STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634560	A. BUILDING _____ B. WING _____	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

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F0000 SS=	INITIAL COMMENTS SKLD Bloomfield Hills was surveyed for a Recertification survey on 10/12/23. Intakes: MI00135357, MI00135629, MI00136648, MI00137049, MI00137216, MI00137249, MI00137390, MI00137456, MI00137521, MI00138203, MI00138394, MI00138430, MI00138440, MI00138910, MI00138955, MI00139117, MI00139121, MI00139363, MI00139444, MI00139985 Census=140	F0000		
F0561 SS= D	Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents	F0561	Resident #101 care plan and Kardex were reviewed to ensure resident choice was identified and documented. The charge nurse was educated on resident□s rights, specifically honoring resident choices. All residents have the potential to be affected by this occurrence. The social worker/designee conducted an audit/interview of residents to identify any residents that had a specific preference or choice related to their plan of care. By 11/06/23 the nursing staff will be educated on the policy for resident rights with a specific focus on honoring residents□ choices. The DON/designee will conduct random interviews on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that nursing staff	11/6/2023

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

Electronically Signed | 10/25/2023

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	in the facility. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #'s MI00138955 and MI00137521. Based on observation, interview and record review the facility failed to honor preferences for the provision of caregivers for one resident (R101) of one residents reviewed for self-determination. Findings include: On 10/10/23 at approximately 10:25 a.m., R101 was observed in their room, laying in their bed receiving care. R101 was queried if they had any concerns regarding their care in the facility and they indicated they do not like having two people in the room while staff are providing care. R101 also indicated that they could not have male staff provide care to them, and they only wanted female caregivers. R101 reported the facility had recently assigned a male caregiver to them that went against their plan of care. On 10/10/23 the medical record for R101 was reviewed and revealed the following: R101 was initially admitted to the facility on 4/14/22 and had Bipolar disorder, Chronic pain and Muscle weakness. A review of R101's MDS (minimum data set) with an ARD (assessment reference date) of 7/19/23 revealed R101 needed extensive assistance with most of their activities of daily living.		are honoring residents rights/choices. The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/06/23 and for sustained compliance thereafter.	

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	R101's BIMS score (brief interview for mental status) was not assessed, but their cognition was documented as being intact via the staff assessment. A review of R101's careplan revealed the following: "Focus-Resident is at risk for/has a psychosocial well-being concern r/t (related to) history of trauma (reported hx (history) of sexual abuse and molestation by male caregiver in the past); requests no male caregivers. Resident declines psychiatric services and/or psychotropic medications. Date Initiated:11/30/2022...Interventions-No male caregivers.-Date Initiated: 11/30/2022" A review of R101's progress notes revealed the following: "10/10/2023 at 02:31-Resident rang call light at 0200, residents assigned CNA (Certified Nursing Assistant) went to answer pt's (patient) call light at approx (approximately). 0205, resident stated he wants peri care, CNA began to gather supplies, Resident stopped CNA and stated 'No you won't provide my care to me, you are not a woman.' Upon entering the room writer stated to resident 'this is your aide who is assigned to care for you tonight, I will be in to assist him.' Resident then stated 'No, you will go to another unit and get a lady to care for me.' Writer stated 'Is it against your religion or your culture to not have a man care for you?' Pt ignored writers question and continued to yell, 'you will not change my care, you will not change my care.' Pt then threaten to call the police. Care was offered			

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	several times by writer and assigned CNA. Resident refused. Safety maintained. Will cont (continue) POC (plan of care)...." On 10/12/23 at approximately 12:15 p.m., Nurse manager "L" (NM "L") was queried regarding R101's preference for female caregivers due to their history of trauma with a male caregiver. NM "L" indicated that the Nurse in charge on 10/10/23 midnight shift should not have assigned a male CNA to R101's room, and that the nurse should have switched out the male for a female that night. NM "L" reported that everyone knows R101 should not be given male caregivers and that they will have to provide education to the Nurse to ensure that R101 is provided female caregivers per their plan of care.			
F0657 SS= D	Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate	F0657	Resident# 29 did not suffer any adverse effects as a result of this occurrence. The resident□s care plan was updated to reflect her behavior of wandering on the unit. All like residents with wandering behaviors have the potential to be affected by this citation. An audit was completed of all residents identified with wandering behaviors to ensure that the resident care plan was updated accordingly. The DON/UM/designee and SW will review EMR dashboard daily for any triggered alerts of resident behaviors including wandering to ensure that residents plan of care is reviewed and care plan updated if needed.	11/6/2023

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	staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00139363 Based on observation, interview and record review, the facility failed to ensure timely revision/updates to the comprehensive plan of care for one resident (R29) of one resident reviewed for wandering/elopement. Findings include: On 10/10/23 at approximately 9:37a.m., R29 was observed wandering in hallway, yelling out at nobody and appeared to be upset. On 10/12/23 the medical record for R29 was reviewed and revealed the following: R29 was initially admitted to the facility on 9/13/22 and had diagnoses including Dementia and Psychotic disorder with delusions. A review of R29's MDS (minimum data set) with an ARD (assessment reference date) of 9/21/23 revealed R29 needed supervision with most of their activities of daily living. R29 was documented as having severely impaired cognition. A review of R29's progress notes pertaining		By 11/06/23 licensed nurses will be educated on the care plan process, specifically the updating of resident care plans as needed with a change in resident plan of care. Nursing staff will notify the SW, Director of Nursing or designee of any change in residents□ behavior to ensure follow and residents care plan is updated to reflect changes. The SW/designee will conduct random audits on the medical records of 5 residents identified for having wandering behaviors weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that residents with wandering behavior or at risk for wandering have active care plans in place. The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/06/23 and for sustained compliance thereafter.	

