STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414090	A. BUILDING _____ B. WING _____	7/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM HEALTH REHAB AND NURSING CENTER	4118 KALAMAZOO AVE S E GRAND RAPIDS, MI 49508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Spectrum Health Rehab and Nursing Center was surveyed for a combined Recertification and Abbreviated survey on 7/10/23 - 7/12/23. Intakes: MI00130314, MI00137046 Census= 128	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 resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and	F0550	This plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or conclusion set forth on this statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. Spectrum Health Rehab and Nursing Center wishes to have this plan of correction stand as its written statement of compliance. F550 Resident Rights/Exercise of Rights Element #1 The identified concerns have been addressed and follow-up completed to satisfaction with Residents #117, #74, and #16. Resident #281 was discharged on 5/23/2023 from the facility per her discharge plan. Element #2 All residents residing in the facility as of July 12, 2023 have the potential to be affected. Element #3 Resident Rights and Patient Rights and Responsibilities Policies has been reviewed and deemed appropriate by the facility Nursing Home Administrator and Director of Nursing. Annual Regulatory Training and New	8/7/2023

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

Electronically Signed | 07/25/2023

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

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	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: MI00130314, MI00137046 Based on observation, interview, and record review, the facility failed to promote dignity in 4 (Resident #117, Resident #74, Resident #281, Resident #16) of 25 sampled residents, and 12 of 13 residents who attended a confidential resident meeting), resulting in: 1.) requests for assistance (call lights) not responded to within a timeframe to meet residents' individualized preferences and needs (Resident #117, Resident #74, Resident #281, and 12 of 13 residents who attended a confidential resident meeting), 2.) Resident #16 referred to by staff in an undignified and disrespectful manner, and 3.) feelings of diminished self-worth and frustration by all residents involved. Findings include: Resident #117 Review of a "Face Sheet" revealed Resident #117 was a female, with pertinent diagnoses which included: spasticity (stiff or rigid muscles) as late effect of cerebrovascular accident (stroke), and dysuria (painful or difficult urination). Review of a "Minimum Data Set" (MDS) assessment for Resident #117, with a reference date of 4/21/23 revealed the "Staff Assessment for Mental Status" indicated Resident #117's "Short-term Memory" was "OK" and Resident		Employee Orientation Training (which also includes Annual Regulatory Training) on Resident Rights has been reviewed and deemed appropriate by the facility Nursing Home Administrator and Director of Nursing. All Spectrum Health Rehab and Nursing Center team members will be re-educated on resident rights in providing an environment that promotes resident dignity and respect by demonstration of timely response to call lights and person-centered referencing of residents. Element #4 A quality-assurance program was implemented under the supervision of the Nursing Home Administrator to monitor compliance of an environment that promotes resident dignity and respect. The Nursing Home Administrator or designated quality-assurance representative will perform the following systematic changes: randomly checking, or weekly checking with residents for any recent concerns with timely response to call lights, person-centered resident referencing, and being treated with dignity and respect. Any deficiencies will be corrected on the spot and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. Element #5 The facility is confident that these corrective measures will be fully implemented by August 7, 2023. The Administrator is responsible for sustained compliance.	

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#117's "Long-term Memory" was "OK". Further review of said MDS revealed Resident #117 required extensive, one-person physical assist for "Transfer" (how resident moves between surfaces including to or from bed, chair, wheelchair ...) and "Toilet use" (how resident uses the toilet room, commode, bedpan, or urinal, transfer on/off toilet, cleanses self after elimination) and that Resident #117 was "Frequently incontinent" of urine.

Review of a current "Care Plan" for Resident #117 revealed, "(Resident #117) has a communication concern related to global aphasia (inability to understand or express speech resulting from brain damage, stroke).

In an observation/interview on 7/10/23 at 11:40 AM, Resident #117 was seated in her wheelchair in her room visiting with "Family Member" (FM) "YY". Resident #117 was non-verbal during the interview but did respond by nodding head for yes/no questions. FM "YY" reported call light wait time had been so long that they (FM "YY") have had to go and look for somebody to assist Resident #117 but was unable to provide specific date(s) that this had occurred. Resident #117 nodded head backwards and forwards in agreement. FM "YY" reported Resident #117 needed a hoyer lift (a machine used to transfer a person between surfaces) for transfers and has had to wait too long to go to the bathroom or get cleaned up after being incontinent.

Resident #74

Review of a "Minimum Data Set" (MDS) assessment for Resident #74, with a reference date of 5/12/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #74 was cognitively intact.

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In an interview on 07/10/23 at 03:23 PM, Resident #74 reported waiting 1-2 hours at times for cares to be provided, after turning on the call light and stated, "...I had to pee myself...good thing they give us briefs..." Resident #74 reported that at times the nursing staff refuse to assist the aides to answer call lights.

In a confidential resident group meeting on 7/11/23 at 3:00 PM, 12 of 13 residents reported that they wait an extended period of time for care needs to be met when turning on their call light. The residents reported that staff turn the call lights off, say they are busy and promise to come back, but they do not. The residents reported that licensed nursing staff often times will not answer call lights when the aides are busy.

Resident #16

Review of a "Face Sheet" revealed Resident #16 admitted to the facility on 9/25/2018 with pertinent diagnoses which included multiple sclerosis, depression, and physical deconditioning.

Review of a "Minimum Data Set" (MDS) assessment for Resident #16, with a reference date of 4/28/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 11, out of a total possible score of 15, which indicated Resident #16 was moderately cognitively impaired. Further review of the same MDS assessment revealed Resident #16 required assistance with eating.

