiled utility room, and it alerted for all call lights activated in the building.

In an interview on 05/09/23 at 09:49 AM,

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	Certified Nursing Assistant (CNA) "BBB" reported the call light system had an alert on each hallway located by the soiled utility rooms and the alert would sound when any call light in the building was activated.			
F0585 SS= E	Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the	F0585		

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	right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision			

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	was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: In a confidential group Resident meeting held on 5/11/23 at 2:30pm, 8 of 13 Residents in attendance reported the facility had not made prompt efforts to resolve their grievances. These 8 Residents reported a lack of follow up on proposed steps toward resolution of grievances which caused them to feel as though their concerns were not important to the Grievance Officer. The Residents also voiced frustration that they often never saw the grievance form again after submitting it, and were not given the opportunity to sign the form to indicate if they were in agreement with the resolution efforts. This citation pertains to Intake # MI00130764 #MI00134506, #MI00131068 #MI00131761, & #MI00134949. Based on interview and record review, the facility failed to provide and document evidence of prompt resolution of grievances in 3 residents (Resident #430, #39 & #62) and 8 residents from a confidential interview from a total of 11 residents reviewed for resolution of grievances, resulting in unresolved grievances and the			

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potential to experience frustration, apprehension, helplessness, and a negative psychosocial outcome for the residents impacting their quality of life.

Findings include:

Resident #430

Review of an "Admission Record" revealed Resident #430, was originally admitted to the facility on 8/28/2022 with pertinent diagnoses which included: difficulty in walking and type 2 diabetes.

During an interview on 5/09/23 at 01:25 PM, Family Member (FM) "AAAA" reported that Resident #430 was admitted to the facility on 8/28/2022 with a purse that was placed in a larger beach bag which was then placed in Resident #430's closet. FM "AAAA" reported that she remembered the purse was in the closet because on 8/30/22 she had gotten into the purse to obtain Tylenol for Resident #430 and placed the purse back in the closet. On 09/1/2022, FM "AAAA" noticed the purse was missing from Resident #430's closet. FM "AAAA" reported that she immediately informed the former NHA (NHA "GGGG") about the missing items, but did not feel like NHA "GGGG" was taking appropriate action, so she called the police. FM "AAAA" reported that the responding police officer talked to Resident #430 and reported that they would be reviewing the facility tapes. FM "AAAA" reported that she did not hear back from NHA "GGGG" regarding the missing items, and the missing contents of the purse were not replaced. FM "AAAA" reported that missing contents form the purse included a visa card, insurance and state ID card, prescription sunglasses, medical alert bracelet, and $194. FM "AAAA " reported that NHA "GGGG" did not reach out to her after

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9/1/2022, but did call another family member to let that family member know that he (NHA "GGGG") did not think the purse was ever in the facility. FM "AAAA" reported that facility staff did not complete an inventory list with Resident #430 upon admission.

Review of Resident #430's "Quality Assurance form" dated 9/1/22 revealed, "...bra inserts were ruined in wash. 9/1 Purse missing from cabinet...Findings: Laundry washed inserts in the wash. Plan/Actions: Will replace inserts... Resolution: No...Inserts will be replaced. Purse was reported missing to the State of Michigan. Reporter Satisfied: No...(FM "AAAA") wants contents of purse replaced..." Receipts attached to form revealed 1 mastectomy insert and 1 medical alert bracelet was replaced by facility.

Review of Resident #430's "Inventory List" dated 9/1/22 did not include Resident #430's purse and was not signed by Resident #430. This form was completed after Resident #430's purse was reported missing.

During an interview on 5/15/23 at 03:09 PM, NHA "A" reported that the investigation was completed by the former NHA "GGGG" and was unable to explain why the inventory sheet was not completed for Resident #430 until after the purse was reported missing, was unsure if the concern was ever resolved, and/or if any of the contents of the purse were replaced.

Resident #39

Review of Resident #39's "Admission Record" revealed Resident #39, was originally admitted to the facility on 3/3/2023 with pertinent diagnoses which included: dysphagia (difficulty swallowing), cognitive communication deficit, muscle weakness, repeated falls, and difficulty in

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	walking. Review of a "Minimum Data Set" (MDS) assessment for Resident #39, with a reference date of 3/9/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 6/15 which indicated Resident #39 was severely cognitively impaired. During an interview on 5/17/2023 at 2:20 PM, Family Member (FM) "YYY" reported that Resident #39 had several clothing items missing from his room which included two turtle neck shirts, one green shirt, one pair of bermuda shorts, and a pair of sweat pants. FM "YYY" reported that they had spoken with Assistant Housekeeping Manager "AA" two days ago and was told they would look for the clothes. FM "YYY" reported that they were not offered any forms to complete regarding the missing items. Review of Resident #39's "Grievance/Missing items Forms" revealed no forms related to the missing items mentioned above. During an interview on 5/17/23 at 02:56 PM, Assistant Housekeeping Manager (AHM) "AA" reported that she had received a list of missing items from FM "YYY" the day before, and that she would try to find the items. Assistant Housekeeping Manager "AA" reported that she did not complete a quality assurance form because it was facility process to try to find the missing items first and if they were not found after a few days, a quality assurance form would be completed and given to the administrator. Assistant Housekeeping Manager "AA" reported that she had not had a chance to look for the missing items yet. Assistant Housekeeping Manager "AA" also reported that Resident #39's family does his laundry, so his clothing items would not be labeled, which made it more			

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	complicated to look for. Assistant Housekeeping Manager "AA" reported that there was not a set amount of days to search for missing items before completing a form, but that it was just something she kept track of herself. AHM "AA" reported that Resident #39 should have an inventory list in the scanned documents section of the medical record. Review of Resident #39's "Scanned Documents" revealed no admission inventory list. In an email on 5/17/23 at 4:39 PM, Corporate Temporary NHA reported that she was unable to provide an inventory list for Resident #39. Resident #39's inventory list was not received prior to exit. Resident #62: Review of an "Admission Record" revealed Resident #62 was a female with pertinent diagnoses which included end stage heart failure, diabetes, COPD, high blood pressure, atrial fibrillation (an irregular, often rapid heart rate), depression, anxiety, and anemia. Review of a "Minimum Data Set" (MDS) assessment for Resident #62, with a reference date of 1/9/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15 which indicated Resident #62 was cognitively intact. In an interview on 05/18/23 at 11:20 AM, LPN "VVV" reported they would try to address the complaint immediately, if they were able to. LPN "VVV" reported the complaint form would be completed and submitted to the administrator. LPN "VVV" reported when she returned to work after being off, she would follow up with the resident to see if the grievance was resolved.			

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	In an interview on 05/17/23 at 02:06 PM, CNA "C" reported they would take the concern to the nurse, let them know of the concern, and allow them to handle the concern for the resident. In an interview on 05/15/23 09:13 AM, Resident #62 reported she submitted a grievance form because she had concerns with not getting her bedding changed, staff care, not receiving water for over 12 hours, not receiving an alternative meal when requested, and being threatened with discharge due to her hospice provider. Review of the "Quality Assurance Form" submitted on 1/31/23 revealed, no signature from Resident #62 agreeing to the resolution. Further review revealed Resident #62's concerns for not getting her bedding changed, staff care, not receiving water for over 12 hours, not receiving an alternative meal when requested, and her missing items were not reviewed or resolved by the grievance officer. Review of the "Quality Assurance Form" submitted on 1/31/23 by Resident #62 revealed, no signature by Resident #62 on the document which indicated she was in agreement with any possible solution. Though no possible resolutions were documented for not getting her bedding changed, staff care, not receiving water for over 12 hours, and not receiving an alternative meal when requested. In an interview on 05/16/23 at 11:28 AM, Confidential Informant "NNN" reported many grievance forms turned in to the grievance officer were missing or did not come back to the resident. Confidential Informant "NNN" reported many residents had expressed their concerns/grievances have gone unheard or had no follow through or had been addressed.			

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	In an interview on 05/15/23 09:13 AM, Resident #62 reported the grievance officer never came and talked to her about her grievance form submitted on 1/31/23. In an interview on 05/18/23 11:53 AM, MDS Coordinator "U" wet and soiled she would bring it to the DON's office for them to address with the staff who were on shift or whatever was relevant towards the wet and soiled, she would complete a concern form for the resident who brought it to her attention. In an interview on 05/17/23 at 02:43 PM, Corporate Temporary NHA "WWW" reported when a staff member was informed of a concern or grievance, the staff member would obtain a quality assistance form and complete the form with the resident, if needed. Corporate Temporary NHA "WWW" reported the form would be given to the grievance coordinator to follow up on the concern/grievance. Corporate Temporary NHA "WWW" reported the grievance coordinator would assign the appropriate department to address the concern/grievance, once completed the form returns to the grievance coordinator and if it was not resolved to follow up with the resident and take the steps necessary to address the concern/grievance. Corporate Temporary NHA "WWW" reported the quality assistance form should be signed by the resident/representative to ensure the resolution was satisfactory to the resident. Corporate Temporary NHA "WWW" stated, "...I follow up with every single grievance and if it wasn't resolved I would go and have a conversation with the resident to see how we could come to a solution..."			
F0600 SS= D	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be	F0600		

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	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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: This citation pertain intake MI00131068 Based on interview and record review, the facility failed to provide an environment free from verbal abuse for 1 (Resident #18) of 3 residents reviewed for abuse, resulting in the resident exposed to profanity, angriness and irritableness creating a hostile environment, and presenting themselves in an unprofessional manner. Findings include: Review of an "Admission Record" revealed Resident #18 was a male with pertinent diagnoses which included paraplegia, stroke, neuropathy (numbness, weakness, and pain in hands and feet form nerve damage), diabetes, contracture (tightening of the tendon) of right hand, muscle weakness, osteoarthritis, and blood clotting disorder. Review of a "Minimum Data Set" (MDS) assessment for Resident #18, with a reference date of 12/26/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15 which indicated Resident #18 was cognitively intact.			

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In an interview on 05/16/23 at 04:18 PM, Resident #18 reported Licensed Practical Nurse (LPN) "X" was in his room performing care on him with another nurse. Resident #18 reported the staff member was using profanity, complaining about having to work as a CNA that shift. Resident #18 looked at the other nurse and gave her a hush like signal moving his finger to his mouth and shaking his head so she would not say anything. Resident #18 did not want LPN "X" to react in an explosive manner as she was already using profanity and expressing her dissatisfaction with her assignment for the day. Resident #18 stated, her behavior and using inappropriate language was not professional and should not have been conducted in front of residents.

In an interview on 05/09/23 at 09:40 PM, Registered Nurse (RN) "E" reported the facility was not very good at holding staff accountable and proceeded to inform this writer of an incident involving LPN "X" who had reported for her shift and was using profanity in the common area in front of residents saying, "F*** this place, F*** this" (she was assigned to work as a CNA this shift as the facility was short of staff). RN "E" reported while LPN "X" was in a resident's room providing care to the resident with another staff member, she was using disparaging language about having to be a CNA, yelling, using profanity in the room. RN "E" reported she finished her task with the one resident and went into another resident's room and proceeded to yell at CNA "OO" who was providing care to a resident. RN "E" reported she proceeded escort LPN "X" out of the building and completed a write up. RN "E" reported she was told by DON "B" she was being too touchy and harsh to write up LPN "X" and the write up was disposed of for LPN "X."

Review of full employee file of LPN "X" revealed

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	no verbal or written write ups in her record. In an interview on 05/15/23 at 03:04 PM, LPN "J" and LPN "S" both reported LPN "X" had on numerous occasions come into the building using profanity and yelling and residents were able to hear her. LPN "J" and LPN "S" both reported LPN "X" had been walked out of the facility "more than once." In an interview on 05/16/23 at 09:03 AM, Resident #16 reported LPN "X" was swearing in the common area in front of other residents. Resident #16 stated, "Sometimes she loses her cool." In an interview on 05/16/23 at 09:34 AM, RN "E" reported CNA "OO" was crying and it was a "big thing." In an interview on 05/16/23 at 11:21 AM, Social Services Director (SSD) "F" reported LPN "X made an inappropriate comment in regards to a resident who had choked on brussel sprouts and was very inappropriate with the profanity she used frequently in front of residents and while taking care of residents. In an interview on 5/16/23 at 1:52 PM, RN "R" reported while working with LPN "X" in Resident #18's room providing care to him. LPN "X" was using profanity, derogatory language about having to work as a CNA. RN "R" reported she was just trying to get the resident cleaned up so she could leave the room. RN "R" reported she saw LPN "X" entered the room with CNA. RN "R" reported the CNA had left the room crying, left the floor for approximately 30 minutes. RN "R" reported she asked the charge nurse to go find the CNA and find out what exactly happened in the room.			

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	In an interview on 5/17/23 at 8:59 AM, CNA "OO" reported LPN "X" had to work as a CNA that day and the language she was using "was ridiculous" and she was using profanity at the nurse's station. CNA "OO" reported she told LPN "X" she would go and provide care to this specific resident who was very particular about who provided care to her. LPN "X" came into the room when I was providing care. CNA "OO" reported she was not going to be threatened, talked down to. CNA "OO" reported LPN "X"'s behavior was affecting everyone at the facility, residents included by her yelling, using profanity, and made residents uncomfortable with her unprofessional behavior. In an interview on 05/17/23 at 11:30 AM, CNA "SSS" reported verbal abuse would be reported to the nurse and then would go and talk with the Administrator. In an interview on 05/17/23 at 01:39 PM, Human Resources "L" reported they typically would receive a paper form which documents the infraction from the DON or the Administrator with instructions indicating the write up be placed in the employee file. HR "L" reviewed the employee file and there were no write ups in the file. HR "L" reviewed a basket of papers which needed to be filed and there was no write up in their as well. HR "L" reported if there were intrusive behaviors in front of a resident, directing aggression in the common area it should be reported. The write ups typically start with the DON and the Administrator. In an interview on 05/18/23 11:22 AM, LPN "VVV" reported if a staff member swore, cussed, and made unprofessional comments about the facility in front of a resident and while providing care to a resident this was "not fair to the resident, and they deserve the respect not to hear that."			

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	In an interview on 05/17/23 at 02:43 PM, Corporate Temporary NHA "WWW" reported if the concern brought to them was an allegation of verbal abuse this would be reported to the state licensing authority within the two hour time frame. Review of "Abuse Education Report" submitted on 5/18/23, revealed, LPN "X" did not complete the required annual training; "Recognizing, Reporting, and Preventing Abuse" and "Understanding Abuse and Neglect." Review of policy, "Abuse Prevention Program" revised on 2/22/18, revealed, " ...Our residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment and involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptom. (Collectively, hereinafter "abuse") ...Abuse Identification, Training and Education: 3. Our abuse prevention/intervention education program includes, but is not necessarily limited to, the following: Monitoring staff on all shifts to identify inappropriate behaviors toward residents (e.g. using derogatory language, rough handling) ...Striving to maintain adequate staffing on all shifts to ensure that the needs of each resident are met ...Expect all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to facility management immediately ... 5. When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility Administrator, DON, or individuals designated will immediately (not to exceed 24 hours if the event does not result in serious bodily injury. NO LATER THAN 2 HOURS IF THE EVENT IS AN ALLEGATION OF ABUSE OR WHERE THERE IS SIGNIFICANT INJURY, OR NEGLECT WHERE THERE IS SERIOUS			

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	BODILY INJURY) notify the following persons or agencies of such incident: 1. The State licensing/certification agency responsible for surveying/licensing the facility; 2. The Resident's Representative (Sponsor) of Record; 3. The Resident's Attending Physician and/or the Medical Director; and 4. Any agencies as required by your state's laws (e.g. Adult Protective Services) ..."			
F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F0609		

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Based on interview and record review, the facility failed to immediately report allegations of abuse and neglect for 2 (Resident #18, and #382) of 3 residents reviewed for abuse and neglect, resulting in allegations of abuse that were not reported to the State Agency timely and the potential for further allegations of abuse and neglect to go unreported.

Findings include:

Resident #18:

In an interview on 05/16/23 at 04:18 PM, Resident #18 reported LPN "X" was in his room performing care on him with another nurse. Resident #18 reported the staff member was using profanity, complaining about having to work as a CNA that shift. Resident #18 looked at the other nurse and gave her a hush like signal moving his finger to his mouth and shaking his head so she would not say anything. Resident #18 did not want LPN "X" to react in an explosive manner as she was already using profanity and expressing her dissatisfaction with her assignment for the day. Resident #18 stated, her behavior and using inappropriate language was not professional and should not have been conducted in front of residents.

Review of Resident #18's incident reports revealed no reports.

Review of Resident #18's progress notes revealed no documentation of the incident occurring.

In an interview on 05/09/23 at 09:40 PM, Registered Nurse (RN) "E" reported the facility was not very good at holding staff accountable and proceeded to inform this writer of an incident involving LPN "X" who had reported for her shift

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	and was using profanity in the common area in front of residents saying, "F*** this place, F*** this" (she was assigned to work as a CNA this shift as the facility was short of staff). RN "E" reported while LPN "X" was in a resident's room providing care to the resident with another staff member, she was using disparaging language about having to be a CNA, yelling, using profanity in the room. RN "E" reported she finished her task with the one resident and went into another resident's room and proceeded to yell at CNA "OO" who was providing care to a resident. RN "E" reported she proceeded escort LPN "X" out of the building and completed a write up. RN "E" reported she was told by DON "B" she was being too touchy and harsh to write up LPN "X" and the write up was disposed of for LPN "X." In an interview on 05/16/23 at 09:03 AM, Resident #16 reported LPN "X" was swearing in the common area in front of other residents. Resident #16 stated, "Sometimes she loses her cool." In an interview on 5/17/23 at 8:59 AM, CNA "OO" reported LPN "X" had to work as a CNA that day and the language she was using "was ridiculous" and she was using profanity at the nurse's station. CNA "OO" reported she told LPN "X" she would go and provide care to this specific resident who was very particular about who provided care to her. LPN "X" came into the room when I was providing care. CNA "OO" reported she was not going to be threatened, talked down to. CNA "OO" reported LPN "X"'s behavior was affecting everyone at the facility, residents included by her yelling, using profanity, and made residents uncomfortable with her unprofessional behavior. In an interview on 05/17/23 at 01:39 PM, Human			

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	Resources "L" reported they typically would receive a paper form which documents the infraction from the DON or the Administrator with instructions indicating the write up be placed in the employee file. HR "L" reviewed the employee file and there were no write ups in the file. HR "L" reviewed a basket of papers which needed to be filed and there was no write up in their as well. HR "L" reported if there were intrusive behaviors in front of a resident, directing aggression in the common area it should be reported. The write ups typically start with the DON and the Administrator. The Director of Nursing (DON) was unavailable for interview during the survey but had specific knowledge of this event. Review of facility reported incidents revealed no reported allegations of verbal abuse involving LPN "X." Resident #382 Review of an "Admissions Worksheet" for Resident #382, dated 4/28/23, revealed Advanced Directives: Full Code. In an interview on 5/17/23 at 2:31pm Confidential Informant "NNN" revealed that Resident #382's Cardiopulmonary Resuscitation was delayed as the result of staff not correctly identifying the Resident during a cardiac arrest. Confidential Informant "NNN" reported during a special training on 5/1/23 staff were made aware of the incident and were re-educated regarding Resident code status and responding to cardiac arrest. Review of Resident #382's incident reports revealed no reports.			

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Review of Resident #382's progress notes revealed no incidents.

In a telephone interview on 5/17/23 at 3:40pm, Certified Nursing Assistant (CENA) "MMM" reported 4/29/23 was the first time in which she had cared for Resident #382. CENA "MMM" reported that at 11:48pm on 4/28/23, CENA "MMM" saw a Resident (whom she believed to be Resident #61) lying face down on the bathroom floor with blood coming from her mouth. CENA "MMM" went to get a nurse, found Licensed Practical Nurse (LPN) "S" on A Hall, and they returned to Resident who was laying on bathroom the floor unresponsive. CENA "MMM" stated "we thought it (the Resident on the floor) was (Resident #61 who shared an adjoining bathroom with Resident #382) ... because Resident #382 was doing so well, we could not imagine it was her". As a result, CENA "MMM" and LPN "S" asked for the code status for Resident #61, rather than for Resident #382. CENA "MMM" stated "it was confusing because both Residents were new, they had names that sounded similar, and we didn't know them very well". CENA "MMM" reported that when the staff realized the Resident on the floor was Resident #382 and that her advanced directives were for a full code, Registered Nurse (RN) "LLL" began chest compressions. CENA "MMM" recalled hearing RN "LLL" call out "compressions initiated at 12:06am".

In a telephone interview on 5/17/23 at 3:58pm, Licensed Practical Nurse (LPN) "S" reported she was working on A hall on 4/29/23 at 11:50pm, when Certified Nursing Assistant "MMM" approached her for help with a resident who had fallen in the bathroom. LPN "S" reported she ran to a bathroom shared by two residents and found a resident lying on her left side, partially face down with no pulse. LPN "S" instructed CENA "MMM" to get the crash cart and LPN "S" ran to

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the hallway to a nearby phone to call a code. LPN "S" reported that Registered Nurse "LLL", the nurse responsible for Resident #382's hall, yelled from the nurse's station that the Resident down had a "do not resuscitate" (DNR) code status." As a result, LPN "S" did not initiate cardiopulmonary resuscitation. LPN "S" then called a Unit Manager on the telephone to report the death. During that conversation, the staff realized the Resident's name and room number did not match. The Unit Manager described Resident #61 and that description did not match the Resident who was on the floor. The staff realized the Resident on the floor, with no pulse, was Resident #382. LPN "S" reported several minutes had passed since Resident #382 had been found. Both LPN "S" and Registered Nurse (RN) "LLL" returned to the nurse's station to determine Resident #382's code status. Upon finding Resident #382 advanced directive status was for a full code, Registered Nurse (RN) "LLL" ran back to Resident #382 and began chest compressions.

In an interview on 5/18/23 at 7:44am, Registered Nurse (RN) "LLL" reported on 4/29/23 she was assigned to Resident #382's hall. RN "LLL" reported she had been off work for several days prior to that night and had not cared for Resident #61 or Resident #382 before. RN "LLL" also reported that because Residents frequently changed rooms, it was often difficult to know which room they were in. At 11:45pm, RN "LLL" was on another hall signing out a narcotic when she heard someone say they needed the crash cart. RN "LLL" pushed the crash cart toward the scene but stopped at the nurse's station when Licensed Practical Nurse (LPN) "S" asked for the code status of (Resident #61). RN "LLL" looked in Resident #61's paper chart, located the code status and yelled back that the Resident had a "Do Not Resuscitate (DNR) code status". RN "LLL" reported that the internet service was down that night so staff did not have access to the electronic

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	medical record and had to rely on the paper charts, which had limited information. RN "LLL" noticed that LPN "S" came from Resident #382's room, rather than from Resident #61's room, and RN "LLL" realized the Resident experiencing cardiac arrest was Resident #382. Both staff quickly returned to the nurse's station to review the code status for Resident #382. RN "LLL" then returned to Resident #382's room, 2 staff members positioned Resident #382 on her back and RN "LLL" began chest compressions. RN "LLL" confirmed the time was 12:06am when chest compressions began. Review of a "Prehospital Care Report Summary" provided by the responding Emergency Medical Services company, section titled "Cardiac Arrest Information" included the estimated time of arrest as: 23:42 (11:42pm), Time of First CPR: 00:06 (12:06am). Section titled "Additional Assessment Notes" revealed the following information: "Pt (patient) found at 23:48 face down in restroom. Staff stated initial discrepancy on DNR (Do Not Resuscitate) status and CPR (Cardiopulmonary Resuscitation) was not initiated until 0006. Staff initially did not have Pt hx (history) and demographics. Pt was pronounced dead in field by physician on scene." Review of policy, "Abuse Prevention Program" revised on 2/22/18, revealed, " ...Our residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment and involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptom. 5. When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility Administrator, DON, or individuals designated will immediately (not to exceed 24 hours if the event does not result in serious bodily injury. NO LATER THAN 2 HOURS IF THE EVENT IS			

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	AN ALLEGATION OF ABUSE OR WHERE THERE IS SIGNIFICANT INJURY, OR NEGLECT WHERE THERE IS SERIOUS BODILY INJURY) notify the following persons or agencies of such incident: 1. The State licensing/certification agency responsible for surveying/licensing the facility ..."			
F0610 SS= D	Investigate/Prevent/Correct Alleged Violatio §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to investigate an allegation of abuse for 1 (Resident #18) of 3 residents reviewed for abuse, resulting in an allegation of abuse not being identified and thoroughly investigated allowing for the potential for future mistreatment and/or abuse. Findings include: Review of an "Admission Record" revealed Resident #18 was a male with pertinent diagnoses which included paraplegia, stroke, neuropathy	F0610		

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(numbness, weakness, and pain in hands and feet form nerve damage), diabetes, contracture (tightening of the tendon) of right hand, muscle weakness, osteoarthritis, and blood clotting disorder.

Review of a "Minimum Data Set" (MDS) assessment for Resident #18, with a reference date of 12/26/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15 which indicated Resident #18 was cognitively intact.

In an interview on 05/16/23 at 04:18 PM, Resident #18 reported LPN "X" was in his room performing care on him with another nurse. Resident #18 reported the staff member was using profanity, complaining about having to work as a CNA that shift. Resident #18 looked at the other nurse and gave her a hush like signal moving his finger to his mouth and shaking his head so she would not say anything. Resident #18 did not want LPN "X" to react in an explosive manner as she was already using profanity and expressing her dissatisfaction with her assignment for the day. Resident #18 stated, her behavior and using inappropriate language was not professional and should not have been conducted in front of residents.

Review of Resident #18's incident reports revealed no reports.

Review of Resident #18's progress notes revealed no documentation of the incident occurring.

In an interview on 05/09/23 at 09:40 PM, Registered Nurse (RN) "E" reported the facility was not very good at holding staff accountable and proceeded to inform this writer of an incident involving LPN "X" who had reported for her shift and was using profanity in the common area in

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front of residents saying, "F*** this place, F*** this" (she was assigned to work as a CNA this shift as the facility was short of staff). RN "E" reported while LPN "X" was in a resident's room providing care to the resident with another staff member, she was using disparaging language about having to be a CNA, yelling, using profanity in the room. RN "E" reported she finished her task with the one resident and went into another resident's room and proceeded to yell at CNA "OO" who was providing care to a resident. RN "E" reported she proceeded escort LPN "X" out of the building and completed a write up. RN "E" reported she was told by DON "B" she was being too touchy and harsh to write up LPN "X" and the write up was disposed of for LPN "X."

Review of full employee file of Licensed Practical Nurse (LPN) "X" revealed no verbal or written write ups in her record.

In an interview on 5/16/23 at 1:52 PM, RN "R" reported while working with LPN "X" in Resident #18's room providing care to him. LPN "X" was using profanity, derogatory language about having to work as a CNA. RN "R" reported she was just trying to get the resident cleaned up so she could leave the room. RN "R" reported she saw LPN "X" entered the room with CNA. RN "R" reported the CNA had left the room crying, left the floor for approximately 30 minutes. RN "R" reported she asked the charge nurse to go find the CNA and find out what exactly happened in the room.

