STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634021	A. BUILDING _____ B. WING _____	6/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN HEALTH AND REHABILITATION CENTER	19933 WEST THIRTEEN MILE ROAD SOUTHFIELD, MI 48076

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F0000 SS=	INITIAL COMMENTS Evergreen Health & Rehab Center was surveyed for a Recertification survey on 6/29/23. Intakes: MI00134296, MI00134568, MI00134669, MI00134725, MI00135004, MI00135478, MI00135548, MI00136471, MI00136649, MI00136779, MI00136878, MI00136918, MI00136943, MI00137185, MI00137579, MI00137667, MI00137787, MI00137804 Census=161	F0000		
F0584 SS= E	Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe	F0584	F-584 Safe, Clean, Comfortable and Homelike Environment Element I: Resident R94 eats her meals in the dining room on Anna's unit (Dementia unit). The meals were served on the tray which prevented a homelike dining experience for all residents who ate in the dining room. During the survey exit conference the facility became aware of non-compliance with the regulation. Resident R94 was interested in her meals being served off the tray. The food is now placed on table linen and or placemat and taken off the tray. Dietary Manager "S" was provided education regarding the policy and procedure. Element II: All residents within the facility are at risk of experiencing a non-homelike dining experience. The facility will implement the removal of trays being placed on the tables in dining rooms and the meal will be placed on table linen and or placemat to provide a homelike dining experience.	7/28/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/24/2023

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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	temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a homelike dining experience based on the reasonable person standard for one resident (R94) and multiple other residents with cognitive impairments who ate their meals in the "Anna's Place" dining room. Findings include: On 6/28/23 at approximately 9:33 a.m., An observation of the breakfast meal was made on the "Anna's Place" dining room in which four residents were observed sitting at the tables eating the breakfast meal. All of the residents were observed to be served their food on "cafeteria" style meal trays without the plates being taken off and put on the table for consumption. On 6/28/23 at approximately 1:35 p.m., During the lunch meal, facility staff were observed serving the lunch meal to the residents in the "Anna's Place" dining room. The staff were observed to serve the meal on "cafeteria" style meal trays and leaving the plates and silverware on them while the residents were served the food. On 6/28/23 at approximately 1:40 p.m., R94		Element III: The policy titled “Dining Room Meal Service” was reviewed and deemed appropriate. The nursing staff will be educated on the policy by July 28, 2023. All meals will be removed from the tray and placed on table linen and or placemat on the dining room table to ensure the residents have a homelike dining experience. Element IV: The dining room meal service will be audited by the nurse supervisor to ensure the facility maintains a homelike dining experience for the residents. The audits will be completed three times a week for one month and once a week for two months. The audits will be brought to the monthly QAPI Committee meeting for review and comments for three months and/or until substantial compliance is noted. The Administrator is responsible for compliance.	

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	was observed eating their lunch meal off of the cafeteria meal tray. R94 was queried if they would have preferred staff remove the meal tray and place their plates on the table like in a home and they stated, "You bet I would." At that time, four other residents were observed eating their lunch meal atop the cafeteria style meal trays. On 6/29/23 at approximately 1:15 p.m., during an observation of the lunch meal, two residents in the "Anna's house" dining room were observed being assisted with the lunch meal by facility staff. Both of residents were observed to have their lunch meals served atop cafeteria style meal trays without the staff removing the plates to provide a homelike experience. On 6/28/23 at approximately 1:49 p.m., during a conversation with Dietary Manager "S", DM "S" was queried if the facility emphasizes a home-like dining experience and they indicated that they try to. DM "S" was queried why the residents who ate in the "Anna's Place" dining room all had to eat their meals on the cafeteria trays verses a traditional home-like experience with the plates on the tables and table linens like the residents in the "main" dining room and they indicated that they were the corporate dietary manager that that the "Anna's Place" dining room was for residents with Dementia and that they were unsure what the policy was about the Dementia unit.			

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	On 6/29/23 a facility document titled "Dining Room Meal Service" "POLICY: To improve the dining experience, residents in the main dining room will be served their meal restaurant-style (plates brought to the table) Residents eating in the unit dining rooms will have meals provided via tray line (trays brought to the table)...3. If dining room meals are delivered on a tray, items will be removed from trays and placed on the table in front of the resident..."			
F0658 SS= D	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medication administration was performed according to professional nursing standards of practice for two (R90 and R253) residents. Findings include: On 6/28/23 at 8:24 AM, Nurse 'JJ' was observed passing medications to R90's roommate. After passing medications to R90's roommate, Nurse 'JJ' entered R90's side of the room carrying a cup of medications to administer to R90. At that time, Nurse 'JJ' took R90's vital signs and discovered their heart rate was low. Nurse 'JJ' took the	F0658	F-658 Services Provided Meet Professional Standards Element I: Resident #90 resides at facility at his baseline. Resident assessed and has no adverse reactions from nurse JJ's deficient practice of failing to ensure medication administration was performed according to professional nursing standards of practice. Resident # 90 was seen by physician. Nurse JJ received individual counseling and education on facilities medication administration policy with focus on medications should be prepared for each resident individually. Education also provided that V/S should be taken before preparing medications that require parameter's for administration. Resident #253 no longer resides at facility. Resident # 253 had met goals and has been discharged back into the community. Nurse X received individual counseling and education on facilities nebulizer administration policy and medication administration policy with focus on medications should not be left at resident's bedside. Element II: All residents requiring medication	7/28/2023

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	medication cup to the medication cart and removed a tablet from the cup and discarded it and then administered the remaining medication to R90. When queried about when medications should be prepared, Nurse 'JJ' reported medications were prepared at the time of administration. When queried about when vital signs were taken to determine whether a medication with parameters was required or needed to be held, Nurse 'JJ' reported vital signs were taken before preparing the medication. When queried about why Nurse 'JJ' had R90's medications with them when they were administering the roommate's medications, Nurse 'JJ' reported they were not supposed to prepare medications like that and should have prepared R90's and R90's roommate's medications individually. Review of R90's clinical record revealed R90 was admitted into the facility on 6/7/23 with diagnoses that included: peripheral vascular disease, acquired absence of other right toe, and legal blindness. On 6/27/23 at 9:55 AM, R253 was observed sitting upright in bed. Nurse 'X' was observed securing a nebulizer aerosol mask to cover R253's nose and mouth. Medication was administered via the nebulizer at that time. At 10:00 AM, there was no nurse observed in R253's room and R253 had the nebulizer mask secured to their face with medication being delivered via nebulizer. At 10:19 AM, R253 was observed with the nebulizer mask		administration have been reviewed to ensure their medication is administered and this practice meets professional standards with focus on the following: Medications are prepared and administered individually. Vital signs are taken prior to administering medications that required parameter's for administration. Residents with orders for nebulizer treatments are assessed by the respiratory therapist for appropriateness and ability to self-administer, nurse remains at bedside for duration of the nebulizer treatment and resident is assessed before and after nebulizer treatment is administered. Element III: Facilities policy on medication administration and administration of nebulizer treatments reviewed and deemed appropriate. All licensed nursing staff will be educated by July 28, 2023 on these policies to ensure medication is administered to meet professional standards of nursing practice. Element IV: To ensure continued compliance the Director of Nursing or designee will randomly audit 12 nurses during medication administration weekly to ensure medication is prepared for each resident is prepared individually, vital signs are taking prior to preparing medications that require parameters and nurse assesses resident prior to nebulizer treatment, remains at bedside for duration of treatment and resident is assessed after nebulizer treatment is administered. Audits will be conducted for 4 weeks and monthly thereafter to ensure medications are administered to meet professional standards of practice. Any concerns will be addressed immediately. The Director of Nursing will report findings to monthly QAPI Committee meeting for three months and/or until substantial compliance is determined.	

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	removed from their face and lying on their chest. The nebulizer remained on. When queried about whether they completed their breathing treatment, R253 reported they did not know and explained they removed the mask because it was "pinching my eye". At that time, a plastic cup that contained multiple tablets of medication was observed on R253's over bed table. When queried about the cup of medication, R253 reported they did not know what medications were in the cup and that the nurse left it on the table. R253 stated, "They left the medicine and said to take it, but I couldn't take it with the mask (nebulizer) on." On 6/27/23 at 12:11 PM, an interview was conducted with Nurse 'X'. When queried about the proper way to administer a nebulizer/breathing treatment, Nurse 'X' reported they were supposed to stay in the room with the resident until the treatment was complete. When queried about whether medications were supposed to be left at the resident's bedside, Nurse 'X' reported they should observe the resident to ensure the medication is taken. When queried about why that did not happen with R253, Nurse 'X' did not offer a response. Review of R253's clinical record revealed R253 was admitted into the facility on 6/13/23 with diagnoses that included: heart failure, Alzheimer's disease, hemiplegia, chronic pulmonary edema, and chronic respiratory failure.		The Director of Nursing is responsible for on-going compliance.	

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	On 6/28/23 at 11:41 AM, an interview was conducted with the Director of Nursing (DON). When queried about procedures for administering a nebulizer treatment, the DON reported the nurse assessed the resident before and after the treatment and sat with the resident for the duration of the treatment unless they were assessed as appropriate to self administer medications. The DON further explained medications were not supposed to be left at the bedside and the nurse was to watch to ensure the resident took the medications. The DON confirmed R253 was not assessed as appropriate for self administration of medications. A policy regarding medication administration was requested from the Administrator. A policy was provided regarding medication orders and timeliness of administration, but did not address medication administration protocols related to the deficiency.			
F0660 SS= D	Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are	F0660	F 660 Discharge Planning Process Element I: Resident 156 no longer resides at facility and has been discharged back into the community at her baseline. Social worker AA provided education on transfer and discharge policy. Element II: All current residents scheduled for upcoming discharge were reviewed by Director of Nursing and Director of Social Services to ensure residents have necessary prescribed pain medication, insulin and medical	7/28/2023

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	identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data		equipment. Corrections were completed if indicated. Element III: Facility policy transfer and discharge reviewed and deemed appropriate. Social Service Department and Licensed Nursing Department will be educated by July 28, 2023 on transfer and discharge policy to ensure residents are discharged with their prescribed pain medication, insulin and medical equipment. Element IV: To ensure continued compliance Director of Nursing or designee will audit all discharges for four weeks then monthly thereafter to ensure residents have necessary prescribed pain medication, insulin and medical equipment. The Director of Nursing will report findings to monthly QAPI Committee meeting for three months and/or until substantial compliance is determined. The Administrator is responsible for compliance.	

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	on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake #MI00136649 Based on interview and record review, the facility failed to ensure a resident was adequately prepared for discharge home for one (R156) of three sampled residents reviewed for discharge planning from a total of three, Findings include: A complaint was filed with the State Agency (SA) that alleged R156 was discharged from the facility without their necessary pain medication, insulin and medical equipment. The complainant reported that R156 suffered from a spinal injury that caused severe pain. They further reported that R156 did not			

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receive a shower chair, grab bars and an extended toilet seat prior to their discharge resulting in the resident not being able to take a shower at home.

A review of R156's clinical record revealed the resident was initially admitted to the facility on 10/30/21 with diagnoses that included: end stage renal disease, spinal injury.

Continued review of R156's record revealed, in part:

Discharge Summary & Instructions: " ...Discharge date: 5/12/2023 ...Medical Equipment Arrangements:2. Yes-arranged ...Medical equipment ordered: ShCh (shower chair), ...Equipment already in home (answer was blank) cognitive: ...Cooperative ...Behavior ....appropriate ...Toilet Use ....3. Assistance x1 ...Bathing ...Assistance x1 ....Where Medication Orders given? YES ...".

A second Discharge Summary & Instructions (lock date 5/12/23) documented: " ...Discharge date: 5/12/23 ...Discharge to home alone ...Medical Equipment Arrangements: ...Yes -arranged ...equipment already in home (blank) ...".