In an interview on 7/11/2023 at 3:13 PM, Resident #16 reported CNA "RR" told her she was mean to her and told her she was a "feed." Resident #16 stated, "she talks to me in that way and I cry."

In an interview on 7/11/2023 at 3:35 PM, CNA

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"RR" stated, "(Resident #16) is a feed, so she has to be in the dining room, all supervision and all feeds need to be in the dining room."

In an interview on 7/12/2023 at 8:06 AM, Resident #16 reported she told Nurse Manager "U" the previous evening that CNA "RR" had been mean to her and Nurse Manager "U" was planning to talk to CNA "RR".

In an interview on 7/12/2023 at 10:59 AM, Nurse Manager "U" reported Resident #16 told her CNA "U" forced her to get out of bed for breakfast and was mean to her. Nurse Manager "U" reported she instructed CNA "U" that using the term "feed" describing a resident is not appropriate and that this should be described as needing assistance with meals.

Resident #281

Review of a "Face Sheet" revealed Resident #281 admitted to the facility on 4/29/2023 with pertinent diagnoses which included atrial fibrillation, obesity, and urinary incontinence.

Review of a "Minimum Data Set" (MDS) assessment for Resident #281, with a reference date of 5/23/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #281 was cognitively intact. Further review of same MDS assessment revealed Resident #281 required assistance with toileting.

In a telephone interview on 7/10/2023 at 4:35 PM, Resident #281 reported she was given a bell to ring in place of her call light while on suicide precautions, but staff was unable to hear the bell. Resident #281 reported she wet herself in bed once because she was unable to hold her urine until staff came to assist her. Resident #281

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	reported this made her feel very isolated. Review of facility policy/procedure "Resident Rights - Continuing Care", effective 10/17/2022, revealed " ...Every resident shall be entitled to humane care and treatment provided with dignity and respect ..."			
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 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 for dining location for 1 resident (Resident #16), of 1 resident reviewed for choices, resulting in the potential for this resident to not meet her highest	F0561	This plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or conclusion set forth on this statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. Spectrum Health Rehab and Nursing Center wishes to have this plan of correction stand as its written statement of compliance. F561 Self-Determination Element #1 The identified concern has been addressed and follow-up completed to satisfaction with Resident #16. Element #2 All residents residing in the facility as of July 12, 2023 have the potential to be affected. Element #3 Resident Rights and Patient Rights and Responsibilities Policies have been reviewed and deemed appropriate by the facility Nursing Home Administrator and Director of Nursing. Annual Regulatory Training and New Employee Orientation Training (which also includes Annual Regulatory Training) on Resident Rights have been reviewed and deemed appropriate by the facility Nursing Home Administrator and Director of Nursing.	8/7/2023

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	practicable physical, mental, and psychosocial well-being. Findings include: Resident #16 Review of a "Face Sheet" revealed Resident #16 admitted to the facility on 9/25/2018 with pertinent diagnoses which included multiple sclerosis, depression, and physical deconditioning. Review of a "Minimum Data Set" (MDS) assessment for Resident #16, with a reference date of 4/28/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 11, out of a total possible score of 15, which indicated Resident #16 was moderately cognitively impaired. Further review of the same MDS assessment revealed Resident #16 required assistance with eating. Review of a "Resident Care Summary" for Resident #16, dated 7/12/2023, revealed " ... (Resident #16) prefers to eat breakfast in bed and get out of bed after breakfast ..." In an observation on 7/11/2023 at 8:21 AM in the dining hall, resident was up in her wheelchair eating breakfast with staff assistance. In an interview on 7/11/2023 at 3:13 PM, Resident #16 reported that she prefers to stay in bed for breakfast, but the Certified Nursing Assistants (CNAs) had been telling her that she had to get up to the dining hall for breakfast. Resident #16 reported the CNAs have been forcing her to get up for breakfast for about a week. Resident #16 reported CNA "RR" recently stated, "I am not going to argue with you, you are going to get up for breakfast, this is the way we are going to do it." Resident #16 reported CNA		All Spectrum Health Rehab and Nursing Center team members will be re-educated on honoring resident preferences/choices. Element #4 A quality-assurance program was implemented under the supervision of the Nursing Home Administrator to monitor compliance of an environment that honors resident preferences/choices. The Nursing Home Administrator or designated quality-assurance representative will perform the following systematic changes: randomly checking, or weekly checking with residents for any recent concerns with personal preferences/choices being honored. Any deficiencies will be corrected on the spot and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. Element #5 The facility is confident that these corrective measures will be fully implemented by August 7, 2023. The Administrator is responsible for sustained compliance.	