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	to their wandering behavior revealed the following: 8/29/2023 at 16:09 "@ (at) 1:30 pm resident came into the hallway attempting to enter other resident's rooms. Staff attempted to redirect, she began yelling, hitting, and spatting <sic> on staff. She briefly returned to her room and started throwing plates of food at the door. She then returned to the hallway yelling and hitting staff. Charge nurse, multiple cenas, and writer stayed in hallway with resident attempting to redirect, however efforts ineffective. She continued to hit staff, however staff was effective with preventing her from entering other resident's rooms. Writer called responsible party, 0 answer message left. NP (Nurse Practitioner) notified with new orders obtained and implemented. Resident remained with 1:1 supervision from multiple nurses, cenas, and management until 3:20pm until she calmed down. Responsible party called and was notified of incident and current intervention..." 9/14/2023 at 14:18 "Resident yelling resistant to all redirections. Attempted to go into other residents' rooms, writer attempted to redirect she spat in writer's face and started punching at writer. Writer provided stand by supervision until resident calmed. Nurse practitioner notified. Writer left message for responsible party. Resident is currently calm in room without s/s (signs/symptoms) of acute distress." 9/14/2023 at 20:50 Medical Practitioner			

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	Progress Note (Physician/PA (Physician Assistant)/NP) "CC (Chief Complaint)- Evaluation and Management of Multiple Medical Problems- HPI (history of presenting illness) - Pt (patient) with increased agitation and combativeness today. This has become recurring intermittently. Pt with history of dementia with psychosis. Pt refuses care often. Ambulates around the facility and her room with baby dolls and other random objects and will hoard items. Pt previously on quetiapine 25mg bid (twice daily) and has since been switched to 50mg qhs (evening). Will keep evening dose the same and add 25mg back to the morning dose. Avoid benzodiazapines routinely secondary to age and dementia. Psych (Psychiatry) to follow up...PLAN.. 7. Elopement precautions..." A review of R29's documented wandering behaviors by the CNA's for the prior 30 days was conducted and revealed R29 displayed wandering behaviors on 9/14, 10/4, 10/8 and 10/9. A review of R29's comprehensive care plan was conducted and did not reveal any focused areas for R29's wandering behavior. On 10/12/23 at approximately 12:15 p.m., during a conversation with Nurse Manager "L" (NM "L"), NM "L" was queried regarding R29's wandering behavior. NM "L" indicated that the staff do their best to try to watch R29 to make sure they don't go into other resident rooms. NM "L" reported they have			

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	never seen R29 try to exit the building, however they do wander in the hallways and that they are confused. At that time, NM "L" was queried regarding the plan of care for R29's wandering behavior and they indicated the did not have one but would talk to the Social Worker about getting one implemented. On 10/12/23 at approximately 2:14 p.m., Social Worker "K" (SW "K") was queried regarding the wandering behaviors for R29. SW "K" indicated that R29 was not an elopement risk, but they did review with IDT (interdisciplinary team) and were going to put in a plan of care to address R29's wandering behavior. On 10/12/23 a facility document titled "Policy/Procedure-Nursing Administration-Elopement" was reviewed and revealed the following: "POLICY: It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement. All residents so identified will have these issues addressed in their individual plan of care...Residents/Elopement: 1. All residents shall be reviewed for safety awareness impairment and elopement/wandering concerns upon admission, readmission, quarterly, significant change in condition and as needed.			

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	2. Residents identified as at risk for elopement/wandering will have a plan of care implemented to address their elopement/wandering behaviors..."			
F0658 SS= D	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: This citation contains two deficient practice statements DPS1 Based on observation, interview and record review the facility failed to ensure one resident (R34) was administered Lactulose, Nasal Spray and two as need(PRN) medications as requested according to professional standards of practice. Findings include: On 10/10/2023 at 10:03 AM a observation of medication administration was conducted. Nurse "S" began a medication pass with first identifying R34. Nurse "S" prepared medications sevelamer, vitamin c, nifedipine, losartan, Eliquis, Coreg, calcitriol, clopidogrel, paroxetine, vitamin D3 and gabapentin and signed them out. Nurse "S" entered the room	F0658	Residents # 34 and #98 did not have any adverse effects as a result of this occurrence. Nurse T and Nurse S were given 1:1 education on the policy of Medication Administration specifically signing out resident medications in the EMR after being administered according to professional standards. All residents have the potential to be affected by this citation. By 11/06/23 Medication Administration competencies will be completed with the licensed nurses to ensure that nurses are following the process for medication administration, including signing out medications after administering to residents according to professional standards. Competency for medication administration with focus on documentation of administering medications after they have been given will be included in the new hire orientation for licensed nurses. The DON/designee will conduct random medication observation audits on 5 licensed nurses weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that nurses are signing out resident medications after administering according to professional standards. The results of the audits will be presented to	11/6/2023