A "Controlled Drug Receipt/Record/Disposition Form" located in R156's electronic record noted the following": "Hydrocodone ...take 2 tablets every 6 hours as needed ...5/12/23 ...left "22" and Gabapentin cap 100MG ...take 2 capsules by

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	mouth ...5/12/23 ...left "14" ...". *It should be noted that there was no indication of the forms that the remaining medication was sent with R156 upon discharge. On 6/29/23 at approximately 10:15 AM, an interview was conducted with Social Worker (SW) "AA". SW "AA" noted that they were familiar with R156's discharge and that the resident had submitted information that noted they did not receive their necessary medications and necessary equipment upon discharge. SW "AA" reported that nursing staff are responsible for the ensuring the proper medication is provided to a resident upon discharge but again noted that they were aware of a glitch in providing pain medication upon discharge and/or ensuring a proper script was timely provided. With respect to the medical equipment, SW "AA" noted that due to R156's insurance status they did not receive all the discharge equipment needed. SW "AA" reported that a representative from (name redacted) human service agency was trying to obtain the necessary medical equipment, but still had not provided all the necessary equipment. On 6/29/23 at approximately 11:37 AM, an interview was conducted with the Director of Nursing (DON). When asked as to the facility policy/protocol to ensure residents with a planned discharge receive their necessary medications and/or equipment, the DON reported that for those residents on Medicaid they generally will be given all the medication			

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	they have left in the building and also physicians can provide them with scripts for their medications. With respect to R156, the DON reported that they should have been given R156 their remaining medications, including their pain meds. On 6/29/23 at approximately 5:20 PM, the DON provided via email: "Controlled Drug Receipt/Record/Disposition Form" that documented, in part, the following": "Hydrocodone ...take 2 tablets every 6 hours as needed ...5/12/23 ...left "22" and Gabapentin cap 100MG ...take 2 capsules by mouth ...5/12/23 ...left "14" ...". *It should be noted that unlike the form noted in the resident's electronic record the form provided by the DON had wording that noted the medication (14 Gabapentin sent with the patient/ 22 hydrocodone sent home with the patient). The facility policy titled, "Transfer and Discharge" (8.8.22) was reviewed and documented, in part: " ...Compliance Guidelines: ...The facility may initiate transfers or discharges in the following limited circumstances: ...The resident's heal has improved ...6. Non-Emergency Transfers or Discharges ...at least 30 days before the resident is transferred or discharged, the Social Service Director will notify the resident ...9. Anticipated Transfers or Discharges ...The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes			

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EVERGREEN HEALTH AND REHABILITATION CENTER	19933 WEST THIRTEEN MILE ROAD SOUTHFIELD, MI 48076

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	...Reconciliation of all pre-discharge medication with the resident's post-discharge medications ...a post discharge plan of care that is developed ....which will assist the resident to adjust to his or her new living environment ...".			
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 Intakes: MI00134568, MI00134669, MI00134725, MI00135548, MI00136878, MI00136943, and MI00137185. Based on observation, interview and record review, the facility failed to ensure residents were consistently provided with showers, removal of facial hair and getting out of bed for four (R132, R153, R124 and R118) of 12 residents reviewed for activities of daily living (ADL's). Findings include: Review of a facility policy titled, "Activities of Daily Living (ADLs), Supporting" dated 10/2021 read in part, "...Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a.	F0677	F 677 ADL Care Provided for Dependent Residents Element I: Resident 132 no longer resides at facility. Resident 153 no longer resides at facility. Resident 124 remains at facility at baseline. Resident 124 provided shower, shaved and well-groomed and placed up in wheelchair. Resident 118 remains at facility at baseline. Resident 118 was provided shower, shaved and well-groomed and placed up in wheel chair. Oakridge Unit, Anna's Place and Redwood provided education on ADL policy regarding ensuring residents are assisted out of bed per there preference, well groomed, shaved and provided showers. Element II: All residents that are dependent on ADL care have the potential to be affected by this cited practice. Resident's care plan was reviewed and updated as needed. All resident's dependent on ADL care were assessed and provided showers to ensure appropriate care and services will be provided for residents who are unable to carry out ADL care independently, with the consent of the resident and in accordance with the care plan, including appropriate support and assistance with showers. Element III: ADL policy reviewed by IDT team and deemed appropriate. All direct care staff will be educated on ADL Care Provided to	7/28/2023

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	Hygiene (bathing, dressing, grooming including hair and nail care, and oral care); b. Mobility (transfer and ambulation, including walking);..." R132 A complaint was filed with the State Agency on 5/22/23 that alleged R132 was not consistently receiving ADL care. Review of the closed record revealed R132 was admitted into the facility on 5/2/23 with diagnoses that included: brain cancer, hemiplegia (paralysis or weakness), and epilepsy. According to the Minimum Data Set (MDS) assessment dated 5/8/23, R132 had moderately impaired cognition, and required the extensive assistance of staff for ADL's including showers. Review of R132's ADL care plan initiated 5/3/23 revealed an intervention that read, "Bathing / hygiene with 1 assistance". Review of Bathing Assist 30 day Look Back for R132 revealed no documentation of showers or bed baths. Review of PRN (as needed) Shower 30 day Look Back for R132 revealed no documentation of showers or bed baths. Review of Shower Sheets revealed three showers documented on 5/9/23, 5/15/23 and 6/7/23.		Dependent Resident's policy and ensuring our residents are assisted out of bed per there preference, well groomed, shaved and provided showers. Education will be completed by July 28, 2023. Element IV: The Director of Nursing or designee will randomly audit 20 resident's per week for four weeks and monthly for two months to ensure resident's dependent on ADL care are showered per plan of care. The Director of Nursing will report the findings to the monthly QAPI Committee meeting for three months and/or until substantial compliance is noted. The Director of Nursing is responsible for on-going compliance.	

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On 6/28/23 at 11:32 AM, Certified Nursing Assistant (CNA) "F" was interviewed and asked how often residents receive showers at the facility. CNA "F" explained residents received two showers a week.

It should be noted that while a resident is at the facility, R132 should have received 10 showers, however, there were only three showers documented as given.

R153

A complaint was filed with the SA that alleged R153 was not receiving weekly showers two times per week.

A review of R153's clinical record documented the resident was admitted to the facility on 1/24/23 with diagnoses that included: cellulitis, gangrene and type II diabetes. A review of the resident's MDS indicated the resident had a Brief Interview for Mental Status (BIMS)score of 15/15 (cognitively intact) and required extensive one to two person assist for most ADLs.

On 6/28/23 at approximately 10:11 AM, the facility was asked to provide any documentation pertaining to R153's showers during their stay at the facility. The following paper shower documents were provided:

1/24/23: R (refused)

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	2/1/23: Shower not provided 2/10/23: Shower not provided * There were not further documentation as to resident receiving showers during their stay at the facility from 1/24/23 to discharge on 2/13/23. Resident #124 On 6/27/23 at approximately 11:04 a.m., R124 was observed in their room, up in their wheelchair. R124 was queried if they had any concerns about facility staff helping them with grooming and they indicated that they have asked to be clean shaved multiple times but that the staff say they do not know how to clean shave. At that time, R124 was observed with an unkept beard. R124 was queried if they are getting regular bathing provided to the them and they reported that they have "missed showers." On 6/29/23 at approximately 10:59 a.m., R124 was observed in their room, laying in their bed. R124 was still observed to still have an unkept beard. R124 was queried if they liked the beard and again R124 indicated they preferred to be clean shaven and reported that they have asked staff to shave it off, however, the staff tell them that that they do not know how. R124 then reported that they were supposed to get showers on Tuesdays and Fridays but have not gotten them.			

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On 6/28/23 the medical record for R124 was reviewed and revealed the following: R124 was initially admitted to the facility on 3/20/23 and had diagnoses including Spinal stenosis and Fusion of spine. A review of R124's MDS (minimum data set) with an ARD (assessment reference date) of 3/26/23 revealed R124 needed extensive assistance with most of their activities of daily living. R124's BIMS score was 10, indicating moderately impaired cognition.

On 6/29/23 at approximately 11:06 a.m., A review of the shower schedule for R124's room revealed R124 was scheduled to be provided regular bathing on Tuesdays and Fridays every week.

A review of Certified Nursing Aide (CNA) bathing documentation for R124 in the electronic medical record revealed only one shower was provided to R124 which was on 6/23/23.

On 6/29/23 at approximately 11:09 a.m., paper "shower sheet" documentation of R124's completed scheduled bathing for the previous 30 days was reviewed with Nurse Manager "O" (NM "O"). NM "O" was only able to provide one bathing sheet for R124 which was for 6/13/23. NM "O" was queried where the other bathing documentation was for the previous 30 days and indicated they did not have any others. NM "O" was queried regarding R124's multiple requests to be

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	clean shaved and the responses they had received of not knowing how to complete a shave. NM "O" reported that it was concerning and that they would have to do education with the staff. NM "O" was queried if a CNA did not know how to provide a clean shave, could they have asked a team member to perform the shave and NM "O" indicated that would have been the appropriate way to handle the request. R118 R118 was a long-term resident of the facility and was originally admitted to the facility on 2/7/22. R118's admitting diagnoses included left hemiplegia and hemiparesis, osteoarthritis, congestive heart failure, and had history of heart valve replacement surgery. R118 had a BIMS score of 15/15, indicative of intact cognition. Based on the most recent Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 5/18/23, R118 needed one-person (staff) extensive assistance with bed mobility and two-person (staff) extensive assistance for transfers in and out of their bed. An initial observation was completed on 6/27/23, at approximately 11:30 AM. R118 was observed in their bed. R118 had a wider bed with a low air loss mattress. An interview was completed with R118 during the initial observation. R118 reported that they had been at this facility for over a year. R118			

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	reported they came over to this facility after they had a stroke and had a left sided weakness. R118 had a Geri chair next to their bed. R118 reported that they came over to get stronger and they were working full time prior to the stroke. When queried about how often they were getting out of their bed, R118 reported that they did not get the assistance when they had asked to get up. R118 reported that staff used the lift, and it takes ten minutes to assist and get them out of their bed. R118 reported that the last time they were assisted to get out of bed was over a week ago. A 2nd observation was completed the same day at approximately 2PM. R118 was observed laying in their bed. R118 added that that they would like to get stronger and stated, "I am only 58" and "I don't want this to be my final stop". A 3rd observation was completed at approximately 4 PM and R118 was in their bed. On 6/28/23, at approximately, 8:50 AM, R118 was observed in their bed and was speaking to a staff member. At approximately 11:30 AM, during another observation, R118 was observed in their bed. Their feet were hanging over the mattress and R118 repositioned themselves in the bed by holding on to the bed frame with their right upper extremity when brought it to their			

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	attention. During this observation, a second interview was completed with R118. During this interview, R118 reported that they had used a wheelchair when they were getting therapy, but now staff had been using this (Geri) chair. R118 reported that they would like to sit up in a wheelchair and move around. R118 reported that if they did not feel good on a day, they had let the staff know on that day. R118 had confirmed they did not get out of bed on 6/27/23. R118 also reported they were not offered the assistance to get up and sit in their chair as they preferred, at least 3 times/week. Review of R118's Electronic Medical Record (EMR) revealed the transfer (in and out of bed) task completed in last 30 days. The transfer task report between 6/29/23 and 5/31/23 were reviewed. The task report read that R118 was out of bed seven days in the last thirty days. The dates R118 was out of bed were recorded as follows: 6/27/23, 6/26/23, 6/20/23, 6/19/23, 6/14/23, 6/9/23, and 6/8/23. The rest of the dates were marked "Activity did not occur". An interview was completed with Director of Nursing (DON) on 6/29/23 at approximately 9:10 AM. The DON was queried about the facility protocol on staff assisting residents who wanted to get of their bed. The DON reported that it was the resident's preference and staff should be accommodating the preferences and assisting the residents.			

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F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation has two deficient practices. Deficient practice #1. This citation pertains to Intake #MI00137787 and MI00137804. Based on interview and record review the facility failed to ensure neuro checks were completed following a resident's fall causing injury to the head for one (R162) of seven residents reviewed for falls/accidents. Findings include: A Complaint was filed with the State Agency (SA) that alleged on 2/23/23 they observed R162 with a bruise on the left side of their head. The Complainant noted that staff did not know what happened, but told them they put R162 back to bed at about 7:00 PM on 2/22/23 and did not provide medical attention. On 2/23/23 the resident was transferred to the hospital and diagnosed with a subdural hematoma and a concussion.	F0684	F 684 Quality of Care Deficient practice #1 Element I: It is the practice of the facility to ensure neuro checks are completed following a resident fall causing injury to the head. Nurse X provided 1:1 education. All nurses working Redwood Unit provided education. R162 no longer resides in the facility. Element II: Residents that currently reside in the facility that experience a fall causing injury to their head have the potential to be affected by this cited practice. An audit was conducted of those residents to ensure neuro checks are completed. Those that did not have neuro checks completed were assessed to ensure neuro status was stable. Element III: The Interdisciplinary Team reviewed the policy and procedure Neurochecks on those residents who hit their head" and deemed it appropriate. Nursing staff will be educated by July 28, 2023 on completed neuro checks following a resident fall causing injury to the head. Element IV: The DON/designee will complete random audits five charts weekly for 4 weeks, then monthly to ensure neuro checks are completed following a resident fall causing injury to the head. Any deficient practice will be corrected/updated immediately. The results will also be taken to the monthly QAPI Committee meeting for three months for review and comments. The results will be presented until substantial compliance is noted.	7/28/2023

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	A facility policy titled, "Neurochecks on those Residents who Hit their Head" (10/1/2017) was reviewed and documented, in part: " ...Policy: Any resident who sustains a fall with head involvement shall have neurochecks times 48 hours ...Any resident who sustains a fall with involvement in the head area shall have a neurocheck using the "Neuro Flow Sheet" as follows: a. Initially then every hour for two hours. b. Every 2 hours times 3. C. Every 4 hours times 4. D. Every shift for the next day (24 hours) ...Each time a neurocheck is done the following items must be checked: a. Vital signs b. LOC (altered level of consciousness). C. pupils ...d. Grasps..e. any complaint of blurred vision, headache or nausea ...Document all findings on neurocheck list ...5. Neurocheck is currently scanned and found in the document management section of the electronic record ...". A review of R162's clinical record revealed the resident was admitted to the facility on 2/21/23 with diagnoses that included: right frontal brain mass with craniotomy. The clinical record noted the resident had a Brief Interview for Mental Status (BIMS) score of 12/15 (moderately cognitively impaired) and required two person assist for transfers. Continued review of the clinical record revealed, in part: 2/22/23 (6:56 PM) Nursing Progress Note:		The Director of Nursing is responsible for on-going compliance. F 684 Quality of Care Deficient practice #2 Element 1: It is the practice of the facility to perform skin and wound assessments consistently administer wound treatments according to physicians' orders and clarify and discontinue orders for a Jackson-Pratt (JP) drain. R90 orders have been reviewed with the physician and updated to reflect R90 current status. Dressing change have been completed per the physician orders. R90 has been assessed and no further issues noted. Element 2: Residents that currently reside in the facility that have dressing change orders have the potential to be affected by this cited practice. An audit was conducted of those residents to ensure dressings were changed per the physician order and the order reflects the resident's current treatment needs. Orders and care plans were reviewed and updated with the physician. No deficiencies were noted. Element 3: The Interdisciplinary Team reviewed the policy and procedure "Skin and Wound Care" and deemed it appropriate. Nursing staff will be educated by July 28, 2023 on Skin and	

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	"Patient tried to get out of bed while eating dinner. No bruising or wounds from injury. Neuro checks were started at 7 PM. *It should be noted that no neuro checks were found in the resident's electronic record. The vital section of the electronic record noted the last vitals taken for R162 were done on 2/22/23 at 8:19 AM. 2/23/23 (3:49 PM) Physical Medicine and Rehabilitation: "Late Entry ...patient is generally sleepy during my exam ...daughter reports that there was an incident overnight which ended with R162 having a swelling/ecchymosis (discoloration) over the left side of their head ...we are unclear on this story as it was unwitnessed, but nursing did document that patient had a fall last night." 2/23/23 (3:45 PM) Nursing Progress Note: "Resident sent out to hospital due to mental status change, resident sent to (name redacted) hospital ...". Incident/Accident (IA) Report: " ...Writer interviewed assigned nurse who stated that upon entering the room R162 was facing the floor with legs partially on the bed and head touching the floor ...Nurse said R162 was trying to answer phone that was on opposite side of the bed ...stated that they bumped their head ...". 2/22/23 (7 PM). A review of R162's Hospital records noted, in part, the following: " ...R162 is presenting with increased confusion over the last day and a		wound care with emphasis on completing wound treatments per the physicians' orders and clarifying if any orders need discharged. Element 4: The DON/designee will complete random audits five charts weekly for 4 weeks, then monthly to ensure wound treatments are completed per the physician orders and clarifying if any orders need discharged. Any deficient practice will be corrected/updated immediately. The audits will be present at the monthly QAPI Committee meeting for three months for review and comments; and/or until substantial compliance is noted. The Director of Nursing is responsible for on-going compliance.	