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	"RR" told her she is a feed and must get up to the dining hall for meals. Resident #16 stated, "she talks to me in that way and I cry." Resident #16 reported the previous day CNA "RR" moved her to another table while eating because the state was here and stated, "you have to sit over here." In in interview on 7/12/2023 at 8:06 AM, Resident #16 reported she discussed her desire to eat breakfast in bed with Nurse Manager "U" the previous night. Resident #16 reported Nurse Manager "U" told her she needed to be up in the dining room for all three meals and would be updating her care plan to reflect this. Resident #16 reported Nurse Manager "U" stated, "I am in charge of this hallway." In an interview on 7/12/2023 at 10:59 AM, Nurse Manager "U" reported she spoke to Resident #16's Durable Power of Attorney that morning, who confirmed that Resident #16 preferred to stay in bed for breakfast. In an interview on 7/12/2023 at 11:31 AM, Nursing Home Administrator (NHA) "A" reported the facility will honor Resident #16's choice to remain in bed for breakfast. Review of facility policy/procedure "Resident Rights - Continuing Care", effective 10/17/2022, revealed " ...Every resident shall be entitled to humane care and treatment provided with dignity and respect. Residents are entitled to all the freedom and privileges of any other citizen ... Participation in planning care, medical treatment, and determining appropriate changes is encouraged ..."			
F0585 SS= C	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	F0585	This plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or conclusion set forth on this statement of deficiencies. This	8/7/2023

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	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 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		plan of correction is prepared solely because it is required by State and Federal law. Spectrum Health Rehab and Nursing Center wishes to have this plan of correction stand as its written statement of compliance. F585 Grievances Element #1 No individual resident was identified. Element #2 All residents residing in the facility as of July 12, 2023 have the potential to be affected. Element #3 Patient Complaint and Grievance Policy has been reviewed and deemed appropriate by the facility Nursing Home Administrator and Director of Nursing. Signage of the State of Michigan Contact Information for reporting abuse, quality of care issues, or other resident right violations postings (located on both main hallways and on nursing units) have been confirmed by the facility Nursing Home Administrator and Director of Nursing Spectrum Health Rehab and Nursing Center□s grievance signage has been updated and reposted throughout the facility which includes information regarding how to file complaints/grievances orally, in writing, and/or anonymously. Concern forms and drop-boxes have been implemented at all unit secretary desks. All Spectrum Health Rehab and Nursing Center team members will be re-educated on resident complaints/grievances□ procedures which include updated signage and options of	

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	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 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		filing orally, in writing, and/or anonymously. Element #4 A quality-assurance program was implemented under the supervision of the Nursing Home Administrator to monitor compliance of an environment that promotes transparency and understanding in resident grievances/complaints procedures. The Nursing Home Administrator or designated quality-assurance representative will perform the following systematic changes: randomly checking, or weekly checking with residents for any concerns or questions regarding resident complaints/grievances procedures. Any deficiencies will be corrected on the spot and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. Element #5 The facility is confident that these corrective measures will be fully implemented by August 7, 2023. The Administrator is responsible for sustained compliance.	

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	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: Based on observation, interview, and record review, the facility failed to 1). clearly identify grievance procedures with the use of signage for residents throughout the facility, 2). inform 13 of 13 residents, who participated in a confidential group meeting, of how to file a written grievance form or that filing a grievance was an option, and 3). implement the facility policy/procedure for grievances, resulting in the potential for care concerns to go unreported and not investigated. Findings include: Review of the facility policy "Patient Complaint and Grievance Policy" dated 2/7/23 revealed, "...1). Patients/Resident representatives/Families are informed how to file a complaint/grievance (including in writing, verbally and anonymously) at the time of admissions and via posting throughout the facility...6). The patient relations or grievance official designee will offer written decision on the grievance to the patient/resident or their representative..." In a confidential resident group meeting on 7/11/23 at 3:00 PM, 13 of 13 residents reported that they did not know who to report concerns/grievances to, they did not know how to file a written concern/grievance, were not offered a way to submit concerns on their own, and did not receive documentation of concern resolutions. The residents did not know who or what an Ombudsman was, and were not aware that they could discuss care concerns with an ombudsman. All 13 residents verbalized dissatisfaction with			

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	resolution of concerns that were verbalized to staff and/or during monthly resident council meetings. On 07/11/23 at 04:27 PM an observation of an 8 inch x 11 inch posting that included 5 small pictures of, the Director of Nursing (DON), Nursing Home Administrator (NHA), Nurse Manager (NM) "U", Nurse Supervisor (NS) "HH", and NS "ZZ", was hanging on a wall at the unit secretaries desk. The paper also included the writing, "Please contact (NS "ZZ") or (NS "HH") for concerns or general information regarding the unit." This statement was typed in approximately 12 font, and below each picture were contact names, numbers and emails, all typed in smaller font. There were no postings that indicated a designated grievance official, or how to submit a written concern/grievance to the facility. There were no paper concern/grievance forms present in the facility. In an interview on 07/11/23 at 04:28 PM, Certified Nursing Assistant (CNA) "W" reported that if a resident expressed a concern, she would enter it into the computer for management to review, but was not sure where the documentation goes from there. CNA "W" reported that residents can submit a written concern if they are not comfortable talking to staff, and those forms were kept at the nurses station. CNA "W" was not able to locate the forms, but stated would find out. In an interview on 07/11/23 at 04:34 PM, Unit Secretary (US) "G" reported that resident concerns/grievances must be verbalized to nursing staff, and if they are not able to resolve the issue, then it is entered into a computer system by the nursing staff. US "G" reported that the facility does not have a process for residents to submit concerns anonymously or in writing.			