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	with cup of medications and R34 asked "Is my pain pill and muscle relaxer in here." Nurse "S" replied "Yes". Handed resident cup of medications took them, we left residents room and went back to medication cart Nurse "S" was asked did resident receive a pain pill and muscle relaxer if so what was the pill named. Nurse "S" replied his gabapentin is the pain pill and no he did not get a muscle relaxer her can get it PRN when resident ask for it. Asked Nurse "S" why tell R34 that there was a pain pill(oxycodone) and muscle relaxer was given if in fact it was not? Nurse "S" replied resident can get muscle relaxer every 8hours as needed so resident will get it later. On 10/10/23 a record review was completed to reconceal medications. Sevelamer, vitamin c, nifedipine, losartan, Eliquis, Coreg, calcitriol, clopidogrel, paroxetine, vitamin D3 and gabapentin were all verified and administered as ordered. There was Lactulose (stool softener) and Nasal Spray signed off on the Medication administration record (MAR) however those medications were never given. On 10/10/23 a record review revealed that R34 was originally admitted to the facility on 8/26/2020 with the medical diagnosis of end stage renal disease, foot drop right foot and generalized anxiety disorder. R34 Minimum Data Set (MDS) showed the Brief interview for Mental Status (BIMs) of a 15. No additional information was provided by		the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/06/23 and for sustained compliance thereafter.	

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	the exit of survey. DPS2 Based on observation, interview and record review failed to ensure two residents (R34 and R98) medications were signed out according to professional standards. Findings include: On 10/10/23 at 1:43 PM a observation of medication administration was conducted. Nurse "T" was interviewed and asked could a medication pass be completed for R98 since there were 9 medications in red indicating that the medications were late or not given. Nurse "T" replied sure, but all the medications that are in red were already given I just did not sign them out yet. Nurse "T" was asked if they were already given why were the medications not given? Nurse "T" replied "sometimes I sign them out when I complete all of my medication administration pass it or sometimes, I sign them out right them it just depends on how the day is going. Nurse "T" was asked is that the way the facility do medication administration pass? Nurse "T" replied "No once we administer a medication, we are supposed to sign them out." On 10/10/23 a record review revealed that R98 was admitted to the facility on 10/31/20 with the diagnosis of deminta, seizures and insomnia due to other mental diseases. With a BIMs score of 5.			

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	On 10/10/23 at 3:44 PM an interview with the Director of Nursing (DON) was conducted and asked how should a medication administration pass be completed? DON replied, "They are suppose to the five checks and then once that is completed removed the medications that are supposed to passed. Then once the medications are puled check one more time to ensure the right resident is selected and give medications. Once the medications are consumed, they are supposed to go back and sign out all medications that are given and or refused. There was no additional information provided by the exit of the survey.			
F0688 SS= D	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	Resident # 25 was re-evaluated by therapy to ensure appropriate order for splint is in place. Application of resident splint was updated in the resident□s medical record for documentation by the nursing staff. Resident was assessed by the charge nurse and application of splint was applied as ordered. All residents with orders for splints have the potential to be affected by this occurrence. The therapy department provided nursing with a list of residents who were evaluated with orders for splints. An audit was completed of all residents with orders for splints to ensure that the application of splints was updated in the resident□s medical record for applying and documentation by the nursing staff. Therapy will provide the Director of	11/6/2023

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	Based on observation, interview, and record review, the facility failed to ensure wrist and hand orthotics were applied per therapy recommendations for one resident (R25) with contractures of six residents reviewed for range of motion and orthotics, resulting in the potential for worsening of contractures. Findings include: On the following dates and times, R25 was observed in their bed with no wrist or hand orthotic in place, but a wrist/hand orthotic marked with an 'L' for the left hand was observed on the shelf above the television: 10/10/23 at 10:13 AM, 10/10/23 at 12:50 PM, 10/10/23 at 2:35 PM, 10/11/23 at 9:00 AM, 10/11/23 at 12:10 PM, 10/11/23 at 2:40 PM, and 10/12/23 at 8:35 AM. A review of R25's clinical record was conducted and revealed they admitted to the facility on 4/2/22 and most recently admitted on 8/12/22 with diagnoses that included: stroke with hemiplegia and hemiparesis, contractures, adjustment disorder, vascular dementia, seizures, dysphagia, lupus, falls and presence of a feeding tube. R25's most recent Minimum Data Set assessment dated 8/16/23 revealed R25 had severe cognitive impairment and required total assist from one to two staff members for activities of daily living. A review of R25's physician's orders was conducted and revealed an order dated 10/3/22 that read, "Nursing to donn <sic> right hand splint up to 8 hours as		Nursing/designee communication for any resident with a new order for splints. The DON/designee will follow up to ensure the residents medical record is updated for the documentation of application of splint and that splints are applied on residents as ordered. By 11/06/23 Licensed nurses and CNAs will be educated on ensuring the application of splints on residents and the documentation of residents application of splints per policy. The DON/designee will conduct random audits and observations on 5 residents with orders for splints weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the occurrence of splint application on residents and that the application of resident splints are documented in the residents medical record. The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/06/23 and for sustained compliance thereafter.	