In an interview on 5/17/23 at 8:59 AM, CNA "OO" reported LPN "X" had to work as a CNA that day and the language she was using "was ridiculous" and she was using profanity at the nurse's station. CNA "OO" reported she told LPN "X" she would go and provide care to this specific

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	resident who was very particular about who provided care to her. LPN "X" came into the room when I was providing care. CNA "OO" reported she was not going to be threatened, talked down to. CNA "OO" reported LPN "X"'s behavior was affecting everyone at the facility, residents included by her yelling, using profanity, and made residents uncomfortable with her unprofessional behavior. The Director of Nursing (DON) was unavailable for interview during the survey and had specific knowledge of this event. Review of facility reported incidents revealed no reported allegations of verbal abuse involving LPN "X." No investigation was completed in regards to the allegations of verbal abuse. Review of policy, "Abuse Prevention Program" revised on 2/22/18, revealed, " ...Our residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment and involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptom. (Collectively, hereinafter "abuse") ...Abuse Identification, Training and Education: 3. Our abuse prevention/intervention education program includes, but is not necessarily limited to, the following: Monitoring staff on all shifts to identify inappropriate behaviors toward residents (e.g. using derogatory language, rough handling) ...Striving to maintain adequate staffing on all shifts to ensure that the needs of each resident are met ...Expect all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to facility management immediately ... "			
F0641 SS= D	Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment	F0641		

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	must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure complete and accurate "Minimum Data Set" (MDS) assessments were completed in 3 of 24 residents (Resident #33, #52 & Resident #71) reviewed for accuracy of assessments, resulting in the potential for inaccurate care plans and unmet care needs. Findings include: Review of the "MDS 3.0 RAI Manual v1.16, Chapter 1: Resident Assessment Instrument (RAI)", revealed "...an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations...It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment..." Resident #33 Review of an "Admission Record" revealed Resident #33 was originally admitted to the facility on 12/1/22. Review of an Admission "Minimum Data Set" (MDS) assessment for Resident #33, with a reference date of 12/7/22 revealed Section F "Preferences for Customary Routine and			

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	Activities" was included on the assessment, but was left blank. Review of a Modified "Minimum Data Set" (MDS) assessment for Resident #33, with a reference date of 12/7/22 revealed Section F "Preferences for Customary Routine and Activities" was included on the assessment, but was left blank. Review of a End of Part A Stay "Minimum Data Set" (MDS) assessment for Resident #33, with a reference date of 12/29/22 revealed Section F "Preferences for Customary Routine and Activities" was not included on the assessment at all. Review of a Quarterly "Minimum Data Set" (MDS) assessment for Resident #33, with a reference date of 3/9/23 revealed Section F "Preferences for Customary Routine and Activities" was not included on the assessment at all. Resident #52 Review of the current quarterly "Minimum Data Set" (MDS) assessment for Resident #52, with a reference date of 03/31/23 revealed that the "Brief Interview for Mental Status" (BIMS) was recorded as "not assessed." Resident #71 Review of an "Admission Record" revealed Resident #71 was originally admitted to the facility on 1/13/23, with pertinent diagnoses which included: cerebral infarction (stroke) and hemiplegia (paralysis) effecting right dominant side. Review of a "Minimum Data Set" (MDS)			

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	assessment for Resident #71, with a reference date of 4/21/23 revealed that Resident #71 had "0" falls prior to and since admission. Review of Resident #71's "Incident Reports" indicated falls on 1/15/23 at 1:25 PM and on 3/14/23 at 11:35 AM. The MDS assessment on 4/21/23 did not accurately reflect the resident's fall history. Review of Resident #71's "Fall Risk Evaluation" dated 5/3/23 indicated that over the past 90 days, Resident #71 had 1-2 falls, no change in cognition and was at low risk for falls. In an interview on 05/15/23 at 03:30 PM, Director of Nursing (DON) reported that Resident #71 was not able to safely ambulate when he admitted to the facility, and when he did try to walk he fell. In an interview on 05/18/23 at 02:12 PM, MDS Coordinator (MDS) "U" reported that the MDS assessments are a multidisciplinary effort, but ultimately MDS "U" is responsible to ensure completeness. MDS "U" reported that the Social Worker (SW) is supposed to complete the "BIMS" and the Activities Director completes the "Preferences for Customary Routine and Activities" section of the MDS assessment. MDS "U" reported that all residents should have these areas assessed quarterly and stated, "...I noticed that parts of the MDS were not being completed...I brought the concern to QAPI a few months ago...but it had not been addressed..."			
F0644 SS= D	Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent	F0644		

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	practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure an annual Level II evaluation was completed for 1 (Resident #16) of 3 residents reviewed for Preadmission Screening and Resident Review (PASARR Screening), resulting in the potential for unmet mental health and psychiatric care needs. Findings include: Review of Resident #16 "Admission Record" revealed Resident #16, was originally admitted to the facility on 4/28/2020 with pertinent diagnoses which included adjustment disorder with anxiety, psychotic disorder with delusions, major depressive disorder, post-traumatic stress disorder, and alzheimer disease with late onset. Review of a "Minimum Data Set" (MDS) assessment for Resident #16, with a reference date of 2/25/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #16 was cognitively intact. Review of Resident #16's "Preadmission Screening (PAS) Annual Resident Review			

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	(ARR)" dated 4/16/2022 indicated the following: Questions 1-4 in section II were marked "Yes": 1. Resident #16 had a current diagnosis of mental illness and dementia. 2. Resident #16 had received treatment for mental illness and dementia. 3. Resident #16 had routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days. 4. There is presenting evidence of mental illness or dementia, including significant disturbance in thought, conduct, emotions or judgement. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others. The instructions at the bottom of the page indicated that if any answers to items 1-6 in Section II were marked "YES" to send one copy to the local Community Mental Health Services program (CMHSP), with a copy of form DCH-3878 if an exemption is requested..." During an interview on 5/15/23 at 09:06 AM, Social Services Director (SSD) "F" reported that she was not responsible for completing Pre Admission Screening Annual Resident Review (PASARR) forms for residents. SSD "F" reported that Regional Social Worker (RSW) "AAA" was responsible for PASARR forms. During an interview on 5/10/23 at 12:50 PM, RSW "AAA" reported that she was aware that there was an outstanding PASARR for Resident #16. RSW "AAA" reported that the PASARR form completed for Resident #16 on 4/16/2022 was never signed by the physician so it could not be submitted. RSW "AAA" reported that the facility should have looked into it, but they did not have anyone in the facility that was responsible for reviewing and following up on the PASARR screenings, so it was missed.			

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	In an interview on 5/16/23 at 4:37 PM, NHA reported not having any additional information on Resident #16's PASARR level II screening.			
F0656 SS= D	Develop/Implement Comprehensive Care Pla §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized 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	F0656		

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	care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop a person centered, comprehensive care plan for 2 of 24 (Resident #49 and Resident #16) residents reviewed for care planning, resulting in the potential for re-traumatization, unmet care needs and inappropriate Resident care and services. Findings include: Resident #49 Review of an "Admission Record" for Resident #49, dated 3/14/23 revealed pertinent diagnoses which included: unspecified sequelae of cerebral infarction(residual effects of a stroke), left hemiplegia and hemiparesis (loss of movement and paralysis on left side of the body), diabetes mellitus(chronic metabolic disease characterized by elevated blood sugar levels), malignant neoplasm of the lung (cancer of the lung that may spread to other parts of the body), major depressive disorder, muscle weakness, lack of coordination, reduced mobility. Review of a Minimum Data Set (MDS) assessment for Resident #49 dated 2/24/23, section "G" "Functional Status" revealed Resident #49 required total assistance for bed mobility and transferring from one surface to another and required a wheelchair for mobility.			

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Review of a "Incident Report" for Resident #49 dated 3/13/23 at 10:40am revealed the Resident was being transported in the facility van while seated in his specialty wheelchair. The van turned a corner and the specialty wheelchair tipped to the left and landed on the floor of the van, resting on its side. Resident #49 remained in the specialty wheelchair, also resting on his life side. Resident was assessed for injuries, none apparent at that time.

In an interview on 5/9/23 at 10:22am Resident #49 reported having a fall in his specialty wheelchair during transport to a medical appointment. Resident #49 reported seeing the driver fasten the wheelchair to the floor and affixing a seatbelt across his body but when the van hit a curb, the chair tipped over and landed on its side. Resident #49 reported feeling emotional distress about possibly being required to use the specialty chair again for transport. Resident #49 reported he wanted to get fitted for dentures, was originally going to an appointment for that process on 3/13/23, arrived too late to be seen, but was fearful of trying to go again. Resident #49 reported having weakness in his torso and left side and stated "If I start to fall, I can't stop myself". "I was really scared that day (referring to the incident on 3/13/23)."

In an interview on 5/10/23 at 11:58am, Unit Manager, Registered Nurse (UM,RN)"P" reported he assessed Resident #49 in the facility parking lot on 3/13/23. Resident #49 was initially lying on his left side, encased in the wheelchair which was also lying on its side. UM, RN "P" reported Resident #49 had no visible injuries, voiced a desire to continue to his medical appointment so UM, RN "P" lifted the Resident and his wheelchair to into an upright position, Transportation Driver "Y" affixed the chair using the same four-point tie down system and the van

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left. UM, RN "P" reported the Interdisciplinary Team (IDT) later decided Resident #49 would only be transported via stretcher for subsequent medical appointments.

In an interview on 5/16/23 at 9:53am with Nursing Home Administrator "A", it was revealed that therapy staff determine when a Resident needs a specialty wheelchair and select the wheelchair that best meets the Resident's needs. The nursing staff develop a care plan outlining appropriate use of the chair and Resident's needs.

In an interview on 5/16/23 at 10:49am, Certified Nursing Assistant (CENA) "GG" reported she did not know Resident #49 well but would look at his care plan and Kardex to obtain any information about his care needs.

Review of Resident #49's care plan revealed no instructions regarding appropriate use of the specialty wheelchair or the Interdisciplinary Team's (IDT)recommendation to transport Resident #49 via stretcher.

Resident #16

Review of Resident #16 "Admission Record" revealed Resident #16, was originally admitted to the facility on 4/28/2020 with pertinent diagnoses which include: Post-Traumatic Stress Disorder.

Review of a "Minimum Data Set" (MDS) assessment for Resident #16, with a reference date of 2/25/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #16 was cognitively intact.

Review of Resident #16's "Admission Record" Revealed Resident #16 revealed a diagnosis of Chronic Post-Traumatic Stress Disorder (PTSD) with onset date of 3/3/2021.

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Review of Resident #16's "Care Plan" did not reveal any care plan goals and interventions related to Resident #16's PTSD diagnosis.

Review of Resident #16's "Social Services Progress Review Assessment" with reference date of 2/20/23 revealed, " ...Trauma Informed Care: 1. Does Resident have a diagnosis of Post-Traumatic Stress Disorder? Yes. 2. Are your PTSD symptoms being managed effectively? Yes. 3. What are your known triggers? War Memories... Social Services Intervention Status: Resident experiences fluctuations in his mood. Resident is being seen by (local Psych services provider) and has med changes..."

During an interview on 5/11/23 at 10:29 AM, Social Services Director (SSD) "F" reported that Resident #16's PTSD diagnosis is related to his military experience, however, the military experience had not been verified. SSD "F" reviewed Resident #16's care plan and reported that the care plan does not address PTSD diagnosis or Resident #16's reported triggers related to talking about the military.

Review of Resident #16's "Psychiatry Progress note" dated of 3/3/2021 revealed, "... Assessment and plan: PTSD: Mildly stable. Staff report this resident is trigger (sic) by anything that reminds him of his military service. Continue Behavioral Health Services..."

Review of Resident #16's "Psychiatry Progress note " dated 5/8/23 revealed, " ... Diagnosis, A/P (assessment and plan), & Billing and Plan: Post-Traumatic Stress Disorder, chronic. Appears stable. Continue SSRI (antidepressant medication) as ordered. Continue behavioral health services.

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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: This citation pertains to Intake # MI00130764, # MI00132304, & # MI00135661. Based on observation, interview, and record review, the facility failed to ensure showers/bed baths were provided per resident preference and plan of care in 8 of 13 residents (Resident #8, #32, #80, #48, #65, #49, #68, & #39) reviewed for "Activities of Daily Living" (ADL) care, resulting in the potential for dissatisfaction with care, hygiene concerns, skin irritation, and low self-esteem. Findings include: According to Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 50742-50744). Elsevier Health Sciences. Kindle Edition. "...Personal hygiene affects patients' comfort, safety, and well-being. Hygiene care includes cleaning and grooming activities that maintain personal body cleanliness and appearance. Personal hygiene activities such as taking a bath or shower and brushing and flossing the teeth also promote comfort and relaxation, foster a positive self-image, promote healthy skin, and help prevent infection and disease..." Review of the policy/procedure "Activities of Daily Living (ADLs)", dated 1/1/22, revealed	F0677		

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"...The facility will ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. This includes the resident's ability to...Bathe, dress, and groom...A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene..."

Resident #8

Review of a "Minimum Data Set" (MDS) assessment for Resident #8, with a reference date of 2/15/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. Further review of this MDS assessment, with a reference date of 2/15/23, revealed Resident #8 was totally dependent on staff for bathing.

In an interview on 5/9/23 at 9:18 a.m., Resident #8 reported when only one "Certified Nursing Assistant" (CNA) is working on the hall "...you can't get a shower. Who's going to watch the hall?" Resident #8 stated "...If you don't tell (the CNA) you want a shower they don't even ask..." Resident #8 reported even when she asks, often there are not enough staff at the facility to complete her shower. Resident #8 stated "...I had two weeks, almost three, without a shower recently..." Resident #8 reported she recently asked to have one of her shower days moved to Thursday, because the originally scheduled day (Friday) was always too short-staffed.

Review of a current "Care Plan" for Resident #8 revealed the focus "...The resident needs activities of daily living assistance..." initiated 5/8/19, with interventions which included "...BATHING/SHOWERING: The resident requires EAx1 (extensive assistance of one staff

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	member). Prefers showers Monday and Thursday morning..." revised 5/2/23. Review of Resident #8's shower/bathing documentation from 2/11/23 to 5/11/23 revealed a total of 13 missed showers/bed baths (no documentation), from a total of 25 scheduled opportunities. Resident #32 Review of a "Minimum Data Set" (MDS) assessment for Resident #32, with a reference date of 1/2/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 11, out of a total possible score of 15, which indicated moderate cognitive impairment. Further review of this MDS assessment, with a reference date of 1/2/23, revealed Resident #32 required extensive staff assistance for bathing. In an interview on 5/9/23 at 11:48 a.m., Resident #32 reported he has missed showers/bed baths while at the facility. Resident #32 unable to clarify time period for missed showers/bed baths. Review of a current "Care Plan" for Resident #32 revealed the focus "...The resident needs activities of daily living assistance..." initiated 8/5/22, with interventions which included "...BATHING/SHOWERING: The resident prefers showers tuesdays and Fridays Second..." initiated 10/28/22, and "...BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated..." initiated 12/15/22. Review of Resident #32's shower/bathing documentation from 2/12/23 to 5/11/23 revealed a total of 16 missed showers/bed baths (no documentation), from a total of 25 scheduled opportunities.			

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Resident #80

Review of a "Minimum Data Set" (MDS) assessment for Resident #80, with a reference date of 2/2/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 11, out of a total possible score of 15, which indicated moderate cognitive impairment. Further review of this MDS assessment, with a reference date of 2/2/23, revealed Resident #80 was totally dependent on staff for bathing.

In an interview on 5/10/23 at 4:30 p.m., "Family Member" (FM) "BBBB" reported while at the facility, Resident #80 went two weeks without a shower or bed bath. Family Member "BBBB" reported they could see Resident #80's dry/scaly skin via FaceTime. Family Member "BBBB" reported at times staff would do a bed bath instead of a shower because "...they (staff) don't want to use the dependent lift to get her up..." Family Member "BBBB" reported they attempted to contact "Director of Nursing" (DON) "B" multiple times about the missed showers and left messages, but the calls were never returned.

Review of a "Care Plan" for Resident #80 revealed the focus "...The resident needs activities of daily living assistance related to CVA (stroke)..." initiated 1/27/23, with interventions which included "...BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. shower schedule Monday and Thursday second shift..." and "...BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated..." both initiated 2/13/23.

Review of Resident #80's shower/bathing documentation from 1/27/23 to 2/24/23 revealed a total of 7 missed showers/bed baths (no documentation), from a total of 8 scheduled

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	opportunities. Review of Resident #80's shower/bathing documentation from 3/6/23 to 4/6/23 revealed a total of 4 missed showers/bed baths (no documentation), from a total of 6 scheduled opportunities. In an interview on 5/16/23 at 9:47 a.m., "Director of Nursing" (DON) "B" reported most residents are scheduled for/offered two showers per week unless they prefer otherwise. DON "B" reported missed showers/bed baths were identified as an area of concern around January/February 2023, and the shower schedule was revamped in an attempt to correct the issue. DON "B" reported many residents refuse showers/bed baths, however, this information is not captured in the documentation. DON "B" reported missed showers/bed baths are discussed daily in the morning meeting, and residents who missed a shower/bed bath should be offered one as soon as the missed care is identified. Resident #48: Review of a "Minimum Data Set" (MDS) assessment for Resident #48, with a reference date of 4/18/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15 which indicated Resident #48 was cognitively intact. Review of current "Care Plan" for Resident #48, revised on 7/10/2018, revealed the focus, " ...The resident needs activities of daily living assistance related to: Deconditioning , Impaired balance, right foot non weight bearing ..." with the intervention " ...BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse ...BATHING/SHOWERING: Provide sponge			

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	bath when a full bath or shower cannot be tolerated ...BATHING/SHOWERING: The resident prefers showers on Tuesday and Fridays on second shift ...TRANSFER: The resident requires limited assist by (1) staff to move between surfaces as necessary ..." Review of "MDS: Section G" assessment for Resident #48 dated 4/18/23, revealed, " ...Bathing: 3. Physical help in part of bathing activity ...One-person physical assist ...Surface to surface transfer ...Not steady, only able to stabilize with human assistance ..." In an interview on 05/08/23 at 02:46 PM, Resident # 48 last night it took the CNAs an hour to come get me out of the bathroom. Resident #48 reported she currently believes she has a yeast infection and needs some medication. Resident #48 reported she believed the yeast infection developed because she was a heavier woman, and she was not getting bathed as often as she should. Resident #48 reported she would like to get a shower every day but "understands that was not how it works here." Resident #48 reported she was "doing all she could to stop the fish smell" and she reported she was aware her hair was greasy and was ready to get another shower. When this writer queried the resident on when she received her last shower/bath she reported "last Monday" (5/1/23). Resident #48 reported therapy provided the bath to her then in the tub and they let her wash herself. Resident #48 reported her hair was so greasy it had to be washed 3 times to remove the greasiness from it. Resident #48 could not remember the last time she had her hair washed prior to 5/1/23. Resident #48 reported she was supposed to get a shower twice a week and when she gets a shower with the CNAs, they want her to "get in and get out." Resident #48 reported she feels very rushed by the staff.			

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	During an observation on 05/09/23 at 12:50 PM, Resident #48 was observed lying in her bed with greasy hair. Resident #48 reported she did not get a shower yesterday when working with occupational therapy assistant (OTA). During an observation on 05/10/23 10:58 AM, Resident #48 was observed lying in her bed with very greasy hair. In an interview on 05/15/23 at 02:39 PM, Resident #48 reported she had received a shower on Wednesday last week (5/10/23) and she hopes to get one tomorrow as she has an appointment on Wednesday (5/17/23) with her surgeon for her wound on her foot. Review of the "Shower Schedule" revealed, Resident #48 was to received showers on Mondays and Fridays. Review of "Task - Bathing" for Resident #48 revealed, From 4/10/23 to 5/10/23 there were 9 opportunities for staff to provide a shower to Resident #65 with only 3 showers provided. Review of "Progress Notes" for Resident #48 revealed, no documented refusals. Review of "Shower Sheets" for Resident #48 revealed, 1 shower sheet completed for the resident on 4/26/23. Resident #65: Review of a "Minimum Data Set" (MDS) assessment for Resident #65, with a reference date of 5/5/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 5 out of 15 which indicated Resident #65 was cognitively impaired. Review of current "Care Plan" for Resident #65,			

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	revised on 3/28/23, revealed the focus, " ...The resident needs activities of daily living assistance related to: traumatic brain injury and frequent falls ..." with the intervention " BATHING/SHOWERING: The resident prefers showers on Monday and Thursdays second shift ..." Review of "MDS: Section G" assessment for Resident #65 dated 11/2/22, revealed, " ...Bathing: 8. Activity itself did not occur during the entire period ...One-person physical assist ...Surface to surface transfer ...Not stead, only able to stabilize with human assistance ..." Review of "MDS: Section G" assessment for Resident #65 dated 2/2/23, revealed, " ...Bathing: 8. Activity itself did not occur during the entire period ...One-person physical assist ...Surface to surface transfer ...Not stead, only able to stabilize with human assistance ...Personal Hygiene: Limited assistance ...One-person physical assist ..." Review of the "Shower Schedule" revealed, Resident #65 was to received showers on Tuesdays and Fridays. Review of "Task - Bathing" for Resident # 65 revealed, From 4/17/23 to 5/17/23 there were 9 opportunities for staff to provide a shower to resident #65 with only 3 showers provided. During an observation on 5/9/23 at 2:37 PM, Resident #65 was observed after having had a shower. Resident #65 stated, "That feels great after months of not getting a shower." Review of "Shower Sheets" for Resident #65 revealed, no shower sheets completed for the resident.			

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	During an observation on 05/18/23 at 02:03 PM, Resident #65 appeared very unkempt, and her hair appeared very greasy and was uncombed. In an interview on 05/17/23 at 10:49 AM, Activity Aide (AA) "G" reported he stopped working as a CNA at the facility because there were numerous instances of him working alone on a hallway quite frequently. AA "G" reported when working alone and you have a whole hallway to yourself you don't have the time to complete the showers for the residents. In an interview on 05/17/23 at 11:30 AM, CNA "SSS" reported when she was on a hallway with only me, which happens a lot, have even been alone on the A hallway, the residents were not getting showers. CNA "SSS" stated, "I can't do it!" In an interview on 05/09/23 at 12:02 PM, Unit Manager (UM) "P" reported the shower sheet was completed with each shower that was given. In an interview on 05/09/23 at 04:56 PM, UM "P" reported for shower refusals the staff were to approach twice and ask the resident if they would like a shower. The CNA and the nurse would sign the shower sheet and note the refusal on the shower sheets and in the electronic medical record. Resident #49 Review of an "Admission Record" for Resident #49, dated 3/14/23 revealed pertinent diagnoses which included: unspecified sequelae of cerebral infarction(residual effects of a stroke), left hemiplegia and hemiparesis (loss of movement and paralysis on left side of the body), diabetes mellitus(chronic metabolic disease characterized by elevated blood sugar levels), malignant			

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neoplasm of the lung (cancer of the lung that may spread to other parts of the body), major depressive disorder, muscle weakness, lack of coordination, reduced mobility.

Review of a Minimum Data Set (MDS) assessment for Resident #49 dated 2/24/23 revealed a Brief Inventory for Mental Status (BIMS) score of 11 which indicated Resident #49 was cognitively impaired. Section "G" of the MDS labeled "Functional Status", revealed Resident #49 scored a "4" for personal hygiene and bathing which indicated he was totally dependent (full staff performance for completion of hygiene tasks).

Review of a care plan for Resident #49 dated 3/8/23 revealed a focus which stated: "The Resident needs activities of daily living assistance. Goal: The Resident will maintain current ability. Interventions: Provide sponge bath when full bath or shower cannot be tolerated, prefers bed baths on Tuesday, Friday, continue to offer showers.

Review of a bed bath and shower records for Resident #49 dated 4/15/23-5/15-23 revealed 2 bed baths were documented in a 30-day period. No showers were documented during that same period.

During an observation on 5/9/23 at 10:15am, Resident #49 lying in bed in a hospital gown, his hair was disheveled and appeared oily, fingernails were noted to extend beyond the tips of the fingers and a black substance coated the underside of several nails.

In an interview on 5/9/23 at 10:22am, Resident #49 voiced feelings of frustration and being uncared for regarding the condition of his fingernails. Resident #49 reported asking staff to

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clean and trim his fingernails, but the task had not been done regularly. Resident #49 reported worrying about the condition of his fingernails because he was feared he would develop a fungal infection.

During an observation on 5/15/23 at 2:33pm, Resident #49 was lying in bed, wearing a hospital gown. Resident #49's fingernails on both hands were longer than the fingertips, some had jagged edges and a black substance coated the underside of the nails.

In an interview on 5/15/23 at 2:43 pm, Certified Nursing Assistant (CENA) "VV" reported Resident #49's fingernails can only be trimmed by a nurse because of his diagnosis of diabetes. CENA "VV" reported if a resident needs their nails trimmed but they have diabetes, the CENA's will ask the nurse to complete the task.

Resident #68

Review of an "Admission Record" for Resident #68 dated 3/21/23 revealed pertinent diagnoses that included: Adult Failure to Thrive (state of decline that is multifactorial), cognitive communication deficit.

Review of a Minimum Data Set (MDS) assessment for Resident #68 dated 2/9/23 revealed a Brief Inventory for Mental Status (BIMS) score of 12 which indicated Resident #68 was cognitively impaired. Section "G" revealed bathing had not occured in the last seven days. Section "GG" labeled "Functional Abilities" revealed Resident #68 required substantial/maximal assistance with bathing and toilet hygiene.

Review of a care plan for Resident #68 dated 12/1/22 revealed focus/goal/interventions which

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stated "The Resident needs activities of daily living assistance related to activity intolerance, deconditioning ...Goal: manage decline, Interventions: showers on Wednesday and Sunday ...".

Review of Resident #68's shower records for 4/15/23-5/15/23 revealed only 2 showers had been offered and both were refused by Resident.

During on observation on 5/15/23 at 2:34pm, Resident #68 was sitting in his wheelchair in the dining room, hair appeared oily and disheveled, face unshaven with whiskers an 1/8 of an inch in length.

During on observation on 5/16/23 at 11:51am, Resident #68 was propelling his wheelchair around the nurse's station with hair that was disheveled and oily, several days of facial hair growth present and a strong smell of urine surrounded the resident.

During on observation on 5/17/23 at 10:16am, Resident #68 was dressed, lying on his bed with disheveled and oily hair, several days growth of facial hair was present, his fingernails were long, and a black substance coated the underside of several nails. A strong smell of urine was present, and Resident #68 was alone in the room.

Resident #39

Review of Resident #39's "Admission Record" revealed Resident #39, was originally admitted to the facility on 3/3/2023 with pertinent diagnoses which included: Dysphagia (difficulty swallowing), cognitive communication deficit, muscle weakness, repeated falls, and difficulty in walking.

Review of "Minimum Data Set" (MDS)

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	assessment for Resident #39, with a reference date of 3/9/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 6/15 which indicated Resident #39 was severely cognitively impaired. Review of Resident #39's " Care Plan" revealed, " Resident needs activities of daily living assistance related to: Dementia. Date initiated 3/3/2023. Goal: Resident will maintain current level of function by next review date. Date initiated 3/3/2023. Interventions: ... Bathing/Showering: Showers scheduled for Tues and Fri 2nd shift. Date initiated 3/3/2023. Oral Care Routine: (AM, PC, HS): Specify brush teeth, rinse dentures, clean gums with toothette, rinse mouth with wash. Date initiated 3/3/2023..." Review of Resident #39's "Orders" revealed, " Oral Care every shift and PRN (as needed) for NPO (Nothing by mouth diet). Order start date 3/3/2023." During an interview on 5/09/23 at 09:20 AM, Resident #39 reported he could not remember the last time he had a shower or bed bath. During an interview on 5/09/23 at 12:28 PM, Family Member (FM) "YYY" reported that Resident #39 was only getting one shower a week. FM "YYY" reported that they had arrived to visit Resident #39 around noon recently, and Resident #39 was still in the clothes that Resident #39 had been in the day before, was visibly soiled, and morning care had not been completed yet. FM "YYY" reported that they are often the person to assist Resident #39 in getting ready and completing oral care on Resident #39 because staff were not doing it. In an observation on 5/10/23 at 09:05 AM, Resident #39 was observed lying in bed on his			

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	back. Resident #39 appeared disheveled, with messy hair. Resident #39 reported that he was wet (incontinent), needed to be cleaned up and that he had been waiting about 1.5 hours for someone to come in and check on him. In an observation on 5/11/23 at 01:23 PM, Resident #39 was observed lying on his back in bed. Resident appeared disheveled with messy hair. Resident #39's dentures were laying on bedside table. During an subsequent interview on 5/11/23 at 01:29 PM, Registered Nurse (RN) "XX" reported that staff had been in to assist Resident #39 this morning, and his care had been completed. RN "XX" reported that "Bath Time Skin Anatomy Diagram" forms are completed by the Certified Nursing Assistant (CNA) every time a resident receives a shower or bed bath, and if the resident refuses the CNA would still complete the form by marking on the sheet that the resident refused care. Review of "Bath Time Skin Anatomy Diagram" forms in a binder at nurses station revealed two forms were completed on Resident #39 for April 2023, dated 4/1/23 and 4/8/23. There were no forms for March or May. Review of Resident #39 "ADL-Bathing tasks" revealed documentation of one bed bath completed for a look back period of 30 days. The bed bath documented on 5/5/23 indicated Resident #39 required total dependence for bed bath. There were no showers documented for the look back period of 30 days. During an interview on 5/11/23 01:39 PM, Registered Nurse (RN) Unit Manager "P" reported that the process for reviewing shower completions had just been changed on 5/8/23 and			

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that the unit managers were now responsible for reviewing the bath sheets and ensuring each resident received a shower on their scheduled shower days. RN-UM "P" reported that prior to May 8th, the facility did not have a official process for ensuring showers were completed. RN-UM "P" reported that the management team was aware that residents were reporting missing scheduled showers. RN-UM "P" reported CNA's were suppose to document showers in the bathing task and complete the bath time sheets. RN-UM "P" reported that he could not explain why there was only one bed bath documented under the bathing task for the last 30 days, or why there were only two bath time sheets completed for Resident #39 for the months of March, April, and May.