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	In an interview on 07/11/23 at 04:45 PM, Social Worker (SW) "M" reported that she was not sure of the process for residents to submit concerns and/or grievances, but that she could find out. In an interview on 07/11/23 at 04:46 PM, Quality of Life Supervisor (QOLS) "C" reported that she usually lead resident council and if residents had concerns, she would not complete a concern/grievance form, but the concerns would be emailed to the appropriate teams and leaders to resolve. QOLS "C" reported that the facility had formal complaint forms at the nurse's station for residents to complete, and stated that it was a green form. QOLS "C" was not able to locate the forms, and reported that she was not sure how residents and/or families would file a concern/grievance with the facility. In an interview on 07/12/23 at 09:12 AM, Licensed Practical Nurse (LPN) "L" reported that if a resident had a concern, she would notify NS "HH" to follow up with the resident. In an interview on 07/12/23 at 12:11 PM, Nurse Supervisor (NS) "HH" reported that if a resident had a concern that was not able to be fixed in the moment, staff should notify a supervisor or unit manager to follow up with the resident, and if still not able to resolve, then the concern would be entered into the "Event Report System" (ERS). NS "HH" reported that a resident would have to ask a staff member to report a concern for them, there is no way for them to submit a concern to the facility on their own. In an interview on 07/12/23 at 01:15 PM, Nurse Manager (NM) "U" reported that if a resident has a complaint, we try to solve it, and if we cannot resolve the concerns we enter the concern into the ERS. NM "U" reported that the ERS is not linked with the residents health record, and the facility			

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	does not have a process in place for residents to submit concerns on their own. In an interview on 07/12/23 at 01:45 PM, NHA reported that if a resident verbalized a concern, staff would enter the concern into the ERS for actions and resolutions. NHA reported that the facility does not offer written concern forms for residents to complete, and does not offer a copy of the resolution of concerns/grievances to residents.			
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	F0656	This plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or conclusion set forth on this statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. Spectrum Health Rehab and Nursing Center wishes to have this plan of correction stand as its written statement of compliance. F656 Develop/Implements Comprehensive Care Plan Element #1 Resident #105 has been assessed and found to have no adverse effects along with his care plan reviewed to ensure interventions are specific to his needs and are accurately implemented. Element #2 All residents who require splints/braces/palm protectors on hands or arms residing in the facility as of July 12, 2023 have the potential to be affected. All like residents have been reviewed by nursing leadership to ensure Care Plans/RCS are written specific to each resident□s needs and are accurately implemented.	8/7/2023

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	resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with 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 implement care planned interventions for 1 (Resident #105) of 25 sampled residents resulting in the potential for increased pain, swelling, and contractures (A condition of shortening and hardening of muscles, tendons, or other tissues that often leads to deformity of joints). Findings include: Review of an "Admission Record" revealed Resident #105, was originally admitted to the facility on 11/4/2021 with pertinent diagnoses which included cognitive impairment secondary to a TBI (traumatic brain injury), quadriplegia (paralysis of all four limbs) and osteoporosis (condition which bones become brittle and fragile). Review of a "Minimum Data Set" (MDS) assessment for Resident #105, with a reference date of 3/31/23 revealed the "Staff Assessment		Element #3 The Care Plan Initiation and Management Policy has been reviewed and deemed appropriate by the facility Nursing Home Administrator and Director of Nursing. All direct care licensed nurses and certified nursing assistants will be re-educated on implementation of Care Plan/RCS interventions specifically related to splints/braces/palm protectors on hands or arms. Element #4 A quality-assurance program was implemented under the supervision of the Director of Nursing to monitor compliance in implementation of Care Plans/RCS interventions. The Director of Nursing or designated quality-assurance representative will perform the following systematic changes: randomly checking, or weekly checking for implementation of care plans for residents with splints/braces/palm protectors on hands or arms. Any deficiencies will be corrected on the spot and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. Element #5 The facility is confident that these corrective measures will be fully implemented by August 7, 2023. The Administrator is responsible for sustained compliance.	

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	for Mental Status" indicated Resident #105's cognitive skills for daily decision making was severely impaired. Review of Resident #105's " Care Assessment Summary" indicated, "Nursing Activities and Treatment: Brace Splint- Continuous. Comments: Apply per therapy schedule/recommendation. Duration: until specified. Extremity: Right and left arm. Upper extremity brace: Wrist/hand palm protector. Start date 1/26/22..." Review of Resident #105's " Care Assessment Summary" indicated, "Nursing Activities and Treatment: Brace Splint- Continuous. Comments: Apply WHO (Wrist-hand orthosis) to R UE (right upper extremity) per schedule. Duration: until specified. Extremity: Right arm. Upper extremity brace: Wrist/hand finger splint. Start date: 1/4/22 ..." In an observation on 7/10/23 at 10:47 AM, Resident #105 was sitting in his wheelchair watching television. It was noted that both of Resident #105's hands were contracted. The fingers on Resident #105's right hand were bent towards the right palm and did not move. Resident #105 was not wearing any splints/braces or palm protectors on either of his hands or arms. In an observation on 7/10/23 at 2:20 PM, Resident #105 was sitting in his wheelchair watching television. It was noted that Resident #105 was not wearing any splints/braces or palm protectors on either of his hands or arms. In an observation on 7/11/23 at 8:32 AM, Resident #105 was sitting in his wheelchair watching television. It was noted that Resident #105 was not wearing any splints/braces or palm protectors on either of his hands or arms.			