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	fall. Patient sustained a head injury yesterday at his care facility with story altering from being pushed and falling on his own. Family notes that he is more confused than normal and is typically AxOx4 ...Hospital Principal Problem (Discharge Diagnoses) 1. Fall with head trauma and altered mental status ...Functional History: ...requiring max assist for bed mobility and mod-max assist x people to stand ...Mental Status Examination ...Patient is drowsy and not arousable. Mood is confused ...Patient. is hallucinating delusional times ...Patient was seen in bed, alert and pleasant but confused ...mentioned that this is not patient's baseline and prior to fall, the patient was recovering from ...surgery, but was not confused ...2/23/23 ...had emesis x1 ..." On 6/29/23 at approximately 11:30 AM, an interview and record review were conducted with the Director of Nursing (DON). The DON was queried as to the facility protocol following a fall. The DON reported that if a fall was not observed and/or if the resident hit their head, Nursing staff should complete neuro checks per their policy. The DON was asked if they were able to locate any documentation on the electronic record that noted neuro checks were completed. The DON could not find any documentation. The DON then contacted the medical record's department to determine if there was any paper documentation noting neuro checks were completed. The medical record's department was not able to find any documentation. When asked if neuro checks			

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should have been completed, the DON reported that they should have been.

Deficient Practice #2

Based on observation, interview, and record review, the facility failed to perform skin and wound assessments consistently, administer wound treatments according to physician's orders, and clarify and discontinue orders for a Jackson-Pratt (JP) drain (a device to drain fluids from a surgical site) for one (R90) of one resident reviewed for non-pressure skin conditions. Findings include:

On 6/27/23 at 10:04 AM, R90 was observed lying in bed. An interview was conducted with R90 regarding their care in the facility. R90 expressed concern that the bandage on their right foot where they had toes amputated had not been changed since they last saw the surgeon. R90 further reported they had surgery and used to have a "drain" in their leg, but it was removed. A healed incision (scar) was observed on R90's right leg.

On 6/28/23 at approximately 8:15 AM, R90 was observed lying in bed. R90 reported nobody had changed the bandage on their right foot.

On 6/28/23 at 8:24 AM, an observation of the bandage on R90's right foot was performed with Nurse 'X'. No date was written on the dressing applied to R90's right foot. When queried about who was responsible to

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	perform R90's wound care, Nurse 'X' reported they were not sure who would do the dressing change. On 6/28/23 at approximately 8:45 AM, the Director of Nursing (DON) was notified that an observation of R90's wound care was needed. On 6/28/23 at approximately 9:15 AM, the DON and Nurse 'P', the facility's wound care coordinator, reported Nurse 'P' already did R90's dressing change. When queried about whether Nurse 'P' saw a date on the dressing applied to R90's right foot when they performed wound care, Nurse 'P' reported the dressing was not dated. At that time, R90's Treatment Administration Record (TAR) was reviewed with Nurse 'P' and the DON and it revealed that prior to 6/28/23, R90's wound treatment had not been completed since 6/25/23. Based on that documentation and the lack of date on R90's dressing, the DON and Nurse 'P' reported they were unable to determine that R90 received any wound treatment to their right foot since 6/25/23. The DON reported if the treatment was done, the nurse should have signed off on the TAR that it was completed. Further review of R90's TAR revealed the wound treatment to R90's right foot was not done on 6/13/23, 6/16/23, 6/17/23, 6/18/23, 6/20/23, 6/23/23, 6/24/23, 6/26/23, and 6/27/23. The physician's order read, "Wound Gel External Gel...Apply to right foot surgical area topically every day shift for surgical.			

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	Cleanser with wound cleanser pat dry. Apply wound gel and cover with dry dressing. Wrap with kerlix daily." Further review of R90's Physician's Orders and TAR revealed active orders to "Cleanse area around JP drain daily with wound cleanser, pat dry. Cover with dry dressing every night shift for surgical". Further review of R90's clinical record revealed the last documented "Total Body Evaluation" was completed on 6/7/23, 21 days earlier. There was no documented assessment of R90's surgical wound to their right toes. On 6/28/23 at 11:41 AM, an interview was conducted with the DON. The DON reviewed R90's clinical record and confirmed there were no documented wound assessments for R90. When queried about whether R90 still had the JP drain, the DON indicated he did not. When queried about why there was an active order to cleanse the area around the JP drain, the DON reported it needed to be discontinued. Review of R90's clinical record revealed R90 was admitted into the facility on 6/7/23 with diagnoses that included: peripheral vascular disease, acquired absence of other right toe, and legal blindness. Review of a Minimum Data Set (MDS) assessment dated 6/13/23 revealed R90 had moderately impaired cognition and no behaviors, including			

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	rejection of care. Review of a facility policy titled, "Skin & Wound Policy" dated 4/2022, revealed, in part, the following: "A full body, or head to toe, skin and oral cavity assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter...Wound treatments will be provided in accordance with physician orders...Treatments will be documented on the Treatment Administration Record...The effectiveness of the treatments will be monitored through ongoing assessment of the wound..."			
F0686 SS= G	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake #MI00135548	F0686	F-686 Treatment Services to Prevent and Heal Pressure Ulcers Element I: Resident #155 no longer resides at facility. Element II: All current Residents with pressure ulcers have been reviewed to ensure the facility properly identifies, thoroughly assesses, implements timely intervention to areas of altered skin integrity, prevents avoidable pressure ulcers from occurring and ensures orders are correctly transcribed to the E-MAR and is to include documentation that the treatment has been completed per physician's order. Element III: Facility Policy "Skin-Pressure Ulcer Guidelines" was reviewed and deemed appropriate. All Nursing staff will be educated by July 28, 2023 on the policy to ensure	7/28/2023

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	Based on interview and record review the facility failed to initiate necessary treatments for one (R155) of seven resident's reviewed for pressure ulcers, resulting in the worsening of a pressure wound to the spine. Findings include: A complaint was filed with the State Agency (SA) that alleged R155 did not receive proper wound treatment for their pressure sores. The complainant reported that the resident was discharge from the facility on or about 2/16/23 and ended up in the hospital on 2/21/23 with unstageable wounds. A review of R155's clinical record revealed the resident was admitted to the facility on 1/16/23 with diagnoses that included: non-displaced fracture of the right femur .... A review of the resident's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact) and required extensive one to two person assist for most Activities of Daily Living (ADLs). Continued review of R155's clinical record documented, in part: 1/17/23: Wound Rounds Note (authored by Wound Nurse Practitioner (NP) "Z" : "I was referred by (name redacted) physician to consult re: back, hip, coccyx wounds ...at the time of admission noted to have aforementioned wounds. Tx (treatment) and advanced pressure downloading		facility properly identifies, thoroughly assesses, implements timely intervention to areas of altered skin integrity and prevents avoidable pressure ulcers from occurring. All nursing staff will be educated by July 28, 2023 regarding ensuring the treatment administration record is completed and signed out after every treatment is completed. Notify provider and wound care of any worsening changes or concerns noted with wounds. Ensure all new orders are verified and read back to provider or wound care consultants to ensure proper orders are entered into the medical record. Element IV: The DON or designee will randomly audit 15 residents per week for four weeks and monthly thereafter to ensure wound care policy is followed. The DON will report any negative findings to the monthly QAPI Committee meeting for three months and/or until substantial compliance is determined. The Director of Nursing is responsible for on-going compliance.	

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	interventions were implemented ...T-Spine DTPI (deep tissue pressure injury), dark nonblanching, no drng (draining), no cellulitis, significant bony processes ...Recommend Tx: foam dressing (an ultra-soft foam that protects and cushions wounds) 3 x/week ...". 1/24/23: Skin and Wound Evaluation: "Type: ...Pressure ...Stage DTI ...Location: Spine ...Area: 1.8 cm, length 3.1, width 1.0 cm ...Wound Bed ...100% wound covered ...Goal of Care: healable ...Dressing appearance: missing." 1/31/23: Wound Rounds Note (authored by NP "Z"):" ...Pt. very resistant to turning/repositioning ...T-spine previous DTPI now open stg 2 ulcer, ...open area granular surrounding tissue fading darkness, slow blanching, scant drng, ...recommend Tx: foam dressing 3x/week ...". 1/31/23: Skin and Wound Evaluation: "Type ...Pressure ...Stage 2 ...Location: spine ...Wound measurements ...Area: 1.8 cm ...length 3.2cm ...width .9 cm ...". 2/7/23: Wound Round Note (authored by NP "Z"): " ...T-spine stg 3 ulcer ...open area darkened with dark nonviable tissue, surrounding tissue darkened, minimal drng ...recommend Tx: Apply M. (Medi honey gel) cover with foam dressing 3x week ...". *It should be noted that following a review of R155's treatment orders for the spine showed			

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no documentation that an order for "Medi honey gel cover with foam dressing 3x per week was implemented as noted in NP "Z"'s note above.

A review of R155's Medication/Treatment Administration (MAR/TAR) record for February 2023 was conducted. The TAR indicated the following: "cleanse spine with wound care and apply Medi honey gel and cover with foam gauze change 3 times a week. Every day shift every Tues, Thu, Sat for wound care. Start date 2/9/2023 ...D/C date 2/8/2023. There was no indication that this treatment was provided to the resident.

2/14/23 Wound Care Note: (authored by NP 'Z"): " ...T-spine ulcer unstageable. Covered with dark necrotic eschar (dead tissue) ...Recommend: Apply M. Honey cover with dry dressing daily and prn.

2/14/23 Skin and Wound Evaluation: " ...Type ...Pressure ...Stage: Unstageable ...location: spine ...Area: 10.6 cm ...Length 13.8 cm ...width 1.7 cm ...".

On 6/29/23 at approximately 2:33 PM, a phone interview and record review were conducted with Wound NP "Z". NP "Z" reported that they do not work exclusively for the facility but are in the building generally on Tuesdays to work with residents referred by the facility staff. NP"Z" was asked about R155 and their recommendation dated 2/7/23 for R155 to receive Medihoney, NP

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	"Z" stated that to their knowledge the treatment recommendation should have been followed. NP "Z" was noted that they were not able to review R155's MAR/TAR. NP "Z" was asked if failure to provide the recommended treatment possibly led to the decline in the resident's pressure ulcer on their spine from a stage II to unstageable. NP "Z" noted again that R155 should have received the recommended Medihoney treatment. NP "Z" noted that after reading their notes, that R155 often refused to be turned. When asked where that information came from, NP "Z" stated that it might have been something I observed myself and/or reported to me by staff. When asked if the R155 ever declined treatment, NP "Z" stated that they did not. *It should be noted that there were no nurses' notes indicating the resident's refusal to be turned. On 6/29/23 at approximately 2:51 PM, an interview and record review were conducted with the Director of Nursing (DON). The DON was queried as the facility's protocol for ensuring resident's receive necessary treatments for wounds. The DON reported that NP "Z" works at the facility generally on Tuesdays along with Wound Nurse "P". After rounds, NP "Z" will give verbal orders and it should be uploaded to the electronic record. When asked about R155, the DON reviewed the resident's record and stated that the recommendation was not placed correctly into R155's record and thus was not given. When asked if the treatment should have			

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	been provided to prevent a decline , the DON stated "Yes". The facility policy titled, "Skin and Wound Policy" (revised 1/22) was reviewed and documented, in part: "Policy: it is our policy to perform a full body skin assessment ...as part of our systematic approach to pressure injury prevention and management. It is also our policy to follow the treatment plans for any wound/skin concerns as ordered by physicians ...wound treatments will be provided in accordance with physician orders, including cleansing method, type of dressing and frequency of dressing change ...".			
F0688 SS= E	Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F0688	F-688 Increase/Prevent Decrease in ROM/Mobility Element I: Resident #118 resides at facility in stable condition. Resident # 118 was assessed for assist bars and the interdisciplinary team deemed the use of assist bars is appropriate for this resident. Assist bars have been placed on residents' bilateral sides of bed according to facilities policy on bed rails and enablers to aid in this resident's mobility. Nurses on Hickory Unit provided education regarding ensuring resident are assisted out of bed per their request and plan of care. Element II: All residents with limited mobility were assessed to ensure appropriate assistive devices were utilized to maintain or improve functional mobility. Staff member CC and BB were provided education on assessment for use of positioning and assistive devices in bed. Element III:	7/28/2023

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	This citation pertains to intake # MI00134296 Based on observation, interview, and record review the facility failed to ensure over an extended period that residents with limited mobility were assessed timely for appropriate assistive devices to maintain or improve functional mobility for one (R118) of one Residents reviewed for mobility and assistive devices resulting in the potential for a decline their bed mobility/self-care, dissatisfaction, and frustration with care. Findings include: A record review revealed R118 was a long-term resident of the facility and was originally admitted to the facility on 2/7/22. R118's admitting diagnoses included left hemiplegia and hemiparesis, osteoarthritis, congestive heart failure, and had history of heart valve replacement surgery. R118 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicative of intact cognition. Based on the most recent Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 5/18/23, R118 needed one-person (staff) extensive assistance with bed mobility and two-person (staff) extensive assistance for transfers in and out of their bed. An initial observation was completed on 6/27/23 at approximately 11:30 AM. R118 was observed in a wider bed with a low air loss mattress. An interview was completed		Bed rail and enabler policy reviewed and deemed appropriate. Licensed therapists, Licensed nurses and CNA's educated on the assessment for use of positioning devices when in bed. Element 1V: To ensure continued compliance Director of Therapy Services or designee will randomly audit 20 residents with limited mobility to ensure residents are assessed timely for appropriate assistive devices to maintain or improve functional mobility. Audits will be conducted weekly for four weeks then monthly thereafter. The Director of Therapy services will report findings to Monthly QAPI Committee meeting until substantial compliance is determined. The Administrator is responsible for compliance.	