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	tolerated. A review of R25's treatment administration records, medication administration records, progress notes, and certified nurse aide tasks was reviewed for documented evidence of splint application, however; no documentation was contained in the record. On 10/12/23 at 9:55 AM, the facility's Director of Nursing (DON) was asked where documentation of splinting or restorative services could be located and they said they would follow-up. On 10/12/23 at 10:27 AM, an Rehab Director 'Q' provided R25's most recent therapy recommendations dated 8/3/23 and the recommendation indicated R25 would wear both a right and left hand wrist orthotic four hours on and one hour off every shift. When asked about communication between therapy and nursing staff for the use of orthotics, Rehab Director 'Q' said a form was filled out and given to nursing and a physician's order was written for the service to be provided. A second review of R25's clinical record revealed there was no physician order for the placement of the right and left wrist hand orthotic. On 10/12/23 at 11:35 AM, a follow-up interview was conducted with the facility's DON and they were asked to provide documentation for R25's wrist and hand			

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	orthotic being placed on them. At 12:25 PM, the DON followed up and said they did not have any documentation.			
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure Physician orders for oxygen therapy were in place for one resident (R118) of two residents reviewed for respiratory care. Findings include: On 10/10/23 at approximately 10:15 a.m., R118 was observed in their room, up in their bed. R118 was observed to having oxygen infusing via nasal cannula at 3LPM (liters per minute) On 10/11/23 at approximately 9:51 a.m., R118 was observed in their room, laying in their bed with their nasal cannula applied with oxygen infusing at 3.5 liters per minute. R118 was queried if they knew how many liters of oxygen they should be provided and	F0695	Resident #118 did not suffer any adverse effects as a result of this occurrence. The residents order for oxygen was verified with the physician and entered into the medical record. All residents have the potential to be affected by this occurrence. An audit was completed on all residents in the facility to ensure that all residents who receive oxygen have an order in place per the physician. The DON/unit managers/designee will review the medical record of resident re-admissions and new admissions to the facility daily to ensure that any resident that is on oxygen has an order to administer from the provider. By 11/06/23 the charge nurses will be educated on ensuring that all residents admitted/re-admitted to the facility on oxygen have an order to administer oxygen per the provider and the medical record/hospital records are viewed to ensure that orders for oxygen are transcribed per the residents plan of care. The DON/designee will conduct random audits on 5 residents medical record weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that residents who receive oxygen have an order to administer from the provider. The results of the audits will be presented to the QAA committee for review and	11/6/2023

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	they reported they should be on four liters. On 10/11/23 at approximately 12:30 p.m., R118 was observed in their room with their nasal cannula infusing oxygen. R118 was still observed to be on 3.5 LPM. On 10/10/23 the medical record was reviewed and revealed the following: R118 was initially admitted to the facility on 9/14/22 and had diagnoses including Chronic obstructive pulmonary disease and Chronic respiratory failure. A review of R118's MDS (minimum data set) with an ARD (assessment reference date) of 9/20/23 revealed R118 needed supervision with most of their activities of daily living. R118's BIMS score (brief interview for mental status) was 14 indicating intact cognition. A review of R118's careplan revealed the following: "Focus-Resident has altered respiratory functioning and/or difficulty breathing r/t (related to) pulmonary hypertension, COPD (Chronic obstructive pulmonary disease), CHF (Congestive heart failure) and utilizes supplemental oxygen-revision-2/10/23...Interventions-OXYGEN SETTINGS: O2 (oxygen) via nasal cannula as ordered..." A review R118's Physician orders did not reveal any orders for the administration of oxygen therapy. On 10/12/23 at approximately 11:36 a.m.,		consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/06/23 and for sustained compliance thereafter.	

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	during a conversation with R118's Nurse "O" and Nurse Manager "L" (NM "L") was queried how many LPM R118 should be provided while on oxygen therapy. Nurse "O" was observed reviewing R118's medical record and reported they did not know because R118 did not have any Physician orders for oxygen. At that time, NM "L" reported that R118 should have orders for oxygen and that they would have to contact the Physician to get some in place and "fix it." On 10/12/23 a facility document titled "Resident Care-Oxygen use" was reviewed but did not reference any instructions for following Physician orders pertaining to the administration of oxygen therapy.			
F0711 SS= E	Physician Visits - Review Care/Notes/Order §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure physician visits/assessments were completed and/or	F0711	Resident #81 medical record was reviewed to ensure physician visits were completed and documented timely. The late entries were noted and addressed with the physician extender. All residents have the potential to be affected by this occurrence. Medical Records conducted an audit of all resident□s medical records to ensure they have been seen by the attending physician/extender per federal regulations. Any concerns identified were addressed with the attending physician/extender. By 11/06/23 the medical records and physician extender will be educated on the federal regulation regarding physician/extender visits, which included timely documentation.	11/6/2023