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	During an interview on 7/11/23 at 12:40 PM, Licensed Practical Nurse (LPN) "DD" reported that they (LPN "DD") were unsure if Resident #105 had any devices used for his hands or arms. During an interview on 7/11/23 at 02:21 PM, Certified Nursing Assistant (CNA) "KK" reported that they thought Resident #105 used to wear a splint but had not seen the splint or palm protectors for awhile, so assumed that the order was discontinued. During an interview on 7/12/23 10:17 AM, Therapy Director " UU" reported that Resident #105 had active orders which were placed by therapy in 01/2022 to wear a brace on his right arm daily and bilateral (right and left) palm protectors daily. During an observation on 7/12/23 at 11:04 AM, Resident #105 was sitting in the main dining area of unit without any splints/braces or palm protectors on either of his hands or arms. During an observation and interview on 7/12/23 at 11:18 AM, LPN " BB" reported not being sure if Resident #105 had orders for and braces/splints, but could find out by looking at the Resident #105's "up down schedule" which was posted in Resident #105's closet. LPN "BB" entered Resident #105's room with surveyor and reviewed Resident #105's "up down schedule" and determined that Resident #105 did have orders in place to wear a splint on his right arm and bilateral palm protectors when he was not wearing the splint on his right arm. LPN "BB" searched Resident #105's room and found a splint in his closet and palm protectors in a drawer in his night stand. LPN "BB" reported that the CNA is responsible for ensuring the devices are placed on residents when they get residents up for the day and following the "up down schedule". LPN			

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"BB" reported that the nurse is responsible for ensuring the CNA's are completing their tasks and that it was missed that day.

Review of Resident #105's "Up Down Schedule" revealed, "Right WHO (Wrist-Hand Orthosis) 2 clicks. Put on at 10:00 am. Take off at 12:00 pm. Put on at 6:30 PM. Take off at 9:00 PM. Bilateral palm protectors. Take off at 10:00 am. Put on at 12:00 PM. Take off at 6:30 PM. Put on at 9:00 PM."

During an interview on 7/12/23 at 12:53 PM, CNA " KK" reported that they were responsible for ensuring that Resident #105's splint/brace and palm protectors were on and off per schedule. CNA "KK" reported that it was missed the past two days because the therapy aides would sometimes complete this task for CNA's and they (CNA "KK") forgot to ensure it was completed. CNA "KK" reported that this task was not something that had to be checked off in the daily charting so it was easy to forget.

During an interview on 7/12/23 at 1:00 PM, Nursing Supervisor (NS) "P" reported that there was not anywhere in the EHR (electronic health record) that CNA's or Nurses were charting when they would place and remove splints/braces. NS "P" reported that CNA's were to follow the "Up Down Schedule" for each resident that is posted in the resident's closet, and that the nurse is responsible for ensuring that the tasks are completed.

A request for additional documentation related to therapy recommendations and orders for nursing staff regarding the splint/palm protectors, and 6/9/23 care conference note was sent to the Administrator and Director of Nursing via email on 7/12/23 at 1:25 PM. No additional records were received.

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F0677 SS= D	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: Based on observation, interview, and record review, the facility failed to provide appropriate Activities of Daily Living (ADL) care, specifically assistance with getting out of bed and incontinence care for 1 resident (Resident #94) of 5 residents reviewed for ADL care, resulting in the potential for avoidable negative physical and psychosocial outcomes for residents who are dependent on staff for assistance. Findings include: Resident #94 Review of an "Admission Record" revealed Resident #94 was originally admitted to the facility on 3/17/21, with pertinent diagnoses which included: Cerebral Vascular Accident (stroke) and Hemiplegia and hemiparesis (paralysis) following cerebral infarction affecting left non-dominant side. Review of a "Minimum Data Set" (MDS) assessment for Resident #94, with a reference date of 6/16/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #94 was cognitively intact. Review of the "Functional Status" revealed that Resident # 94 was completely dependent on 1 person for transfers, and required supervision for eating.	F0677	This plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or conclusion set forth on this statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. Spectrum Health Rehab and Nursing Center wishes to have this plan of correction stand as its written statement of compliance. F677 ADL Care Provided for Dependent Residents Element #1 The identified concerns have been addressed and follow-up completed to satisfaction with Resident #94. Element #2 All dependent residents residing in the facility as of July 12, 2023 have the potential to be affected. Element #3 Assessment and Management of Resident Physical Function Status and Resident Rights Policies have been reviewed and deemed appropriate by the facility Nursing Home Administrator and Director of Nursing. New Employee Orientation Training and OVT (Orientation Validation Tool) of direct care licensed nurses and certified nursing assistants have been reviewed and deemed appropriate by the facility Nurse Educator, Nursing Home Administrator and Director of Nursing. All direct care licensed nurses and certified nursing assistants will be re-educated on compliance of Care Plan/RCS interventions	8/7/2023

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	Review of Resident #94's "Resident Care Summary (guide for direct care)" revealed, "...Eating Safety: Supervision/Aspiration Risk; Up in Chair for Meals; Upright After Meals - 30 minutes...Bed Mobility: Dependent; Assist x 2...Transfer: Dependent; Lift - Mechanical; Sling - X-Large; Assist x 1...Toileting: Bladder Incontinent; Bowel Incontinent; Brief...Assist x 1...Comments: Prefers to lay down after meals, please offer following meals..." In an interview on 07/10/23 at 09:23 AM, Resident #94 reported that he was frustrated with staff not maintaining his "up-down" schedule and stated, "...likes to get up for breakfast, lay down around 10:00 AM and then back up for lunch..." Resident #94 reported that staff get him up into his chair around 6:00 AM and sometimes don't lay him down until after 12:00 PM. During an observation and interview on 07/11/23 at 12:49 PM Resident #94 was sitting in his chair and reported that he had been in his chair since 6:00 AM (7 hours), was wet, tired and needed to lay down. Certified Nursing Assistant (CNA) "W" transferred Resident #94 into bed using the "Maxi Move" hoyer (mechanical) lift. CNA "W" reported that third shift staff had gotten Resident #94 dressed and into his chair to help out first shift. CNA "W" performed incontinence care for Resident #94; Resident #94's incontinence brief was observed heavily saturated with urine, and noted to be lined with 2 additional incontinence pads that were also saturated. The saturated brief and incontinence pads were replaced with new dry ones. CNA "W" reported that it would make sense for Resident #94 to be on an up-down schedule, but that there was no information in the residents record to indicate that and stated, "...it just says up with meals and offer to lay down..." During an observation and interview on 07/12/23		specifically related to up/down schedules and the provision of incontinence care for dependent residents. Element #4 A quality-assurance program was implemented under the supervision of the Director of Nursing to monitor compliance in provision of appropriate Activities of Daily Living (ADL) care for dependent residents. The Director of Nursing or designated quality-assurance representative will perform the following systematic changes: randomly checking, or weekly checking for implementation of dependent residents Care Plan/RCS interventions specifically related to up/down schedules and the provision of incontinence care for dependent residents. Any deficiencies will be corrected on the spot and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. Element #5 The facility is confident that these corrective measures will be fully implemented by August 7, 2023. The Administrator is responsible for sustained compliance.	