During an interview on 05/11/23 at 10:57 AM, CNA "VV" reported that there was usually only two CNA's assigned to each hall, and that management did not help. CNA "VV" reported that the managers were aware of the concerns that the CNA's had regarding their current workload. CNA "VV" reported that she cannot provide the care that she would like for residents due to workload. CNA "VV" reported that the majority of the residents on the hall required two person assist, in addition to high fall risks and behaviors that required frequent supervision. CNA "VV" reported that showers get missed because they required two staff, and that would leave the rest of the residents unsupervised.

Review of "Facility Assessment" indicated that 31 residents in the facility required limited to extensive assistance with 1-2 staff members, and 39 residents that were completely dependent on staff for assistance. Resident census at the time of survey was 78.

During an interview on 5/11/23 at 03:18 PM,

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	CNA "EE" reported that most days each hall had two CNA's and the workload was not manageable. CNA "EE" reported that CNA's were not able to complete showers because they didn't have time. CNA "EE" reported that it was not safe for two CNA's to leave the floor to complete a shower for a resident that required two staff members to assist because it would leave the rest of the hall unsupervised. CNA "EE" reported that many residents required two person assist for transfers, and some for behaviors. CNA" EE" reported that management was aware of CNA's concerns but they did not offer to help. CNA "EE" reported that CNA's were usually the only staff members to answer call lights.CNA" EE" reported feeling unsupported by the nurses and management team. In an observation on 5/15/23 at 02:47 PM, Resident #39 was observed sitting in a wheelchair in the hallway. Resident #39 hair was greasy and unkempt. Resident #39's shirt was covered with dry skin and his mouth was observed dry with cracked upper and lower lips. During an interview on 5/18/23 at 12:06 PM, FM "YYY" reported that they were concerned that Resident #39 had missed another shower this week, and that the staff member they spoke to was unable to provide any evidence that a shower was completed when asked. FM "YYY" reported that Resident #39 does not like for his hair to go unwashed, and that it can be upsetting for him to miss out on this.			
F0678 SS= J	Cardio-Pulmonary Resuscitation (CPR) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.	F0678		

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	This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide immediate cardiopulmonary resuscitation (CPR) per the standards of practice and facility policy for 1 of 1 resident (Resident #382) reviewed for CPR, from a total sample of 24 Residents, resulting in an immediate jeopardy for Resident #382 whose advanced directive indicated she was a full code. Resident #382 was found by Licensed Practical Nurse (LPN) "S" on 4/29/23 at 11:48pm without respirations or a pulse and did not receive CPR for at least 15 minutes. Resident #382 was pronounced dead at 12:37am on 4/30/23. Findings include: A review of a facility policy titled "Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS)", dated 12/1/22 revealed guidelines as follows: "If a Resident experiences a cardiac arrest or respiratory arrest ...facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services, in accordance with the Resident's advance directives and any related physician order, such as code status or in the absence of advance directives or a DNR order." A review of the American National Red Cross CPR and AED for Professional Rescuers Participant Handbook (2016) revealed that for every minute Cardiopulmonary Resuscitation is delayed, the victim's chance for survival is reduced by about 10 percent. A review of an "Admission Record" for Resident #382 dated 4/28/23, revealed pertinent diagnoses that included: Chronic Respiratory Failure			

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(condition in which the lungs cannot get adequate oxygen into the blood), Chronic Obstructive Pulmonary Disease (constriction of the airways), Pulmonary Embolism (blood clot in the lungs), Congestive Heart Failure (chronic condition in which the heart does not pump the blood as well as it should) and Diabetes Mellitus (chronic condition that affects the way the body processes blood sugar).

In an interview on 5/17/23 at 2:31pm Confidential Informant "NNN" revealed that Resident #382's Cardiopulmonary Resuscitation was delayed as the result of staff not correctly identifying the Resident during a cardiac arrest. Confidential Informant "NNN" reported that all staff had been re-educated regarding identifying a Resident's code status because of the incident.

A review of an "Admissions Worksheet" for Resident #382, dated 4/28/23, revealed Advanced Directives: Full Code.

A review of "Orders- Administration Note" for Resident #382, dated 4/30/23 at 12:08pm, entered by Registered Nurse "UU", revealed Resident #382 was pronounced deceased at 0037 that day.

In an interview on 5/17/23 at 2:35pm, Admissions Coordinator "T" revealed that Resident #382 was admitted to the facility after 6:30pm on 4/28/23. The Admission Coordinator was not present at the time of Resident #382's admission to the facility. Admission Coordinator "T" reported Resident #382's code status was listed as "full code" in the admissions worksheet which was included in an admission packet left at the nurse's station on 4/28/23 at 6:00pm.

In a telephone interview on 5/17/23 at 3:08pm, Registered Nurse (RN) "UU" reported she completed the nursing admission assessment for

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	Resident #382 on 4/28/23 and that Resident #382 was listed as a "full code" for her advanced directives. In a telephone interview on 5/17/23 at 3:40pm, Certified Nursing Assistant (CENA) "MMM" reported 4/29/23 was the first time in which she had cared for Resident #382. CENA "MMM" reported that at 11:48pm on 4/28/23, CENA "MMM" saw a Resident (whom she believed to be Resident #61) lying face down on the bathroom floor with blood coming from her mouth. CENA "MMM" went to get a nurse, found Licensed Practical Nurse (LPN) "S" on A Hall, and they returned to Resident who was laying on bathroom the floor unresponsive. CENA "MMM" stated "we thought it (the Resident on the floor) was (Resident #61 who shared an adjoining bathroom with Resident #382) ... because Resident #382 was doing so well, we could not imagine it was her". As a result, CENA "MMM" and LPN "S" asked for the code status for Resident #61, rather than for Resident #382. CENA "MMM" stated "it was confusing because both Residents were new, they had names that sounded similar, and we didn't know them very well". CENA "MMM" reported that when the staff realized the Resident on the floor was Resident #382 and that her advanced directives were for a full code, Registered Nurse (RN) "LLL" began chest compressions. CENA "MMM" recalled hearing RN "LLL" call out "compressions initiated at 12:06am". In a telephone interview on 5/17/23 at 3:58pm, Licensed Practical Nurse (LPN) "S" reported she was working on A hall on 4/29/23 at 11:50pm, when Certified Nursing Assistant "MMM" approached her for help with a Resident who had fallen in the bathroom. LPN "S" reported she ran to a bathroom which was shared by two Residents and found a Resident lying on her left side, partially face down with no pulse. LPN "S"			

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	instructed CENA "MMM" to get the crash cart and LPN "S" ran to the hallway to a nearby phone to call a code. LPN "S" reported that Registered Nurse "LLL", the nurse responsible for Resident #382's hall, yelled from the nurse's station that the Resident down had a "do not resuscitate" (DNR) code status." As a result, LPN "S" did not initiate cardiopulmonary resuscitation. LPN "S" then called a Unit Manager on the telephone to report the death. During that conversation, the staff realized the Resident's name and room number did not match. The Unit Manager described Resident #61 and that description did not match the Resident who was on the floor. The staff realized the Resident on the floor, with no pulse, was Resident #382. LPN "S" reported several minutes had passed since Resident #382 had been found. Both LPN "S" and Registered Nurse (RN) "LLL" returned to the nurse's station to determine Resident #382's code status. Upon finding Resident #382 advanced directive status was for a full code, Registered Nurse (RN) "LLL" ran back to Resident #382 and began chest compressions. In an interview on 5/18/23 at 7:44am, Registered Nurse (RN) "LLL" reported on 4/29/23 she was assigned to Resident #382's hall. RN "LLL" reported she had been off work for several days prior to that night and had not cared for Resident #61 or Resident #382 before. RN "LLL" also reported that because Residents frequently changed rooms, it was often difficult to know the Residents' room assignments. At 11:45pm, RN "LLL" was on another hall signing out a narcotic when she heard someone say they needed the crash cart. RN "LLL" pushed the crash cart toward the scene but stopped at the nurse's station when Licensed Practical Nurse (LPN) "S" asked for the code status of (Resident #61). RN "LLL" looked in Resident #61's paper chart, located the code status and yelled back that the Resident had a "Do Not Resuscitate (DNR) code status". RN "LLL" reported that the internet service was down			

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that night so staff did not have access to the electronic medical record and had to rely on the paper charts, which had limited information. RN "LLL" noticed that LPN "S" came from Resident #382's room, rather than from Resident #61's room, and RN "LLL" realized the Resident experiencing cardiac arrest was Resident #382. Both staff quickly returned to the nurse's station to review the code status for Resident #382. RN "LLL" then returned to Resident #382's room, 2 staff members positioned Resident #382 on her back and RN "LLL" began chest compressions. RN "LLL" confirmed the time was 12:06am when chest compressions began.

Review of a "Prehospital Care Report Summary" provided by the responding Emergency Medical Services company, section titled "Cardiac Arrest Information" included the estimated time of arrest as: 23:42 (11:42pm), Time of First CPR: 00:06 (12:06am). Section titled "Additional Assessment Notes" revealed the following information: "Pt (patient) found at 23:48 face down in restroom. Staff stated initial discrepancy on DNR (Do Not Resuscitate) status and CPR (Cardiopulmonary Resuscitation) was not initiated until 0006. Staff initially did not have Pt hx (history) and demographics. Pt was pronounced dead in field by physician on scene."

On 5/17/23 at 5:15pm Nursing Home Administrator (NHA) "A" was notified of an Immediate Jeopardy concern that began on 4/29/23 and was identified on 5/17/23 when staff failed to provide Cardiopulmonary resuscitation to Resident #382.

On 5/18/23 the survey team verified the facility completed the following steps to remove the Immediate Jeopardy:

1. On 4/30/23, the facility audited Resident names

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	on door plaques to ensure accuracy. 2. On 4/30/23, the facility audited Resident code status to ensure each Resident had a code status listed and the information matched. 3. On 4/30/23, the facility audited the purple binder in the nurse's station to ensure each Resident had a face sheet. 4. On 5/2/23 the facility completed educated of all staff regarding: a. Actions to take when a Resident is found unresponsive. b. During a code, Residents should always be referred to by their room number c. Ways to confirm a Resident's identity d. When in doubt, divert to Full code and start cardiopulmonary resuscitation e. Code status location in medical record f. How to announce a code g. Code status must be obtained at admission and entered in electronic medical record h. Overnight and weekend admissions will have a resident photo taken by the Manager on Duty and uploaded into the electronic medical record. Manager on Duty will print the face sheet with the photo and place it in the Resident's chart and the purple binder. 5. An Adhoc QAPI meeting was held on 5/1/23 6. DON (Director of Nursing) or designee will			

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	review new admissions to ensure code status was ordered and identified in each location of the medical record, a picture was taken and uploaded to the electronic medical record, face sheet was added to the Resident's paper chart and the purple binder. 7. DON(Director of Nursing) or designee will audit new admissions weekly. The facility was identifed as in compliance effective 5/10/23 due to a concern identified during the onsite survey of inaccurate medical record for code status.			
F0684 SS= J	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00133629. Based on interview and record review, the facility failed to ensure licensed staff adequately assessed and communicated an acute change in condition to the medical provider for 1 if 1 resident (Resident #331) reviewed for acute change in condition, resulting in an immediate jeopardy beginning the morning of 4/22/2023 when the CNA (certified nursing assistant) recognized a change of condition in Resident #331 and notified the RN (Registered Nurse) who noted the change of condition but failed to contact the medical	F0684		

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	provider for further orders. Resident #331 was transported to the local hospital on 4/23/2023 when during a video chat her family member demanded that the facility send her to the hospital due to her lethargy and decreased responsiveness. Resident #331 was evaluated at the local Emergency Department and was found to be actively having a myocardial infarction with a completely blocked coronary artery (STEMI). Resident #331 was admitted to critical care with cardiogenic shock and urosepsis and expired on 4/25/2023. This deficient practice placed all residents in the facility (79 residents on 5/8/2023) at risk for serious harm, injury, and/or death. Findings include: Review of an "Admission Record" revealed Resident #331 admitted to the facility on 9/2/2016 with pertinent diagnoses which included Alzheimer's Disease, cognitive communication deficit, and bipolar disorder. Review of a "Minimum Data Set" (MDS) assessment for Resident #331, with a reference date of 3/3/2023 revealed a "Staff Assessment for Mental Status" score of 3, which indicated Resident #331 was severely cognitively impaired. Review of Resident #331's active orders on 4/22/2023 revealed that Resident #331 was full resuscitate (full code). Review of a current "Care Plan" focus for Resident #331, initiated 9/5/2016, revealed that Resident #331 had elected full code status. Further review revealed a current dementia and anxiety "Care Plan" intervention, initiated 8/27/2018, directing staff to observe Resident #331 for symptoms of an acute physical/psychiatric condition and notify the medical provider as indicated. Further review			

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revealed a current altered cardiovascular status "Care Plan" intervention, initiated 1/27/2023, directing staff to monitor, document, and report to the medical provider as needed any symptoms of coronary artery disease including shortness of breath.

In an interview on 5/4/2023 at 3:45 PM, Family Member of Resident #331 "GGG" reported he requested the facility send Resident #331 to the hospital on 4/23/2023 when during a video chat he noticed that she did not look good and staff were unable to wake her for the visit.

In an interview on 5/11/2023 at 8:46 AM, CNA "C" reported the morning before Resident #331 went to the hospital he noticed she was hardly talking, was breathing different, and she was gasping for breath. CNA "C" stated "she (Resident #331) just seemed really different." CNA "C" reported he notified the nurse of Resident #331's change in condition. CNA "C" reported the next day Resident #331 was a little worse and he was present during the video chat when Family Member of Resident #331 "GGG" noticed that something was wrong with Resident #331 and wanted her to be sent to the hospital. CNA "C' reported he notified the nearest nurse of Family Member of Resident #331 "GGG"'s request and RN (Registered Nurse) "QQ" coordinated transfer of Resident #331 to the local emergency department.

In an interview on 5/11/2023 at 9:25 AM, CNA "C" reported that Resident #331 had dementia and was unable to communicate her condition to staff. CNA "C" reported that Resident #331 relied on staff to recognize any changes from her baseline.

In an interview on 5/10/2023 at 2:19 PM, RN "QQ" reported he was Resident #331's nurse the day that she was sent to the hospital and the prior

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day. RN "QQ" reported he was notified by CNA "C" that Resident #331 was not acting like herself the day before she was transferred to the hospital. RN "QQ" reported Resident #331 was lethargic, not yelling out like she normally would, and was slumped over in her chair more than normal. RN "QQ" reported Resident #331 was still acting lethargic the next day and was quiet. RN "QQ" reported that Resident #331's family member during a video chat insisted that she be sent to the hospital. RN "QQ" reported that he coordinated EMS transfer to the hospital at the son's request and then notified the on-call doctor.

In an interview on 5/10/2023 at 2:48 PM, RN "QQ" reported he took Resident #331's vital signs the day before she went to the hospital when her change in condition was reported to him. RN "QQ" checked the electronic medical record and was unable to find any documentation of these vital signs. RN "QQ" reported that he did not notify the medical provider of Resident #331's change of condition when he was first aware the day prior to her hospitalization. RN "QQ" reported he did not notify the medical provider of the change in condition until the following day when Family Member of Resident #331 "GGG" requested she be sent to the local emergency department.

In an interview on 5/11/2023 at 9:59 AM, CNA "OO" reported she was working with Resident #331 the day she went to the hospital and the day before. CNA "OO" reported she noticed something was off with Resident #331, she was having a hard time breathing. CNA "OO" reported during a video chat Resident #331's son stated, "I want her out now."

In an interview on 5/11/2023 at 10:06 AM, Activities Aide "G" reported he went to Resident #331's room at noon the day she went to the

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hospital to initiate a video chat with Family Member of Resident #331 "GGG". Activities Aide "G" reported Family Member of Resident #331 "GGG" requested she be sent to the hospital when she did not respond to him on the video chat. Activities Aide "G" reported Resident #331 was not talkative like normal, was not moving much, and sounded wheezy. Activities Aide "G" reported Resident #331 could not articulate well and was not able to verbalize what was wrong with her because of her dementia.

In an interview on 5/15/2023 at 8:35 AM, Medical Doctor "RRR" reported he expects to be contacted by nursing staff for new open wounds, fevers, abnormal vital signs, patient complaints, new admissions, history and physicals, discharges, and changes in resident condition.

Review of hospital records from Resident #331's hospitalization on 4/23/2023 revealed the local hospital found Resident #331 to be actively having a myocardial infarction upon her arrival to the emergency department. Resident #331 was reported as having shortness of breath that was abnormal for her by family members in the emergency department. An EKG (electrocardiogram) revealed Resident #331 to be having a STEMI (ST Elevation Myocardial Infarction) and she was sent to the cardiac catheterization lab and treated for total occlusion of the left anterior descending artery of the heart by stenting. Resident #331 was admitted to critical care with cardiogenic shock versus sepsis and expired two days later on 4/25/2023.

Review of Resident #331's death certificate revealed cause of death to be multiple organ failure, refractory shock, STEMI, and sepsis due to complicated UTI (urinary tract infection).

Review of facility policy/procedure "Notification

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	394160	A. BUILDING _____ B. WING _____	5/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF WESTWOOD	2575 N DRAKE RD KALAMAZOO, MI 49006

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	of Changes", reviewed 1/1/2022, revealed " ...The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification ... Circumstances requiring notification include: Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: life-threatening conditions, or clinical complications ... Circumstances that require a need to alter treatment ..." On 5/11/2023 at 11:35 AM, NHA (Nursing Home Administrator) "A" was notified of an Immediate Jeopardy that began on 4/22/2023 and was identified on 5/11/2023 when clinical staff failed to recognize an acute change of condition in Resident #331 and the need to notify the medical provider. On 5/11/2023, the survey team verified the facility completed the following to remove the Immediate Jeopardy. 1- Resident #331 expired on 4/25/2023. 2- On 5/11/2023, the Medical Director was notified of the immediate jeopardy. The Medical Director reviewed the Ad-Hoc QAPI plan for assessing residents residing in the facility for a change of condition and deemed the actions appropriate. 3- On 5/11/2023, all 72 residents were assessed by the licensed nurse and direct care staff were interviewed for changes in condition. Any identified changes were reviewed with the provider with orders received as needed for treatment.			

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	4- On 5/11/2023, the Notification of Change policy was reviewed by the NHA and DON and deemed appropriate. 5- On 5/11/2023, an Ad-Hoc QAPI was meeting was held to review the Notification of Changes Policy and this plan. 6- Beginning on 5/11/2023, direct care staff is being re-educated on the Notification of Changes Policy, including education regarding SBAR and/or Stop and Watch program for changes in condition. At the time this abatement was submitted, 24 of 67 direct care staff members have been educated. No direct care staff member will be allowed to work without education. 7- New admissions and residents with any changes in condition will be reviewed 5x per week by the DON/designee to ensure that the provider was notified and any ordered follow up was completed. 8- Weekly x 4 and then monthly the DON/designee will conduct an audit of residents with changes in condition to ensure that the provider was notified and that the follow up was completed. Although the Immediate Jeopardy was removed on 5/11/2023, the facility remained out of compliance at a scope of actual harm that is not immediate jeopardy, and severity of isolated due to not all education had been completed and sustained compliance had not yet been verified by the State Agency.			
F0686 SS= D	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident,	F0686		

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	the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide pressure ulcer care and treatment consistent with professional standards of practice for 1 (Resident #80) of 5 residents reviewed for pressure ulcer treatment, resulting in the potential for further skin breakdown and overall deterioration in health status. Findings include: Review of an "Admission Record" revealed Resident #80 admitted to the facility on 10/22/2020 with pertinent diagnoses which included multiple sclerosis and quadriplegia. Review of a "Minimum Data Set" (MDS) assessment for Resident #80, with a reference date of 1/2/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #80 was cognitively intact. Review of Resident #80's local hospital documentation from her 12/6/2022 to 12/27/2022 admission revealed " ...(stage) 2 coccygeal and back decubitus ulcers - present on admission ..."			

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Review of Resident 80's Electronic Health Record on 5/18/2023 at 10:54 AM revealed no routine documentation of wound assessments or measurements.

Review of Resident #80's Electronic Health Record "Discharge" form revealed she discharged home with her daughter 2/4/2023 with wound treatment orders for her left upper back and left gluteal fold.

Review of Resident #80's "Physician's Orders", discontinued 2/6/2023, revealed " ...left upper back: cleanse with (normal saline), apply collagen with silver to wound bed and cover with Optifoam ... left lower gluteal fold: cleanse with (normal saline) air dry and apply Optifoam daily ..."

In an interview on 5/18/2023 at 11:36 AM, Regional Clinical Care Coordinator "M" reported there is not much documented for Resident # 80's wound measurements and treatments. Regional Clinical Care Coordinator "M" was not able to find any wound measurement documentation and no documentation regarding the improvement or decline of Resident #80's wounds. Regional Clinical Care Coordinator "M" reported Unit Manager "O" was in charge of wound care during this time frame. Regional Clinical Care Coordinator "M" reported pressure ulcer and wound care was identified as an area needing improvement and and ongoing QAPI was being completed on this.

In an interview on 5/18/2023 at 1:30 PM, Unit Manager "O" reported resident had MASD (moisture associated skin damage) for a long time prior to her hospitalization in December and returned from the hospital with a decubitus ulcer.

Review of facility policy/procedure "Pressure

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	Injury Prevention and Management", revised 1/1/2022, revealed " ...This facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries ... The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying factors; monitoring the impact of the interventions; and modifying the interventions as appropriate ..." Review of the past non-compliance documentation during an annual and abbreviated survey from 5/8/2023-5/18/2023 reflected the facility implemented the following interventions that resolved the non-compliance: 1. Skin sweep performed by nursing management and any issues identified were measured with updated orders and updated care plans. 2. Education on skin assessments, documentation of skin impairments, and entering of treatment orders completed with nursing staff. 3. Skin assessments to be completed upon admission and when scheduled. When indicated, orders for treatment will be initiated and the care plan will be updated. 4. Identified issues will be reviewed in the next clinical meeting by the interdisciplinary team to ensure appropriate treatment and that the care plan reflects the clinical needs of the resident. Updates will be made by the interdisciplinary team as indicated. 5. Weekly, identified wounds will be measured and assessed for needs or changes to the treatment and plan of care. Any changes needed will be reviewed with the provider and treatment orders			

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	will be updated. 6. The DON/Designee will audit 3 new admissions per week to ensure that the skin assessment is accurate and that treatments are appropriate. 7. The DON/Designee will audit 10 resident skin assessments for accuracy and to ensure identified concerns have orders for treatments and their care plan is updated. 8. The DON/Designee will audit 3 residents with wounds to ensure that they are classified correctly, the treatment is appropriate, and that the provider was notified when indicated. 9. Audit findings will be presented to the facility QAPI committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The facility stated compliance with this action plan was achieved as of 2/7/2023.			
F0689 SS= J	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 five (5) Deficiency Practice Statements (DPS). DPS #1	F0689		

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Based on observation, interview and record review, the facility failed to properly identify and accurately assess residents to ensure safety and prevent an elopement for 1 of 4 residents (Resident #71) reviewed for elopement/wandering, resulting in an Immediate Jeopardy when on 5/13/23 Resident #71 exited the facility at an unknown time, unbeknownst to staff, and was identified walking outside by a laundry staff member, between 6:30PM-7:00PM. This deficient practice placed 4 residents, identified as at risk for elopement, at risk for serious harm, injury, and/or death.

Findings include:

Review of an "Admission Record" revealed Resident #71 was originally admitted to the facility on 1/13/23, with pertinent diagnoses which included: cerebral infarction (stroke) and hemiplegia (paralysis) effecting right dominant side.

Review of a "Minimum Data Set" (MDS) assessment for Resident #71, with a reference date of 4/21/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 8, out of a total possible score of 15, which indicated Resident #71 was cognitively impaired. Review of the "Functional Status" revealed that Resident #71 was independent with transfers and ambulation.

In an interview on 05/15/23 at 12:54 PM, Assistant Manager Housekeeping (AMH) "AA" reported that she exited the facility's service door to get some fresh air on 5/13/23 at approximately 6:30-7:00 PM, to find Resident #71 walking in the driveway. AMH "AA" reported that she did not encourage Resident #71 to come back into the facility, but immediately went back into the facility and notified Licensed Practical Nurse (LPN) "ZZ".

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In an interview on 05/15/23 at 01:38 PM, LPN "ZZ" reported that AMH "AA" told her that Resident #71 was outside of the patio in the driveway and stated, "...I had just started my shift and was getting report...so I went out and he (Resident #71) was just about to cross the street...I followed him down the sidewalk...then he turned around and walked right back in with me..." LPN "ZZ" reported that she did not observe Resident #71 exit the building and did not know how long he had been outside. LPN "ZZ" reported that Resident #71 is a smoker and goes outside to the patio on his own to smoke, but that she had not given him cigarettes that night. LPN "ZZ" reported that she phoned Director of Nursing (DON) while she was outside with Resident #71 and stated, "...she (DON) did not have any concerns...just to do the assessments and to explain to the resident that he had to sign the LOA book before he left the facility..."