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	documented timely for one (R81) of two residents reviewed for physician visits, resulting in delayed practitioner assessments, and the increased potential for lack of coordination of care. Findings include: Review of the clinical record revealed R81 was admitted into the facility on 2/24/20, readmitted on 8/19/22 with diagnoses that included: type 2 diabetes mellitus with other specified complication. According to the Minimum Data Set (MDS) assessment dated 9/6/23, R81 had intact cognition. Review of the physician and/or extender notes revealed from 8/22/22 to 10/10/23 there were a total of 27 physician/extender assessments documented for R81. 12 of these assessments were identified as "late entry" by Nurse Practitioner (NP 'B') and were not available timely to other disciplines of the interdisciplinary team for extended periods of time which had the potential to impact timely coordination of care. These late entries included: A late entry was documented as created on 8/15/23 for 7/25/23. A late entry was documented as created on 8/7/23 for 6/23/23. A late entry was documented as created on		The DON/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure physician visits are completed and documented timely in the medical record. The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 11/06/23 and for sustained compliance thereafter.	

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	7/27/23 for 6/19/23. A late entry was documented as created on 7/19/23 for 5/30/23. A late entry was documented as created on 6/12/23 for 4/21/23. A late entry was documented as created on 4/25/23 for 3/16/23. A late entry was documented as created on 1/5/23 for 12/16/22. A late entry was documented as created on 12/23/22 for 11/15/22. A late entry was documented as created on 12/22/22 for 11/8/22. A late entry was documented as created on 12/7/22 for 9/27/22. A late entry was documented as created on 11/27/22 for 9/12/22. A late entry was documented as created on 10/13/22 for 7/21/22. On 10/11/23 2:45 PM, an interview was conducted with the Director of Nursing (DON). They reported they had been in their position since the first week of August 2023. The DON was informed of the concern with the delay in documentation from NP 'B' and potential lack of timely coordination of care.			

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	When asked about the frequency of Physician 'C' and NP 'B's visits at the facility, the DON reported they had not seen Physician 'C' but NP 'B' came usually Monday through Friday. When asked if the Physician and/or their extenders saw a resident, when would their documentation be available for review, the DON reported they normally put them right in the clinical record. On 10/11/23 at 1:25 PM, an interview was conducted with the Administrator and Regional Nurse Consultant (RNC 'A'). They were informed of the concern with NP 'B's multiple late entries and reported they would investigate further. On 10/12/23 at 9:49 AM, a phone interview was attempted with NP 'B' to discuss the concern with their documentation but was not able to be completed. On 10/12/23 at 10:20 AM, an interview was conducted with the DON and Regional Nurse Consultant (RNC 'A'). They were informed of the abrupt conversation with NP 'B' as well as concerns with delayed documentation. When asked how the interdisciplinary team was able to coordinate care if the physician/extender documentation was not provided timely, both the DON and RNC 'A' acknowledged the concern and reported they would be following up with NP 'B'. Review of documentation provided by the facility revealed there was no formal policy			

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	provided for physician/extender documentation, but the facility had identified a quality assurance performance improvement plan from 2/20/2022 in regard to physician visits in accordance with federal regulations.			
F0712 SS= E	Physician Visits-Frequency/Timeliness/Alt NPP §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure physician evaluations were alternated between the physician and extenders (Nurse Practitioner/NP) as required for one (R81) of two residents reviewed for physician visits. Findings include:	F0712	Resident #81 medical record was reviewed to ensure physician visits were completed and documented timely. The late entries were noted and addressed with the physician extender. Resident #81 has been seen by the attending physician and the visits between the attending physician and physician extender will alternate moving forward. All residents have the potential to be affected by this occurrence. Medical Records conducted an audit of all resident□s medical records to ensure they have been seen by the attending physician/extender per federal regulations and these visits alternate between the physician and physician extenders. Any concerns identified were addressed with the attending physician/extender. A process will be set up to track all physician and extender visits to ensure they comply with the federal regulation requirements and facility expectations. Any physician and/or physician extenders identified as being out of compliance will be addressed by the administrator. By 11/06/23 the administrator will educate all attending physicians and their extenders on the federal regulation regarding physician/extender visits, which will include but is not limited to alternating visits between the attending physician and physician	11/6/2023