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	with R118 during the initial observation. R118 reported that they had been at this facility for over a year. R118 reported they came over to this facility after they had a stroke and had a left sided weakness. R118 had a Geri chair next to their bed. R118's feet were observed hanging over the edge of the mattress. When queried further R118 reported that they had requested a longer bed. During the interview, R118 lowered the head end of bed to reposition. R118 used their right hand to reach over to the end of the bed frame to pull and reposition in the bed. R118 was successful in their repositioning. R118 reported that it would help if they had a bar or device on their bed to hold on so they could move and reposition in their bed as needed as it would help them get better with their mobility in bed. When queried if they had spoken with anyone, R118 reported that they had spoken with therapy staff and nursing staff, and they received a response that the facility was not able to provide a trapeze (overhead bar used to assist with mobility in bed) because of the lift that was being used to get them in and out bed. When queried if they had spoken with the facility staff about the mobility or assist bar on their bed, R118 answered "YES" and reported that were notified that facility did not allow any device on the bed. R118 had been at the facility from 2/7/22 (approximately over a year and five months). R118 had multiple physical and occupational evaluations during their stay at this facility.			

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A 2nd observation was completed the same day at approximately, 2PM. R118 was observed laying in their bed. R118 added that that they would like to get stronger and stated, "I am only 58" and "I don't want this to be my final stop". R118 reported that they would like to get stronger and would like to use a wheel chair.

A 3rd observation was completed at approximately 4 PM and R118 was in their bed.

On 6/28/23 at approximately 8:50 AM, R118 was observed in their bed and was speaking to a staff member. At approximately11:30 AM, during another observation, R118 was observed in their bed. Their feet were hanging over the mattress and R118 repositioned themselves in the bed by holding on to the bed frame with their right upper extremity when brought it to their attention. During this observation, a second interview was completed with R118. During this interview, R118 reported that they had used a wheelchair when they were getting therapy several months ago, but now staff had been using this (Geri) chair. R118 reported that they would like to sit up in a wheelchair and move around.

A review of R118's Electronic Medical Record (EMR) revealed a Physical Therapy (PT) evaluation dated 4/28/23. Functional mobility assessment in this PT evaluation read, "Bed

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	mobility - Total dependence with attempts to initiate". Prior level(s) of function read, "Bed mobility = Max (A) (Maximal Assistance); Transfers = Total Dependence with attempts to initiate; patient currently at baseline- referral for LUE (Left upper Extremity) splinting and LUE edema. The Musculo skeletal section of the PT assessment did not reveal any assessment of strength and Range of Motion (ROM) of the right lower extremity. R118 used their right arm and right leg for mobility and positioning in bed. The neuro muscular assessment section read in part, "Sitting Balance = Static sitting - DNT (Did Not Test) and Dynamic sitting - DNT (Did Not Test). R118's PT evaluation did not have any baseline assessment for sitting balance, however had goal for standing in the standing frame. It should be noted that moderate upper body strength and trunk control are needed to be able to use a standing frame safely. A goal was established without a base line assessment of the critical neuromuscular elements. The evaluation and plan of care did not address the change in bed mobility from the prior level of function as noted on this evaluation. The evaluation did not assess or address the need for any assistive devices to improve R118's mobility in bed. Occupational Therapy (OT) evaluation dated 4/26/23, revealed that R118 needed assistance with their bed mobility, it was not addressed under the current plan of care established by OT that nursing will continue to provide assistance. R118's care plan revealed that they were at risk for loss of			

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	mobility and risk for pressure ulcer. An interview was completed with staff member "BB" and staff member "CC" on 6/28/23 at approximately 1:15 PM. Staff members "BB" and "CC" were queried on the assessment for use for positioning and assistive devices in bed. Staff member "BB" reported that they had assessed the need for assistive device(s) in bed to maintain or improve mobility in bed. Staff member "BB" was queried specifically on R118 and why they were not assessed for assistive devices. Staff member "BB" reported that the facility did not use any assist bars in the beds. They would do an assessment for a trapeze. No further explanation was provided on why this was not addressed prior even after R118 had brought it to the attention of the staff members. An interview was completed with Director of Nursing (DON) on 6/29/23 at approximately 9:10 AM. The DON was queried about the facility protocol on staff assisting residents who wanted to get of their bed. The DON reported that it was the resident's preference and staff should be accommodating the preferences and assisting the residents. The DON was queried on the assistive devices in Resident's beds to assist with their mobility and positioning. The DON reported that they were providing assistive devices as needed after assessments. When queried further about assist bars in bed, The DON reported that the facility currently did not have any			

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	residents using the assist bars on the beds. They would follow up with the team and provide an assistive as needed. A request for policy on assistive devices and positioning devices was requested and received the Critical Element Pathway for Positioning, Mobility, and Range of Motion via e-mail.			
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: This citation pertains to intake #'s MI00136943 and MI00136471. Based on observation, interview, and record review, the facility failed to perform a wheelchair transport in a safe manner and thoroughly investigate the root cause of an injury; and failed to follow the plan of care for two (R4 and R110) of eight Residents reviewed for accidents hazards, resulting in an injury (bruising, redness, swelling, and pain) to R4's ankle and potential for further falls. Findings include: R4	F0689	F 689 Free of Accidents Hazards Supervision and Devices Element I: It is the practice of the facility to perform wheelchair transport in a safe manner and thoroughly investigate the root cause of an injury and follow the plan of care of residents. R4 no longer resides in the facility. R110 plan of care has been reviewed and updated as needed. Staff involved in R110 incidents have been disciplined. Element II: Residents that currently reside in the facility have the potential to be affected by this cited practice. An audit was conducted on current residents to ensure wheelchair transport is being completed in a safe manner, investigation to the root cause of injuries is completed, and plan of care of the current residents are being followed. Element III: The Interdisciplinary Team reviewed the policy and procedure “Accident and Incident report” and deemed it appropriate. Nursing staff will be educated by July 28, 2023 on the Accident and Incident Report Policy with emphasis on performing wheelchair transport in a safe manner and thoroughly investigate	7/28/2023

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	On 6/27/23 at 10:48 AM, R4 was observed in their bed. An interview was conducted at that time. When queried about their care in the facility, R4 reported they had pain in their leg due to an incident that occurred with the physical therapist the week prior. R4 explained that the therapist had them in a wheelchair and it did not have foot rests. R4 reported the therapist instructed them to place their right foot on top of their left foot and began rolling the wheelchair. R4 explained their right food fell off of their left foot and went under the wheelchair as the therapist pushed the wheelchair forward. R4 yelled for the physical therapist to stop pushing the wheelchair. Later when R4 was back in their room, they experienced pain in their right foot and it turned purple and was bruised and swollen. R4 stated, "It still hurts!". Review of an incident report for R4, completed by Nurse 'KK', dated 6/15/23 revealed, "Writer called to room, observed resident's right leg swollen and bruised. Resident stated therapy was pushing her down the hallway, she didn't have any leg rest on her wheelchair, resident stated therapist told her to cross her right leg over her left, when the right leg fell off the other leg, she stated as the therapist pushed her, her leg went under the wheelchair..." On 6/28/23 at 4:58 PM, an interview was conducted with Nurse 'KK'. When queried about the incident that happened to R4 on		the root cause of an injury and follow the plan of care of residents. Element IV: The DON/designee will complete random audits 5 charts weekly for 4 weeks, then monthly for two months thereafter to ensure wheelchair transport in a safe manner and thoroughly investigate the root cause of injury and follow the plan of care of residents. Any deficient practice will be corrected/updated immediately Results will also be taken to the monthly QAPI Committee meeting for three months for review and comments and/or until substantial compliance is determined. The Director of Nursing is responsible for on-going compliance.	

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	6/15/23, Nurse 'KK' reported R4 asked them to look at their leg and said when the physical therapist took them in the wheelchair there were no footrests. The therapist asked R4 to cross their legs and their leg came uncrossed and went under the wheelchair as it was being pushed. Nurse 'KK' explained that R4 reported they yelled for the therapist to stop . Nurse 'KK' reported when they assessed R4's leg, it was "red, swollen, and bruised from the ankle up the leg and was warm to touch." On 6/29/23 at 12:15 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked about any investigation that was done to look into the incident documented on the incident report for R4 on 6/15/23. The DON reported the therapy director had completed an investigation and would provide it. The DON stated, "It was a one time occurrence and education was done". Review of a "Witness Statement" written and signed by Physical Therapy Assistant (PTA) 'LL' on 6/16/23 revealed the following: "...PTA taking pt (patient) back to room. Pt's leg fell off leg rest, pt stated, "Stop". PTA stopped and placed RLE (right lower extremity) back on leg rest. PTA asked pt is she was ok or in pain. Pt stated she was ok and had no pain. PTA brought pt to her room and left her in w/c (wheelchair) and removed leg rests". On 6/29/23 at 1:56 PM, an interview was			

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	conducted with PTA 'LL'. When queried about what happened with R4 during wheelchair transport on 6/15/23, PTA 'LL' stated, "I did not see her leg at any time go under the wheelchair". PTA explained they were bringing R4 back to their room in a wheelchair, R4 said to "Stop!". PTA reported R4 had leg rests and that R4 did not like one of the leg rests. When queried about why R4 said there were no leg rests used, PTA 'LL' reported R4 was not telling the truth. When queried about how R4's leg ended up bruised, red, and swollen afterwards, PTA 'LL' reported R4 did not report any pain to them. On 6/29/23 at approximately 2:00 PM, the DON was further interviewed. When queried about whether anyone investigated to see if R4's wheelchair did in fact have foot rests, the DON indicated they did not. Review of R4's clinical record revealed R4 was admitted into the facility on 9/18/20 and readmitted on 5/22/23 with diagnoses that included: chronic obstructive pulmonary disease and bilateral primary osteoarthritis of the knees. Review of a MDS assessment dated 5/28/23 revealed R4 had intact cognition and required limited assistance with locomotion in the wheelchair. R110 R110 was admitted to the facility on 11/10/22. R110's admitting diagnoses included Stroke with left sided weakness,			

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	glaucoma, legal blindness, dementia, aphasia (inability to speak or comprehend due to damage to the brain) and dysphagia (difficulty swallowing food). R110 had a Brief Interview of Mental Status (BIMS) 00/15, indicative of severe cognitive impairment. R110 was receiving their nutrition through Percutaneous Endoscopic Gastrostomy (PEG) tube (A tube inserted through the wall of the abdomen directly into the stomach. It allows air and fluid to leave the stomach and can be used to give drugs and liquids, including liquid food, to the patient). Review of R110's Electronic Medical Record (EMR) revealed a Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 11/16/22. MDS assessment revealed that R110 needed extensive assistance from two staff members to assist with their positioning and mobility in bed. R110 was totally dependent on two staff assistance with their toileting. Review of R110's Kardex read, "Bed mobility - 2 person assist". Review of R110's care plan revealed R110 was at risk of falls due to impaired safety awareness due to impaired cognition, vision, and comprehension. Further review of R110's EMR revealed a nursing progress note dated 6/9/23, that read in part, "Resident alert with some confusion. Resident is mostly non-verbal, but does appear to think and process questions when asked. Approximately 6:20 am, Writer was passing am meds and heard a noise in			

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	resident's room. Writer called out to assigned CENA, what's wrong? CENA responded '' (omitted) on the floor. Writer asked CENA (Certified Nursing Assistant) what happened? and CENA responded ''I turned (omitted) over to change (omitted) and (omitted) rolled out of bed''. Resident noted lying face up on floor on window side of bed eyes open. Resident was alert and writer asked if (omitted) hit (omitted) head? Resident answered'' no'' CENA stated also that resident did not hit (omitted) head. Writer assessed resident for injuries. No injuries noted...". Incident report and facility investigation was requested on 6/28/23. Incident report received via e-mail revealed the description of the incident as noted in the above paragraph. The facility did not have any additional documentation on the investigation, root cause analysis, and follow up after the incident. Nursing Progress note dated 6/11/23 completed at 19:19 read, "Xray of head/neck, and right hip requested by (relationship omitted) and (relationship omitted). Ordered by MD (Name Omitted), on call NP". An initial observation was completed on 6/27/23 at approximately 4:10 PM. R110 was observed in their bed. R110's head of the bed was up partially. R110 was not responding appropriately to any questions. A facility signage on the resident message board read,			