In an interview on 05/15/23 at 01:24 PM, DON reported that she had received a call from LPN "ZZ" on 5/13/23 reporting that Resident #71 had exited the building and stated "...she (LPN "ZZ") said that he (Resident #71) was on the sidewalk across the street by the high school...taking a walk while he was smoking...he was never out of her (LPN "ZZ's") sight...she (LPN "ZZ") saw him walk out the door and was trying to catch up with him (Resident #71) when she called..." DON reported that this was not an elopement because Resident #71 was never out of sight and stated, "...I don't know what door he exited...I assumed the front door...I didn't ask..." DON reported that she requested that LPN "ZZ" complete a safe smoking assessment and an elopement risk assessment for Resident #71 following the incident on 5/13/23, and that the assessment confirmed that Resident #71 was not at risk for elopement and was safe to smoke unsupervised on the patio. DON reported that the incident was

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	discussed in a managers meeting that morning. In an interview on 05/15/23 at 01:15 PM, Resident #71 reported that on 5/13/23 he had asked for his cigarettes around 6:30 PM and then went outside to smoke on the patio. Resident #71 reported that there was no one around, he was out there for a while, and then decided to go for a walk. Resident #71 reported that he knew that facility didn't want him to do that, but that he had done it before and just came back before anyone noticed him gone. In an interview on 05/15/23 at 01:46 PM, Resident #71's legal guardian (LG) "QQQ" reported that Resident #71 has always been a smoker and reported that Resident #71 was allowed to smoke on the back patio of the facility alone. LG "QQQ" reported that he does not want Resident #71 to leave the facility unsupervised, except when Resident #71 is on the patio smoking and stated, "...he still gets confused and forgets what he is doing and where he is sometimes...I don't want him walking around outside alone..." LG "QQQ" reported that he had not been contacted by the facility at all regarding Resident #71 exiting the building unsupervised on 5/13/23 and stated, "...I went through my phone and don't see any contact from the facility..." In an interview on 05/15/23 at 03:30 PM, DON reported that Resident #71 was assessed not at risk for elopement upon admission on 1/14/23 because he was not able to ambulate safely, and when he did try to walk he fell and stated, "...he has improved since then, but was not reevaluated..." DON reported that Resident #71 had been assessed on 1/14/23 as non-smoking, and did not know when Resident #71 started smoking or where Resident #71 got his cigarettes. DON reported that Resident #71 was reassessed			

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	for elopement risk on 5/14/23 by LPN "ZZ" (the nurse that assisted him back into the facility) and he was determined not at risk, and was also determined to be safe to smoke independently. In a subsequent interview on 5/15/23 at 3:40 PM, DON reported that she had found another elopement risk assessment completed on 4/17/23 for Resident #71 and that he was determined to not be at risk at that time. DON reiterated and reported that on 5/13/23 Resident #71 did not elope, but that he left the building unsupervised and did not tell anyone, and that Resident #71 did not have orders for independent LOA. Review of Resident #71's "Progress Note" dated 05/13/2023 at 6:48 PM written by DON revealed, " (Resident #71) decided to go out the front door to smoke and took a walk with (LPN "ZZ") directly behind him. (Resident #71) was in no danger, stayed on the side walk, and was never out of visual site of nurse. (Resident #71) came back to facility with (LPN "ZZ") without complications. No concerns/ Educated on him needing to sign out in the LOA book and have his dad's permission to go for walks." This note was inaccurate considering the above statements from staff. Review of Resident #71's "Progress Note" dated 05/14/2023 at 12:31 AM written by LPN "ZZ" revealed, "...multiple attempt to notify resident's son that resident left campus this evening vm (voicemail) is full and no call back thus far. This nurse immediately notified (on call staff) of walk, no new orders att (at this time). This nurse educated (Resident #71) on importance of using LOA book and having permission of guardian for going off campus to maintain safety also went over safe smoking practices with (Resident #71) who verbalized understanding."			

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	Review of Resident #71's "Care Plan" revealed no care plan related to smoking, and no care plan related to independent LOA (leave of absence). Review of Resident #71's "Physician Orders" indicated that Resident #71 did not have orders for an independent LOA (leave of absence), and did not have orders for being safe to smoke. Review of Resident #71's "Nursing Admission Evaluation" dated 1/14/23 indicated that Resident #71 was not a smoker at that time, and had no plans to smoke or use tobacco related products while staying at the facility. Review of Resident #71's "Safe Smoking Evaluation" revealed no record existed. Review of Resident #71's "Fall Risk Evaluation" dated 5/3/23 indicated that over the past 90 days, Resident #71 had 1-2 falls, no change in cognition and was at low risk for falls. Review of Resident #71's "Risk of Elopement/Wandering Review" dated 4/17/23 revealed, "1. Is the resident cognitively impaired with poor decision making skills (ie. intermittent confusion, cognitive defects or disorientation)? NO, 2. Elopement History: ...Leaving the facility without supervision when supervision is required? NO. Leaving the facility without informing staff? NO...Summary of Review: Resident is at list for elopement/wandering at this time? NO..." Review of Resident #71's "Risk of Elopement/Wandering Review" dated 5/14/23 at 1:08 AM revealed, "1. Is the resident cognitively impaired with poor decision making skills (ie. intermittent confusion, cognitive defects or disorientation)? NO, 2. Elopement History: ...Leaving the facility without supervision when			

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	supervision is required? NO. Leaving the facility without informing staff? NO...Summary of Review: Resident is at list for elopement/wandering at this time? NO..." This document was inaccurate considering that Resident #71 eloped on 5/13/23 and has a BIMS of 8. During an observation on 5/16/23, the distance from the patio gate where Resident #71 exited, to the road was approximately 250 feet of paved driveway surface that sloped downhill towards the road. The road was a busy main street with a 45 mph speed limit. There was a school and sidewalk on the far side of the road. The patio gate was not locked. On 5/15/23 at 04:20 PM, Nursing Home Administrator (NHA) and DON were notified and received written notification of the immediate jeopardy that began on 5/13/23 due to the facility's failure to properly identify and accurately assess to ensure safety, and prevent an elopement for Resident #71. Review of Resident #71's updated "Risk of Elopement/Wandering Review" dated 5/15/23 at 5:43 PM revealed, "1. Is the resident cognitively impaired with poor decision making skills (ie. intermittent confusion, cognitive defects or disorientation)? NO, 2. Elopement History: ...Leaving the facility without supervision when supervision is required? YES, Times: 1. Leaving the facility without informing staff? YES, Times: 1...Summary of Review: Resident is at list for elopement/wandering at this time? YES. Elopement/Wandering risk as evidence by: left facility without LOA book signing and his guardian being notified, he has been educated and does verbalize understanding...Comments: at risk for elopement, wander guard in place."			

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	Review of Resident #71's "Physician Orders" revealed, "Elopement Risk: Wander Guard placed to right wrist...Check function and expiration date of wanderguard/electronic bracelet. Start date 5/16/23." Review of Resident #71's "Safe Smoking Evaluation" dated 5/14/23 at 1:05 AM indicated that Resident #71 was safe to smoke independently. There was no documentation prior to this indicating that Resident #71 was a smoker. On 5/16/23 at 10:00 AM a review of "Residents at Risk for Elopement/Wandering" indicated a total of 4 residents at risk in the facility, including Resident #71. On 5/16/23 at 10:30 AM, the exit door on the southeast side of the dining room was observed unlocked, and opened easily without a delay or an alarm sounding. This door opened to a fenced in patio where residents went to smoke. RMD "SS" reported that the dining room door was a fire exit door, but that it gets locked with an Allen wrench from 6:00 PM to 6:00 AM every day. RMD "SS" reported that the fence around the patio does not lock and cannot be locked, because it is a fire exit. RMD "SS" reported that the exit door originally required a code to open, but the system no longer worked, therefore the door had a screecher installed that alarmed when the door was open and stopped automatically when the door was closed, but the batteries were removed from the screecher alarm early this morning when a new keyed alarm was installed, which was observed on the top right-hand side of the door. RMD "SS" reported that the new keyed alarm was not functioning yet on the dining room door. RMD "SS" reported that the dining room exit door was not connected to the "wanderguard" system, and therefore would not alarm if a "wanderguard" bracelet was near the door. There			

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	394160	A. BUILDING _____ B. WING _____	5/18/2023

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	was no staff observed supervising the door prior to or during this observation. The interview and observation presented safety concerns related to an unsupervised, unlocked door with no alarm, that lead to an unlocked patio. In an interview on 5/16/23 at 9:30 AM, Regional Maintenance Director (RMD) "SS" reported that the facility had 9 exit doors and 2 of them were connected to the "Wanderguard" system, the main entrance and the therapy door. RMD "SS" reported that he was not able to test those doors to ensure they were functioning, and reported that 3 residents were newly assigned Wanderguard bracelets last night and there are no extras to use for testing. RMD "SS" reported that the wanderguard doors are checked along will all doors, daily, weekly, and monthly. RMD "SS" reported that he ordered additional wanderguard bracelets and that he would notify me as soon as they arrived. In an interview on 5/16/23 at 10:35, NHA reported that she was not aware that the dining room exit door did not have a functioning alarm and stated, "...the screecher should have been utilized until the new alarm was up and running...the door should not be locked until 10:00 PM..." NHA reported that the door had been unlocked and unsupervised for approximately 3 1/2 hours, and was not able to confirm that none of the residents exited through the door. On 5/16/23, NHA initiated a "Code Yellow" emergency to ensure all residents were accounted for and safe. On 5/16/23 at 10:40 AM observed RMD "SS" installed batteries in the screecher door alarm in the dining room. At that time the NHA assigned a staff member to sit at the door to ensure that no residents exited the building unsupervised.			

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	In an interview on 5/16/23 at 10:55 AM, NHA reported will revise the immediate jeopardy removal plan and date of compliance to reflect the non-compliance discovered when the dining room door was observed open and unsupervised, and complete re-education to all staff related to "Code Yellow" policy and procedures. 1. Resident #71 returned to the building voluntarily and accompanied by the nurse on 5/13/2023. 2. Following this event, Resident #71 was re-assessed per policy via elopement risk review and skin assessment. Upon reviewing the assessment that was completed 5/14/2023, a new assessment was completed showing the resident is an elopement risk. Resident #71 is free from physical and emotional trauma related to the event. 3. On 5/13/2023, Resident #71's father was contacted and voicemail was full. Resident #71's provider was informed of him exiting the facility on 5/13/2023 with no new orders received. 4. On 5/15/2023, an audit of current residents residing in the facility was completed to insure (sic) current residents were safe and accounted for. 5. From 5/15/2023, residents residing in the facility had new "Risk of Elopement Assessment" completed by licensed nurses to verify accuracy of risk. 6. On 5/15/2023, residents residing in the facility who were identified as being at risk for elopement per the "Risk of Elopement Assessment" were reviewed by the nursing leadership to review current elopement risk, orders requiring documentation, care plan, and Kardex (direct care			

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	guide) to ensure appropriate assessment and intervention were in place. 7. An audit was completed on 5/15/2023 by DON, of the elopement book to verify that residents at risk for elopement had an elopement photo sheet in place. Resident #71's photo and elopement profile was placed in facility elopement book. 8. Beginning 5/15/2023 re-education was provided by the Staff Development Coordinator/designee related to the facilities Elopement Prevention Policies and Procedures which included prevention and management, reporting responsibilities, maintaining door alarms and wander control systems, responding to alarms and ensuring doors are secured when passing through and no employee was allowed to work without receiving education. Currently, 36 out of 110 employees have been educated. 9. The Elopement Prevention and Management Program was reviewed by the NHA and DON on 5/15/2023, and deemed appropriate. 10. An Ad -Hoc QAPI (Quality Assessment Performance Improvement) meeting was held on 5/15/2023 to review the Risk for elopement, orders requiring documentation, care plan, and Kardex to ensure appropriate assessment and interventions were in place. 11. On 5/15/2023, a code yellow drill was conducted to validate that employees on the schedule were able to complete the procedure per policy. 12. On May 16, 2023, from roughly 7 AM through 10:30 AM, the back door of the facility was temporarily disengaged due to Maintenance Director changing alarms. This door was not			

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	watched, and a Code Yellow was called shortly after and all residents were accounted for. 13. On May 16, 2023, all staff were re-educated on Code Yellow policies and procedures. Currently, 40 of 110 staff members have been re-educated." During an observation and interview on 5/18/23 at 1:50 PM, RMD "SS" reported that he had borrowed a wanderguard bracelet from a sister facility to test the door alarms. The therapy door locked and alarmed loudly when the wanderguard bracelet was near the door. The door at the main entrance did not lock and did not alarm when the wanderguard bracelet was near the door. RMD "SS" reported that he would look into why the door at the main entrance door was not functioning as expected with the wanderguard system. At 2:00 PM RMD "SS" reported that the shipment of wanderguard bracelets had arrived by mail and they did worked, but then when observed by this surveyor, the door at the main entrance still did not lock or alarm when the wanderguard bracelet was near. This door did have an alarm when opened without using the code. Although the Immediate Jeopardy was removed on 5/16/2023, the facility remained out of compliance at a scope of no actual harm with the potential for more than minimal harm that is not immediate jeopardy and severity of isolated due to not all education had been completed and sustained compliance had not yet been verified by the State Agency. DPS #2 Based on interview, and record review, the facility failed to ensure falls were identified and included the completion of post fall assessments			

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and a comprehensive fall investigation in 1 of 16 residents (Resident #1) reviewed for accidents, resulting in a delay in coordination of care post fall and incomplete documentation of an unwitnessed fall.

Findings include:

Review of an "Admission Record" revealed Resident #1 was originally admitted to the facility on 4/15/2009, with pertinent diagnoses which included: COPD (chronic obstructive pulmonary disease).

Review of a "Minimum Data Set" (MDS) assessment for Resident #1, with a reference date of 3/23/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #1 was cognitively intact. Review of the "Functional Status" revealed that Resident #1 was independent for transferring and walking.

In an interview on 05/09/23 at 10:04 AM, Resident #1 reported that she had constant chronic pain and that she had new pain in her tailbone due to a fall about 2 weeks ago. Resident #1 reported that she had slipped on her mask that was on the floor and fell backwards onto her bed. Resident #1 reported that when she puts her call light on, its usually for pain medication and sometimes during the night she waits 1-2 hours for someone to come and stated, "...I get up and go to the nurses station to find someone..." Resident #1 reported that call light long wait times is repeatedly talked about in resident council and still remains a problem.

Review of Resident #1's records did not include any documentation related to a fall on 4/27/23.

Review of Resident #1's "Fall Risk Evaluation"

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	dated 11/30/22 indicated that Resident #1 had no falls in the past 90 days and was at low risk for falls. This was the most recent documentation related to falls. In an interview on 05/17/23 at 01:00 PM, Resident #1 reported that she had fallen on 4/27/23 just before 2:00 PM, and Unit Manager Registered Nurse (UM-RN) "P" had heard the crash and came to see what happened. Resident #1 reported that she did not feel bad initially, but then later that day she began having pain in her tailbone and stated, "...the nurses and aides knew...they got me ice packs..." Resident #1 reported that she had a brief visit with the doctor and he had mentioned doing an x-ray and stated, "...I guess he forgot..." Resident #1 reported that her bones were very brittle due to osteoporosis, and she had broken her sternum last year just by bumping the hand rail on her bed. Resident #1 reported that she has had to ask for assistance with toileting since the fall and stated, "...I definitely haven't been able to do the things that I used to..." In an interview on 05/17/23 at 01:19 PM, RN "E" reported that she was not working the day Resident #1 fell, but that Resident #1 had told her about it that day. In an interview on 05/17/23 at 01:47 PM, UM-RN "P" reported that he had heard crash in Resident #1's room and he had went to see what the noise was and stated, "...she (Resident #1) was on the ground...she said that she had slipped and fell against the bed, but couldn't get up so she lowered herself to the floor..." UM-RN "P" reported that this was not considered a fall, and he did not document it, that Resident #1 did not have any injuries and stated, "...she always has pain..." UM-RN "P" reported that he did not complete an assessment, did not perform neurological checks,			

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	did not notify the physician and stated, "...she was able to get herself back up...it wasn't a fall..." In an interview on 05/17/23 at 04:08 PM UM-LPN "O" reported that she was not aware of Resident #1 falling on 4/27/23 and that there was no documentation in the record of a fall. UM-LPN "O" reported that if Resident #1 fell back onto her bed, it would be considered a fall, and an assessment should be completed and documented, and the physician should be notified. In an interview on 05/17/23 at 04:22 PM, Certified Nursing Assistant (CNA) "BBB" reported that Resident #1 did fall a couple weeks ago and stated, "...I had to help her more that next week, she couldn't get her feet up onto the bed herself...she asks for ice packs...she said her tailbone hurts..." CNA "BBB" reported that Resident #1 had been independent with transfers prior to the fall. Review of Resident #1's "Nurse Note" dated 5/17/2023 at 6:52 PM revealed, " This nurse was made aware of this incident today and went to speak with the resident (Resident #1) to see what she needed if she was ok and what her pain level was. She indeed is doing ok her tailbone hurts, and she is still able to independently ambulate around her room and down the hall provider notified." Review of Resident #1's "Provider Telehealth Visit Note" dated 5/17/2023 revealed, "Resident is complaining of tailbone pain. She had a fall on 4-27-2023 and did not report any pain. X-ray of L-S (lower) spine and coccyx." DPS #3 This citation pertains to intake # MI00135634			

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	Based on observation, interview, and record review, the facility failed to identify hazards and risks for 2 of 6 Residents (Resident #49 and Resident #72) who were seated in specialty wheelchairs not recommended for transport use when transported by the facility to medical appointments, resulting in a fall for Resident #49, emotional distress, and a potential for more than minimal harm as the result of improper use of assistance devices. Findings include: Resident #49 Review of an "Admission Record" for Resident #49, dated 3/14/23 revealed pertinent diagnoses which included: unspecified sequelae of cerebral infarction(residual effects of a stroke), left hemiplegia and hemiparesis (loss of movement and paralysis on left side of the body), diabetes mellitus(chronic metabolic disease characterized by elevated blood sugar levels), malignant neoplasm of the lung (cancer of the lung that may spread to other parts of the body), major depressive disorder, muscle weakness, lack of coordination, reduced mobility. Review of a Minimum Data Set (MDS) assessment for Resident #49 dated 2/24/23, section "G" "Functional Status" revealed Resident #49 required total assistance for bed mobility and transferring (moving from one surface to another) and required a wheelchair for mobility. Review of a care plan for Resident 349 dated 11/5/22 revealed focus/goal/interventions as follows: "Resident is at risk for falls related to ...weakness ...hemiplegia ... Goal: Reduce risk of serious injury ...Interventions: Determine causative factors of fall and resolve ...".			

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	Review of a "Incident Report" for Resident #49 dated 3/13/23 at 10:40am revealed the Resident was being transported in the facility van while seated in his specialty wheelchair. The van turned a corner and the specialty wheelchair tipped to the left and landed on the floor of the van, resting on its side. Resident #49 remained in the specialty wheelchair, also resting on his life side. Transportation Driver "Y" called the facility, described Resident #49's position on the floor of the van to Director of Nursing(DON) "B", and under the direction of DON "B", Resident #49 was transported back to the facility (distance of 1.5 miles) in the specialty wheelchair as it rested on its side on the van floor. Resident #49 was assessed for injuries, assisted to the original upright position, and then transported to a medical appointment approximately 100 miles away. In an interview on 5/9/23 at 10:22am Resident #49 reported he had a fall in his specialty wheelchair during transport to a medical appointment. Resident #49 reported feelings of distress about the fall, and that he worried regularly that he may have undiagnosed injuries as a result of the fall. Resident #49 did not recall the date of the incident, but reported it occured when he was en route to a dental appointment. Resident #49 described seeing the driver fasten the wheelchair to the floor and placing a seatbelt across Resident #49's body. When the van hit a curb, the chair tipped over and landed on its side. Resident #49 reported feeling emotional distress about possibly being required to use the specialty chair again for transport and stated "it's not safe". Resident #49 reported feeling emotional distress because he wanted an appointment to get fitted for dentures, felt dentures would improve his quality of life, but was fearful of using the specialty wheelchair in the van again. Resident #49 reported having weakness in his torso and left side and stated "If I start to fall, I can't stop			

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	myself". "I was really scared that day (referring to the incident on 3/13/23)." In an interview on 5/10/23 at 9:23am, Transportation Driver "Y" reported he had worked for the facility for about a year and half and had received a brief (5-10 minute) training on securing wheelchairs using the van's four-point tie down system when he began the job. Transportation Driver "Y" reported Resident #49 was transported in his specialty wheelchair on 3/13/23. Resident #49's wheelchair was affixed to the floor of the van using the van's four-point tiedown system and a seatbelt which also connect to the floor, was positioned across the torso of the Resident. Transportation Driver "Y" reported he hit a curb on the second turn of the trip at which time Resident #49's wheelchair tipped onto its side, resting on the van floor with Resident #49 still seated in it. Transportation Driver "Y" stopped the van, attempted to lift Resident #49 and his wheelchair back into an upright position but could not do so. He called the facility, explained the incident/Resident #49's positioning on the floor of the van to Director of Nursing (DON) "B" who instructed him to transport Resident #49 back to the facility. The Resident was assessed at the facility, cleared to resume transport to the medical appointment and Resident #49 agreed. Transportation Driver "Y" reported Resident #49 "whined the whole way" to the appointment and was frustrated when he arrived too late and could not be seen. When queried about how the chair tipped over, Transportation Driver "Y" stated "I think the front tiedowns came off the chair". Transportation Driver "Y" reported there were no factory installed tie down latches on Resident #49's specialty chair. Transportation Driver "Y" reported feeling uncomfortable using this type of wheelchair for transporting Residents, that he believed the chairs "aren't necessarily safe for this use", but the facility had continued to do so.			

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	Transportation Driver "Y" confirmed he had transported Resident #49 and Resident #72 multiple times in their specialty wheelchairs. Review of Resident transportation trips from 2/23 -5/23 (provided by the facility) revealed Resident #49 had been transported by the facility on 2/6/23, 2/14/23 and 3/13/23. In an interview on 5/10/23 at 11:58am, Unit Manager, Registered Nurse (UM,RN)"P" reported he assessed Resident #49 in the facility parking lot on 3/13/23. Resident #49 was initially lying on his left side, encased in the wheelchair which was also lying on its side. UM, RN "P" reported Resident #49 had no visible injuries, voiced a desire to continue to his medical appointment so UM, RN "P" lifted the Resident and his wheelchair to into an upright position, Transportation Driver "Y" affixed the chair using the same four-point tie down system and the van left. UM, RN "P" reported the Interdisciplinary Team (IDT) later decided Resident #49 would only be transported via stretcher for subsequent medical appointments. UM, RN "P" was unsure if anyone told Resident #49 about the plan to use a stretcher for future transport. In an interview on 5/11/23 at 11:31am Rehab Program Manager "EEE" reported therapy staff recommended the specialty wheelchair used by Resident #49 due to his poor trunk control and rotated posture. Rehab Program Manager "EEE" reported the manuals for specialty chairs are kept with the device so the information is accessible to all staff. When queried about the appropriateness of Resident #49 using the specialty wheelchair for vehicle transport, Rehab Program Manager said she was unsure if the manufacturer recommended use for transport for that particular device. In an interview on 5/16/23 at 9:53am with			

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	Nursing Home Administrator "A", it was revealed that therapy staff determine when a Resident needs a specialty wheelchair and select the wheelchair that best meets the Resident's needs. NHA "A" reported she did not know if staff members reviewed the manuals provided with each specialty chair to determine appropriate use, if staff members were trained on appropriate use of specialty chairs, and reported she was unsure if specialty wheelchairs in use were regularly inspected for defects. NHA "A" reported she would "look into" the questions and follow up. At the conclusion of the survey, no additional information had been provided by NHA "A". NHA "A" did report she was believed all (name brand)specialty chairs being used to transport Residents of the facility were approved for such use. Review of the manufacturer's manual (2018) for Resident #49's specialty wheelchair, revealed section 2 titled "Safety Requirements", 2.1 stated: "Before the chair is put into service, this manual must be read thoroughly by the caregiver(s) directly responsible for the resident's care". Section 2.5.6 "Unintended Movement-Danger of Falling" stated: "We recommend (brand name) chairs for indoor use within a long-term care institution and where there is not enough slope to cause the chairs to move unaided. Chairs used where the surface is uneven or sloped are at risk of unintended movement and could become a serious danger to the resident ..." Section 2.8 "Maintenance" stated: "In regular use, after the initial inspection and functional testing, the chair should be inspected and tested bimonthly. We recommend visually inspecting for signs of wear, damage, loose or missing fasteners, and other safety concerns." Section 7 "Warranty" revealed WC-19 Transportation Certified Products (a standard that specifies design and performance requirements for wheelchairs that are suitable for use as seats in motor vehicles. The guiding			

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	principles for the standard originate from automotive crash-protection principles that are effective in reducing occupant injuries and fatalities.) Vehicle Transport Products and Options are available by factory install only. It can NOT be retrofit to existing models or serviced in the field. All components of the vehicle transport packages are subject to specific maintenance requirements, to maintain the "manufacturer's"' warranty. Resident #72 Review of an "Admission Record" for Resident #72 dated 1/20/23 revealed pertinent diagnoses that included: Cerebral Infarction (area of tissue death in the brain), Hemiplegia and Hemiparesis (loss of movement and paralysis on one side of the body), Muscle Weakness. Review of a Minimum Data Set (MDS) assessment for Resident #72 dated 4/28/23, Section "G" revealed the Resident required extensive assistance for bed mobility, transferring (moving from one surface to another) and moving his wheelchair. Review of a care plan for Resident #72 dated 1/23/23 revealed focus/goal/interventions as follows: Focus "Resident is at risk for falls related to recent CVA(stroke) with profound weakness and lack of safety awareness", Goal "The Resident will not sustain serious injury", Interventions "Anticipate and meet needs", "Staff do not park (brand name of Resident #72's specialty wheelchair) chair in room unattended". Review of Resident transportation trips from 2/23 -5/23 (provided by the facility) revealed Resident #72 had been transported by the facility on 3/8/23, 4/3/23, 4/5/23 and 5/4/23.			

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	In a telephone interview with Manufacturer Representative (representative of the specialty wheelchair manufacturer) "CCCC" on 5/10/23 at 9:00am the serial number for Resident #49 and Resident #72's wheelchair was provided. Manufacturer Representative "CCCC" reviewed the serial numbers and reported that neither wheelchair was recommended for use during vehicle transport. Manufacturer Representative "CCCC" reported that the wheelchairs lacked factory installed tie down latches which would make the chairs at risk for tipping over when used for transport in a vehicle with a four-point tie down system. During an observation of Resident #49 and Resident #72's specialty wheelchairs on 5/11/23 at 9:15am, it was confirmed that the wheelchairs did not factory installed tiedown latches on the frames. DPS # 4 Based on observation, interview, and record review, the facility failed to implement interventions to prevent a fall for 1 of 13 residents (Resident #39) revewed for accidents/hazards, resulting in the resident performing an unsafe self-transfer and the potential for major injury. Findings include: Review of an "Admission Record" revealed Resident #39, was originally admitted to the facility on 3/3/2023 with pertinent diagnoses which included cognitive communication deficit, muscle weakness, repeated falls, and difficulty in walking. Review of a "Minimum Data Set" (MDS) assessment for Resident #39, with a reference date of 3/9/2023 revealed a "Brief Interview for			

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	Mental Status" (BIMS) score of 6/15 which indicated Resident #39 was severely cognitively impaired. In an observation on 5/09/23 at 9:20 AM, Resident #39 was observed lying on back in bed. Resident #39's call light was observed hanging on the floor underneath the bed and out of reach. In an observation on 5/10/23 at 09:05 AM, Resident #39 was observed lying in bed on his back. Resident #39's call light was on the floor under the bed and out of reach. During an interview on 5/9/23 at 9:10 AM, Registered Nurse (RN) "XX" reported that Resident #39 does use his call light when he needs help. In an observation on 5/15/23 at 09:01 AM, Resident #39 was observed lying in bed on back. Resident #39's call light was clipped to his bed, but hanging down towards the floor out of reach. In an observation on 5/16/23 at 09:54 AM, Resident #39's roommate (Resident #47) was observed yelling out for staff assistance in the hallway outside of Resident #39's room. Resident #47 reported Resident #39 was on the floor. Resident #39 was observed kneeling on the floor next to his bed using his arms to hold onto the bed. The call light was observed lying on the ground under Resident #39's bed. Resident #39 stated loudly, "My knees are killing me. I have been waiting 45 minutes for someone to come help me." Regional Clinical Care Coordinator (RCCC) " M", Licensed Practical Nurse (LPN-UM) Unit Manager "O" and RN "E" entered Resident#39 room and assisted Resident #39 back to bed using a hoyer (device to help transfer residents) lift. Resident #39 reported that he was trying to get out of bed. LPN-UM "O" clipped			

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Resident #39's call light to his bed near his right shoulder (out of reach), and then LPN-UM "O" and RN "XX" left the room.

During an interview on 5/16/23 at 11:00 AM, Resident #39 asked this surveyor for assistance in finding his call light. Resident #39 was unable to see or grab his call light which was clipped to his bed near his right shoulder. RN "XX" entered Resident #39's room and confirmed that Resident #39 could not reach the call light.