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at 08:51 AM Resident #94 was lying in his bed, with the head of bed (HOB) at approximately 20 degrees (not sitting up). Resident #94 was eating from his breakfast tray in front of him. Resident #94 reported that he had asked staff to lay him down after breakfast yesterday, but they did not, therefore he wasn't getting up until after lunch this time.

During an observation on 07/12/23 at 10:36 AM Resident #94 was lying in bed with his clothing protector from breakfast still in place.

During an observation and interview on 07/12/23 at 11:53 AM Resident #94 was lying in bed with his clothing protector from breakfast pushed to the side of his head, and holding his call light in his hand. Resident #94 reported that he had pressed his call light earlier that morning to get a brief change and up for lunch, and had spoken to staff and they told him that they would be back later. Resident #94 reported that the last time he had a brief change was on third shift.

In an interview on 07/12/23 at 12:25 PM, Nurse Supervisor (NS) "HH" reported that Resident #94 does have an up-down schedule and stated, "...up for all meals and laid down after meals...and in the dining room for meals because of the risk for aspiration..." NS "HH" reported that the facility does not use additional incontinence pads in the incontinence briefs due to increased risk of skin breakdown and infections, and that Resident #94 should not have multiple incontinence products used at the same time.

During an observation and interview on 07/12/23 at 12:29 PM in Resident #94's room, CNA "GG" was preparing to get Resident #94 up into his chair. Resident #94's incontinence brief was observed heavily saturated with urine and noted to have 2 additional incontinence pads inside that

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	were also saturated. CNA "GG" reported that Resident #94 gets double briefs just in case he urinates a lot and that she does it because that's the way it's always done.			
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure resident safety with bed mobilty, mechanical-lift transfers and eating for 1 resident (Resident #94) of 2 residents reviewed for accident hazards, resulting in the potential for accidents and serious injury. Findings include: Resident #94 Review of an "Admission Record" revealed Resident #94 was originally admitted to the facility on 3/17/21, with pertinent diagnoses which included: Cerebral Vascular Accident (stroke) and Hemiplegia and hemiparesis (paralysis) following cerebral infarction affecting left non-dominant side. Review of a "Minimum Data Set" (MDS) assessment for Resident #94, with a reference date of 6/16/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 13, out of a total	F0689	This plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or conclusion set forth on this statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. Spectrum Health Rehab and Nursing Center wishes to have this plan of correction stand as its written statement of compliance. F689 Free of Accident Hazards/Supervision/Devices Element #1 Resident #94 has been assessed and found to have no adverse effects. Element #2 All residents who require a mechanical lift for transfers and/or are at risk for aspiration in the facility as of July 12, 2023 have the potential to be affected. Element #3 Assessment and Management of Resident Physical Function Status and Care Plan Initiation & Management Policies have been reviewed and deemed appropriate by the facility Nursing Home Administrator and Director of Nursing. New Employee Orientation Training, OVT (Orientation Validation Tool), and mechanical lift competencies of direct care licensed nurses and certified nursing assistants have been reviewed and deemed appropriate by	8/7/2023

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	414090	A. BUILDING _____ B. WING _____	7/12/2023