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	"Transfers - Hoyer. Locomotion - Geri chair; Bed mobility - x 2; Toileting - Bed Level x 2". A second observation was completed on 6/28/23, at approximately, 12:45PM. R 110 was observed in their bed with their eyes closed. A private duty care giver "GG" was sitting next to R110's bed. Pvt duty care giver "GG" was interviewed during this observation. Care giver "GG" was arranged by R110's family and they reported that they had been providing care for R110 for approximately two years. The care giver was queried about the fall. Care giver "GG" reported that R110 rolled out of their bed on the right side, during care. Care giver "GG" Reported that R110 needed two-person assistance and the care giver was providing assistance without a second staff member. An interview was completed with Director of Nursing (DON) on 6/29/23 at approximately 1 PM. The DON was queried about R110's fall incident. DON reported that, if a Resident's plan of care indicated two-person assistance, there should have been two staff members. The staff member did not have a second person to assist R110 during the incident. The DON verified and confirmed that the staff member no longer worked at the facility, after the incident. A facility document titled "Accident and Incident Report", dated 6/20/22, read in part,			

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	"The purpose of this policy is: (a) to comply with State and Federal rules. (b) to provide prompt medical care for injured residents. (c)to monitor frequency, severity and location of resident incidents/accidents. (d) to look for Facility or resident trends. (e) to properly care plan for residents. (f) to prevent a re-occurrence of a similar incident. (g) to provide timely follow-up of corrective measures. (h) to evaluate the efficacy of the corrective measures; and (i) to provide an immediate reference source for a more thorough investigation (if needed)".			
F0690 SS= G	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	F0690	F 690 Bowel and Bladder Incontinence, Catheter and UTI Element I: It is the practice of the facility to timely review abnormal lab results. R58 was reviewed and assessed by R58's attending physician. The attending physician evaluated R58 current	7/28/2023

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	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 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 #MI00134725 Based on observation, interview and record review the facility failed to timely review abnormal lab results for one (R58) out of four residents reviewed for Urinary Tract Infection (UTI) resulting in a delay in treatment for a UTI and hospitilization. Findings include: A complaint was filed with the State Agency (SA) that alleged R58 had a UTI (urinary tract		medical condition and abnormal lab results. Direction was given to provide care needs as deemed appropriate from the attending physicians assessment. Element II: Residents that currently reside in the facility with abnormal labs have the potential to be affected by this cited practice. An audit was conducted on current residents with abnormal labs to ensure abnormal labs are reviewed timely and treatment implementation is indicated. Element III: The Interdisciplinary Team reviewed the policy and procedure “Lab values, reporting of” and deemed it appropriate. Nursing staff will be educated by July 28, 2023 on Lab values, reporting of Policy with emphasis on timely review of abnormal labs. Element IV: The DON/designee will complete random audits 10 charts weekly for 4 weeks, then monthly thereafter to ensure timely review abnormal lab results. Any deficient practice will be corrected/updated immediately Results will also be taken to the monthly QAPI Committee meeting for three months for review and comments; and/or until substantial compliance is determined. The Director of nursing is responsible for on-going compliance.	

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infection) that was left untreated resulting in R58 being sent to the hospital on 1/29/23 after they were observed with a change in mental status.

On 6/27/23 at approximately 10:45 AM, R58 was observed lying in bed. The resident was alert but not able to answer most questions asked including a history of UTI(s) or Hospitalization. The resident expressed that they were in pain but were not able to activate their call light with their hand. A nurse was asked to come assist the resident.

A review of R58's clinical record noted the resident was initially admitted to the facility on 7/18/22 with diagnoses that included, in part: heart disease, brain and bone cancer and depressive disorder. A review of the resident Minimum Data Set (MDS) noted the resident was significantly cognitively impaired and required extensive one to two person assist for most activities of daily living (ADL) and was incontinent of both bladder and bowl.

Continued review of R58's clinical record revealed, in part, the following:

1/21/23: Nursing Note: " ...wife told writer she noticed resident has pain on groin when urinating. Logged the complains<sic> in MD (medical doctor) book ...".

1/23/23: Physician Team: "(R58) is seen today for general medical visit ... family report that

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	he has groin pain with urination. On my arrival he is groaning in pain as CENA (certified nursing assistant) is washing him up. He admits to pain with "using the bathroom" ...will order a UA (urinalysis) to r/o (rule out) infection ...". 1/24/23: "Spoke with (MD "HH") to review Urinalysis ...". 1/25/23: Physician Team: " ...R58 is seen today for ...f/u (follow up) on pain and urinary complaints ...UA obtained to r/o (rule out) infection, and it appears contaminated ...". 1/27/23: Laboratory Results: "1/27/23 (9:57 PM) Culture, Urine ...Reviewed (1/29/23 at 8:26 AM) ...Collection Date ...1/24/23 ...Reported date: 1/27/23 ...Ord. Provider: Dr. "HH" Results for R58 ... Culture, Urine ... Escherichia Coli ...>100,000 ...Source: Urine, Clean Catch". 1/27/23: Nursing Progress Note: "Labs placed in MD book for review". 1/27/23: Nursing Progress Note: "While giving resident afternoon pain pill, resident was reluctant to take water ...". 1/29/23: Nursing Progress Note: " ...checked with Dr. "HH" to clarify she was aware of urine culture results ....No new orders received. Dr. "HH" said she would review notes ...".			

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	1/29/23: Physician Team: "Results of urine culture reveals a single, pan-sensitive E. Coli ....He is afebrile, allergic to penicillin, has chronic kidney disease ...Use of IM (intramuscular) gentamicin (an aminoglycoside used to treat serious bacterial infections) ...as a single dose could be used if he develops more symptoms. I will evaluate him in the morning." *It should be noted that IM gentamicin was not provided to the resident. 1/29/23: Nursing Progress Note: " ...Assign CENA notified writer resident did not eat breakfast ...family came in around lunch and have concerns of residents ...mental state. Log for physician to contact family ...". 1/29/23 (6:07 PM): Nursing Progress Note:" ...Pt. (patient) observed with stroke like symptoms ...Pt sent to (name redacted Hospital) ...". A facility "Concern Form" along with an attached e-mail was reviewed and it documented, in part: "...Date received: 2/7/23...Documentation of Concern...per hospital record family expressed quality of care...(R58) positive for UTI ...e-mail...Patient was reportedly positive for UTI on 1/24 as tested by facility, however the UTI was left untreated...patient was hospitalized 1/29. Patient was discovered by family member to be unresponsive in his room, contracted and lying in bed...".			

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	Hospital records dated 1/29/23 were reviewed and documented, in part: "(R58) presents with complaint(s) of Altered mental status ...stopped eating 2 days ago ...spoke with patient's sister ...she notes last week (R58) was complaining of burning with urination. A UA (urinalysis) and UC (urine culture) were completed on 1/24/23 with E-Coli (bacteria that originates in the intestine and migrated to the bladder causing UTIs) ... She notes (R58) did not get ABX (antibiotics) at the facility. She notes he subsequently started eating and drinking less ...Reported fever at facility ...Temp 100.2. ...admitted to our hospital secondary to worsening levels of alertness, reduced oral intake ...sepsis, complicated UTI ...The patient was identified to have a UTI with E. coli ...Infectious Disease Consultation ...Date of Admission 1/29/23 ...Date of Consultation ...1/30/23 ...urine cultures form 1/24/23 had recovery of E. coli ...Empiric antibiotic therapy consisting of Vancomycin and Cefepime has been initiated ...". On 6/28/23 at approximately 5:22 PM and 6/29/23 at approximately 9:19 AM, attempts were made to contact Dr. "HH" via phone. While a return call was attempted by Dr. "HH" no phone interview was conducted before the end of the Survey. *It was noted by the facility that Dr. "HH" was no longer providing physician services at the facility. On 6/29/23 at approximately 9:43 AM an interview and record review were conducted			

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	with Medical Director (MD) "K". MD "K" again reported that Dr. "HH" no longer provided services at the facility. MD "K" was asked as to the facility policy/protocol for reporting lab results to resident's physicians. MD "K" noted that abnormal lab results should be reported immediately to a resident's treating physician. When asked if R58's lab results (Friday: 1/27/23) should have been reviewed on the date reported as they noted the resident was positive for E Coli, MD "K" reported they should have. MD "K" stated that sometimes the results end up in the logbook, however the physicians also need to be contacted especially when results arrive on the weekend. When asked if a quicker response to the positive E. Coli results (1/27/23) may have prevented R58 change in condition and hospital stay, MD "K" noted that an earlier antibiotic treatment might have been helpful. On 6/29/23 at approximately 3:23 PM, an interview was conducted with the Director of Nursing (DON). The DON was queried as to the protocol/policy pertaining to lab results. The DON reported that the facility is to timely report the results of abnormal lab results so as not to delay any necessary treatment. The facility policy for labs results was reviewed and documented, in part, as follows: "Policy: It is the policy of this facility to promptly notify the attending physician or physician extender of laboratory values			

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	...Explanation and Compliance Requirements: The facility must promptly notify the attending physician of lab results. Delayed notification may contribute to delay in changing the course of treatment or care plan. The lab will determine parameters for "Panic/Abnormal" or "Normal" lab results ...Abnormal notifications: a. Notify physician or physician extender with lab result and resident current condition. b. Add Review to document notification of result(s) and condition (date, time, name of individual reported to, new orders if applicable) ...Physician or physician extender will sign off on ...Abnormal lab result ...5. If there is not response from the physician or physician extender within 2 hours of notification of Panic/Abnormal lab, contact the Director of Nursing or his/her designee for further instructions.			
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 preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F0692	F 692 Nutrition Hydration Status Maintenance Element I: Resident #51 no longer at facility. Resident has been discharged back into community. Element II: All residents receiving IV fluids were assessed to ensure that IV fluids are being monitored for hydration status. Element III: Facilities policy on hydration has been reviewed and deemed appropriate. All licensed nursing staff and dietician will be educated by July 28, 2023, on the use of IV fluids, assessment and monitoring for hydration.	7/28/2023

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	§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: Based on observation, interview and record review, the facility failed to ensure assessment and monitoring of hydration for one (R51) of one resident reviewed for hydration. Findings include: On 6/27/23 at 9:51 AM, R51 was observed lying in bed. An intravenous (IV) catheter was observed in R51's right wrist connected to an IV bag of 0.9% Sodium Chloride Injection USP (United States Pharmacopoeia) hanging on a pole. Review of the clinical record revealed R51 was admitted into the facility on 12/7/21 and readmitted on 6/8/23 with diagnoses that included: kidney disease, dementia and stroke. According to the Minimum Data Set (MDS) assessment dated 6/14/23, R51 had moderately impaired cognition and required the extensive assistance of staff for activities of daily living (ADL's). Review of R51's nutritional care plan initiated 6/14/23 revealed an intervention that read, "Offer food and beverage selections". Review of R51's June 2023 Medication Administration Record (MAR) revealed an		Element IV: The DON/designee will complete random audit 10% of the residents weekly for 4 weeks, then monthly thereafter to ensure the use of IV fluids are assessed and monitored for hydration. Any deficient practice will be corrected/updated immediately Results will also be taken to the monthly QAPI Committee meeting for three months for review and comments; and/or until substantial compliance is determined. The Administrator is responsible for compliance.	

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order dated 6/26/23 that read, "Sodium Chloride Intravenous Solution 0.9 % (Sodium Chloride), Use 75 ml/hr (milliliters/hour) Intravenously every shift for Dehydration x2 Liters". An additional order dated 6/20/23 read, "Sodium Chloride Solution 0.9%, Use 75 ml/hr intravenously every shift for dehydration for 1 Day administer 2 L (Liters)". Both orders were documented as given.

Review of R51's progress notes revealed:

A Nursing Note dated 6/21/23 at 12:35 AM read in part, "IV access initiated on the Left forearm and resident started on Sodium Chloride Solution 0.9 % 2L for dehydration, bag 1 of 2 infusing at 75 ml/hr..."

A Physician Team Note dated 6/23/23 at 2:25 PM read in part, "...Patient received 2 L IVF (intravenous fluid) per lab results elevated BUN (blood urea nitrogen) and CR (creatinine)... Per patient poor appetite, RD (Registered Dietitian) following... LABS AND DIAGNOSTICS: 6/19-... BUN 31, CR 2.46... " It should be noted that elevated BUN and CR levels can indicate dehydration.

A Physician Team Note dated 6/26/23 at 1:33 PM read in part, "...Labs reviewed and IVF ordered due to elevated BUN and CR... Per patient poor appetite, RD following... LABS AND DIAGNOSTICS: ...6/26-... BUN 27, CR 2.01..."