During an interview on 5/16/23 at 10:25 AM, Certified Nursing Assistant (CNA) " BBB" reported that Resident #39 had been telling staff all morning that he wanted to go home, and he was attempting to get out bed earlier to go home. CNA "BBB" reported that the last time she checked on Resident #39 was around 9:00 AM, and she had helped place his legs back in his bed and told him to stay in bed. CNA "BBB" reported she did not know if Resident #39's call light had a clip to prevent the call light from falling to the floor.

During an interview with 5/16/23 at 10:59 AM, Resident #39's roommate (Resident #47) reported that he had observed Resident #39 attempting to get out of bed earlier in the morning and that staff assisted Resident #39 back into bed. Review of Resident #47's "Brief Interview for Mental Status" (BIMS) score revealed a score of 15/15 which indicated Resident #47 was cognitively intact.

Review of Resident #39's "Care Plan" revealed, "... At risk for falls related to deconditioning. Date initiated 3/3/2023. Goal: The resident will be free of falls. Interventions: ...Anticipate resident's needs based on nursing assessments. Date initiated 3/6/2023. Be sure resident's call light is within reach and encourage the resident to

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use it for assistance as needed. Dated initiated 3/3/2023..."

Review of Resident #39's "Post fall assessment" dated 5/16/23 revealed, "...Date of fall: 5/16/23...9a. Describe new physician orders: x-ray of pelvis...Fall re-evaluation: ...8. Change in mood/behavior that may have contributed to the fall? YES. 8a. Describe change in mood/behavior: Res. was asking to move to new room, res. confused at times...Plan of care Review: 1. New interventions implemented post fall: (no completed)...2. Date care plan reviewed and/or updated, as indicated: 5/16/23."

DPS #5

Based on observation, interview, and record review, the failed to provide adequate supervision with eating/drinking based on assessment and plan of care for 1 of 13 resident (Resident #39) reviewed for accident hazards, from a total sample of 24 residents, resulting in the potential for aspiration (accidentally inhaling fluid into the lungs).

Findings include:

Review of an "Admission Record" revealed Resident #39, was originally admitted to the facility on 3/3/2023 with pertinent diagnoses which included: dysphasia (difficulty swallowing), cognitive communication deficit, muscle weakness, repeated falls, and difficulty in walking.

Review of a "Minimum Data Set" (MDS) assessment for Resident #39, with a reference date of 3/9/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 6/15 which indicated Resident #39 was severely cognitively impaired.

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	Review of Resident #39's " Orders" revealed, " NPO (nothing by mouth) diet. NPO texture, for NPO, may have ice chips with supervision. Date initiated 3/3/2023. " Review of Resident #39's "Care Plan" revealed, " Resident requires tube feeding (device used to provide nutrition to people who cannot eat or drink by mouth) related to Dysphasia (difficulty swallowing). Goal: The resident will be free of aspiration through review date. Interventions: May have ice chips supervised. Date initiated 3/3/2023..." Review of Resident #39's "Speech Therapy Evaluation and Plan of Treatment" dated 4/20/23-5/19/23 revealed, " ... Clinical Bedside Assessment of Swallowing:...During ice chip trials, pt (patient) demonstrated mild prolonged mastication (chewing) and mild difficulty with manipulation in oral cavity...During 1/4 trials, pt began chewing ice chip, against stated recommendations, and then began coughing intensely; presumably pt had premature spillage over BOT (base of tongue) and then did not initiate swallow while chewing causing possible penetration/aspiration. In the past, pt has has silent aspiration (choking), but pt was able to cough during these trials...How often does patient require supervision/assistance at mealtime d/t (due to) swallowing safety? 0-25% of the time... Recommendations:...When trialing ice chips, pt should be upright and take one at a time..." Review of Resident #39's most recent "Speech Therapy Treatment Encounter Notes" revealed, " dated 5/9/2023: Precautions: ...impulsive, aspiration risk, reduced deficit awareness. Summary of daily skilled service: ...continues to demonstrate great difficulty initiating swallow and demonstrates fatigue throughout task..."			

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	In an observation on 5/10/23 at 10:04 AM Resident #39 was observed lying in bed on his back with head of bed elevated to 45 degrees. Resident #39's tray table was observed with a cup of ice chips with a spoon in the cup. Resident #39's tray table was at the bedside in reach of Resident #39. There were no staff members present in Resident #39's room. In an observation on 5/11/23 at 04:22 PM a loud noise was heard near Resident #39's room. When Resident #39's room was entered a cup of ice was observed on the floor and Resident #39 reported he had dropped it. There were no staff supervising Resident #39 at this time. During an interview on 5/11/23 at 04:23 PM, LPN "LL" reported that she thought Resident #39 was allowed to have ice chips unsupervised. LPN "LL" checked Resident #39 care plan and reported that she did not see any requirements for supervision when eating ice chips. LPN "LL" reviewed Resident #39 orders with this surveyor, which revealed the order requiring supervision with ice chips. LPN "LL" reported that she was unaware of that order and was surprised that this order had not been communicated to her in shift report before. During an interview on 5/11/23 at 4:42 PM, Registered Nurse (RN) Unit Manager "P" reported that he expected nurses to look under orders for dietary recommendations, and was not normally discussed in shift report. In an observation on 5/15/23 at 9:01 AM, Resident #39 was observed lying in bed on his back with head of bed elevated to 45 degrees. A cup of ice chips with a spoon was observed on Resident #39's tray table in reach for Resident #39. There were no staff in Resident #39's room during observation.			

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In an observation on 5/15/23 at 09:31 AM, Resident #39 was observed sitting up in bed eating ice chips and there were no staff supervising Resident #39.

During an interview on 5/15/23 at 09:35 AM, RN "XX" reported that Resident #39 should not have ice chips unsupervised because his diet is NPO due to swallowing difficulties. RN "XX" was unaware that Resident #39 had ice chips in his room, and was not sure who had given Resident #39 the ice chips.

During an interview on 5/15/23 at 09:54 AM, LPN-UM "O" reported that Resident #39's diet order is NPO because of swallowing difficulties, and that he required supervision when eating ice chips. LPN-UM "O" reported that there had been several nursing meetings where this had been discussed so all staff were aware of this order. LPN-UM "O" also reported that the information was noted in Resident #39's Kardex (Care order for CNA's).

During an interview on 5/15/23 at 10:22 AM, Program Manager Physical Therapy Assistant (PTA) "EEE" reported that Resident #39 was ordered strict NPO with ice chips only with supervision by the Speech Language Pathologist.

During an interview on 5/15/23 at 10:15 AM, CNA "CCC" was not able to identify Resident #39 as a resident that required supervision for eating.

In an observation on 5/15/23 at 2:31 PM in Resident #39's room, a full cup of ice chips was observed on the night stand. The cup was dated 5/15/23 and writing on the cup stated "full cup of ice chips".

In an observation on 5/17/23 at 03:59 PM

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	Resident #39 was observed lying in bed on his back with the head of the bed elevated to 45 degrees. There was a cup of ice dated 5/17/23 sitting on Resident #39's bed, within reach. There were no staff supervising Resident #39. During an in interview on 5/17/23 at 04:11 PM, CNA "DD" reported that she had passed the water and ice chips for residents earlier in the afternoon, but she did not pass one to Resident #39. CNA "DD" reported that she did not know Resident #39 had ice chips in his room. CNA "DD" reported that she was aware that Resident #39 could not have ice chips without supervision. CNA "DD" reported there was no place that CNA's have this information wrote down for passing water and ice, and that she just knew of this order because she was there when Resident #39 was admitted.			
F0690 SS= D	Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F0690		

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	receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00131068. Based on observation, interview and record review, the facility failed to provide coordination of care and services for a Foley catheter (flexible tube inserted through the urethra and into the bladder to drain urine) and maintenance of a suprapubic catheter (a tube inserted into the bladder through the abdominal wall to drain urine) according to professional standards of practice for urinary catheters for 2 of 5 residents (Resident #52 and Resident #73), resulting in the potential for unnecessary use of a catheter and infections. Findings include: Resident #52 Review of an "Admission Record" revealed Resident #52 was originally admitted to the facility on 6/23/22, with pertinent diagnoses which included: cerebral infarction (stroke) and Benign Prostatic Hyperplasia (BPH) with lower urinary tract symptoms. Review of a "Minimum Data Set" (MDS) assessment for Resident #52, with a reference			

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date of 12/29/22 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #52 was cognitively intact. This was the most recent BIMS assessment for Resident #52.

In an observation and interview on 05/09/23 at 10:31 AM, Resident #52 was lying in bed, and a catheter bag was observed hanging from the bed frame. Resident #52 reported that he has been trying to get rid of his catheter and was told that someone was going to come talk to him about it and stated, "...I don't want it in...I don't know why they want to keep it...I don't know why I have it in the first place...its been there for months..."

In an interview on 05/15/23 at 09:53 AM, Resident #52 reported that the foley catheter feels terrible and that he was told weeks ago that it was going to be removed, but that the doctor is no longer working in the facility and stated, "...it hurts...its tender inside...I hope it comes out soon..."

Review of Resident #52 "Responsible Party" on record indicated that Resident #52 made his own medical and financial decisions.

Review of Resident #52's "Physician Orders" revealed "Monitor urine from indwelling catheter...every shift for urine monitoring. Start date: 2/9/23."

Review of Resident #52's "Physician Orders" revealed "PLEASE DC (discontinue) FOLEY (catheter), BLADDER SCAN (check for amount of urine in bladder) Q (every) SHIFT AND ST (straight) CATH IF RESIDUAL IS OVER 300 CC. Start date: 3/29/23." The order was not completed and was discontinued on 5/4/23 verbally by the DON with the comment "voiding without complications." The order comment did

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not include why the foley catheter was not removed.

In an interview on 05/17/23 at 11:10 AM, Certified Nursing Assistant (CNA) "VV" reported that Resident #52 went to the hospital a couple months ago for a breathing issue and came back with a foley catheter and stated, "...he complains that it hurts..."

In an interview on 05/17/23 at 11:18 AM, Licensed Practical Nurse (LPN) "J" reported that Resident #52 had an order to remove the foley catheter on 3/29/23, but that it was not removed and there were no progress notes or physician notes related to the reason Resident #52 needed a foley catheter long-term.

In an interview on 05/17/23 at 11:28 AM, Registered Nurse (RN) "XX" reported that Resident #52 had requested the foley catheter be taken out after he returned from the hospital in March and that she informed Unit Manager-LPN "O" of the resident's request.

In an interview on 05/17/23 at 11:34 AM, LPN "VVV" reported that Resident #52's orders for foley catheter were unclear, and voiding without complications would be a reason to remove the foley catheter, and not a reason to keep the catheter.

Review of Resident #52's "Census Record" indicated that he was transferred to the hospital 2/4/23, and returned to the facility on 2/7/23, and then transferred to the hospital on 3/20/23, and returned to the facility on 3/23/23.

Review of Resident #52's "Nursing Evaluation Summary" dated 2/7/2023 at 8:12 PM revealed, "arrived by ambulance from (Hospital) after being there since 2/5/23- cath to dependent drainage

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	with tea colored urine- earlier today is was reddish due to him trying to pull out his cath- he reportedly was on supervised status to prevent him from pulling on it, did ask to have it taken out but no pulling observed or reported..." Review of Resident #52's "Hospital Discharge Summary" dated 2/7/23 indicated to schedule an appointment with the urology (urinary system) and continence specialist in 2-3 weeks for follow-up of urinary obstruction and foley catheter. Review of Resident #52's "Urinary Continence Evaluation" dated 3/31/23 revealed, "1. Diagnosis that may impact urinary continence: (BPH) and urinary tract infection...Was resident continent of urine at the time of admission: YES...Is a catheter in use: YES. Date inserted: (space is blank). Reason for catheter: obesity and (BPH)..." In an interview on 05/17/23 at 10:46 AM, Resident #52 reported that he had not had a follow up appointment with a Urologist (doctor that specializes in diseases of the urinary tract) and stated, "...I don't know why I have it (catheter)...I have asked them to take it out...they say I have to talk to a doctor about it but nobody comes to talk to me..." In an interview on 05/17/23 at 11:48 AM, UM-LPN "O" reported that she was not aware of an order to remove Resident #52's catheter, and reported that Resident #52 had a diagnosis of obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow), which was diagnosed at the hospital from a CT scan. UM-LPN "O" was not able to confirm that the resident had been informed and education about his catheter, that he was provided information related to the risks and benefits for the use of a catheter and/or involved in the care planning related to the use of a foley catheter			

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	while in the facility. Review of the facility policy "Catheterization" dated 10/20/20 revealed, "...1. Any decision regarding the use of an indwelling urinary catheter will be based on the resident's condition and goals for treatment. The resident and/or representative will be included in discussions about the indications, use, potential benefits and risks of urinary catheters, and alternatives to help support the resident ' s right to make an informed decision. 2. The use of an indwelling urinary catheter will be in accordance with physician orders, which will include the diagnosis or clinical condition making the use of the catheter necessary, size of the catheter and balloon, and frequency of change (if applicable). 3. Examples of appropriate indications for indwelling urethral catheter use: a. Resident has acute urinary retention or bladder outlet obstruction; b. Need for accurate measurements of urinary output;...4. Documentation to support decision making will be included in the medical record, including but not limited to: a. Clinical or medical conditions demonstrating the need for an indwelling urinary catheter. b. Assessment of incontinence, including the type, frequency, duration, and complicating factors associated with the incontinence. c. Assessment of psychosocial and functional factors affecting urinary continence status. d. Services provided to restore normal bladder function to the extent possible. e. Response to interventions prior to the decision to use an indwelling catheter. f. Resident's wishes and prognosis. 5. Indwelling urinary catheters will be used on a short-term basis, unless the resident's clinical condition warrants otherwise. The interdisciplinary team, with the support and guidance from the physician, will assure the ongoing review, evaluation, and decision making regarding the insertion, continuation, or removal of an indwelling urinary catheter. 6. Indwelling urinary catheters (urethral or suprapubic) will be			

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	utilized in accordance with current standards of practice, with interventions to prevent complications to the extent possible. Possible complications include, but are not limited to: urinary tract infection, blockage of the catheter, expulsion of the catheter, pain, discomfort, and bleeding. 7. The plan of care will address the use of an indwelling urinary catheter, including strategies to prevent complications. Resident #73 Review of an "Admission Record" revealed Resident #73 admitted to the facility on 3/1/2023 with pertinent diagnoses which included rectal abscess and encephalopathy. Review of a "Minimum Data Set" (MDS) assessment for Resident #73, with a reference date of 3/7/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #73 was moderately cognitively impaired. In an observation on 5/10/2023 at 8:41 AM, Resident #73's urinary catheter bag was hanging from his bed frame, and urinary catheter bag and tubing were lined heavily with old sediment to the point that it was difficult to ascertain the color and cloudiness of the urine. Review of Resident #73's Electronic Health Record on 5/10/2023 at 12:07 PM revealed no documentation of change of urine collection bag, tubing, or catheter since his admission to the facility on 3/1/2023. Review of Resident #73's active "Physician's Orders" on 5/10/2023 at 12:07 PM revealed an order to monitor urine from indwelling catheter for color and cloudiness, and to change indwelling catheter as needed as clinically			

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	indicated if signs and symptoms of obstruction including leakage and increased sediment, infection, or if the closed system was compromised. In an observation and interview on 5/10/2023 at 1:48 PM, DON (Director of Nursing) "B" reported Resident #73's order is to change urinary catheter as needed. DON "B" reported Resident #73's urinary catheter, collection bag, and tubing had not been changed since his admission to the facility. Upon observation of Resident #73's urinary catheter bag and tubing, DON "B" noted the heavy sediment and reported at the least his urinary collection bag and tubing should be changed. DON "B" instructed Unit Manager "P" to contact the medical provider for further direction. In an observation on 5/11/2023 at 1:23 PM in Resident #73's room, his urinary collection bag and tubing had been replaced. In an interview on 5/11/2023 at 1:28 PM, Unit Manager "P" reported Resident #73's urinary catheter collection bag and tubing had been replaced yesterday per the medical provider.			
F0692 SS= D	Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F0692		

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preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:

This citation pertains to intake MI00133629.

Based on interview and record review, the facility failed to ensure care and services were provided to maintain sufficient hydration for a resident at risk for altered hydration status for 1 (Resident #331) of 2 residents reviewed for hydration, resulting in the potential for dehydration, unmet resident needs, and unnecessary negative physical, mental, and psychosocial outcomes.

Findings include:

Review of an "Admission Record" revealed Resident #331 admitted to the facility on 9/2/2016 with pertinent diagnoses which included Alzheimer's Disease, cognitive communication deficit, and bipolar disorder.

Review of a "Minimum Data Set" (MDS) assessment for Resident #331, with a reference date of 3/3/2023 revealed a "Staff Assessment for Mental Status" score of 3, which indicated Resident #331 was severely cognitively impaired.

Review of a current potential for skin alteration "Care Plan" intervention for Resident #331, initiated 6/8/2022, directed staff to encourage good nutrition and hydration. Review of a current renal insufficiency "Care Plan" intervention for Resident #331, initiated 1/10/2022, directed staff

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	to encourage fluids throughout the shift. In an interview on 5/4/2023 at 3:45 PM, Family Member of Resident #331 "GGG" reported facility staff were not offering Resident #331 water according to her care plan. Family Member of Resident #331 "GGG" reported Resident #331 had dementia and didn't remember to drink. Family Member of Resident #331 "GGG" reported there have been times that he visited Resident #331 and there was no water available to her in the room. In an interview on 5/15/2023 at 11:05 AM, Confidential Informant "NNN" reported during Resident #331's bi-weekly video chats, Family Member of Resident #331 "GGG" would have her hold up Resident #331's hand and pinch her knuckle to check for dehydration. Confidential Informant "NNN" reported Family Member of Resident #331 "GGG" frequently mentioned dehydration during video chats. Confidential Informant "NNN" reported Resident #331 was frequently dehydrated when skin turgor was checked. Confidential Informant "NNN" reported that she brought this up at morning meetings with NHA (Nursing Home Administrator) "A", DON (Director of Nursing) "B", and Unit Managers present. Confidential Informant "NNN" reported these conversations were not taken seriously. Confidential Informant "NNN" reported when she was in the room Resident #331's water was always full with the ice melted, as if it had been sitting and not used. Confidential Informant "NNN" reported Resident #331 would not drink without staff assistance, requiring prompting.			
F0699 SS= D	Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of	F0699		

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	practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to identify post traumatic stress disorder (PTSD) triggers and develop individualized care plan interventions to mitigate triggers for 1 (Resident #65) of 24 residents reviewed for trauma informed care, resulting in the potential of re-traumatization due to staff not being informed and knowledgeable of the resident's past trauma. Findings include: Review of an "Admission Record" revealed Resident #65 was a female with pertinent diagnoses which included traumatic brain injury, diffuse traumatic brain injury (used to describe prolonged posttraumatic state in which there was loss of consciousness from the time of injury that continues beyond 6 hours), repeated falls, lack of coordination, contusion (bruising) and laceration (tears in brain tissue) of cerebrum with loss of consciousness, alcohol dependence with intoxication delirium (altered level of consciousness, impaired attention, disorientation, and visual hallucinations), anxiety, and cognitive social or emotional deficit following a stroke. Review of a "Minimum Data Set" (MDS) assessment for Resident #65, with a reference date of 5/5/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 5 out of 15 which indicated Resident #65 was cognitively impaired. Review of current "Care Plan" for Resident #65,			

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	revised on 2/14/23, revealed the focus, " ...The resident has impaired cognitive function impaired thought processes r/t (related to) Psychotropic drug use, Short term memory loss, h/x PTSD and alcohol dependency ..." with the intervention " ...The resident will maintain current level of cognitive function through the review date ...The resident will be able to communicate basic needs on a daily basis through the review date ...Resident needs will be anticipated by staff through the review date ...Communicate with the resident/family/caregivers regarding resident's capabilities and needs ...Cue, reorient and supervise as needed ...Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion ...Present just one thought, idea, question or command at a time ...Provide the resident with a homelike environment ..." Review of "Orders" for Resident #65 revealed, " ...BusPIRone HCl Tablet 5 MG ...Give 1 tablet by mouth three times a day for anxiety ...Start Date: 05/04/23 ..." Review of Resident #65's medical record does not show any services provided by facility behavioral health care services providers to address PTSD. Review of "Social Serviced Progress Review" completed on 5/4/23, revealed, " ...E. Trauma Informed Care (PC-PTSD-5) ...1. Does the resident have a diagnosis of Post-Traumatic Stress Disorder (PTSD) ...Yes ...2. Are your PTSD symptoms being manager effectively?...Yes ...3. What are your known triggers?...Uncertain ..." Review of "Social Serviced Progress Review" completed on 5/4/23, revealed, " ...C. Cognitive Mental Status ...2. Memory issue(s) ...Yes ...Short and long term memory lapses ...Disorganized			

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	thinking ...Brief Interview for Mental Status (BIMS) score of 7 ...Feeling down, depressed, or hopeless ...Poor appetite or overeating ...Trouble concentrating on things, such as reading the newspaper or watching television ...Wandering ...Things that make you become anxious/agitated: Wanting to get out of her but is "stuck" ...Resident's relationship with the roommate, other residents and staff/volunteers ..."Depends on the day" ... Review of Resident #65's progress notes in her medical record showed no mention of trauma or any trauma triggers or interventions. Review of "Task - Mood/Behavior" revealed no interventions or triggers for trauma. In an interview on 05/15/23 at 04:40 PM, Social Services Director (SSD) "F" reported the resident had the diagnosis of PTSD and was not sure why, she was a resident at a sister facility in town and she entered with that diagnosis. SSD "F" reported she was behind on assessments as those prior to her had not kept up to date with the social services requirements and she had not been given her full responsibilities and was supported by corporate. SSD "F" reported there was an initial social work assessment which included the trauma assessment and then there was a quarterly assessment. SSD "F" reported based on those assessments she "hasn't had anyone go that far to need services." In an interview on 05/16/23 at 02:59 PM, Social Services Director (SSD) "F" reported she had a conversation with Resident #65 and her sisters and discovered the resident had a history of abusive relationships, was an alcoholic, experienced homelessness, infidelity in her marriage. SSD "F" reported her last husband left her for someone else and this caused Resident			

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	#65 to begin drinking again after being sober for 8 years. According to Substance Abuse and Mental Health Services Administration (SAMHSA) publication, "Trauma- Informed Care in Behavioral Health Services" revealed, " ...Use of substances can vary based on a variety of factors, including which trauma symptoms are most prominent for an individual and the individual's access to particular substances. Unresolved traumas sometimes lurk behind the emotions that clients cannot allow themselves to experience. Substance use and abuse in trauma survivors can be a way to self-medicate and thereby avoid or displace difficult emotions associated with traumatic experiences. When the substances are withdrawn, the survivor may use other behaviors to self-soothe, self-medicate, or avoid emotions. As likely, emotions can appear after abstinence in the form of anxiety and depression ..." https://www.ncbi.nlm.nih.gov/books/NBK207191/			
F0725 SS= F	Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when	F0725		

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	waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake numbers MI00130764, MI00132304, MI00130620, MI00134506, MI00131068, MI00132056, MI00133919, MI00133629 and MI00134227. Based on observation, interview, and record review, the facility failed to ensure adequate nurse staffing to promote the physical, mental, and psychosocial well-being in 7 of 24 sampled residents (Resident #48, #62, #4, #8, #19, #42, and #18) reviewed for staffing, resulting in unmet care needs and the potential for physical and psychosocial harm for all residents in the facility. Findings include: Review of the Centers for Medicare and Medicaid (CMS) Form 672 (Resident Census and Conditions of Residents) submitted for review on 3/22/21 indicated a census of 78. The form revealed 75 residents were dependent on staff for bathing; 73 residents were dependent on staff for dressing; 68 residents were dependent on staff for transferring, and 70 residents were dependent on staff for toilet use. Review of the "Master Schedule" for Nurse Supervisor First Shift 6:45 AM to 3:15 PM had an open position for part time nurse and a full-time nurse; Second shift 2:45 PM to 11:15 PM, had an open position for a part time nurse for			

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	coverage on Saturday and Sunday on the first week of the rotation. Nurse Supervisor Third Shirt 10:45 PM to 7:15 AM, had an open full-time position ..." Review of the "Master Schedule" for Nurse Aide First Shift 6a - 6p had one full time opening, and two part time openings; Nurse Aide Second Shift 3pm-11pm had three full time openings and one part time opening; Nurse Aide Third Shift 11pm - 7am had a part time opening ..." Review of "Birchwood BLC Hall Group List 1st and 2nd Shift" revealed, " ...Group 1 (Hall Trays) Vitals Soiled Utility ...201-1, 201-2, 203-1. 203-2, 206-1, 206-2, 208-1, 208-2, 211-1, 211-2, 215-1, 215-2 ... (Note: 12 residents) ...Group 2: (DR/Water/Meal Tickets) ...202-1, 202-2, 2-4-1, 204-2, 205-1, 205-2, 207-1, 207-2, 209-1, 209-2, 213-1, 213-2 ...(Note: 12 residents) ..." Review of "A Hall Group List" revealed, " ...A1: Waters/Hall Trays ...101, 103-1, 103-2, 104-1, 104-2, 105-1, 105-2, 108-1, 108-2, 116-1, 116-2 ...(Note: 11 Residents) A2: Vitals/DR ...102-1, 102-2, 107-1, 107-2, 109-1. 109-2, 110-1, 110-2, 111-1, 111-2, 117-1, 117-2 ...(Note: 12 Residents) ...A3: Hall Trays/Trash ...106-1, 106-2, 112-1, 112-2, 113-1, 113-2, 114-1, 114-2, 115-1, 115-2 ...(Note: 10 Residents) ..." Review of the "Time Detail" for 4/23/23, revealed, 7 Certified Nurse Aides (CNAs) worked on 1st shift, 7 CNAs worked on 2nd shift, and 6 CNAs worked on 3rd shift. Review of the "Time Detail" for 1/31/23, revealed, 1st Shift: 1 CNA - 6 AM - 10 AM, 1 CNA 10 AM - 2 PM, 1 CNA 4:20 - 6:30 PM, 1 CNA 10 AM - 8 PM, 1 10 AM - 6:18 PM, 1 CNA 6 AM - 12 PM, and 3 CNA who worked 6 AM - 6 PM which equals 5.5 CNAs on the floor for 1st			

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	shift. This includes coverage from the Scheduler "K" and Unit Manager "O". Review of the "Time Detail" for 1/17/23, revealed, 1st shift had 6 CNAs minimum was to be 8 CNAs; and 2nd shift of the facility had 5 CNAs minimum was 8 CNAs. Review of the "Time Detail" for 10/13/22, revealed, 1st shift: 3 CNAs 6 AM - 2 PM, 1 CNA - 6 AM - 10 AM, 1 CNA 11:36 AM -1:46 PM, 1 CNA 6 AM - 6 PM which equals 5 CNAs worked and no coverage was provided Scheduler "K" or a Unit Manager. 7 CNAs worked on 2nd shift (2:00 PM - 10:00 PM) and 4 CNAs worked on 3rd shift (10:00 PM to 6:00 AM). Review of the "Time Detail" for 9/8/22, revealed, 1st: 5 CNAs in 6 AM, 1 CNA in 10 AM equal to 6 CNAs, 4 CNAs only from 2 PM to 6 PM, 6 CNAs 6 PM to 10 PM, and 5 CNAs 10 PM to 6 AM. In an interview on 05/09/23 at 09:40 AM, Registered Nurse (RN) "E" reported on the weekends the facility had very low staffing due to the low staffing because of call ins and staff members just not showing up. In an interview on 05/10/23 at 08:56 AM, Housekeeper "IIII" reported sometimes in the evenings there would be one CNA and they would ask me to help them so the resident doesn't fall and hurt themselves. Housekeeper "IIII" reported at times the housekeeping department was short staffed and the CNAs were having to do housekeeping duties in the resident's rooms. During an observation on 05/15/23 08:45 AM, Scheduler "K" was observed working on the floor as a CNA on B hall. This writer observed Admissions Coordinator "T" assisting a resident.			