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	possible score of 15, which indicated Resident #94 was cognitively intact. Review of the "Functional Status" revealed that Resident # 94 required extensive assistance of 1 person for bed mobility (moves side to side, to and from lying position), total dependence of 1 person for transfers, and supervision for eating. The information related to bed mobility differs from the care summary. Review of Resident #94's "Resident Care Summary (guide for direct care)" revealed, "...Eating Safety: Supervision/Aspiration Risk; Up in Chair for Meals; Upright After Meals - 30 minutes...Bed Mobility: Dependent; Assist x 2...Transfer: Dependent; Lift - Mechanical; Sling - X-Large; Assist x 1..." The care needs for bed mobility defer from the MDS assessment record. In an interview on 07/10/23 at 09:23 AM, Resident #94 reported that he preferred to get out of bed for meals. Resident #94 reported that he had wounds on his feet from the hoyer (mechanical) lift and stated, "...they (staff) bang my feet every day..." During an observation and interview on 07/11/23 at 12:49 PM Resident #94 was sitting in his chair, Certified Nursing Assistant (CNA) "W" transferred Resident #94 to bed using the "Maxi Move" hoyer lift; Resident #94 was raised into the air from his chair and CNA "W" maneuvered the hoyer lift over to the bed, then came around the side and positioned Resident #94 over the bed and used the remote to lower the resident into bed. CNA "W" reported that it was difficult to maneuver the lift with one person, and that most people asked for a second person because of the residents size, but that the facility did not require 2 people for this particular lift. CNA "W" performed incontinence care for Resident #94, repositioning the resident onto his side and then		the facility Nurse Educator, Nursing Home Administrator and Director of Nursing. All direct care licensed nurses and certified nursing assistants will be re-educated on compliance of Care Plan/RCS interventions specifically related to safety with bed mobility, mechanical lift transfers, and eating precautions. Element #4 A quality-assurance program was implemented under the supervision of the Director of Nursing to monitor compliance of Care Plan/RCS implementation specifically related to safety with bed mobility, mechanical lift transfers, and eating precautions. The Director of Nursing or designated quality-assurance representative will perform the following systematic changes: randomly checking, or weekly checking for implementation of dependent residents Care Plan/RCS interventions specifically related to safety with bed mobility, mechanical lift transfers, and eating precautions. Any deficiencies will be corrected on the spot and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. Element #5 The facility is confident that these corrective measures will be fully implemented by August 7, 2023. The Administrator is responsible for sustained compliance.	

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back multiple times. CNA "W" did not have a second staff member to assist with bed mobility, the bed was in high position, and Resident #94 was not able to hold onto the hand rail when turned to his right side due to his left arm paralysis.

During an observation and interview on 07/12/23 at 08:51 AM Resident #94 was lying in his bed, with the head of bed (HOB) at approximately 20 degrees (not sitting up). Resident #94 was eating from his breakfast tray in front of him. Resident #94 reported that he had asked staff to lay him down after breakfast yesterday, but they did not, therefore he wasn't getting up until after lunch this time.

In an interview on 07/12/23 at 12:25 PM, Nurse Supervisor (NS) "HH" reported that Resident #94 does have an up-down schedule and stated, "...up for all meals and laid down after meals...and in the dining room for meals because of the risk for aspiration..."

During an observation on 07/12/23 at 12:29 PM in Resident #94's room, CNA "GG" was preparing to get Resident #94 up into his chair. Resident #94's feet were observed with gauze bandages on right big toe, right pinky toe, and left big toe. With the bed in high position, CNA "GG" rolled Resident #94 onto his right side, the resident was on the very edge of the bed, with his chest up against the hand rail. Resident #94 was not able to hold the hand rail due to his left arm paralysis. CNA "GG" reported that Resident #94 gets double briefs just in case he urinates a lot. CNA "GG" rolled Resident #94 back and forth in bed several times during incontinence care, getting dressed and to place the hoyer sling underneath him; there was not a second staff member to assist with bed mobility. Using the hoyer lift, CNA "GG" maneuvered Resident #94

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	approximately 10 feet in distance across the room (high in the air) and into his chair. During the transfer, Resident #94's feet banged up against the wall, and then Resident #94's legs began to spasm (shake). CNA "GG" did not acknowledge that Resident #94's feet had hit the wall. In a subsequent interview on 07/12/23 at 12:48 PM, CNA "GG" reported that it was not easy to roll Resident #94 in bed and transfer into his chair and stated, "...he should be a 2 person for safety, but with that new lift we can do it with 1 person..."			
F0698 SS= D	Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed ensure post dialysis assessment and monitoring for 1 resident (Resident #75) of 1 resident reviewed for dialysis care, resulting in the potential for the resident to not meet her highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #75 Review of a "Face Sheet" revealed Resident #75 admitted to the facility on 9/4/2021 with pertinent diagnoses which included end stage kidney disease and dialysis.	F0698	This plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or conclusion set forth on this statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. Spectrum Health Rehab and Nursing Center wishes to have this plan of correction stand as its written statement of compliance. F698 Dialysis Element #1 Resident #75 has been assessed and found to have no adverse effects. Element #2 All residents on dialysis in the facility as of July 12, 2023 have the potential to be affected. Element #3 The Hemodialysis Policy and the EPIC Navigator Dialysis Return Instructions have been reviewed and deemed appropriate by the facility Nurse Educator, Nursing Home Administrator and Director of Nursing.	8/7/2023

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	Review of a "Minimum Data Set" (MDS) assessment for Resident #75, with a reference date of 6/2/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #75 was cognitively intact. Review of current dialysis "Care Plan" interventions for Resident #75, initiated 9/30/2021, directed nursing staff to obtain vitals and weight upon return from dialysis, observe for and document signs and symptoms of infection to area around access site, observe site for bleeding, and assess site for thrills and bruits. In an observation on 7/11/2023 at 12:40 PM in Resident #75's room, Resident #75 was sitting in her wheelchair waiting for her lunch. Resident #75 reported staff had not evaluated her since she returned to the facility after having offsite dialysis treatment that morning. In an interview on 7/11/2023 at 12:46 PM, Licensed Practical Nurse (LPN) "SS" reported Resident #75 returned from dialysis at 11:00 AM. LPN "SS" reported he had not yet evaluated Resident #75 since she returned from dialysis. In an interview on 7/11/2023 at 4:25 PM, LPN "SS" reported that he had not yet evaluated Resident #75 since she returned from dialysis that morning. LPN "SS" reported he normally gets a set of vitals, listens for a thrill, checks the site, and reviews the hemodialysis communication sheet when residents return from hemodialysis. In an interview on 7/12/2023 at 8:23 AM, Resident #75 reported staff never check her vitals when she returns from dialysis, and they never look at her access site. Resident #75 reported there are times when dialysis staff do not place the bandage on her arm tight enough after dialysis		All direct care licensed nurses will be re-educated on post dialysis assessment and monitoring of residents documented within the EPIC Navigator. Element #4 A quality-assurance program was implemented under the supervision of the Director of Nursing to monitor compliance of post dialysis assessment and monitoring of residents. The Director of Nursing or designated quality-assurance representative will perform the following systematic changes: randomly checking, or weekly checking for implementation of post dialysis assessment, monitoring, and documentation. Any deficiencies will be corrected on the spot and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. Element #5 The facility is confident that these corrective measures will be fully implemented by August 7, 2023. The Administrator is responsible for sustained compliance.	