Further review of R51's progress notes

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	revealed one Dietary Note dated 12/14/21. No other Dietary progress notes were found. On 6/28/23 at 2:29 PM, RD "J" was interviewed and asked about R51 receiving 2 L of IVF two separate times. RD "J" explained she had been notified about R51 receiving 2L of IVF on 6/27/23, but had not known about R51 receiving 2 L of IVF on 6/20/23... had seen R51 on 6/27/23 and brought her ice water and ice cream... R51 drank the ice water like she was thirsty and ate all the ice cream. When asked what was being done to prevent further dehydration, RD "J" explained she would have to look into it a little more, but would add more liquids to R51's meal trays. On 6/28/23 at 3:22 PM, Dr. "K", R51's attending physician, was interviewed and asked about R51 receiving 4 L of IVF in a week's time. Dr. "K" explained R51's BUN and CR indicated dehydration, so IVF was ordered. When asked about the Physician Team progress notes documented that the RD was following, but RD "J" saying she was unaware of R51's dehydration and IVF order, Dr. "K" explained there appeared to be a lack of communication, that everyone should be aware and that all staff should be encouraging the resident to drink more fluids. On 6/29/23 at 9:05 AM, Certified Nursing Assistant (CNA) "L" was interviewed and asked how she knew if a resident needed encouragement to drink fluids. CNA "L"			

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	explained the nurse would tell the CNA's if someone needed encouragement to drink fluids. On 6/29/23 at 9:29 AM, CNA "M" was interviewed and asked how she knew if a resident needed encouragement to drink fluids. CNA "M" explained all residents should be encouraged to drink fluids, but the nurse would tell them in the morning if there was anyone that needed extra encouragement. On 6/29/23 at 9:15 AM, the Director of Nursing (DON) was interviewed and asked about the apparent lack of communication with R51's first 2 L of IVF and then the subsequent second 2 L of IVF needed. The DON explained she would look into the matter. The DON was asked if a resident would readily drink fluids, like when RD "J" gave R51 ice water, should staff be encouraging the resident to drink more fluids. The DON agreed they should. No further information was provided prior to the end of the survey. Review of a facility policy titled, "Hydration" dated 9/29/17 read in part, "...It is the policy of this Facility to provide ample fluids to all residents... Fluid needs will be evaluated by the dietitian on the initial nutritional assessment, annual nutritional assessment, and as needed. If the resident is deemed to have higher fluid needs, the dietitian may adjust the fluids provided at meals			

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	accordingly..."			
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: This citation pertains to Intake #MI134568 Based on observation, interview and record review, the facility failed to ensure consistent communication between the hemodialysis center and the facility for one (R152) of three residents reviewed for dialysis. Findings include: A complaint was filed with the State Agency (SA) that alleged R152 had missed dialysis appointments and often left for dialysis without a coat. A review of R152's clinical record revealed R152 was initially admitted on 1/18/23 and had diagnoses that included: CVA (stroke), type II diabetes and end stage renal disease. A review of R152's MDS (minimum data set) noted the resident had a BIMS score (brief interview of mental status) of 12/15 (moderately impaired cognition) and required extensive two-person assistance for transfers and bed mobility.	F0698	F 698 Dialysis Element I: Resident # 152 no longer resides at facility. Resident's medical record reviewed and no negative outcome noted. Element II: Residents that require hemodialysis have the potential to be affected by this cited practice. All residents on hemodialysis were audited to ensure dialysis services were provided, consistent with professional standards of practice, comprehensive person-centered care plan, the resident's goals and preferences are met and consistent coordination of care between the facility and dialysis center are followed. Element III: Hemodialysis policy reviewed and deemed appropriate. Licensed Nursing staff will have education by July 28, 2023 on hemodialysis policy and procedure to ensure dialysis services were provided, consistent with professional standards of practice, comprehensive person-centered care plan, the resident's goals and preferences are met, consistent coordination of care between the facility and dialysis center are followed and that dialysis communication forms are completely filled out when resident receives dialysis services. Element IV: Director of nursing services or designee will randomly audit 5 residents a week for four weeks and monthly for two months thereafter to ensure dialysis services were provided, consistent with professional standards of practice, comprehensive person-centered care plan, the resident's goals and	7/28/2023

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	Continued review of R152's clinical record noted, in part, the following: Order (1/19/23): "Dialysis Treatment Center (name redacted) ...Tues, Thurs, Sat ...". *It should be noted that on 1/20/23 the Order was changed to Mon, Wed, and Friday at the same Dialysis Treatment Center. 1/21/23: Nursing Note: "Resident missed chair time to Dialysis due to improper Hoyer pad. Resident arrived back to facility at 1:00 PM . Dialysis appointment rescheduled for Monday ...". Hemodialysis Communication (1/30/23): "Pre-Dialysis ...What medications were given prior to dialysis? None ...Medications sent with resident: none ...For Dialysis Center to Complete ...Complications during dialysis: patient yelling out. Please give pain med ...post-Dialysis: patient screaming in pain ...". *It should be noted that no additional Hemodialysis Communication forms were found in R152's electronic record. On 6/29/23 at approximately 11:50 AM, the Director of Nursing (DON) was asked to provide any additional Hemodialysis communication forms from 1/19/23 through 2/1/23. The DON stated that they were not able to locate any additional communication forms. When asked if the forms should be completed each time the resident goes to dialysis, the DON reported that the forms should be completed.		preferences are met and consistent coordination of care between the facility and dialysis center are followed and that dialysis forms are completed in their entirety when resident received dialysis services. The Director of Nursing will report findings to the monthly QAPI Committee meeting for three months for review and/or until substantial compliance is determine. The Director of Nursing is responsible for on-going compliance.	

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	The facility policy titled, "Hemodialysis" (4/1/22) was reviewed and documented, in part: " ...The facility will provide the necessary care and treatment, consistent with professional standards of practice. This will include:ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments at a certified dialysis facility ...ongoing communication and collaboration with the dialysis facility regarding dialysis care and services ...".			
F0726 SS= D	Competent Nursing Staff §483.35 Nursing Services 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to	F0726	F 726 Competent Nursing Staff Element I: It is the practice of the facility to ensure nursing staff have the skills and competencies necessary to care for resident's needs. Nurse PP and N provided 1:1 education. Element II: Residents that currently reside in the facility have the potential to be affected by this cited practice. An audit was conducted to ensure no residents were affected by this deficient practice. No concerns were noted. In addition, all nursing personnel files were reviewed for a current competency education form. Element III: The Interdisciplinary Team reviewed the policy and procedure for skills and competencies and deemed it appropriate. HR and in-service director will be educated by July 28, 2023 on nursing staff to have the skills and competencies necessary to care for resident's needs. A nursing competency clinic was implemented to ensure all nursing staff received a competency evaluation. Additional	7/28/2023

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	demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure two (Nurse 'PP' and Nurse Aide 'N') of 11 nursing staff reviewedf had the skills and competencies necessary to care for residents' needs. Findings include: Review of a complaint submitted to the State Agency revealed an allegation that a newly licensed nurse was assigned to a unit with residents who had high acuity medical issues and they did not feel comfortable working on that unit. On 6/23/23 at 4:12 PM, a phone interview was conducted with the complainant who reported they ended up leaving the facility after they were assigned to a high acuity unit that they were not comfortable with as a newly licensed nurse. The complainant explained that the rehabilitation unit had residents who had tracheotomies and were "unstable". The complainant reported they received orientation when they started working at the facility, but they were paired with another new nurse for training on the floor who did not know how to do everything.		education will be provided if indicated. Element IV: The DON/designee will complete five audits weekly for 4 weeks and monthly thereafter to ensure nursing staff have the skills and competencies necessary to care for resident's needs. Any deficient practice will be corrected/updated immediately. The results will also be taken to the monthly QAPI Committee meeting for review and comments; and/or until substantial compliance is determined. The Director of Nursing is responsible for on-going compliance.	

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	On 6/27/23 at 10:34 AM, Nurse 'PP' was observed entering a resident's room and administering medication without donning personal protective equipment required for contact precautions and did not properly sanitize items brought into the room. Review of a list of employees provided by the facility revealed nurse aide 'N' was not certified. On 6/29/23 at 10:47 AM, an interview was conducted with Human Resources Coordinator (HR) 'OO". When queried about training for new employees and how nursing staff were evaluated for competencies prior to working the floor on their own, HR 'OO' explained nurses and nurse aides were provided training "on the floor" and had a set of skills that were signed off on by a preceptor to ensure they were competent with the skills needed to meet the residents' needs. HR 'OO' explained that was done over multiple days as all skills may not need to be done on the same day. The former staff development nurse provided additional training as needed. HR 'OO' explained that they currently did not have Staff Development personnel. Personnel files including any competency evaluations/skills checklists were requested for nurse aide 'N' and Nurse 'PP' Review of nurse aide 'N's personnel file revealed their date of hire was 3/7/23. Review			

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	of a "Certificate of Completion" that indicated they completed the nurse aide training program on 4/7/23. Review of a "CNA New Hire and Annual Skills Checklist" for nurse aide 'N' indicated they were a new hire and they were competent in all skills required as of 3/20/23. The skills included hands on tasks and patient care tasks that were documented they were verified competent via demonstration. It should be noted that on 3/20/23, nurse aide 'N' had not yet completed a nurse aide training program. Review of Nurse 'PP's personnel file indicated they were hired on 5/11/23. Review of a "Nursing...New Hire and Annual Skills Checklist" revealed all skills were deemed competent by demonstration or discussion on one day, 5/17/23. The auditor signed the form, but the employee (Nurse 'PP') did not sign the form to indicate they completed the competencies. On 6/29/23 at 3:35 PM, HR 'OO' was further interviewed. When queried about why Nurse Aide 'N' was able to complete a competency evaluation for CNA skills prior to completing a nurse aide training course, HR 'OO' did not have a response. HR 'OO' reported Nurse Aide 'N' should not have been demonstrating CNA skills prior to completing a training course. HR 'OO' explained the competency evaluation for Nurse 'PP' should have been signed by both the auditor and the staff			

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EVERGREEN HEALTH AND REHABILITATION CENTER	19933 WEST THIRTEEN MILE ROAD SOUTHFIELD, MI 48076

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	member to ensure it was complete. On 6/29/23 at 4:40 PM, an interview was conducted with the Director of Nursing (DON) who did not know why Nurse Aide 'N' had competencies evaluated prior to completing an official nursing assistant training program.			
F0761 SS= E	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure appropriate storage and/or labeling of	F0761	F-761 Label /Storage of Drugs and Biologicals Element I: All unlocked medication carts were immediately locked to ensure safe storage of drugs and biologicals. Nurse P, Nurse X, Nurse Y and Nurse E provided 1:1 education on locking medication carts to ensure safe storage of drugs and biologicals. The 3 opened and up labeled insulin pens were immediately removed from medication cart and disposed of. The opened and undated Latanoprost Ophthalmic Solution eyedrops were immediately removed from medication cart and disposed of. Element II: Medication carts on all units were audited to ensure they were locked and safe storage of drugs and biologicals is followed including all multi-dose biological are labeled and dated per facility policy. Element III: Facilities policy on Medication storage of drugs and biologicals reviewed and deemed appropriate. All Licensed nursing staff will be educated by July 28, 2023 on policy to ensure medication carts are locked and safe storage of drugs and biologicals are followed including all multidose biologicals are labeled and dated per facility policy.	7/28/2023

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	medications and treatments/biologicals in three of five medication carts and one treatment carts reviewed, resulting in the potential for unauthorized entry, misuse, contamination, and diversion of narcotics and controlled substances. This deficient practice has the potential to affect multiple residents in the facility. Findings include: According to the facility's policy titled, "Medication & Treatment Cart Storage" dated 5/4/2022: "...It is the policy of this facility to ensure all supplies for treatments and medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security...All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls...Only authorized personnel will have access to the keys to locked compartments..." On 6/27/23 at 10:19 AM, an unlocked treatment cart was observed in the hallway outside of room 116. There was no nursing staff in view of the treatment cart. Nurse 'P' was observed to exit from the room and		Element IV: To ensure continued compliance Director of Nursing or designee will randomly audit 10 medication carts weekly for four weeks and monthly thereafter to ensure medication carts are locked and ensure drugs and biologicals are safely stored including multi-dose biologicals are labeled and dated per facility policy. Any concerns will be addressed immediately. The Director of Nursing will report findings to Monthly QAPI Committee meeting for three months and until substantial compliance is determined. The Director of Nursing is Responsible of on-going compliance	

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	proceeded to access treatment supplies from the unlocked drawer of the cart and re-enter room 116 without ensuring the cart was locked. On 6/27/23 at 12:09 PM, the medication cart outside the roof access room on Anna's House (facility's secured unit) was unlocked with no nursing staff nearby. The drawers of the cart were able to be opened and were accessible to all residents/visitors/staff. On 6/27/23 at 12:11 PM, Nurse Manager 'O' was observed coming down a hallway around the nursing desk and was asked if they knew where a nurse was. Nurse Manager 'O' acknowledged the unsecured medication cart and proceeded to ask a nursing assistant if they knew where the Nurse was. That staff reported Nurse 'E' was in a room (approximately four doors down the hallway). On 6/27/23 at 12:13 PM, Nurse 'E' exited the room and was asked by Nurse Manager 'O' to come to the medication cart. When asked about the unlocked medication cart, Nurse 'E' reported they shouldn't have left it like that, but help was needed in a room. On 6/27/23 at approximately 9:41 a.m., An unlocked-unattended medication cart was observed next to room 127. On 6/27/23 at approximately 9:44 a.m., Nurse "X" was observed coming down the hall and was queried regarding the unlocked-			

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	unattended medication cart. Nurse "X" indicated that the cart should be locked and was observed locking it. On 6/28/23 at approximately 2:35 p.m., a medication cart was reviewed for labeling and storage and the following was observed: 1. An opened and undated lantus Pen-Lantus SoloStar Subcutaneous Solution Pen-injector, was observed in the cart opened and undated. 2. An opened and undated insulin pen for a discharged resident). 3. An opened and undated insulin pen that did not contain a resident name. and 4. An opened and undated Latanoprost Ophthalmic Solution (Latanoprost) eyedrop. On 6/28/23 at approximately 2:48 p.m., a second medication cart was reviewed for labeling and storage and an opened vial of insulin was observed in the cart with Licensed Practical Nurse "Y". The vial indicated that it should be refrigerated when stored. LPN "Y" was queried why the vial was in the medication cart and they indicated that it should have been put back in the refrigerator. LPN "Y" was queried regarding the labeling and storage of medications in the medication carts and they indicated that they should be dated on the day they are opened and refrigerated if the medication says it should be.			
F0770 SS= D	Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must	F0770	F 770 Laboratory Services	7/28/2023

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	provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00137804. Based on observation, interview and record review the facility failed to ensure a Physician ordered laboratory diagnostic were completed in a timely manner for one resident (R67) of one residents reviewed for laboratory diagnostics. Findings include: On 6/29/23 the medical record for R67 was reviewed and revealed the following: R67 was initially admitted to the facility on 12/2/22 and had diagnoses including Dementia, Chronic obstructive pulmonary disease and Severe Protein Calorie Malnutrition. A review of R67's MDS (minimum data set) with an ARD (assessment reference date) of 6/9/23 revealed R67 needed extensive assistance from facility staff with with most of their activities of daily living. R67's BIMS score (brief interview of mental status) was 11 indicating moderately impaired cognition. A Physician progress note dated 6/22/23 revealed the following: "following up on pelvic pain Notified by staff that pt (patient)		Element I: Resident R67 resides at facility at baseline. The labs that were ordered on 6.22.23 were immediately ordered per physician's order. Nurse that received order for CBC and CMP provided 1:1 education on processing lab orders including filling out lab requisition to ensure that lab is communicated to laboratory for completion. Element II: All labs ordered were audited to ensure they were completed per physician's order, including lab requisition completed and placed in lab book. Element III: Facilities policy on labs reviewed and deemed appropriate. All licensed nursing staff will be educated by July 28, 2023 on facilities lab policy and to ensure that lab orders were completed per physician's order with focus on and requisition being completed and placed in log book for lab to be communicated for completion. Element IV: To ensure continued compliance Director of Nursing or designee will randomly audit 20 medical records weekly for weeks and monthly thereafter to ensure physician order laboratory diagnostics were completed in a timely matter including lab requisition being completed and placed in log book to be completed. The audit results will be presented to the monthly QAPI Committee meeting for three months for result and comments, and/or until substantial compliance is determined. The Director of Nursing is responsible for on-going compliance.	