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	In an interview on 05/15/23 at 09:57 AM, Staff Development (SD) "V" reported the education was assigned monthly to be completed by the end of the month. SD "V" reported halfway through the month she runs a report to see where the staff were in all completing the educations. SD "V" reported the facility does not allow staff to complete the trainings at home via the app and there were "not a lot of extra computers" so they would print out the training as a PDF, include the test, and an answer sheet in a folder kept at the nurse's station for those not able to get on a computer or who may learn better with paper in hand. SD "V" reported she would come to the floor and do spot checks or offer to assist with a task with the nursing staff to determine their competency with their duties. SD "V" reported she does not document the education provided on the spot. In an interview on 05/15/23 at 10:04 AM, SD "V" reported she had observed a concern with customer service she would have a one on one conversation with the staff person and discuss the expectations of how to treat residents with dignity, respect, and to meet their needs. In an interview on 05/15/23 at 10:28 AM, Admissions Coordinator "T" reported she was pulled from working as Admissions today to work on the floor as a CNA, she reported she was certified as a CNA, and she has been pulled from her Admissions duties other times to work on the floor due to low staffing. Admissions Coordinator "T" reported she would be working on the floor as a CNA today until we leave the facility for the day. During an observation on 05/16/23 at 09:24 AM, there were only two CNAs on the floor. Review of the "Nursing Schedule" for 5/16/23 revealed, there were only two CNAs on A hall and B hall, the facility had to pull the scheduler to			

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help cover the floor due to call ins.

In an interview on 05/16/23 at 09:35 AM, Scheduler "K" reported she was working on the floor again today to fill in for call ins.

In an interview on 05/16/23 at 11:09 AM, Social Services Director "F" reported she had observed the lack of support for the CNAs, for the new CNAs not being mentored and placed on the floor to work when not done with orienting to the floor and then other staff getting upset because the new ones were not picking it up quickly.

In an interview on 5/16/23 at 04:00 PM Unit Manager (UM) "O" reported the facility first shift nurses left at 2:00 PM, The SD "F" covered C hall, Unit Manager "O" covered B hall, and MDS Coordinator "U" covered D hall. UM "O" reported the second shift nurses do not come in until 6 PM.

In an interview on 05/17/23 at 10:49 AM, Activity Aide (AA) "G" reported he stopped working as a CNA at the facility because there were numerous instances of him working alone on a hallway quite frequently. AA "G" reported when you are working alone and you have a whole hallway to yourself you don't have the time to complete the showers for the residents. AA "G" reported it was difficult to find anyone to assist when need for providing personal care for those who were two person assists.

During an observation on 05/17/23 at 11:10 AM, observed Licensed Practical Nurse (LPN) "J" covering both A Hall and C Hall. There was no CNA assigned to C Hall until 10:00 AM and she was covering D Hall as well.

In an interview on 05/17/23 at 11:30 AM, CNA "SSS" reported when she was on a hallway with

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only her, which happens a lot, have even been alone on the A hallway, the residents were not getting showers. CNA "SSS" stated, "I can't do it!" CNA "SSS" reported she went to PRN and I make my own schedule as I have another job. CNA "SSS" reported the facility was contacting her every other day.

In an interview on 05/17/23 at 12:54 PM, Licensed Practical Nurse (LPN) "Q" reported she works as a PRN staff. LPN "Q" reported she was contacted by the facility quite often to work, "almost every day." LPN "Q" stated reported she had a full time job and she works at the facility when she was able to. LPN "Q" reported staffing wise the facility was short staffed with CNAs, "they need help and some days only the nurse was on the hallway, the facility was short all the time."

In an interview on 05/17/23 at 02:02 PM, CNA "C" reported they had worked at the facility for a long time as a Restorative Aide but due to staffing they do not have the program anymore. CNA "C" reported staffing was "hit and miss and most for the time they worked with 5 or 6 CNAs".

In an interview 05/18/23 at 10:05 AM, Scheduler "K" reported there were a couple of call ins today and she was working to find staff to fill those openings, but she was also working on the floor to assist the CNAs due to those call ins.

Resident #48:

Review of an "Admission Record" revealed Resident #48 was a female with pertinent diagnoses which included diabetic, cellulitis of right lower limb, high blood pressure, thyroid disorder, high cholesterol, anxiety and wound on her right foot.

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	Review of current "Care Plan" for Resident #48, revised on 7/10/2018, revealed the focus, " ...The resident needs activities of daily living assistance related to: Deconditioning , Impaired balance, right foot non weight bearing ..." with the intervention " ...BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse ...BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated ...BATHING/SHOWERING: The resident prefers showers on Tuesday and Fridays on second shift ...TRANSFER: The resident requires limited assist by (1) staff to move between surfaces as necessary ..." In an interview on 05/08/23 at 02:46 PM, Resident # 48 last night it took the CNAs an hour to come get me out of the bathroom. Resident #48 reported she currently believes she has a yeast infection and needs some medication. Resident #48 reported she believed the yeast infection developed because she was a heavier woman, and she was not getting bathed as often as she should. Resident #48 reported she would like to get a shower every day but "understands that was not how it works here." Resident #48 reported she was "doing all she could to stop the fish smell" and she reported she was aware her hair was greasy and was ready to get another shower. When this writer queried the resident on when she received her last shower/bath she reported "last Monday" (5/1/23). Resident #48 reported therapy provided the bath to her then in the tub and they let her wash herself. Resident #48 reported her hair was so greasy it had to be washed 3 times to remove the greasiness from it. Resident #48 could not remember the last time she had her hair washed prior to 5/1/23. Resident #48 reported she was supposed to get a shower twice a week and when she gets a shower with the CNAs, they want her to "get in and get out." Resident #48 reported she feels very rushed by the staff.			

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Resident #62:

Review of an "Admission Record" revealed Resident #62 was a female with pertinent diagnoses which included end stage heart failure, diabetes, COPD, high blood pressure, atrial fibrillation (an irregular, often rapid heart rate), depression, anxiety, and anemia.

Review of a "Minimum Data Set" (MDS) assessment for Resident #62, with a reference date of 1/9/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15 which indicated Resident #62 was cognitively intact.

In an interview on 05/15/23 at 08:53 AM, Resident #62 reported a couple of weeks ago a hall didn't have an aide and they took an aide from B hallway to work on that hallway. Resident #62 reported there was only one aide on our hallway because of moving them. Resident #62 reported a lot of staff had walked out on the facility due to the way they were spoken to. Resident #62 reported the administration had yelled at a CNA and she had screamed back at them if the managers treated staff decently and staff wouldn't leave, then the work would get done. Resident #62 reported the administration staff and unit managers were "very rude" to the new CNAs and it appeared they expected them "to be pros" and did not provide them with any support.

In an interview on 05/16/23 at 10:33 AM, Scheduler "K" reported she wore scrubs to work because she never knew if she would be needed on the floor due to call offs. Scheduler "K" stated, "...Like today, there were call ins and when I get the chance I try to call and text people to see if they would come in..." Scheduler "K" was

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	working on the floor today as a CNA due to the call ins. Scheduler "K" reported the master schedule was posted and it was a period of 4 weeks. The schedule never changes unless staff request a PTO day. Scheduler "K" reported the facility used a system which sends out a mass alert to staff and it will send me alerts if the a staff member would like to pick up a shift. If she was not able to get anyone to pick up, she then starts to make phone calls and sends out texts. Scheduler "K" reported the facility was staffed with 8 CNAs and 4 Nurses on first shift, 8 CNAs an d4 Nurses on 2nd shift, and 5 CNAs and 2 Nurses on 3rd shift. Scheduler "K" reported the break down was A hall: 3 CNAS as there is more need there...B hall: 2 CNAs there...C hall: 1 CNA as there were 8 residents there and the other hallways would come to assist for those who need two assist; and D hall: 2 CNAs there. Scheduler "K" reported the facility did use a mandation system with a green dot on the schedule so staff know the days they were likely to get mandated and could make arrangements for child care and such. Scheduler "K" reported the facility could only use the green dot mandation to mandate a staff member for call ins and not for not having enough coverage that day due to the hole in the master schedule. Scheduler "K" reported one of their weeks on the master schedule was not scheduled as it should be and she worked on trying to get it filled. Review of the "Facility Assessment" updated on 4/27/23, revealed, "...Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies..Number Needed Daily on Average Based on Acuity...RNs to Acuity...3...LPN to Acuity...6 ...Nursing Assistants to Acuity...20..." Resident #4			

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	Review of a "Minimum Data Set" (MDS) assessment for Resident #4, with a reference date of 1/3/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. In an interview on 5/8/23 at 3:26 p.m., Resident #4 reported staffing is an issue at the facility, and at times there is only one "Certified Nursing Assistant" (CNA) assigned to D-Hall on day shift. Resident #4 reported when only one CNA is assigned to D-Hall on day shift, beds are not made and call lights are not responded to in a timely manner. Resident #8 Review of a "Minimum Data Set" (MDS) assessment for Resident #8, with a reference date of 2/15/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. In an interview on 5/9/23 at 9:18 a.m., Resident #8 reported staffing at the facility is "...very light..." Resident #8 stated "...They say we have enough...(but) we don't have enough at all..." Resident #8 reported last night there was only one "Certified Nursing Assistant" (CNA) assigned to D-Hall on second shift. Resident #8 reported the CNA was unable to assist all of the residents to bed, and had to get help from another hall to complete the assignment. Resident #8 reported she requires two staff members for assistance with transfers and stated "...When it's time for me to get up and they only have one person, that person has to go find someone to help..." which takes additional time. Resident #8 reported call light response times can be 45 minutes to an hour at times, depending on the staffing levels.			

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	Resident #8 reported medications have been late and showers have been missed due to low staffing. Resident #19 Review of a "Minimum Data Set" (MDS) assessment for Resident #19, with a reference date of 2/19/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. In an interview on 5/10/23 at 9:49 a.m., Resident #19 reported staffing is an issue at the facility, often due to staff calling in and the shifts not being filled. Resident #19 reported showers are missed/pushed off until the next shift and call lights are not responded to in a timely manner due to low staffing. Resident #42 Review of a "Minimum Data Set" (MDS) assessment for Resident #42, with a reference date of 12/13/22, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. In an interview on 5/11/23 at 8:52 a.m., Resident #42 stated "...Most of the time we are short-staffed, especially with CNA's (Certified Nursing Assistants)..." Resident #42 reported at times the nurses are assigned two halls, which results in late medications. Resident #42 reported showers have been missed due to low staffing. Resident #18 Review of a "Minimum Data Set" (MDS) assessment for Resident #18, with a reference			

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date of 12/26/22, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated he was cognitively intact.

In an interview on 5/11/23 at 11:42 a.m., Resident #18 reported there is often only one "Certified Nursing Assistant" (CNA) assigned to D-Hall in the afternoon. Resident #18 reported staffing has been an issue at the facility for a long time, with one nurse often assigned two hallways. Resident #18 reported this has resulted in late medications and long call light wait times. Resident #18 stated showers have been missed "...because they are short of staff..." Resident #18 reported staffing is even worse on the weekends, and stated "...They will hardly have nobody to work..."

In an interview on 5/10/23 at 12:09 p.m., "Certified Nursing Assistant" (CNA) "EE" reported at times, there is only one CNA scheduled on D-Hall, and stated it "...takes time..." to find assistance for residents who require two person care. CNA "EE" reported care for residents on D-Hall can be time consuming, and take upwards of 45 minutes to an hour for each person, which results in long wait times for the remaining residents. CNA "EE" stated "...It's a lot..." CNA "EE" stated in regard to scheduled showers "...We just do what we can...(and) pray the managers come help. We work short a lot..." CNA "EE" stated "...It's impossible for me as one person to get everybody up, and feed them, and change them..." CNA "EE" reported the staffing issue is often due to call-ins where management doesn't step in to fill the open position, and stated "...They just leave us by ourselves..."

In an interview on 5/18/2023 at 12:27 PM, Activities Aide/Certified Nursing Assistant "G" reported he began working at the facility as a CNA. Activities Aide/Certified Nursing Assistant

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	"G" reported that he worked alone on a hall as a CNA a couple times. Activities Aide/Certified Nursing Assistant "G" reported when working alone on a hall as a CNA, it is harder to get people up, showers are not able to be performed, and call lights take up to 2 or 3 hours to be responded to. During an interview on 05/11/23 at 10:57 AM, CNA "VV" reported that there was usually only two CNA's assigned to each hall, and that management did not help. CNA "VV" reported that the managers were aware of the concerns that the CNA's had regarding their current workload. CNA "VV" reported that she cannot provide the care that she would like for residents due to workload. CNA "VV" reported that the majority of the residents on the hall required two person assist, in addition to high fall risks and behaviors that required frequent supervision. CNA "VV" reported that showers get missed because they required two staff, and that would leave the rest of the residents unsupervised. Review of "Facility Assessment" indicated that 31 residents in the facility required limited to extensive assistance with 1-2 staff members, and 39 residents that were completely dependent on staff for assistance. During an interview on 5/11/23 at 03:18 PM, CNA "EE" reported that most days each hall had two CNA's and the workload was not manageable. CNA "EE" reported that CNA's were not able to complete showers because they didn't have time. CNA "EE" reported that it was not safe for two CNA's to leave the floor to complete a shower for a resident that required two staff members to assist because it would leave the rest of the hall unsupervised. CNA "EE" reported that many residents required two person assist for transfers, and some for behaviors. CNA" EE"			

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	reported that management was aware of CNA's concerns but they did not offer to help. CNA "EE" reported that CNA's were usually the only staff members to answer call lights.CNA" EE" reported feeling unsupported by the nurses and management team. Review of Fundamentals of Nursing (Potter and Perry) 8th edition revealed: "Burnout is the condition that occurs when perceived demands outweigh perceived resources (Potter et al., 2013a). It is a state of physical and mental exhaustion that often affects health care providers because of the nature of their work environment. Over time, giving of oneself in often intense caring environments sometimes results in emotional exhaustion, leaving a nurse feeling irritable, restless, and unable to focus and engage with patients (Potter et al., 2013b)...Compassion fatigue impacts the health and wellness of nurses and the quality of care provided to patients...When a nurse experiences ongoing stressful patient relationships, he or she often disengages (Slatten et al., 2011)...It is not uncommon for nurses who are experiencing compassion fatigue to become angry or cynical and have difficulty relating with patients and co-workers (Young et al., 2011). Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 1671-1672). Elsevier Health Sciences. Kindle Edition."			
F0760 SS= D	Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f) (2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: This citation pertains to MI00134146.	F0760		

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Based on interview and record review, the facility failed to prevent significant medication errors in 1 (Resident #24) of 2 residents reviewed for antibiotic use, resulting in the potential for infection and negative physical, mental, and psychosocial outcome.

Findings include:

Review of an "Admission Record" revealed Resident #24 admitted to the facility on 7/22/2022 with pertinent diagnoses which included spinal stenosis and right artificial hip joint.

Review of a "Minimum Data Set" (MDS) assessment for Resident #24, with a reference date of 4/12/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #24 was cognitively intact.

In an interview on 5/8/2023 at 2:28 PM, Resident #24 reported that she returned to the facility on 12/28/2022 following hip surgery and instructed the nurse that her IV antibiotics were to start immediately. Resident #24 reported that it took a week for the facility to begin administering her IV antibiotics.

Review of Resident #24's local hospital "Final Report Infectious Disease Antibiotics Summary", dated 12/23/2022 at 2:05 PM, revealed an order for Resident #24 to receive 2 Grams of Cefazolin beginning 12/23/2022 and stopping 2/4/2023.

Review of Resident #24's local hospital "Final Report Progress Note", dated 12/25/2022 at 5:37 PM, revealed the plan to discharge to the skilled nursing facility with antibiotic orders via PICC line per Infectious Disease.

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	Review of a "Nursing Evaluation Summary" progress note dated 12/28/2022 at 6:00 PM revealed Resident #24 returned from a local hospital following right hip surgery and medications were reviewed by the medical doctor. Review of a "Nursing Evaluation Summary" progress note dated 12/29/2022 at 5:49 AM revealed Resident #24 had a PICC (Peripherally Inserted Central Catheter) line and stated that she was to have 6 weeks of IV antibiotics. The medical doctor instructed staff to maintain the PICC line until IV medications could be verified. Review of a "Nurses' Notes" progress note dated 1/1/2023 at 12:21 PM revealed the medical doctor gave an order to discontinue Resident #24's PICC line but the resident stated that she was to have 6 weeks of antibiotics. The medical doctor then ordered PICC line flushes until antibiotics could be clarified. Review of Resident #24's "Physician's Orders" revealed an order for IV Cefazolin being placed on 1/3/2023 at 10:00 PM. Review of Resident #24's "Medication Administration Record" revealed IV Cefazolin beginning the evening of 1/3/2023. Review of a "Nurses' Notes" progress note dated 1/4/2023 at 3:23 PM revealed antibiotics given via Resident #24's PICC line. In an interview on 5/11/2023 at 1:32 PM, Admissions Coordinator "T" reported that she was not working for the facility when Resident #24 admitted in December. Admissions Coordinator "T" reported that typically centralized admissions would send all admission information to her prior to admission. Admissions Coordinator "T" reported that she would			

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	communicate IV antibiotic orders to the Unit Managers and would expect any such medications to start immediately upon admission. In an interview on 5/11/2023 at 1:54 PM, Unit Manager "O" reviewed Resident #24's local hospital discharge documentation and reported the admitting nurse should have contacted the pharmacy to verify orders to ensure the antibiotics start immediately or as soon as possible. Unit Manager "O" reported there was no reason Resident #24's IV antibiotics could not have started upon admission to the facility. Unit Manager "O" reported that maybe the medical doctor dropped the ball.			
F0761 SS= D	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive 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:	F0761		

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Based on observation, interview, and record review, the facility failed to securely store and label resident medications for 1 of 6 residents (Resident #39) and 1 of 4 medication carts, resulting in the potential for the compromise of medications, and or the misappropriation of medications.

Findings include:

Resident #39

Review of Resident #39's "Admission Record" revealed Resident #39, was originally admitted to the facility on 3/3/2023 with pertinent diagnoses which included: dysphagia (difficulty swallowing), cognitive communication deficit, muscle weakness, repeated falls, and difficulty in walking.

Review of a "Minimum Data Set" (MDS) assessment for Resident #39, with a reference date of 3/9/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 6/15 which indicated Resident #39 was severely cognitively impaired.

In an observation on 5/17/23 at 10:21 AM Resident #39 was observed lying in bed on his back with the head of the bed elevated to 45 degrees. Resident #39's tube feed (a tube used to provide nutrition to people who cannot obtain nutrition by mouth) was running Jevity (tube feed nutritional supplement) and there was no open date, no start date, no start time, or initials of the nursing staff member that started the tube feed on the bottle. The bottle of Jevity was observed with approximately 200 of 1000 ml left in the bottle.

During an interview on 5/17/23 at 10:35 AM,

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	Registered Nurse (RN) "XX" reported that she had not observed Resident #39's tube feed that day and that the bottle of Jevity was started by the night shift nurse. Review of Resident #39's "Medication Administration Record (MAR)" revealed, " Enteral Feed Order. One time a day for NPO (Nothing by mouth diet). OFF Jevity 1.5 22 hours a day 70 cc/hr. Start date 5/11/2023 at 1400. During an observation on 5/15/23 at 8:55am, the medication cart in D Hall was unlocked with no nursing staff present. Drawers to the cart opened freely. Resident # 68 was walking alone nearby and was observed opening the door to the food cart independently. A review of Resident #68's Minimum Data Set (MDS) assessment dated 2/9/23 revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the Resident was moderately cognitively impaired. Section I of the MDS revealed Resident #16 had a diagnosis of Metabolic Encephalopathy (alteration in consciousness caused by brain dysfunction). At 9:02am, Registered Nurse (RN) "UU" opened a door from a resident's room and entered the hallway. In an interview on 5/15/23 at 9:02am, Registered Nurse (RN) "UU" reported she was the nurse for the unit and was responsible for the medication cart. RN "UU" reported she mistakenly left the cart unlocked when she stepped into a Resident's room to administer insulin. RN "UU" reported the cart should always be locked when unattended and failure to do so could result in medication diversion and /or accidental ingestion of medication.			

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F0804 SS= F	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: This citation pertains to Intake # MI00130764, #MI00132304, MI00134949 & # MI00133919. Based on observation, interview, and record review, the facility failed to provide palatable food products in 8 of 9 residents (Resident #8, #19, #42, #52, #22, #62, #44, & #57) reviewed for food palatability, and 6 of 13 residents from the confidential group interview, resulting in dissatisfaction with meals, decreased food acceptance, and the potential for nutritional decline. Findings include: Review of the policy/procedure "Menus and Adequate Nutrition", dated 1/1/22, revealed "...The purpose of this policy is to assure menus are developed and prepared to meet resident choices including their nutritional, religious, cultural, and ethnic needs, while using established guidelines...Menus shall reflect input from residents and resident groups...The resident council will be included periodically in menu planning, and efforts will be made to accommodate requests..." In a confidential group interview on 5/11/23 at 2:30 p.m., 6 of 13 residents in attendance reported a lack of variety in the menu.	F0804		

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Review of a "Resident Council Concern Form", dated 3/17/23, revealed "...Quality of food could be better. Would like to know about changing food vendors/companies...Want to talk to corporate about menu...Asked Council to clarify "quality" of food (and) they stated they're tired of seeing the same meal over (and) over..."

Resident #8

Review of a "Minimum Data Set" (MDS) assessment for Resident #8, with a reference date of 2/15/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.

In an interview on 5/9/23 at 9:18 a.m., Resident #8 reported she just finished her breakfast meal (a hot pocket from her personal food items). Resident #8 stated "...They (staff) didn't heat it right..." referring to the hot pocket. Resident #8 reported the muffin sandwich that was sent down from the kitchen was cold and she didn't like the type of bread used. Resident #8 reported the flavor of the food served is "...not good..." and stated "...I don't know who plans the meals. Some of the stuff (doesn't) even go together..." (referencing a day when pork loin was served with white beans and stewed tomatoes). Resident #8 stated "...Usually when the food gets to us it's cold. Every once and awhile you get lucky..." Resident #8 reported food concerns have been brought to both Resident Council and the Food Council meetings "...over and over again..." with no improvement in food temperature or quality.

Resident #19

Review of a "Minimum Data Set" (MDS) assessment for Resident #19, with a reference date of 2/19/23, revealed a "Brief Interview for

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Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.

In an interview on 5/10/23 at 9:49 a.m., Resident #19 reported the food served at the facility "...is terrible..." Resident #19 reported the menu is repetitive, the chicken served is "...rubbery...", and the other meats are often overcooked and tough. Resident #19 reported the food is often cold by the time it is served, especially when she eats in her room.

Resident #42

Review of a "Minimum Data Set" (MDS) assessment for Resident #42, with a reference date of 12/13/22, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.

In an interview on 5/11/23 at 8:52 a.m., Resident #42 stated she started eating her meals in the dining room because the food is "...supposed to be hot, and it's not..." Resident #42 reported staff often leave the meal cart door open in the dining room when serving trays, letting the food get cold. Resident #42 reported the flavor leaves "...more to be desired..." and the sides served "...are not very good. I hate stewed tomatoes..."

Resident #52

Review of a "Minimum Data Set" (MDS) assessment for Resident #52, with a reference date of 12/29/22 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #52 was cognitively intact.

In an interview on 5/9/23 at 10:31 AM, Resident

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#52 reported that the food is terrible and the vegetables that the facility served are semi raw, and he will not eat them.

Review of Resident #52's "Weight Records" revealed "198.2 Lbs (pounds) on 5/1/23...206.2 Lbs on 11/11/22" This indicated a 3.88% weight loss over the past 6 months.

Resident #22:

Review of a "Minimum Data Set" (MDS) assessment for Resident #22, with a reference date of 3/22/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 14 out of 15 which indicated Resident #22 was cognitively intact.

In an interview on 05/09/23 at 09:14 AM, Resident #22 reported she believed the items on her breakfast tray were supposed to be something like an egg McMuffin "without the egg." Resident #22 reported she thought the meat was supposed to be ham but it was too thick, tough, and salty. Resident #22 reported the eggs here taste like powdered eggs, dry and always cold. Resident #22 reported the food was "like institutionalized" food, definitely not "home cooked."

Resident #62:

Review of a "Minimum Data Set" (MDS) assessment for Resident #62, with a reference date of 1/9/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15 which indicated Resident #62 was cognitively intact.

During an observation on 05/15/23 at 8:53 AM, observed a cup of coffee and eggs on Resident #62's breakfast tray. Resident #62 reported she had to ask the staff to go and get her a cup of hot

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chocolate for her breakfast. Resident #62 reported the food was always cold and when she had asked for a salad, she only received lettuce with a bunch of onions, staff had to go and get her some cheese for her salad. Resident #62 had received fish for dinner, and she does not like fish and had asked for a salad to replace it. Resident #62 reported the staff member she had asked had forgotten the salad and she had to ask another staff member to bring her a salad.

Review of Resident #62's meal tickets for breakfast, lunch, and dinner revealed, " ...No coffee, no mushrooms, no fish ...Breakfast: Wants hot chocolate, no eggs, give yogurt or cottage cheese, and wants oatmeal ..."

Resident #44:

Review of a "Minimum Data Set" (MDS) assessment for Resident #44, with a reference date of 4/12/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 10 out of 15 which indicated Resident #44 was moderately cognitively impaired.

In an interview on 05/09/23 at 08:40 AM, Resident #44 reported her eggs were "ice cold" and her breakfast was not very good, and the food was always cold.

In an interview on 05/18/23 at 09:56 AM, Dietary Director "FF" reported she had interviewed the resident on their preferences, allergies, whole food groups, juices prefer. DD "FFF" reported when there were new employees, she met with them and would inform them if a resident makes a request or doesn't want or like something they should let her know as her "door is always open, or they could put a note in my box." DD "FFF" reported the CNAs go to the residents with the meal tickets and take their orders, bring those

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	back to the kitchen for the meal preparation based on those tickets. Resident #57 Review of a "Minimum Data Set" (MDS) assessment for Resident #57, with a reference date of 11/28/2022 revealed a "Brief Interview for Mental Status" (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #57 was cognitively intact. In an interview on 5/8/2023 at 12:14 PM, Resident #57 reported breakfast is often cold because it takes a long time for the aides to pass trays. In an interview on 5/15/2023 at 10:39 AM, Resident #57 reported breakfast was cold over the weekend. Resident #57 reported the eggs were cold this morning but she ate them anyway. Resident #57 stated, "Don't they have containers, to keep the food warm?" In an interview on 5/16/2023 at 9:14 AM, Resident #57 reported the eggs on her breakfast tray were cold again this morning. Resident #57 reported she wished the facility would put the eggs in a bowl with an insulated cover to keep them warm. An interview with Dietary Director (DD) "FF", at 12:05 PM on 5/8/23, found that the facility does pull test trays on occasion. When asked what the tray is evaluated for, Dietary Director "FF" stated, appearance, texture, and temperature. When asked what the ideal temperature is for hot food being served, DD "FF" stated over 145F or higher. A test tray was plated at 12:40 PM on 5/8/23, for B hall, the test tray made it to B hall at 12:55 PM			

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	and after all trays were delivered, the surveyor brought the tray back to the conference room at 1:03 PM. Temperatures at this time were Pork 110F, Stewed tomatoes 135F, and white beans 135F. The pork was served in a stir fry seasoning and was the only thing on the plate. The tomatoes and beans came in covered insulated bowls.			
F0813 SS= D	Personal Food Policy §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to monitor personal refrigerators for 2 of 2 residents (Resident #52 and #8) reviewed for food storage, resulting in unsafe food storage and the potential for food borne illness. Findings include: Resident #52 Review of a "Minimum Data Set" (MDS) assessment for Resident #52, with a reference date of 12/29/22 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #52 was cognitively intact. Review of "Functional Status" revealed, Resident #52 was totally dependent on staff for transfers and moving between locations in his room once in his wheelchair. During an observation and interview on 05/09/23 at 10:31 AM in Resident #52's room, a small refrigerator was observed next to Resident #52's	F0813		

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bed. The contents of the refrigerator included soda, condiments, an opened container of Eggnog with an expiration date of February 2023 and a container of butter with an expiration date of February 2023. None of the containers were dated with an open date. Resident #52 reported that he is supposed to take care of the refrigerator, but that he was not able to get out of bed. Resident #52 was not able to confirm when the last time the refrigerator had been cleaned or monitored for safe temperature range.