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	and she bleeds through to her clothing and her clothing needs to be changed. In an interview on 7/12/2023 at 10:45 AM, Nurse Manager "U" reported staff should assess residents upon return from dialysis, including the access site for bleeding. In an interview on 7/12/2023 at 11:31 AM, Director of Nursing (DON) "B" reported nursing staff are expected to get vital signs and perform an assessment upon return from dialysis including assessing the access site. In an email correspondence dated 7/12/2023 at 3:41 PM, DON "B" reported nursing practice post dialysis treatment is to " ...Enter nurses note indicating (resident) has returned and an assessment was completed- including cognition, (hemodialysis) site, comfort level, (vitals), and that completed paperwork was received ..." Review of facility policy/procedure "Care for Hemodialysis Patients and Residents", effective 2/3/2021, revealed " ...(hemodialysis) interventions may be found throughout the person-centered care plan including the physician orders and will include ... Monitoring of vitals and weights as ordered ... Monitoring of access site and any associated care ... Post-(hemodialysis) monitoring as ordered ..."			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using	F0812	This plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or conclusion set forth on this statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. Spectrum Health Rehab and Nursing Center wishes to have this plan of correction stand as its written statement of compliance.	8/7/2023

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	produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to: 1. Ensure frozen food items were stored under sanitary conditions, and 3. Discard out-of-date and expired resident food items. These conditions resulted in an increased risk of contaminated foods and an increased risk of food borne illness that affected all residents who consume food from the kitchen/pantries. Findings include: During an observation/interview with "Nutrition Services Manager" (NSM) "TT" during the initial kitchen tour on 7/10/23 at 10:05 in the Main Kitchen Freezer, noted a moderate amount of ice build-up on the pipes next to the blower fan located above opened, and loosely sealed frozen food product. It was noted that pieces of ice from the ice build-up on the pipes had fallen into the opened boxes of frozen garlic toast, biscuits, and yeast roll dough that were located below the pipes. NSM "TT" acknowledged visualization of the same, reported product would need to be discarded, and a work order would be created to get the issue fixed. During an observation/interview with NSM "TT" during the initial kitchen tour on 7/10/23 at 10:40 AM in the "Woods and Gardens" resident		F812 Food Procurement, Store/Prepare/Serve - Sanitary Element #1 No residents were identified as being directly affected. Element #2 All residents residing in the facility as of July 12, 2023 have the potential to be affected. A review of the infection control monitoring for the facility reveals no signs or symptoms related to contaminated food or food borne illnesses. Element #3 The Food Handling - Sanitation Policy, Food Handling - Storage Policy, and Patient/Resident Unit - Labeling and Dating Food Standards have been reviewed and deemed appropriate by the facility Nutrition Service Manager, Nursing Home Administrator, and the Director of Nursing. Work Order #241963 Kitchen Freezer Inspection/Repair All nutrition service team members will be re-educated on ensuring frozen food items are stored under sanitary conditions and discarding all out-of-date resident food items. Element #4 A quality-assurance program was implemented under the supervision of the Nursing Home Administrator Director to monitor sanitary conditions and storage of food items. The Nutrition Services Manager or designated quality-assurance representative will perform the following systematic changes: randomly checking, or weekly checking to ensure facility frozen food items are stored	

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	refrigerator/freezer, noted an opened bottle of cranberry juice in the refrigerator that was 75% empty and was not labeled with an opened or discard date, and a box of frozen waffles in the freezer with a "best by" date of 6/8/23. NSM "TT" reported the juice should have been labeled with an opened date and discard date and since it had not been, it should be discarded. NSM "TT" reported that the waffles should have already been discarded. During an observation/interview with NSM "TT" during the initial kitchen tour on 7/10/23 at 10:50 AM in the "Dunes" resident refrigerator/freezer, noted 2 boxes of French toast sticks in the freezer with a "use by" date of 5/18/23. NSM "TT" reported the French toast sticks should have already been discarded. During an observation/interview with NSM "TT" during the initial kitchen tour on 7/10/23 at 11:00 AM in the "Lakeshore" resident refrigerator/freezer, noted a chicken vegetable stir fry packaged frozen meal with a "best by" date of 6/23/23, 2 boxes of prepared packaged creamed chipped beef with a "best by" date of March, 2023 and a container of prepared packaged broccoli cheddar soup with a "use by" date of 2/16/23. NSM "TT" reported all products should have already been discarded.		under sanitary conditions and all out-of-date resident food items are discarded. Any deficiencies will be corrected on the spot and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. Element #5 The facility is confident that these corrective measures will be fully implemented by August 7, 2023. The Administrator is responsible for sustained compliance.	