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	has been complaining of lower pelvic pain and dysuria last few days. tramadol was adjusted to q8h (every eight hours) and labs ordered. Will check UA (urine analysis) and urine cx (culture). she also admits to burning on skin while urinating and flucanazole ordered x1 for possible yeast infection. Continue to monitor closely...Plan:...8. routine labs showing Cr (creatinine)0.64, Hg (hemoglobin)11.0, WBC (white blood cell)11.0, repeat labs pending...12. Plan discussed with nursing In detail Plan as written, will follow up on labs..." A physician's order dated 6/22/23 revealed the following: "CBC (complete blood count), BMP (basic metabolic panel)" An attempt to review of R67's laboratory results for the CBC/BMP on 6/22/23 did not reveal any results and was not available in the record. On 6/29/23 at approximately 9:02 a.m., Nurse Manager "O" (NM "O") was queried regarding the missing lab results ordered on 6/22/23. NM "O" Stated there was a miscommunication between the Nurse Practitioner and the Nursing staff to process the lab and that no lab request form was noted to be in the laboratory binder and it was never done. On 6/29/23 a facility document pertaining to laboratory diagnostics was reviewed however it did not describe the process for ensuring the timely completion and processing of Physician ordered labs.			

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	No lab results from the CBC/BMP ordered on 6/22/23 for R67 were provided before the end of the survey.			
F0809 SS= E	Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure meals were served in a timely manner and per facility scheduled times for residents that resided within the Anna's House (secured unit), resulting in delayed meal service and dissatisfaction with the dining experience. Findings include:	F0809	F-809 Frequency of Meals and Snacks at Bedtime Element I: The Registered dietician has reviewed resident R55 and the resident has not been affected nutritionally by this deficient practice. The meal delivery schedule was revised and presented to staff and resident council on 7/18/23. The delivery schedule was posted at each nursing station. Element II: The Registered dietician has reviewed weights for residents in Anna's house and determined no one affected nutritionally by this deficient practice. Element III: Dietary staff will be educated on the revised meal delivery schedule by July 28, 2023. In addition, the importance of meals being served on time was discussed. Element IV: The certified dietary manager/designee will audit meal delivery times for timeliness to ensure the meal schedule is being followed. Audits will be completed three times a week for one month and then once a week for the next two months. Audits will be present at the QAPI Committee meetings for three months for review and comments; and/or until substantial compliance is determined. The Administrator will be responsible for compliance.	7/28/2023

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	According to the documentation of facility scheduled mealtimes, the meals were to be provided for Breakfast from 7:30 AM - 8:30 AM; Lunch from 11:30 AM - 12:30 PM; and Dinner from 4:30 PM - 5:30 PM. On 6/28/23 at 12:15 PM, observations of the facility's lunch meal setup revealed an adequate number of dietary staff, including the Interim Dietary Manager (Staff 'S'). It was reported the last unit to be served meals was on Anna's House. It was also identified there were three food transport carts to be delivered to the unit. The first food cart left the kitchen at 1:13 PM; the second food cart left the kitchen at 1:28 PM; and the third food cart left the kitchen at 1:30 PM. On 6/28/23 at 1:32 PM, Dietary Aide 'V' was asked about why the lunch meal was so late and they reported the food was behind because of "short staff". On 6/28/23 at 1:33 PM, Interim Dietary Manager (Staff 'S') was asked about the dietary staffing and reported they were not sure, but would obtain the actual staffing for today. When asked about why the lunch meal was so late today, Staff 'S' reported it wasn't because they were short-staffed, it was due to having new staff and the increase in facility census from 140 to 160's. On 6/28/23 at 1:40 PM, the final food tray for			

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	Anna's House was removed from the food cart. On 6/29/23 at 8:23 AM, R55's Family Member was interviewed by phone. When asked about concerns at the facility, R55's Family Member explained the meals are frequently served late, as an example, on 6/28/23, lunch was not served until 1:40 PM and dinner will sometime be served at 6:30 PM, an hour after it is supposed to be served...it is "ridiculous" because the residents are just sitting in the dining room with nothing to do, they just sit there for hours.			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a	F0812	F-812 Food Procurement, Store/Prepare/Serve Sanitary Element I: There are no specific residents identified by this deficient practice. A. The open pecans were immediately discarded. B. The new freezer door arrived and was installed on 7/11/23. The certified dietary manager went through the freezer on the same date and discarded items covered with heavy frost/ice. C. Prior to the end of survey, all hard-boiled eggs were discarded, as well as the unsealed package of whipped cream and the meatloaf. D. The certified dietary manager tested the temperatures for the dish machine multiple times the week following survey and it was determined the dish machine was functioning appropriately. E. The ice scoop container was thoroughly cleaned and a log sheet was implemented to	7/28/2023

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	sanitary kitchen; ensure food items were properly labeled, dated, and stored; monitor and maintain refrigerator and freezer temperature logs; and ensure proper functioning of the dish machine, resulting in the increased potential for cross-contamination and foodborne illness. These deficient practices had the potential to affect all residents that consume food from the kitchen. On 6/27/23, during an initial tour of the kitchen with Interim Dietary Manager (Staff 'S') between 8:56 AM - 9:45 AM, the following items were observed: In the dry storage room, there was an opened plastic bag of pecans that were stored on a top shelf. The package was not properly sealed and was open to air, and there was no date of when it had been opened. The temperature log on the outside of the walk-in freezer was documented as last completed on 6/26/23 for evening shift. In the walk-in freezer, the entire left side of the freezer ceiling, wall and storage shelving underneath had thick build-up of ice. Staff 'S' reported there was a problem with the seal on the door which had been an issue for a while now, but a new door had been ordered. There were multiple food items stored underneath the left side of the freezer which were contaminated and covered with thick,		check the container daily for cleanliness and sanitized. F. The areas underneath the juice and coffee machines were thoroughly cleaned. G. The flooring behind the oven and the meal/prep tray line areas have been thoroughly cleaned. H. All items stored underneath the tray line were removed and run through the dish machine. They were returned after the shelving was cleaned and are being stored inverted. I. All items stored on the shelf under tray line across from the oven have been removed. Cleaning items that were not discarded were moved to the janitor's closet. J. The chicken and beef flavored bases from the reach-in cooler were discarded. K. All utensils in the drawer underneath the prep sink were cleaned as well as the interior of the drawer. L. The certified dietary manager ordered an irreversible dish plate thermometer. Its use will be implemented upon arrival to test the interior temp of the dish machine. Element II: All residents are at risk due to this deficient practice. Element III: A. Dietary staff will be re-educated in the use of cleaning schedules and proper cleaning of equipment, walls, and floors. B. Dietary staff will be re-educated on proper storage, labeling and dating of all opened items stored in the refrigerators and freezers. C. Dietary staff will be re-educated on taking and recording dish machine temperatures as well as the use of the irreversible dish plate thermometers to monitor the internal	

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	frozen ice build-up. There were several opened boxes of frozen hamburger patties stored at the back of the freezer that had thick, frozen ice build-up on the box. When asked about those items, Staff 'S' reported those were part of their always available menu. Staff 'S' began to move several boxed items that had been contaminated from the left side of the freezer to the storage unit on the right side and when asked about moving the items, Staff 'S' reported those would be discarded. When asked why they had moved the contaminated items with those that were not, Staff 'S' offered no further response and began to remove the items again. There were several other food items that were not wrapped properly, exposed to air with visible ice build-up on the food product which included a package of white turkey patties, flour tortillas, cookie dough, beef patties, corn and mixed vegetables and English muffins. In the walk-in cooler, there was a large plastic container of hard cooked eggs that were observed to have an arrived date of 6/23/23. The lid to this container of hard cooked eggs was broken, ill-fitting and exposed the contents to open air. Inside the container, there was a clear bag of hard boiled eggs that was filled with liquid. The bag was not sealed and the liquid had spilled out of the		temperature of the machine daily. D. All facility staff will be re-educated on requirements for handwashing upon entering the kitchen beyond the doorway. E. Re-education will occur by July 28, 2023. Element IV: A. The consultant dietician will round in the kitchen to ensure all identified items have been corrected at least on a monthly basis and as indicated from the audit results. B. The certified dietary manager/designee will audit the cleaning schedules, walls, equipment and floors three times a week for one month then once a week for the next two months. C. The certified dietary manager/designee will audit for proper labeling of opened food items to ensure opened items contain item name, opened date and use by date. Audits will be completed three times a week for one month then once a week for the next two months. D. The certified dietary manager/designee will audit the dish machine temp log as well as visualization of dish machine gauges to ensure proper temperatures are reached and documented. Audits will be completed three times a week for one month then once a week for the next two months. E. The certified dietary manager/designee will audit handwashing to ensure handwashing is occurring when staff enter the kitchen. Audits will be completed three times a week for one month then once a week for the next two months. F. Audits will be brought to the monthly QAPI Committee meeting for review and comments; and/or until substantial compliance is determined. The Administrator will be responsible for compliance.	

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	bag and into the plastic container. Additionally, there was an opened and unsealed package of whipped cream; there was a metal storage shelving unit on wheels that contained several trays of food that had a large piece of meatloaf (gray in color) that was undated, loosely wrapped and exposed to air. When asked who was responsible for monitoring the food items for proper storage, labeling, and discard, Staff 'S' reported every morning the manager monitors that and goes through fridges, and also it was normally done by afternoon supervisor. Staff 'S' reported there were several changes to the dietary management within the last few weeks. The high temp dish machine was not observed in use as of 9:17 AM. The log to document temperatures twice daily (in the morning and in the evening) had not be done for 6/27/23. When asked when the high temp dish machine should be tested, Staff 'S' reported when staff first came in (at beginning of shift). The ice machine was observed to have an ice scoop container secured on the left side of the machine. The inside of the ice scoop container was observed to have a build-up of standing water with brownish colored debris in the bottom.			

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	There was a large accumulation of debris underneath the juice and coffee machines. The flooring behind the oven was heavily soiled with food debris (tater tots) and crumbs. The flooring under the meal prep/tray line area was observed to have a thick build-up of debris. The under shelving of the meal prep/tray line contained various sized bowls and plates that were stored right side up. Several bowls were observed to be soiled with a dark colored substance. When asked about the storage of the above items and whether they should be stored right side up, Staff 'S' reported since they were stored underneath, that was ok. When asked about the contaminated bowls, they reported that was not good and proceeded to remove the soiled bowls. The shelf under the meal prep/tray line across from the oven was observed to have a clear plastic container with several heavily soiled, greased/soiled rags, sponges and a grill scraper. When asked about the storage of these items, Staff 'S' asked Dietary Staff 'Q' who reported that had been there a while. The reach-in cooler near the prep sink was observed to have two large containers of chicken flavored base and one large container of beef flavored base. The three containers were observed to have broken			

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	tops which did not properly seal and exposed the inside contents. The small prep sink located next to the oven was observed to have a small drawer underneath. Observation of the contents of the drawer revealed several utensils (spoons, ladles, etc) were soiled with dried food debris and there was also dried food debris on the bottom of the drawer. On 6/28/23 at 11:30 AM, a follow-up visit to the kitchen with Staff 'S' revealed ongoing concerns with improper sealing of the chicken and beef flavored base; soiled flooring and food remained behind the oven and under the meal prep/tray line area; soiled surfaces near the juice and coffee machines. Additionally, the high-temp dish machine was observed to be in use. Review of the temperature log revealed there was no temperature monitoring done for 6/27/23 morning shift or 6/28/23 morning shift. When asked about whether staff had monitored the high temp dish machine since the log was blank, Staff 'S' proceeded to run their thermometer through the dish machine. One of the dietary staff was asked about how they were to monitor the temperature and reported there were strips that they couldn't find, so they used the digital reading on the outside of the dish machine. Staff 'S' was asked about the protocol for monitoring the temperature and they reported that dietary staff should be testing at start of each shift,			

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	but deferred to the maintenance staff and reported they also monitored it every day, so they weren't concerned. On 6/28/23 at 12:04 PM, Activity Aide (Staff 'T') was observed to enter the kitchen from the north door, and go into the walk-in freezer, without hand-washing or using hand-sanitizer. Staff 'T' exited the freezer and was asked about what the process was for hand-washing upon entering the kitchen. Staff 'T' reported they had washed their hands before entering the kitchen and attempted to show how they opened the door with their wrist behind the door handle, unsuccessfully. When asked about what they had been educated on regarding infection control practices in the kitchen, they offered no further response. On 6/28/23 at 12:37 PM, signage posted on the wall outside of the kitchen's south door read, "Health Department Regulation Prohibits Entry to Kitchen by Anyone Other than Kitchen Personnel". On 6/28/23 at 12:53 PM, an interview was conducted with the Maintenance Director (Staff 'U'). When asked about their department's monitoring of the dish machine temperatures as reported by Staff 'S', they reported they monitored the water temperatures for the kitchen, but not the final rinse temperature as that should be done by the dietary staff before using, to make sure it was the correct temperature.			