On 5/9/23 at 10:35 AM review of a "Log" that was hanging on the front of Resident #52's refrigerator was labeled with Resident #52's name, there was not a month recorded on the log, but the 1st and 2nd dates were completed and indicated "38" with the initials "JO". The top of the log included the text "Temp Range 37-42 Degrees F (fahrenheit)".

Resident #8

Review of an "Admission Record" revealed Resident #8 was a female, with pertinent diagnoses which included diabetes, heart failure, high blood pressure, arthritis, reduced mobility, and muscle weakness.

Review of a "Minimum Data Set" (MDS) assessment for Resident #8, with a reference date of 2/15/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. Further review of this MDS assessment, dated 2/15/23, revealed Resident #8 was totally dependent on staff for transfers and moving between locations in her room once in her wheelchair.

In an observation and interview on 5/9/23 at 9:18 a.m., Resident #8 was noted in bed in her room.

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	Observed a small dorm-style fridge (which contained personal food items) in her room, along the wall with a temperature log on the front. Noted the only dates filled out on the log were the 1st (39 degrees Fahrenheit) and the 2nd (37 degrees Fahrenheit). No additional temperatures documented on log. Resident #8 stated in regard to the temperature log "...They (staff) always tell me that I'm supposed to do that..." In an observation and interview on 5/10/23 at 10:18 a.m., observed the small dorm-style fridge in Resident #8's room. Noted the temperature log on the front had an additional temperature documented on the 3rd (40 degrees Fahrenheit). Resident #8 reported a staff member checked the temperature of the fridge the night before and documented this additional temperature. In an interview on 5/16/23 at 9:47 a.m., "Director of Nursing" (DON) "B" reported if a resident is physically able, it is the resident's responsibility to monitor personal fridge temperatures and discard expired food items. DON "B" reported if a resident is physically unable, staff would be responsible to go through the personal fridge to check temperatures and throw out old food items. DON "B" reported Resident #8 is responsible for her own fridge. DON "B" reported she was unsure if there was a facility policy in place in regard to personal refrigerators in resident rooms. Review of a facility policy "Use and Storage of Food Brought in by Family or Visitors" Date Implemented: 07/31/2020 Date Reviewed/ Revised: 01/01/2022 revealed, "It is the right of the residents of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident. Policy Explanation and Compliance Guidelines:			

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	1.Family members or other visitors may bring the resident food of their choosing. 2.All food items that are already prepared by the family or visitor brought in must be labeled with content and dated. a.The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator. b.The prepared food must be consumed by the resident within 3 days. c.If not consumed within 3 days, food will be thrown away by facility staff...4.It is the responsibility of the resident and/or resident representative to maintain said container and items in the container...7.The facility staff will assist residents in accessing and consuming food that is brought in by resident and family or visitors if the resident is not able to do so on their own."			
F0835 SS= F	Administratio §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00134506. Based on interview, and record review, the facility failed to ensure the facility was administered in a manner that maintains the safety and care of residents so residents may reach their highest practicable physical, mental, and psychosocial well-being for all 78 residents who reside at the facility, resulting in quality care not being provided to residents, insufficient management of facility staffing, a lack of follow-up in regard to concerns voiced by staff, and unresolved resident grievances.	F0835		

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Findings include:

In an interview on 5/8/23 at 12:43 p.m., Ombudsman "FFFF" reported ongoing issues at the facility involving staffing, missed showers/baths, and unresolved resident grievances. Ombudsman "FFFF" reported attempts have been made to resolve these issues, however Administrator "A" is "...difficult to work with..." Ombudsman "FFFF" reported they have been working with corporate staff for many of these issues because "...we didn't feel like we were getting anywhere with management..."

In an interview on 5/8/23 at 2:56 p.m., Ombudsman "EEEE" reported when residents bring up concerns to management, Administrator "A" signs off on the concerns as resolved, even when the residents were not informed of a resolution or aware of any follow-up.

In an interview on 5/18/23 at 11:31 a.m., "Confidential Informant" (CI) "PPP" reported they regularly attend "Quality Assurance and Performance Improvement" (QAPI) meetings. CI "PPP" reported staffing levels for nurses and "Certified Nursing Assistants" (CNA's) have been an issue for a period of time. CI "PPP" reported they have asked about bringing the concerns involving staffing to the QAPI meeting to develop a corrective action plan, however, Administrator "A" turned down the proposal.

In an interview on 5/18/23 at 11:48 a.m., "Social Services Director" (SSD) "F" reported Administrator "A" often treats staff and management poorly, and described an instance where she was "...scolded..." in front of her peers for her response to a surveyor's question. SSD "F" stated "...Good people (staff) are leaving and the residents are just collateral damage..." SSD "F"

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	reported several department heads are actively seeking new positions, and multiple staff have already left due to poor treatment by Administrator "A". SSD "F" stated Administrator "A" "...talks at the residents, not to them..." and is disrespectful to staff. SSD "F" reported the facility has a hard time obtaining and keeping staff due to these issues. Review of a "Resident Council Concern Form", dated 2/16/23, revealed "...Administrator is unapproachable. Would like to see her on the floor getting to know residents instead of sitting in her office (with) the door closed..." Review of a "Resident Council Concern Form", dated 2/16/23, revealed "...Many concern forms are not really followed up on, especially the ones from Res (resident) council. We have said the same concerns about (Administrator "A") since Nov (November) (2022)..." Review of a "Resident Council Concern Form", dated 2/16/23, revealed "...Communication is lacking in all departments...Residents feel that staff members (have) a hard time following through with things..." Review of a "Resident Council Concern Form", dated 2/16/23, revealed "...Residents feel like (Administrator "A") talks at people instead of to them. Lacks empathy, compassion (and) understanding..." Review of the "Resident Council Meeting Minutes", dated 4/27/23, revealed issues with concern forms not being followed up on. In a confidential group interview on 5/11/23 at 2:30 p.m., 8 of 13 residents in attendance reported issues with resolution of grievances and a lack of follow-up in regard to resident concern forms.			

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Resident #9

Review of an "Admission Record" revealed Resident #9 was originally admitted to the facility on 3/12/21. Review of a "Minimum Data Set" (MDS) assessment for Resident #9, with a reference date of 3/4/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #9 was cognitively intact.

Review of FRI (Facility Reported Incident) dated 5/17/23 at 2:31 PM revealed, "...Incident Summary (Resident #9) alleges that (NHA) threatened to discharge her to a hotel with no services, causing her mental anguish for that past 2 weeks."

In an interview on 05/09/23 at 09:26 AM, Resident #9 reported that the NHA can be antagonizing.

In an interview on 05/17/23 at 12:48 PM, Confidential Informant (CI) "DDDD" reported that the NHA made Resident #9 cry and stated, "...told her that she had 30 days to get out and it didn't matter if she went to a hotel or a homeless shelter..."

In an interview on 05/17/23 at 02:28 PM, Resident #9 reported that the NHA told her that she needed to pay or be discharged and that she would send her to a hotel and stated, "...she was being rude and very matter of fact...like she always does...I am used to it..." Resident #9 reported that the DON is worse.

Resident #71

Review of an "Admission Record" revealed Resident #71 was originally admitted to the

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	facility on 1/13/23. In an interview on 05/15/23 at 01:38 PM, Licensed Practical Nurse (LPN) "ZZ" reported that Assistant Housekeeping Manager (AMH) "AA" came to her and reported that Resident #71 was outside of the patio in the driveway and stated, "...I had just started my shift and was getting report...so I went out and he (Resident #71) was just about to cross the street...I followed him down the sidewalk...then he turned around and walked right back in with me..." LPN "ZZ" reported that she did not observe Resident #71 exit the building and did not know how long he had been outside. LPN "ZZ" reported that Resident #71 is a smoker and goes outside to the patio on his own to smoke, but that she had not given him cigarettes that night. LPN "ZZ" reported that she phoned Director of Nursing (DON) while she was outside with Resident #71 and stated, "...she (DON) did not have any concerns...just to do the assessments and to explain to the resident that he had to sign the LOA book before he left the facility..." In an interview on 05/15/23 at 01:24 PM, DON reported that she had received a call from LPN "ZZ" on 5/13/23 reporting that Resident #71 had exited the building and stated "...she (LPN "ZZ") said that he (Resident #71) was on the sidewalk across the street by the high school...taking a walk while he was smoking...he was never out of her (LPN "ZZ's") sight...she (LPN "ZZ") saw him walk out the door and was trying to catch up with him (Resident #71) when she called..." DON reported that this was not an elopement because Resident #71 was never out of sight and stated, "...I don't know what door he exited...I assumed the front door...I didn't ask..." DON reported that she requested that LPN "ZZ" complete a safe smoking assessment and an elopement risk assessment for Resident #71 following the incident on 5/13/23, and that the assessment			

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	confirmed that Resident #71 was not at risk for elopement and was safe to smoke unsupervised on the patio. DON reported that the incident was discussed in a managers meeting that morning. In an interview on 05/15/23 at 03:30 PM, DON reported that Resident #71 was assessed not at risk for elopement upon admission on 1/14/23 because he was not able to ambulate safely, and when he did try to walk he fell and stated, "...he has improved since then, but was not reevaluated..." DON reported that Resident #71 had been assessed on 1/14/23 as non-smoking, and did not know when Resident #71 started smoking or where Resident #71 got his cigarettes. DON reiterated and reported that on 5/13/23 Resident #71 did not elope, but that he left the building unsupervised and did not tell anyone, and that Resident #71 did not have orders for independent LOA. Review of Resident #71's "Progress Note" dated 05/13/2023 at 6:48 PM written by DON revealed, " (Resident #71) decided to go out the front door to smoke and took a walk with (LPN "ZZ") directly behind him. (Resident #71) was in no danger, stayed on the side walk, and was never out of visual site of nurse. (Resident #71) came back to facility with (LPN "ZZ") without complications. No concerns/ Educated on him needing to sign out in the LOA book and have his dad's permission to go for walks." This note was inaccurate considering the above statements from staff. Resident #1 Review of an "Admission Record" revealed Resident #1 was originally admitted to the facility on 4/15/2009. Review of a "Minimum Data Set" (MDS) assessment for Resident #1, with a reference date of 3/23/23 revealed a "Brief			

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Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #1 was cognitively intact.

In an interview on 05/09/23 at 10:04 AM, Resident #1 reported that she had problems getting assistance during the night, the facility is very short-handed, and sometimes it takes 1-2 hours for the call light to be answered. Resident #1 reported that the long call light response time is frequently discussed in resident council, and that during the last resident council meeting it was discovered that the NHA had resolved the concern forms, but had not actually done anything.

In an interview on 05/18/23 at 02:12 PM, MDS Coordinator (MDS) "U" reported that the MDS assessments are a multidisciplinary effort, but ultimately MDS "U" is responsible to ensure completeness. MDS "U" reported that the Social Worker (SW) is supposed to complete the "BIMS" and the Activities Director completes the "Preferences for Customary Routine and Activities" section of the MDS assessment. MDS "U" reported that all residents should have these areas assessed quarterly and stated, "...I noticed that parts of the MDS were not being completed...I brought the concern to QAPI a few months ago...but it has not been addressed..."

Resident #48

Review of an "Admission Record" revealed Resident #48 was a female with pertinent diagnoses which included diabetic, cellulitis of right lower limb, high blood pressure, thyroid disorder, high cholesterol, anxiety and wound on her right foot.

Review of current "Care Plan" for Resident #48, revised on 7/10/2018, revealed the focus, " ...The

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	resident needs activities of daily living assistance related to: Deconditioning , Impaired balance, right foot non weight bearing ..." with the intervention " ...BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse ...BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated ...BATHING/SHOWERING: The resident prefers showers on Tuesday and Fridays on second shift ...TRANSFER: The resident requires limited assist by (1) staff to move between surfaces as necessary ..." In an interview on 05/08/23 at 02:46 PM, Resident # 48 last night it took the CNAs an hour to come get me out of the bathroom. Resident #48 reported she currently believes she has a yeast infection and needs some medication. Resident #48 reported she believed the yeast infection developed because she was a heavier woman, and she was not getting bathed as often as she should. Resident #48 reported she would like to get a shower every day but "understands that was not how it works here." Resident #48 reported she was "doing all she could to stop the fish smell" and she reported she was aware her hair was greasy and was ready to get another shower. When this writer queried the resident on when she received her last shower/bath she reported "last Monday" (5/1/23). Resident #48 reported therapy provided the bath to her then in the tub and they let her wash herself. Resident #48 reported her hair was so greasy it had to be washed 3 times to remove the greasiness from it. Resident #48 could not remember the last time she had her hair washed prior to 5/1/23. Resident #48 reported she was supposed to get a shower twice a week and when she gets a shower with the CNAs, they want her to "get in and get out." Resident #48 reported she feels very rushed by the staff. Resident #62			

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Review of an "Admission Record" revealed Resident #62 was a female with pertinent diagnoses which included end stage heart failure, diabetes, COPD, high blood pressure, atrial fibrillation (an irregular, often rapid heart rate), depression, anxiety, and anemia.

Review of a "Minimum Data Set" (MDS) assessment for Resident #62, with a reference date of 1/9/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15 which indicated Resident #62 was cognitively intact.

In an interview on 05/15/23 at 08:53 AM, Resident #62 reported a couple of weeks ago a hall didn't have an aide and they took an aide from B hallway to work on that hallway. Resident #62 reported there was only one aide on our hallway because of moving them. Resident #62 reported a lot of staff had walked out on the facility due to the way they were spoken to. Resident #62 reported the administration had yelled at a CNA and she had screamed back at them if the managers treated staff decently, the staff wouldn't leave, then the work would get done. Resident #62 reported the administration staff and unit managers were "very rude" to the new CNAs and it appeared they expected them "to be pros" and did not provide them with any support.

In an interview on 05/15/23 at 09:02 AM, Resident #62 reported last week someone came into her room as she was asleep. Resident #62 reported the staff member informed her "keep her ink warm to sign the (discharge) paper as she was out of here." Resident #62 reported she had received a discharge notice indicated she had 90 days to "be out of the facility."

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	In an interview on 05/09/23 09:40 PM, Registered Nurse (RN) "N" reported the weekends, most of them were below state minimums, there were those staff who call in and don't show up, no consequences for the staff, there were staff who argue with residents and nothing happened to them. RN "N" reported the administration was not very good at holding staff accountable for the treatment of residents. RN "N" reported the staff were very aware "you don't defy managers or question what they tell you" and were very afraid of losing their jobs. RN "N" reported the NHA and DON were "very confrontational, they let you know you will lose your job." RN "N" reported when they were off they worried about the treatment and safety of the residents at the facility. In an interview on 05/17/23 at 01:39 PM, Human Resources (HR) "L" reported the DON, who was suspected pending investigation at that time, contacted him and provided him with a list of employees she wanted written up. HR "L" reported there was no context or background of an incident or action to justify writing those staff members up, just the list was provided. HR "L" reported he had received numerous complaints in regards to the Administrator and had forwarded them to the corporate office with no follow up from them, he was aware of. Review of "Vendor" Course Completion Report dated 5/18/2023, revealed, the Nursing Home Administrator had not completed the education for Resident Rights. Review of "Vendor" Course Completion Report dated 5/18/2023, revealed, the Nursing Home Administrator and the Director of Nursing had not completed the education for Effective Communication.			

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	Resident #331 Review of an "Admission Record" revealed Resident #331 admitted to the facility on 9/2/2016 with pertinent diagnoses which included Alzheimer's Disease, cognitive communication deficit, and bipolar disorder. Review of a "Minimum Data Set" (MDS) assessment for Resident #331, with a reference date of 3/3/2023 revealed a "Staff Assessment for Mental Status" score of 3, which indicated Resident #331 was severely cognitively impaired. Review of a current potential for skin alteration "Care Plan" intervention for Resident #331, initiated 6/8/2022, directed staff to encourage good nutrition and hydration. Review of a current renal insufficiency "Care Plan" intervention for Resident #331, initiated 1/10/2022, directed staff to encourage fluids throughout the shift. In an interview on 5/4/2023 at 3:45 PM, Family Member of Resident #331 "GGG" reported facility staff were not offering Resident #331 water according to her care plan. Family Member of Resident #331 "GGG" reported Resident #331 had dementia and didn't remember to drink. Family Member of Resident #331 "GGG" reported there have been times that he visited Resident #331 and there was no water available to her in the room. In an interview on 5/15/2023 at 11:05 AM, Confidential Informant "NNN" reported during Resident #331's bi-weekly video chats, Family Member of Resident #331 "GGG" would have her hold up Resident #331's hand and pinch her knuckle to check for dehydration. Confidential Informant "NNN" reported Family Member of Resident #331 "GGG" frequently mentioned dehydration during video chats. Confidential			

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	Informant "NNN" reported Resident #331 was frequently dehydrated when skin turgor was checked. Confidential Informant "NNN" reported that she brought this up at morning meetings with NHA (Nursing Home Administrator) "A", DON (Director of Nursing) "B", and Unit Managers present. Confidential Informant "NNN" reported these conversations were not taken seriously. Confidential Informant "NNN" reported when she was in the room Resident #331's water was always full with the ice melted, as if it had been sitting and not used. Confidential Informant "NNN" reported Resident #331 would not drink without staff assistance, requiring prompting. In a confidential group interview held on 5/11/23 at 2:30pm 8 of 13 Residents voiced concern regarding a lack of leadership at the facility. Residents reported grievances not being addressed, missing items not being replaced, staff members not being held accountable to facility policies, and care needs going unmet as a result. One resident stated "Our concerns don't mean anything to Nursing Home Administrator (NHA) "A", others agreed. In an interview on 5/15/23 at 10:32am at Confidential Informant (CI) "NNN" reported Nursing Home Administrator (NHA) "A" directed CI "NNN" to omit specific content from several requested documents prior to submitting them to the survey team. CI "NNN" reported the information was valid and relevant to the care of Residents but NHA "A" did not want surveyors to have the information. In an observation on 5/09/23 at 9:20 AM, Resident #39 was observed lying on his back in bed. Resident #39's call light was observed hanging on the floor underneath the bed and out of reach.			

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	During an interview on 5/09/23 at 12:28 PM, Family Member (FM) "YYY" reported that Resident #39's call light is frequently observed on the floor and out of reach. During an interview on 5/09/23 at 09:20 AM, Resident #39 reported he could not remember the last time he had a shower or bed bath. During an interview on 5/09/23 at 12:28 PM, Family Member (FM) "YYY" reported that Resident #39 was only getting one shower a week. FM "YYY" reported that they had arrived to visit Resident #39 around noon recently, and Resident #39 was still in the clothes that Resident #39 had been in the day before, was visibly soiled, and morning care had not been completed yet. FM "YYY" reported that they are often the person to assist Resident #39 in getting ready and completing oral care on Resident #39 because staff were not doing it. In an observation on 5/10/23 at 09:05 AM, Resident #39 was observed lying in bed on his back. Resident #39's call light was on the floor under the bed and out of reach. Resident #39 reported that he needed to be cleaned up and had been waiting for 1.5 hours for someone to come in and check on him. In an observation on 5/11/23 at 01:23 PM, Resident #39 was observed lying on his back in bed. Resident appeared disheveled with messy hair. Resident #39's dentures were laying on bedside table. During an subsequent interview on 5/11/23 at 01:29 PM, Registered Nurse (RN) "XX" reported that staff had been in to assist Resident #39 this morning, and his care had been completed. RN "XX" reported that "Bath Time Skin Anatomy Diagram" forms are completed by the Certified			

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	Nursing Assistant (CNA) every time a resident receives a shower or bed bath, and if the resident refuses the CNA would still complete the form by marking on the sheet that the resident refused care. Review of "Bath Time Skin Anatomy Diagram" forms in a binder at nurses station revealed two forms were completed on Resident #39 for April 2023, dated 4/1/23 and 4/8/23. There were no forms for March or May. Review of Resident #39 "ADL-Bathing tasks" revealed documentation of one bed bath completed for a look back period of 30 days. The bed bath documented on 5/5/23 indicated Resident #39 required total dependence for bed bath. There were no showers documented for the look back period of 30 days. During an interview on 5/11/23 01:39 PM, Registered Nurse (RN) Unit Manager "P" that he could not explain why there was only one bed bath documented under the bathing task for the last 30 days, or why there were only two bath time sheets completed for Resident #39 for the months of March, April, and May. During an interview on 05/11/23 at 10:57 AM, CNA "VV" reported that there was usually only two CNA's assigned to each hall, and that management did not help. CNA "VV" reported that the managers were aware of the concerns that the CNA's had regarding their current workload. CNA "VV" reported that she cannot provide the care that she would like for residents due to workload. CNA "VV" reported that the majority of the residents on the hall required two person assist, in addition to high fall risks and behaviors that required frequent supervision. CNA "VV" reported that showers get missed because they required two staff, and that would leave the rest			

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of the residents unsupervised.

Review of "Facility Assessment" indicated that 31 residents in the facility required limited to extensive assistance with 1-2 staff members, and 39 residents that were completely dependent on staff for assistance. Resident census at the time of survey was 78.

During an interview on 5/11/23 at 03:18 PM, CNA "EE" reported that most days each hall had two CNA's and the workload was not manageable. CNA "EE" reported that CNA's were not able to complete showers because they didn't have time. CNA "EE" reported that it was not safe for two CNA's to leave the floor to complete a shower for a resident that required two staff members to assist because it would leave the rest of the hall unsupervised. CNA "EE" reported that many residents required two person assist for transfers, and some for behaviors. CNA" EE" reported that management was aware of CNA's concerns but they did not offer to help. CNA "EE" reported that CNA's were usually the only staff members to answer call lights.CNA" EE" reported feeling unsupported by the nurses and management team.

In an observation on 5/15/23 at 02:47 PM, Resident #39 was observed sitting in a wheelchair in the hallway. Resident #39 hair was greasy and unkempt. Resident #39's shirt was covered with dry skin and his mouth was observed dry with cracked upper and lower lips.

During an interview on 5/18/23 at 12:06 PM, FM "YYY" reported that they were concerned that Resident #39 had missed another shower this week, and that the staff member they spoke to was unable to provide any evidence that a shower was completed when asked. FM "YYY" reported that Resident #39 does not like for his hair to go

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unwashed, and that it can be upsetting for him to miss out on this.

During an interview on 5/09/23 at 12:28 PM, Confidential informant (CI) "KKK" reported that they had expressed their concerns related to Resident #39's care to management the management team on multiple occasions, but the concerns were never addressed. CI "KKK" reported that there had been multiple occasions when they were told that the Nursing Home Administrator "A" (NHA) would call them, but that the NHA "A" never called them back.

In an interview on 05/09/23 at 09:40 AM, Registered Nurse (RN) "E" reported on the weekends the facility had very low staffing due to the low staffing because of call ins and staff members just not showing up.

In an interview on 05/10/23 at 08:56 AM, Housekeeper "IIII" reported sometimes in the evenings there would be one CNA and they would ask me to help them so the resident doesn't fall and hurt themselves. Housekeeper "IIII" reported at times the housekeeping department was short staffed and the CNAs were having to do housekeeping duties in the resident's rooms.

During an observation on 05/15/23 08:45 AM, Scheduler "K" was observed working on the floor as a CNA on B hall. This writer observed Admissions Coordinator "T" assisting a resident.

In an interview on 05/15/23 at 09:57 AM, Staff Development (SD) "V" reported the education was assigned monthly to be completed by the end of the month. SD "V" reported halfway through the month she runs a report to see where the staff were in all completing the educations. SD "V" reported the facility does not allow staff to complete the trainings at home via the app and

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there were "not a lot of extra computers" so they would print out the training as a PDF, include the test, and an answer sheet in a folder kept at the nurse's station for those not able to get on a computer or who may learn better with paper in hand. SD "V" reported she would come to the floor and do spot checks or offer to assist with a task with the nursing staff to determine their competency with their duties. SD "V" reported she does not document the education provided on the spot. In an interview on 05/15/23 at 10:04 AM, SD "V" reported she had observed a concern with customer service she would have a one on one conversation with the staff person and discuss the expectations of how to treat residents with dignity, respect, and to meet their needs.

In an interview on 05/15/23 at 10:28 AM, Admissions Coordinator "T" reported she was pulled from working as Admissions today to work on the floor as a CNA, she reported she was certified as a CNA, and she has been pulled from her Admissions duties other times to work on the floor due to low staffing. Admissions Coordinator "T" reported she would be working on the floor as a CNA today until we leave the facility for the day.

During an observation on 05/16/23 at 09:24 AM, there were only two CNAs on the floor.

Review of the "Nursing Schedule" for 5/16/23 revealed, there were only two CNAs on A hall and B hall, the facility had to pull the scheduler to help cover the floor due to call ins.

In an interview on 05/16/23 at 09:35 AM, Scheduler "K" reported she was working on the floor again today to fill in for call ins.

In an interview on 05/16/23 at 11:09 AM, Social Services Director "F" reported she had observed

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	the lack of support for the CNAs, for the new CNAs not being mentored and placed on the floor to work when not done with orienting to the floor and then other staff getting upset because the new ones were not picking it up quickly. In an interview on 5/16/23 at 04:00 PM Unit Manager (UM) "O" reported the facility first shift nurses left at 2:00 PM, The SD "F" covered C hall, Unit Manager "O" covered B hall, and MDS Coordinator "U" covered D hall. UM "O" reported the second shift nurses do not come in until 6 PM. In an interview on 05/17/23 at 10:49 AM, Activity Aide (AA) "G" reported he stopped working as a CNA at the facility because there were numerous instances of him working alone on a hallway quite frequently. AA "G" reported when you are working alone and you have a whole hallway to yourself you don't have the time to complete the showers for the residents. AA "G" reported it was difficult to find anyone to assist when need for providing personal care for those who were two person assists. During an observation on 05/17/23 at 11:10 AM, observed Licensed Practical Nurse (LPN) "J" covering both A Hall and C Hall. There was no CNA assigned to C Hall until 10:00 AM and she was covering D Hall as well. In an interview on 05/17/23 at 11:30 AM, CNA "SSS" reported when she was on a hallway with only her, which happens a lot, have even been alone on the A hallway, the residents were not getting showers. CNA "SSS" stated, "I can't do it!" CNA "SSS" reported she went to PRN and I make my own schedule as I have another job. CNA "SSS" reported the facility was contacting her every other day.			

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F0842 SS= E	Resident Records - Identifiable Informatio §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in	F0842		

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	State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physicia's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain complete and accurate medical records for 4 out of 24 residents (Resident #71, #5, #1, and #331) reviewed for medical records, resulting in inaccurate and incomplete medical records and the potential for facility staff and providers not having all of the pertinent information to care for residents. Findings include: According to the Fundamentals of Nursing, 6th Edition (Mosby, Patricia A. Potter, Anne G. Perry, 2005 Page 481) High quality documentation and reporting are necessary to enhance efficient, individualized client care. Quality documentation and reporting have five important characteristics: They are factual, accurate, complete, current, and organized. Resident #71 Review of an "Admission Record" revealed Resident #71 was originally admitted to the			

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	facility on 1/13/23, with pertinent diagnoses which included: cerebral infarction (stroke) and hemiplegia (paralysis) effecting right dominant side. Review of a "Minimum Data Set" (MDS) assessment for Resident #71, with a reference date of 4/21/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 8, out of a total possible score of 15, which indicated Resident #71 was cognitively impaired. In an interview on 05/15/23 at 01:38 PM, Licensed Practical Nurse (LPN) "ZZ" reported that Assistant Manager Housekeeping (AMH) "AA" came to her on 5/13/23 between 6:30-7:00 PM and reported that Resident #71 was outside of the patio in the driveway and stated, "...I had just started my shift and was getting report...so I went out and he (Resident #71) was just about to cross the street...I followed him down the sidewalk...then he turned around and walked right back in with me..." LPN "ZZ" reported that she did not observe Resident #71 exit the building and did not know how long he had been outside. LPN "ZZ" reported that Resident #71 is a smoker and goes outside to the patio on his own to smoke. Review of Resident #71's "Progress Note" dated 05/13/2023 at 6:48 PM written by the Former DON revealed, " (Resident #71) decided to go out the front door to smoke and took a walk with (LPN "ZZ") directly behind him. (Resident #71) was in no danger, stayed on the side walk, and was never out of visual site of nurse. (Resident #71) came back to facility with (LPN "ZZ") without complications. No concerns/ Educated on him needing to sign out in the LOA book and have his dad's permission to go for walks." The progress note was inaccurate considering the above statement from staff.			