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	Review of the clinical record revealed R81 was admitted into the facility on 2/24/20, readmitted on 8/19/22 with diagnoses that included: type 2 diabetes mellitus with other specified complication. According to the Minimum Data Set (MDS) assessment dated 9/6/23, R81 had intact cognition. Review of the physician and/or extender notes revealed from 8/22/22 to 10/10/23 there were a total of 27 physician/extender assessments documented for R81. Only one of these practitioner assessments were completed by a physician (Physician 'D') on 8/31/23. 22 of these practitioner assessments were completed by NP 'B' on 8/22/22, 8/25/22, 8/29/22, 9/12/22, 9/27/22, 11/8/22, 11/15/22, 12/16/22, 1/27/23, 2/24/23, 3/14/23, 3/16/23, 4/10/23, 4/21/23, 5/30/23, 6/19/23, 6/23/23, 7/10/23, 7/13/23, 7/25/23, 10/3/23, and 10/10/23. Four of these practitioner assessments were completed by NP 'E' on 10/3/22, 11/6/22, 11/8/22 (also seen by NP 'B' on same date), and 11/17/22. On 10/11/23 at 2:45 PM, an interview was conducted with the Director of Nursing (DON). They reported they had been in their position since the first week of August 2023. The DON was informed of the concern with the lack of Physician and Extender visits as required. When asked about the frequency of Physician 'C' and NP 'B's visits at the facility, the DON reported they had not seen Physician 'C' but NP 'B' came usually Monday through Friday. When asked if the Physician		extenders. By 11/06/23 the administrator will educate medical records on the federal regulation regarding physician/extender visits, which includes alternating visits between the attending physician and physician extenders. The DON/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the attending physician completes the initial visit and there after the visits may alternate between the attending physician and physician extenders. The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 11/06/23 and for sustained compliance thereafter.	

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	and/or their extenders saw a resident, when would their documentation be available for review, the DON reported they normally put them right in the clinical record. The DON reported they weren't sure if Physician 'C' dictated their documentation and entered later, but that should still be uploaded into the clinical record. On 10/11/23 at 1:25 PM, an interview was conducted with the Administrator and Regional Nurse Consultant (RNC 'A'). They were informed of the concern with lack of Physician visits being alternated between visits and reported they would investigate further. On 10/12/23 at 9:49 AM, a phone interview was attempted with NP 'B' to discuss the concern with their lack of alternating visits with the Physician but was not able to be completed. On 10/12/23 at 10:20 AM, an interview was conducted with the DON and Regional Nurse Consultant (RNC 'A'). They were informed of the abrupt conversation with NP 'B' as well as concerns with lack of alternating physician/extender assessments. It was reported that this concern had been discussed previously and would have to be addressed again. Review of documentation provided by the facility revealed they had previously identified a quality assurance performance			

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	improvement plan from 2/20/2022 regarding physician visits in accordance with federal regulations.			
F0758 SS= D	Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the	F0758	Resident #105 was seen by psych services with psychotropic medication reviewed. No new orders at this time. All like residents with ordered psychotropic medications in the facility have the potential to be affected. An audit was completed on all residents on psychotropic medications reviewing with psych services to ensure that residents were receiving the appropriate dosage of psychotropic medication. The Psychotropic Drug Use Policy was reviewed and deemed appropriate. By 11/06/23 the facility providers not contracted by psych services will be educated on the referral process for a psych evaluation for the increase or reduction of residents on psychotropic medication to ensure that residents are receiving the appropriate dosage. The Social worker/designee will conduct random audits on 5 residents on psychotropic medication weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that residents with a change in psychotropic medication receive the appropriate follow up by psych services. The results will be presented to the QAA committee for review and consideration of further corrective action. The Administrator/designee will be	11/6/2023

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	resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide justification for the increase of an antipsychotic medication (Quetiapine/Seroquel) including identified targeted behaviors for one (R105) of five residents reviewed for unnecessary medications. Findings include: On 10/10/23 at 10:00 AM resident was observed in room in the Geri chair. Resident was nonverbal was able to make eye contact but could not answer questions asked. A review of R105's clinical record revealed the resident was initially admitted to the facility on 8/4/22 with diagnoses that included: Picks Disease (front-temporal dementia), aphasia and delirium. A review of the residents Minimum Data Set (MDS) documented that the resident had a Brief Interview for Mental Status (BIMS) score of 0 (severely cognitively impaired). Review of the behavior section of the MDS showed no behaviors. Further review of the clinical record revealed the following: 2/10/23 (Care Plan Progress Note): " ...met for quarterly care conference ...Residents mood has been stable with no reported concerns,		responsible for assuring substantial compliance is attained through this plan of correction by 11/06/23 and for sustained compliance thereafter.	

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	no behaviors noted or reported. Guardian denies observing hallucinations. Discussed for psych services to assess for possibility of GDR (gradual dose reduction) for one or both antipsychotics ...). 2/14/23 (Medication Order): "Quetiapine 50 MG (milligrams) ...Give 200 mg by mouth at bedtime for depression ...). D/C (discontinued date 2/14/23). 2/14/23 (Medication Order): Quetiapine 50 MG ... Give 100 mg by mouth at bedtime for depression ...". 3/16/23: (Behavioral Care Services): " ...Pt. (patient) on Hospice care ...Seen today for medication review ...Seroquel decreased to 100 mg on 2/14/23 by PCP (primary care physician) ...Pt. seen in his room in bed ...Calm without anxiety or agitation ...". 5/11/23 (Behavioral Care Services): " ...admitted on 8/4/22 for continuation of care ...Haldol decreased ... Seroquel decreased to 100 mg on 2/14/23 ...Behavior log reviewed x14 days, no incidents ...". 5/27/23 (Order Summary): "Quetiapine Fumarate Oral Tablet 200 MG - Give 1 tablet by mouth at bedtime for depression ...". Care Plan: "Focus: Resident has a behavior concern r/t (due to) episodes of refusing fluids (5/23/23) ...Interventions: "Monitor behavior episodes with interdisciplinary team			