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Staff 'U' also reported there was a log that the kitchen staff documented on. Staff 'U' was informed that the log had been reviewed and was not documented as completed for the morning on 6/27/23 or 6/28/23, and that Staff 'S' 'had deferred to the maintenance staff for monitoring documentation.

On 6/28/23 at 1:32 PM, an interview was conducted with Dietary Aide (Staff 'V'). When asked about the process of infection control practices for when anyone enters this kitchen, Staff 'V' reported all staff were to wash hands immediately upon entering. When asked about if they've observed other staff entering without washing hands, Staff 'V' reported they had, especially at the north door.

According to the 2017 FDA Food Code section 2-301.14 When to Wash, "Food employees shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: ...(E) After handling soiled equipment or utensils; ...(I) After engaging in other activities that contaminate the hands."

According to the 2017 FDA Food Code section 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation, "(A) Food shall be protected from cross contamination by: ...(2) Except

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	when combined as ingredients, separating types of raw animal foods from each other such as beef, fish, lamb, pork, and poultry during storage, preparation, holding, and display by: ...(b) Arranging each type of food in equipment so that cross contamination of one type with another is prevented,". According to the 2017 FDA Food Code section 3-302.12 Food Storage Containers, Identified with Common Name of Food, "Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD." According to the 2017 FDA Food Code section 3-304.12 In-Use Utensils, Between-Use Storage, "During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: ...(E) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous (time/temperature control for safety food)..." According to the 2017 FDA Food Code section 3-305.11 Food Storage. 1. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from			

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	contamination by storing the FOOD: 1. (1) In a clean, dry location; 2. (2) Where it is not exposed to splash, dust, or other contamination; and 3. (3) At least 15 cm (6 inches) above the floor. According to the 2017 FDA Food Code section 3-307.11 Miscellaneous Sources of Contamination, "FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306." According to the 2017 FDA Food Code section 3-501.17: "Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day			

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	1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety." According to the 2017 FDA Food Code section 4-302.13 Temperature Measuring Devices, Manual and Mechanical Warewashing, (B) In hot water mechanical warewashing operations, an irreversible registering temperature indicator shall be provided and readily accessible for measuring the utensil surface temperature. According to the 2017 FDA Food Code Section 4-601.11 Equipment, Food-Contact Surfaces, NonfoodContact Surfaces, and Utensils. "(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. Pf (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." According to the 2017 FDA Food Code section 4-602.13 Nonfood-Contact Surfaces, "Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues." According to the 2017 FDA Food Code			

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	section 4-701.10 Food-Surfaces and Utensils, "Equipment food-contact surfaces and utensils shall be sanitized." According to the 2013 FDA Food Code section 4-703.11 Hot Water and Chemical, After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in: (B) Hot water mechanical operations by being cycled through EQUIPMENT that is set up as specified under §§ 4-501.15, 4-501.112, and 4-501.113 and achieving a utensil surface temperature of 71 degrees Celsius (160 degrees Fahrenheit) as measured by an irreversible registering temperature indicator; According to the 2017 FDA Food Code Section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. "(A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLEUSE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored:			

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(1) In a self-draining position that allows air drying; and

(2) Covered or inverted..."

According to the 2017 FDA Food Code Section 6-501.12 Cleaning, Frequency and Restrictions.

"(A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.

(B)Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of FOOD is exposed such as after closing."

According to the facility's policy titled, "Kitchen Sanitation to Prevent the Spread of Viral Illness" dated 2/21/2023:

"...Hand washing i. Employees must wash their hands and exposed portions of their arms at designated hand washing facilities at the following times...Immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles; - During food preparation, as often as necessary to remove soil and contamination and prevent cross contamination when changing tasks...After engaging in other activities that contaminate the hands...The food service director or designee will ensure that all standards of

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	practice are maintained regarding cleaning, sanitizing wares, equipment and all food contact surfaces...The food service director or designee will ensure that the dishmachine is effectively sanitizing either by the hot water method or with chemical sanitizer and logged. Logs will remain on file for 90 days...All other food contact surfaces and equipment shall be washed, rinsed and sanitized per USDA Food Code Recommendations..." According to the facility's policy titled, "Food Storage" dated 12/26/2022: "...It is the responsibility of the Dietary staff and supervisors to ensure that food is stored, labeled and used within the recommended time guidelines to prevent food borne illness...Temperatures of the food storage areas, including dry storage, refrigeration and freezers shall have thermometers and be monitored and recorded daily...Guidelines for food labeling and dating must be adhered to by all food service personnel and closely monitored by the food service manager...All foods removed from original packing and must have an arrival date. If food has a manufacturers expiration date, an open date will be added to the label, which includes food like: cottage cheese, bulk yogurt, sour cream etc...All food packaging that is open for use and returned like deli meat must be labeled with arrival date and open date...Leftover foods must be immediately frozen, labeled and dated for later use. If			

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	refrigerated, the food must be discarded within 72 hours. Frozen leftovers must be used within 30 days..."			
F0847 SS= D	Entering into Binding Arbitration Agreements §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits	F0847	F-847 Entering into Binding Arbitration Agreements Element I: To ensure the arbitration agreement is completed by the legal authorized representative for cited resident R152, a new arbitration agreement was presented and completed with resident R152 since resident R152 is their own legal representative. Element II: All residents who completed an arbitration agreement were reviewed to ensure the legal authorized representative signed the agreement. A new arbitration agreement would be completed if a non-legal authorized representative completed the document. The review did not indicate non-compliance with the remaining residents. Element III: The policy and procedure titled, “Arbitration Agreement Policy” was reviewed and deemed appropriate. The admission staff will be re-educated on the policy by July 28, 2023. The facility has a form titled, “Appointment of Resident Representative”. When a resident request another individual to legally represent them, the Appointment of Resident Representative form will be completed by the resident prior to admission paperwork/arbitration agreement being reviewed and signed by the representative. Element IV: The Admission Director will audit 10% of new admissions weekly for four weeks then monthly for two months to ensure the legal	7/28/2023

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	or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a legally authorized representative signed a binding arbitration agreement (a legal contract that dictates an out-of-court alternate form of dispute resolution) for one resident (R152) of four residents reviewed for binding arbitration agreements. Findings include: On 6/27/23 the medical record for R152 was reviewed and revealed the following: R152 was initially admitted on 1/18/23 and had diagnoses that included: CVA (stroke), type II diabetes and end stage renal disease. A review of R152's MDS (minimum data set) noted the resident had a BIMS score (brief interview of mental status) of 12/15 (moderately impaired cognition) and required extensive two-person assistance for transfers and bed mobility. An Arbitration Agreement located in the resident's electronic record was reviewed. The Agreement documented, in part, the following: " ...This voluntary Arbitration		authorized representative signature is on the arbitration document. Immediate correction will occur if non-compliance is noted. The audits will be brought to the QAPI Committee monthly meeting for review and comments. The Administrator will be responsible for monitoring compliance.	

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	Agreement ...is entered into by ...facility and between R152 and if applicable (no name was placed in this section) Resident's Legally Authorized Representative ...The Arbitrator has Sole Jurisdiction. The arbitrators will be the only ones with the authority and jurisdiction to resolve all party disputes, including wrongful death ...by signing this agreement you are waiving the right to have all disputes decided by a judge, jury or by trail. The arbitrator's decision is final and binding ...". This form was signed not by the resident but by (name redacted) family member on 1/19/23. Further review of R152's clinical record did not reveal any documentation that R152's family member had any legal authority to sign R152's binding arbitration agreement. There was no documentation that R152 had been declared incompetent. On 6/29/23 at approximately 11:05 AM, an interview was conducted with Admission Staff "II". Staff II was asked as to the facility protocol/policy regarding binding Arbitration. Staff "II" reported that they will go over the Arbitration agreement with the resident and/or the resident representative so that they have an understanding of what binding arbitration means. When asked as to why R152's Arbitration Agreement was signed by a family member who had not yet been designated as a legal representative, Staff II stated that they would look into the matter.			

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	A form titled "Appointment of Resident Representative" was provided by Staff "II". The form documented, in part: "I R152 have applied for admission as a resident to (name redacted) facility ...In order to assist me in the admission process, and assist me during my stay in the facility, I hereby designate as my Resident Representative ...X (typed name of R152's family) ...". *It should be noted that the form was not signed by R152 and a signature by Resident Representative was noted as an e signed. A review of the facility policy titled, "Arbitration Agreement Policy" (9/1/2021) noted, in part: "It is the policy of FACILITY NAME ...to present the Arbitration Agreement to Resident/Resident's Legally Authorized Representative (emphasis added) after the admission paperwork is completed ...".			
F0880 SS= E	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and	F0880	F 880 Infection Prevention & Control Element I: It is the practice of the facility to ensure that proper infection control practices were followed for transmission-based precautions. R148 was assessed with no concerns. Nurse “PP” and Certified Nursing Assistant “QQ” were educated and disciplined. Element II: Residents that currently reside in the facility that require transmission-based precautions, have the potential to be affected by this cited practice. An audit of those residents was conducted to ensure that proper infection	7/28/2023

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	634021	A. BUILDING _____ B. WING _____	6/29/2023

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	other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:		control practices were followed for transmission-based precautions. No concerns noted. Element III: The Interdisciplinary Team reviewed policy and procedure for transmission-based precautions and deemed it appropriate. Nursing department will be educated by July 28, 2023 on policy and procedure for transmission-based precautions with emphasis on Clostridium Difficile contact precautions. Element IV: The DON/Designee will complete five audits weekly x 4 weeks, and monthly thereafter to ensure proper infection control practices were followed for transmission-based precautions. Any deficient practices will be corrected/updated immediately. The results will be presented to the monthly QAPI Committee meeting for three months; and/or until substantial compliance is determined. The Director of Nursing is responsible for on-going compliance.	

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	Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were followed for one (R148) of three residents reviewed for transmission-based precautions (TBP). Findings include: On 6/27/23 at 10:34 AM, signage was observed on R148's door that indicated they were on "Contact Precautions" (Contact precautions prevent transmission of infectious agents that are spread by direct or indirect contact with the resident or their environment). The signage also indicated a gown, gloves, and separate and/or sanitized equipment was required when entering that room. At that time, Nurse 'PP' was observed entering R148's room without a gown. R148 was observed passing medication to R148 without gloves. Nurse 'PP' was holding a plastic basket that contained a glucometer and was full of unused lancets. Nurse 'PP' exited R148's room and wiped the outside of the basket that contained the lancets with a sanitizing wipe and placed it into the medication cart immediately without waiting for the sanitizer to dry. When queried about why a gown and gloves were not donned before entrance to R148's room, Nurse 'PP' reported they did not know and reported they wore gloves. Nurse 'PP' did not offer a response when queried about bringing the basket of lancets into the room and using improper sanitizing techniques.			

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	On 6/27/23 at 10:43 AM, Certified Nursing Assistant (CNA) 'QQ' was observed to enter R148's room without donning a gown or gloves. CNA 'QQ' entered the room, touched the privacy curtain, did not perform hand hygiene, then exited the room, grabbed clean gloves located outside of R148's room, and entered another resident's room down the hall. 6/27/23 at approximately 12:20 PM, a CNA entered R148's room without donning a gown. The CNA reported there were no more gowns in the PPE bin. The CNA delivered a lunch tray to R148 making contact with their environment, and left the room. On 6/28/23 at approximately 11:41 AM, an interview was conducted with the Director of Nursing (DON). When queried about PPE use for residents on contact precautions, the DON reported they were required to don a gown and gloves prior to entrance to the room, doff the PPE prior to exiting, and performing hand hygiene. When queried about whether Nurse 'PP' should have brought the basket of lancets into R148's room, the DON reported they should not have and they should have waited 4 minutes after using sanitizing wipes before placing it back into the medication cart. Review of R148's clinical record revealed R148 was admitted into the facility on 6/9/23 with diagnoses that included: pneumonia.			

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	Review of R148's physician's orders revealed an order started on 6/16/23 for "Contact Precautions Reason: r/o (rule out) C-Diff (Clostridium Difficile)..." Review of a facility policy titled, "Isolation Precautions" dated 7/1/20, revealed, in part, the following: "...'Contact precautions' are measures that are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the resident or the resident ' s environment...Recommendations for Personal Protective Equipment (PPE)...Contact...Gloves Whenever touching the patient ' s intact skin or surfaces and articles in close proximity to the patient (e.g., medical equipment, bed rails). Don gloves upon entry into the room or cubicle...Gowns Whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle..."			