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	In an interview on 05/15/23 at 01:46 PM, Resident #71's legal guardian (LG) "QQQ" reported that Resident #71 has always been a smoker and reported that Resident #71 had been allowed to smoke on the back patio of the facility independently. Review of Resident #71's "Nursing Admission Evaluation" dated 1/14/23 indicated that Resident #71 was not a smoker at that time, and had no plans to smoke or use tobacco related products while staying at the facility. There were no other evaluations on record for Resident #71 related to smoking. Review of Resident #71's "Safe Smoking Evaluation" revealed no evaluation existed in the record. Review of Resident #71's "Physician Orders" on 5/15/23 indicated that Resident #71 did not have orders for being safe to smoke independently. Review of Resident #71's "Care Plan" on 5/15/23 revealed no care plan related to smoking and/or at risk for elopement. Review of Resident #71's "Risk of Elopement/Wandering Review" dated 5/14/23 at 1:08 AM revealed, "1. Is the resident cognitively impaired with poor decision making skills (ie. intermittent confusion, cognitive defects or disorientation)? NO, 2. Elopement History: ...Leaving the facility without supervision when supervision is required? NO. Leaving the facility without informing staff? NO...Summary of Review: Resident is at list for elopement/wandering at this time? NO..." This document was inaccurate considering that Resident #71 eloped on 5/13/23 and has a BIMS of 8, which would indicate cognitive impairment.			

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	Resident #5 Review of an "Admission Record" revealed Resident #5 was originally admitted to the facility on 2/22/19. Review of Responsible party - clinical indicated Resident #5 was listed. Review of Resident #5's "Physician Orders" indicated that Resident #5 was "Full Code" status, indicating that Resident #5 would want CPR (cardiopulmonary resuscitation) active date 2/2/23. Review of Resident #5 "Advance Directive" signed and dated 2/2/23 by Resident #5 revealed, "I do not choose to formulate or issue any Advance Directives at this time. I want efforts made to prolong my life and want life sustaining treatment to be provided." Review of Resident #5's "Hospice Records" located in Resident #5's paper chart revealed a DNR (Do Not Resuscitate: No CPR) order signed and dated on 1/14/23 by Resident #5, and signed and dated on 1/17/23 by a physician. In an interview on 05/09/23 at 02:44 PM, Social Services Director (SSD) "F" reported that Resident #5 was competent to make her own medical decisions and she has chosen hospice services and stated, "...not aware of the DNR order..." SSD "F" reported that the facility currently had Resident #5's code status order as "Full Code", which contradicts with the DNR document in the hospice records. In an interview on 05/11/23 at 10:21 AM, Resident #5 reported that she did not want CPR to be performed in the event of a medical emergency. In an interview on 05/11/23 at 10:53 AM, SSD			

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	"F" reported that Resident #5 had chosen a DNR code status and that the facility had completed a new order for her that day. Review of Resident #5's newly formulated "DNR Order" indicated signed and dated on 5/10/23 by Resident #5, and signed and dated on 5/11/23 by a physician. Resident #1 Review of an "Admission Record" revealed Resident #1 was originally admitted to the facility on 4/15/2009. Review of a "Minimum Data Set" (MDS) assessment for Resident #1, with a reference date of 3/23/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #1 was cognitively intact. In an interview on 05/17/23 at 01:00 PM, Resident #1 reported that she had fallen on 4/27/23 just before 2:00 PM, and Unit Manager Registered Nurse (UM-RN) "P" had heard the crash and came to see what happened. Resident #1 reported that she did not feel bad initially, but then later that day she began having pain in her tailbone and stated, "...the nurses and aides knew...they got me ice packs..." Resident #1 reported that she had a brief visit with the doctor and he had mentioned doing an x-ray and stated, "...I guess he forgot..." Review of Resident #1's records did not contain any documentation related to a fall on 4/27/23. Review of Resident #1's "Fall Risk Evaluation" dated 11/30/22 indicated that Resident #1 had no falls in the past 90 days and was at low risk for falls. This was the most recent documentation related to falls.			

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	In an interview on 05/17/23 at 01:47 PM, UM-RN "P" reported that he had heard crash in Resident #1's room and he had went to see what the noise was and stated, "...she was on the ground...she said that she had slipped and fell against the bed, but couldn't get up so she lowered herself to the floor..." UM-RN "P" reported that this was not considered a fall, he did not document it, and that Resident #1 did not have any injuries and stated, "...she always has pain..." UM-RN "P" reported that he did not know if the physician was notified. In an interview on 05/17/23 at 04:08 PM, UM-LPN "O" reported that she was not aware of Resident #1 falling on 4/27/23 and that there was no documentation in the record of a fall. UM-LPN "O" reported that if Resident #1 fell back onto her bed, it was still considered a fall, and an assessment should be documented, and the physician should be notified. Review of Resident #1's "Nurse Note" dated 5/17/2023 at 6:52 PM revealed, " This nurse was made aware of this incident today and went to speak with the resident to see what she needed if she was ok and what her pain level was. She indeed is doing ok her tailbone hurts, and she is still able to independently ambulate around her room and down the hall provider notified." Resident #331 Review of an "Admission Record" revealed Resident #331 admitted to the facility on 9/2/2016 with pertinent diagnoses which included Alzheimer's Disease, cognitive communication deficit, and bipolar disorder. Review of a "Minimum Data Set" (MDS) assessment for Resident #331, with a reference date of 3/3/2023 revealed a "Staff Assessment for			

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	Mental Status" score of 3, which indicated Resident #331 was severely cognitively impaired. In an interview on 5/10/2023 at 2:48 PM, RN "QQ" reported he took Resident #331's vital signs the day before she went to the hospital (4/22/2023) when her change in condition was reported to him. RN "QQ" checked the electronic medical record and was unable to find any documentation of these vital signs. Review of the electronic medical record on 5/10/2023 at 2:30 PM revealed no evidence of vital signs being documented on 4/22/2023.			
F0865 SS= E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other	F0865		

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	survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)			

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	(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to identify quality deficiencies and implement appropriate corrective action plans in a timely manner, resulting in the potential for negative physical and psychosocial outcomes and decreased quality of life. Findings include: Review of the policy/procedure "QAPI (Quality Assistance and Performance Improvement) Plan", dated 10/24/22, revealed "...It is the policy of this facility to systematically collect data as part of the QAPI program to ensure the care and services it delivers meet acceptable standards of quality in accordance with recognized standards of practice. In addition the purpose of this document is to serve as a plan to assist the facility in development, implementation, and maintenance of an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The goal is to create a process that ensures care and services delivered meet accepted standards of			

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	quality...Key components of this plan may include...Identifying and prioritizing quality deficiencies...Systematically analyzing underlying causes of systemic quality deficiencies...Developing and implementing corrective action or performance improvement activities...Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed..." In an interview on 5/8/23 at 12:43 p.m., Ombudsman "FFFF" reported missed showers/baths have been a "...big issue..." at the facility. Ombudsman "FFFF" stated "...For a while, many people weren't getting showers...Only those who would fight for it..." Ombudsman "FFFF" reported for a period of time, staff would say many of the residents declined/refused showers, however many of the residents say they "...are not even being asked..." Review of a "Resident Council Concern Form", dated 3/17/23, revealed "...CNA's (Certified Nursing Assistants) write that showers are being refused but they aren't. Residents state they ask CNA to come back but they don't...Resolution: Showers have to be signed by resident (and) staff if shower is refused..." In an interview on 5/16/23 at 9:47 a.m., "Director of Nursing" (DON) "B" reported missed showers/baths were identified as an issue around January/February 2023. DON "B" reported as part of the process to correct the issue, the residents were interviewed for preferences and the shower schedule was modified. DON "B" reported missed showers/baths was a current, ongoing QAPI corrective action plan. DON "B" reported there have been some improvements, however documentation of showers/baths and bathing refusals still "...has a lot of room to grow..."			

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	In an interview on 5/18/23 at 11:31 a.m., "Confidential Informant" (CI) "PPP" reported they regularly attend QAPI meetings. CI "PPP" reported identified issues or concerns should be brought to QAPI by each department. CI "PPP" reported missed showers/baths have not been discussed in QAPI, and no corrective action plan has been initiated. In an interview on 5/18/23 at 11:48 a.m., "Social Services Director" (SSD) "F" recalled one QAPI meeting was held within the past few months. SSD "F" reported the April 2023 meeting kept "...getting put off and postponed..." until it didn't happen. SSD "F" reported missed showers/baths were never discussed in QAPI, and no corrective action plans were implemented. SSD "F" reported "...a while back..." Administrator "A" had management survey the residents for shower preferences, saying that they were going to redo the schedule, however this was never completed. SSD "F" reported there was no follow-up in regard to the missed showers/baths, and no audits completed. In an interview on 5/18/23 at 1:35 p.m., Administrator "A" reported QAPI meetings are held monthly, and include department heads and the Medical Director. Administrator "A" reported the last QAPI meeting was held 3/24/23. Administrator "A" reported a QAPI meeting was not held in April 2023. Administrator "A" reported missed showers/baths was a recently identified concern. Administrator "A" stated "...We found out that the managers weren't following up on refusals..." Administrator "A" reported this concern initially came up during resident council. Administrator "A" reported part of the corrective action plan was to have the residents sign their shower sheet to verify the refusal. Administrator "A" reviewed the notes in regard to the missed showers/baths and confirmed that the corrective action plan in regard to missed			

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	showers/baths started on 5/5/23. Administrator "A" confirmed that the topic of missed showers/baths has not yet been discussed in a QAPI meeting, and at this point is an informal project.			
F0921 SS= F	Safe/Functional/Sanitary/Comfortable Enviro §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake # MI00130764. #MI00132056, #MI00134949 & # MI00132304. Based on observation, interview, and record review, the facility failed to maintain shared resident equipment, spa rooms, and general cleanliness of resident rooms in 3 of 7 residents (Resident #8, #19, & #62) reviewed for environment, resulting in the potential for contamination, poor ventilation, and decreased satisfaction in living environment. Findings include: Resident #8 Review of an "Admission Record" revealed Resident #8 was a female, with pertinent diagnoses which included heart failure. Review of a "Minimum Data Set" (MDS) assessment for Resident #8, with a reference date of 2/15/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.	F0921		

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	In an observation and interview on 5/9/23 at 9:18 a.m., Resident #8 was in bed in her room. Resident #8 reported she had a shower yesterday and stated "...They need better ventilation in the shower room because you can't breathe in there...it was so stuffy..." Resident #8 reported room cleanings are not thorough. Observed a standing pedestal fan at the foot of Resident #8's bed with a large amount of visible dust buildup on the back of the fan. Resident #19 Review of an "Admission Record" revealed Resident #19 was a female, with pertinent diagnoses which included heart failure, obstructive lung disease, and heart disease. Review of a "Minimum Data Set" (MDS) assessment for Resident #19, with a reference date of 2/19/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. In an observation and interview on 5/10/23 at 9:49 a.m., Resident #19 was in bed in her room. Resident #19 reported the shower rooms are often messy, with towels on the floor. Resident #19 stated in regard to the cleanliness of the shower chairs "...I don't trust the seats so I make them wipe them down..." Observed a large white pedestal fan in Resident #19's room, near the bathroom, with a significant buildup of visible dust on the surface of the fan. Resident #19 reported the fan had not been cleaned since the previous summer. Observed the air vent on the ceiling of Resident #19's bathroom had a visible buildup of dust. In an interview on 05/16/23 at 09:54 AM, Family Member (FM) "TTT" reported the handles for the			

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	heater in her room were broken and it was extremely hot in her room, the windows were so frosted the resident could not see out of them, there was a hole in the wall with no patch on it, the bathroom vent was extremely dirty and the louvres of the vent were coated. FM "TTT" reported the resident's room was very dusty and the foot board to her bed was cracked. Resident #62: Review of an "Admission Record" revealed Resident #62 was a female with pertinent diagnoses which included end stage heart failure, COPD, and atrial fibrillation (an irregular, often rapid heart rate). Review of a "Minimum Data Set" (MDS) assessment for Resident #62, with a reference date of 1/9/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15 which indicated Resident #62 was cognitively intact. In an interview on 05/15/23 at 09:02 AM, Resident #62 reported housekeeping does not completely clean the room when they come in to clean. Resident #62 reported the housekeeper will sweep/mop the area from the entry door, across the room which was at the foot of their beds but does not get between the two beds or the sides of the beds closest to the walls for her and her roommate. Resident #62 reported they don't dust, wipe down areas, clean our tables, clean the windows, "nothing gets done except to empty the garbage." In an interview on 05/17/23 at 09:30 AM, Housekeeper "ZZZ" reported she had an assigned hallway, cleaned the nurse's station, entry foyer, bathroom, dining room, employee break room, and then goes back and checks the dining room			

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	prior to leaving. Housekeeper "ZZZ" reported the housekeepers do complete the checklist and sign off when they were done with their assignments. In an interview on 05/08/23 at 02:10 PM, revealed, Assistant Housekeeping Manager "AA" reported the housekeeping staff complete a checklist which indicated they have cleaned the room. Assistant Housekeeping Manager "AA" reported they also have the QCI (quality control inspection) to follow up and would pick random rooms on the list to inspect. Review of the "Housekeeper Checklist" revealed, "...Begin cleaning resident rooms (using the 5 and 7 step cleaning method)...5 Step Procedure: Pull trash/Replace liner...Horizontal Surfaces...Vertical Surfaces...Dust Mop...Damp Mop...7 Step Procedure: Check/refill supplies...Pull trash/Replace liner...Dust Mop/Sweep...Clean Sink Area/Tub...Clean Commode/Base...Clean Walls/Partitions...Damp Mop..." During a tour of the environment, with Maintenance Director "SS" and Regional Housekeeping Manager "CC", at 2:20 PM on 5/8/23, it was observed that the shower floor in the D hall spa room was found with excessive black slime accumulation on the back right shower. When asked about the black accumulation, Maintenance Director and Regional Housekeeping Manager "CC" stated that they have had troubles maintaining this section of the floor and have tried multiple cleaning agents to take off the black in the grout and on the tiles. Further review of the room found a shower chair with heavy accumulation of slime debris on the underside crevices on each side of the chair. During a tour of the D hall shower room, at 8:42 AM on 5/10/23, it was observed that shower			

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room had been used in the morning, due to water on the floor and wet shower beds, and was found humid and muggy with no obvious signs that the ventilation was working. One of the shower beds was observed with skin flakes on the mesh netting and the other shower bed was found with black accumulation along the back perimeter of the mesh netting where the upper body would lay. A review of the back shower floor found it had been cleaned since last observation, but still shown black staining in the grout and some portions of the tile.

An interview with Maintenance Director "SS" at 8:55 AM on 5/10/23, found that there were concerns over ventilation not working in the D hall shower room.

A review of the D hall shower room and the D hall soiled Utility room, starting at 9:00 AM on 5/10/23, found that neither was showing working ventilation after the surveyor placed paper towel over the exhaust ducts in each room. Maintenance Director "SS" stated he would go on the roof and get it checked out.

At 9:05 AM on 5/10/23, Maintenance Director "SS" and the surveyor went on the roof to evaluate the exhaust fan for D hall, it was found that the belt for the fan was broken and the motor would not start. Maintenance Director "SS" stated he would check into the issue and make sure it gets repaired.

During a tour of B hall, at 3:25 PM on 5/10/23, it was observed that the exhaust ventilation system in 202 Resident Bathroom and B hall soiled utility room, did not seem to be working. It was also observed that no light shield was present on the B hall by resident room 206.

Review of the policy/procedure "Routine

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	Cleaning and Disinfection", dated 2/1/22, revealed "...It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible..." Review of the policy/procedure "Routine Bathroom Cleaning", dated 2/1/22, revealed "...It is the policy of this facility to establish policies, procedures and guidelines to provide a clean and sanitary environment for residents, staff and visitors in order to prevent cross contamination and transmission of healthcare-associated infection (HAI)...Report areas of mold, cracked, leaking or damaged items in need of repair..."			
F0941 SS= F	Communication Training §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the provision of effective communication training for 103 staff review for communication training. This deficient practice had the potential affect all 79 residents in the facility. Findings include: Review of "Vendor" Course Completion Report dated 5/18/2023, revealed, 103 employees out of 126 employees had not completed the education for Effective Communication. No Therapy staff or Housekeeping staff listed on the report for completion of the education.	F0941		

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	Review of "Facility Assessment" reviewed by the QAPI Committee on 5/1/2023, revealed, the effective communication training was not referenced in the facility training topics as required training for facility staff. In an interview on 05/15/23 at 09:57 AM, Staff Development (SD) "V" reported the education in the vendor education system was assigned monthly to be completed by the end of the month. SD "V" reported halfway through the month she runs a report to see where the staff were in completing the educations. SD "V" reported the facility does not allow staff to complete the trainings at home via the app and there were "not a lot of extra computers" so she would print out the training as a PDF, include the test, and an answer sheet in a folder kept at the nurse's station for those not able to get on a computer or who may learn better with paper in hand. In an interview on 05/18/23 at 02:04 PM, NHA "A" reported the vendor education system was monitored by the NHA and the Staff Development coordinator and a report was ran to see who may be struggling to complete the trainings. NHA "A" reported the corporate office assigned the vendor education system trainings to be completed monthly. This writer requested the monthly calendar of assigned vendor education training, but it was not received prior to exit.			
F0942 SS= F	Resident Rights Training §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is not met as	F0942		

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	394160	A. BUILDING _____ B. WING _____	5/18/2023

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	evidenced by: Based on interview and record review, the facility failed to ensure the provision of training for compliance and ethics requirements for 81 employees out of 126 employees reviewed for resident rights training. This deficient practice had the potential to result in all resident rights and the facility's responsbilities for care with the potential to affect all 79 facility residents. Findings include: Review of "Vendor" Course Completion Report dated 5/18/2023, revealed, 81 employees out of 126 employees had not completed the education for Resident Rights. No Therapy staff or Housekeeping staff listed on the report. Review of "Facility Assessment" reviewed by the QAPI Committee on 5/1/2023, revealed, the resident rights training was not referenced in the facility training topics as required training for facility staff. In an interview on 05/15/23 at 09:57 AM, Staff Development (SD) "V" reported the education in the vendor education system was assigned monthly to be completed by the end of the month. SD "V" reported halfway through the month she runs a report to see where the staff were in completing the educations. SD "V" reported the facility does not allow staff to complete the trainings at home via the app and there were "not a lot of extra computers" so she would print out the training as a PDF, include the test, and an answer sheet in a folder kept at the nurse's station for those not able to get on a computer or who may learn better with paper in hand. In an interview on 05/18/23 at 02:04 PM, NHA			

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	"A" reported the vendor education system was monitored by the NHA and the Staff Development coordinator and a report was ran to see who may be struggling to complete the trainings. NHA "A" reported the corporate office assigned the vendor education system trainings to be completed monthly. This writer requested the monthly calendar of assigned vendor education training, but it was not received prior to exit. Review of policy, "Resident Rights" reviewed 1/1/22, revealed, " ...Employees shall treat all residents with kindness, respect, and dignity ... Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity ...Orientation and in-service training programs are conducted to assist our employees in understanding our resident's rights ..."			
F0943 SS= F	Abuse, Neglect, and Exploitation Training §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F0943		

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	failed to provide annual required abuse prevention education for 27 employees. This has the potential to affect all 79 residents residing in the facility at the time of the survey. Findings include: Review of "Vendor" Course Completion Report dated 5/18/2023, revealed, 27 employees out of 126 employees had not completed Understanding Abuse and Neglect and/or Recognizing, Reporting, and Preventing Abuse. No Therapy staff or Housekeeping staff listed on the report. Review of "Facility Assessment" reviewed by the QAPI Committee on 5/1/2023, revealed, the abuse training was not referenced in the facility training topics as required training for facility staff. In an interview on 05/15/23 at 09:57 AM, Staff Development (SD) "V" reported the education in the vendor education system was assigned monthly to be completed by the end of the month. SD "V" reported halfway through the month she runs a report to see where the staff were in completing the educations. SD "V" reported the facility does not allow staff to complete the trainings at home via the app and there were "not a lot of extra computers" so she would print out the training as a PDF, include the test, and an answer sheet in a folder kept at the nurse's station for those not able to get on a computer or who may learn better with paper in hand. In an interview on 05/18/23 at 02:04 PM, NHA "A" reported the vendor education system was monitored by the NHA and the Staff Development coordinator and a report was ran to see who may be struggling to complete the trainings. NHA "A" reported the corporate office assigned the vendor education system trainings to			

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	be completed monthly. This writer requested the monthly calendar of assigned vendor education training, but it was not received prior to exit. Review of policy, "Abuse Prevention Program" revealed, "...Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Our abuse prevention program provides policies and procedures that govern, at a minimum: o Protocols for conducting employment background checks; o Mandated annual staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, exploitation, mistreatment, neglect, stress management, dealing with violent behavior or catastrophic reactions, etc;...Abuse Identification, Training and Education: 3. Our abuse prevention/intervention education program includes but is not necessarily limited to, the following: Training all staff and practitioners how to resolve conflicts appropriately; o Allowing staff to express frustration with their job, or in working with difficult residents; o Assisting or rotating staff working with difficult or aggressive residents; o Informing residents and family members upon the resident's admission to the facility how and to whom to report complaints, grievances, and incidents of abuse; o Involving the resident/family group council in developing, monitoring and evaluating the facility's abuse prevention program; o Helping staff to deal appropriately with stress and emotions; o Training staff to understand and manage a resident's verbal or physical aggression; o Instructing staff about how cultural, religious and ethnic differences can lead to misunderstanding and conflicts; o Monitoring staff on all shifts to identify inappropriate behaviors toward residents (e.g., using derogatory language, rough handling			

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	of residents, ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in their clothing/beds, etc.); o Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect; o Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues; o Conducting background checks to avoid hiring persons or admitting new residents who have been found guilty (by a court of law) of abusing, neglecting, or mistreating individuals or those who have had a finding of such action entered into the state nurse aide registry or state sex offender registry; o Involving Attending Physicians and the Medical Director when findings of abuse have been determined; o Involving qualified psychiatrists and other mental health professionals to help the staff manage difficult or aggressive residents; o Identifying areas within the facility that may make abuse and/or neglect more likely to occur (e.g., secluded areas) and monitoring these areas regularly; o Striving to maintain adequate staffing on all shifts to ensure that the needs of each resident are met; and o Expect all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to facility management immediately..."			
F0944 SS= F	QAPI Training §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F0944		

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	failed to complete Quality Assurance and Improvement (QAPI) training for 126 staff reviewed out of 126 staff, resulting in the potential for staff for lack of knowledge of the elements and goals of the facility's QAPI program, their role and potential input, and unmet resident care needs due to an ineffective QAPI program. Findings include: Review of "Vendor" Course Completion Report dated 5/18/2023, revealed, 126 employees out of 126 employees had not completed the education for QAPI. No Therapy staff or Housekeeping staff listed on the report. Review of "Facility Assessment" reviewed by the QAPI Committee on 5/1/2023, revealed, the quality assurance resident rights training was not referenced in the facility training topics as required training for facility staff. In an interview on 05/15/23 at 09:57 AM, Staff Development (SD) "V" reported the education in the vendor education system was assigned monthly to be completed by the end of the month. SD "V" reported halfway through the month she runs a report to see where the staff were in completing the educations. SD "V" reported the facility does not allow staff to complete the trainings at home via the app and there were "not a lot of extra computers" so she would print out the training as a PDF, include the test, and an answer sheet in a folder kept at the nurse's station for those not able to get on a computer or who may learn better with paper in hand. In an interview on 05/18/23 at 02:04 PM, NHA "A" reported the vendor education system was monitored by the NHA and the Staff Development coordinator and a report was ran to			

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	see who may be struggling to complete the trainings. NHA "A" reported the corporate office assigned the vendor education system trainings to be completed monthly. This writer requested the monthly calendar of assigned vendor education training, but it was not received prior to exit. Review of policy, "QAPI Plan" reviewed/revised on 10/24/22, revealed, "...e. QAPI training that outlines and informs staff of the elements of QAPI and goals of the facility will be mandatory for all staff. (At the facility level, regional level and the corporate level, completed in Relias)..."			
F0946 SS= F	Compliance and Ethics Training §483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85- §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the provision of training for compliance and ethics requirements for 30 employees reviewed for compliance training. This deficient practice had the potential to result in unethical and unprofessional staff conduct, with the potential to affect all 79 facility residents. Findings include:	F0946		

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	Review of "Vendor" Course Completion Report dated 5/18/2023, revealed, 30 employees out of 126 employees had not completed at least one of the following educations, PSTG Compliance Code of Conduct and/or Basics of Corporate Compliance. No Therapy staff or Housekeeping staff listed on the report, per the regulatory updated requirements. Review of "Facility Assessment" reviewed by the QAPI Committee on 5/1/2023, revealed, the compliance and ethics training was not referenced in the facility training topics as required training for facility staff. In an interview on 05/15/23 at 09:57 AM, Staff Development (SD) "V" reported the education in the vendor education system was assigned monthly to be completed by the end of the month. SD "V" reported halfway through the month she runs a report to see where the staff were in completing the educations. SD "V" reported the facility does not allow staff to complete the trainings at home via the app and there were "not a lot of extra computers" so she would print out the training as a PDF, include the test, and an answer sheet in a folder kept at the nurse's station for those not able to get on a computer or who may learn better with paper in hand. In an interview on 05/18/23 at 02:04 PM, NHA "A" reported the vendor education system was monitored by the NHA and the Staff Development coordinator and a report was ran to see who may be struggling to complete the trainings. NHA "A" reported the corporate office assigned the vendor education system trainings to be completed monthly. This writer requested the monthly calendar of assigned vendor education training, but it was not received prior to exit.			

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F0949 SS= F	Behavioral Health Training §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the provision of training for behavioral health care and services for 36 staff reviewed for behavioral health care training. This deficient practice had the potential to result in unmet behavioral health care needs and services for residents, with the potential to affect all 79 facility residents. Findings include: Review of "Vendor" Course Completion Report dated 5/18/2023, revealed, 36 employees out of 126 employees had not completed at least one of the following educations, Teepa Snow Challenging Behaviors and/or Dementia Care: Challenging Behaviors and Direct Care Staff. No Therapy staff or Housekeeping staff listed on the report. Review of "Facility Assessment" reviewed by the QAPI Committee on 5/1/2023, revealed, the behavioral management training was not referenced in the facility training topics as required training for facility staff. In an interview on 05/15/23 at 09:57 AM, Staff Development (SD) "V" reported the education in the vendor education system was assigned monthly to be completed by the end of the month. SD "V" reported halfway through the month she runs a report to see where the staff were in	F0949		

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	completing the educations. SD "V" reported the facility does not allow staff to complete the trainings at home via the app and there were "not a lot of extra computers" so she would print out the training as a PDF, include the test, and an answer sheet in a folder kept at the nurse's station for those not able to get on a computer or who may learn better with paper in hand. In an interview on 05/18/23 at 02:04 PM, NHA "A" reported the vendor education system was monitored by the NHA and the Staff Development coordinator and a report was ran to see who may be struggling to complete the trainings. NHA "A" reported the corporate office assigned the vendor education system trainings to be completed monthly. This writer requested the monthly calendar of assigned vendor education training, but it was not received prior to exit.			