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	to review potential underlying cause. Consider location, time of day, persons involved and situations ...". *It should be noted that there were no documents in R105's electronic clinical record that noted any increase in behavior/hallucination or further information as to why the resident's Quetiapine was increased from 100 MG to 200 MG on 5/27/23. On 10/12/23 at approximately 1:38 PM an interview was conducted with Social Worker (SW) 'K". SW "K" was asked if they were aware as to the increase in R105's Quetiapine/Seroquel and asked to provide documentation that would show why there was an increase in the resident's antipsychotic medication. SW "K" reported that the increase was ordered by the resident's primary care physician but could not provide any documentation relating to R105's behaviors and/or what initiated an increase in the resident's medication. On 10/12/23 at approximately 2:12 PM, an interview and record review were conducted with the DON (Director of Nursing) regarding the increase of Seroquel on 5/27/23 and any additional documentation that address the resident's behaviors or reasoning for the increase. The DON was able to review R105's record and reported that they were not able to find any documentation that addressed the increase in the medication. The DON was			

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	asked whether there should have been a documented rationale that addressed the increase and they noted that there should have been. The facility policy titled, "Best Practice Behavioral & Psychotropic Medication Monitoring" (Updated 7/30/20): " ...Patients utilizing psychotropic medication, whether scheduled or PRN (as needed) will me monitored for symptoms with documentation within medical record when observed ...Nursing Management ...will create orders for Behavior Tracking ...to address patient specific medications ...each shift, Licensed Nurse will document via eMAR (electronic Medication Administration Record) of specific behavior were exhibited ...patients utilizing psychotic medications or exhibiting active behavior symptoms, Nursing Management/Social Service ...will create a patient specific task for Behavior Documentation Q shift ...When a behavior or symptom is observed ...they will log into PCC and document the type of behavior observed ...".			
F0770 SS= D	Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must 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	F0770	Resident #29 did not suffer any adverse effects as a result of this occurrence. Resident was evaluated by the provider, any labs ordered were carried out by the charge nurse and confirmed by the unit manager. The lab results will be communicated to the provider once obtained with follow up documentation and results scanned into the resident□s medical record.	11/6/2023

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	evidenced by: This citation pertains to intake #MI00139363 Based on observation, interview and record review, the facility failed to provide timely laboratory services to two (R29 and R81) of two residents reviewed for laboratory services. Findings include: According to the facility's policy titled, "Diagnostic Tests" dated 7/11/2018: "It is the policy of this facility to provide or obtain laboratory services...Ordered laboratory services ...will be handled in a proficient manner to ensure timeliness, accuracy, and proper follow up..." R81 On 10/10/23 at 1:30 PM, R81 was observed laying in bed. When asked about whether they had any concerns, they reported the were worried about having their blood sugar checked and stated, "I've wanted to follow up to have them to a A1C (Hemoglobin A1C - a blood test that measures average blood sugar levels over the past three months) to see where I'm at cause I'm diabetic. I know I don't follow it (therapeutic diet for diabetes) but I'd still like to know."		Resident # 81 did not suffer any adverse effects as a result of this citation. Resident was evaluated by the provider, and any labs ordered were carried out by the charge nurse and confirmed by the unit manager. The lab results will be communicated to the provider once obtained with follow up documentation and results scanned into the resident□s medical record. All residents have the potential to be affected by this occurrence. An audit was completed on all residents from August to present for any labs ordered by the physician that were not obtained/documented. Any lab noted to be ordered that was not obtained, the physician was notified, and labs were re-ordered per the physician. Any labs verified as being drawn, with no evidence of documentation in the resident□s medical record was followed up with the provider for review and input into the resident□s medical record. The DON/unit managers/designee will review the EMR orders portal daily for labs pending confirmation to ensure that labs ordered by the provider are confirmed and ordered by the charge nurse prior to them being cleared. The DON/unit managers/designee will check the lab portal daily for timely results of ordered labs. lab results will be communicated to the physician for follow up and documentation. The lab results will be printed and scanned into the resident□s medical record within 24 to 48 hours of this process. By 11/06/23 charge nurses will be educated on the policy of laboratory services, specifically ensuring that resident labs ordered by the provider are carried out when ordered. Education will include the notification of the provider upon receipt of lab results and	

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	Review of the clinical record revealed R81 was admitted into the facility on 2/24/20, readmitted on 8/19/22 with diagnoses that included: type 2 diabetes mellitus with other specified complication. According to the Minimum Data Set (MDS) assessment dated 9/6/23, R81 had intact cognition. Review of the physician orders revealed R81 was not prescribed insulin, but received Metformin 500 Milligrams two times a day since 8/20/22 for diabetic management. There were no current orders to include blood sugar (BS) monitoring. The last documented blood sugar levels were from June 2022 which included BS levels of "266, 340, 363, 384, and 391". Additionally a review of the clinical record in accordance with physician ordered labs revealed the only available lab result of R81's "HgbA1C" was from 2/6/23 which had a result of "8.4" (which indicated high result), and a glucose result of "287" (which indicated high as reference range was 65-99). There was a lab ordered on 7/10/23 which included "HgbA1C", but there were no lab results available in the clinical record for review. Review of the physician/extender progress notes included: A late entry on 8/11/23 at 11:53 AM for 7/13/23 at 11:53 AM by Nurse Practitioner		documentation in the resident□s medical record. The DON/designee will conduct random audits on 5 residents medical record weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that residents labs are carried out when ordered with follow up by the physician and documentation in the resident□s medical record. The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/06/23 and for sustained compliance thereafter.	

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	(NP 'B') read, "...Labs reviewed...HgbA1C 9.6%...Assessment...DM II (diabetes mellitus type 2) with other complications...Plan...Metformin for DM..." The lab result referenced in this late entry was not available for review in R81's clinical record. There was a lab ordered on 10/1/23 by Wound Care NP 'G' which included HgbA1C. As of this review on 10/11/23, there was no indication this had been completed. On 10/11/23 at 1:08 PM, an interview was conducted with R81's Nurse 'J'. When asked about whether they monitored R81's blood sugar levels, Nurse 'J' reported they did not currently but recalled doing that a while ago when the resident was in another area of the facility. At that time, Nurse 'J' was asked about the lab order from 10/1/23 and upon review of the clinical record, Nurse 'J' reported the most recent lab result was from 2/6/23, but also confirmed an order on 10/1/23. Nurse 'J' further accessed the current laboratory and confirmed there were no labs completed or processed, and would have to follow-up further. On 10/11/23 at 1:25 PM, an interview was conducted with Administrator and Clinical Corporate Nurse. They were informed of the concern with labs not being completed and requested to provide lab contracts and dates and names for what lab services were at the facility and they reported they would			

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	investigate further and follow up with the DON and provide additional documentation. On 10/11/23 2:45 PM, an interview was conducted with the Director of Nursing (DON). They reported they had been in their position since the first week of August 2023. The DON was informed of the concern with R81's labs not being completed as ordered, or available for review and they reported they had a discussion with NP 'G' who reported they didn't need the order anymore. The DON was informed that the concern remained that the lab was not completed and NP 'G's decision to not follow-through with the original lab order was changed once identified as a concern during the survey. The DON was asked about the facility's policy for diabetic management and reported they would have to follow-up. The facility later reported they did not have a policy for diabetic management. On 10/12/23 at 9:49 AM, a phone interview was attempted with NP 'B' but was not able to be completed. On 10/12/23 at 10:20 AM, an interview was conducted with the DON and Regional Nurse Consultant (RNC 'A'). They were informed of the abrupt conversation with NP 'B' as well as concerns with diabetic management and labs as ordered. The DON and RNC 'A' reported there was a concern with the change in laboratory providers and were unable to obtain documentation from the former			

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	provider which abruptly ended their contract in July 2023. There was no further documentation of any lab results provided by the end of the survey. R29 On 10/10/23 at approximately 9:37 a.m., R29 was observed wandering in hallway, yelling out at nobody specific and appeared to be upset. On 10/12/23 the medical record for R29 was reviewed and revealed the following: R29 was initially admitted to the facility on 9/13/22 and had diagnoses including Dementia and Psychotic disorder with delusions. A review of R29's MDS (minimum data set) with an ARD (assessment reference date) of 9/21/23 revealed R29 needed supervision with most of their activities of daily living. R29 was documented as having severely impaired cognition. A Physician's laboratory order dated 9/26/23 revealed the following: "CMP (comprehensive metabolic panel) on next lab (laboratory) draw" Further review of the medical record did not reveal any results from the lab draw order on 9/26/23 nor any indication that R26's Physician had been notified of the results. On 10/12/23 at approximately 12:15 p.m., during a conversation with Nurse manger "L" (NM "L"), NM "L" was queried regarding the			

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	disposition and results of the CMP ordered on 9/26/23. NM "L" was observed looking up the CMP lab in the laboratory online portal and they indicated they had requested it on 9/26/23 but that there were no results and no indication that the CMP had been drawn. NM "L" indicated they did not know what happened with the lab draw and would have to call the Physician to see if they still wanted it done since so much time had elapsed since they had ordered it. NM "L" was queried who is responsible for ensuring timely follow up of outstanding laboratory orders and they reported the Nursing staff should have followed up. No documentation regarding the disposition or results of R29's CMP lab draw ordered on 9/26/23 was provided before the end of the survey.			
F0842 SS= E	Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The	F0842	Residents #336, 440, 636, 438, 96 did not suffer any ill effects as a result of this occurrence. Resident # 438 LG/representative was notified of some of the medical records of resident #636 being mixed with #438 medical record. Current guardianship papers have been requested from the son without success for R96, social worker will petition the court for a public guardian to ensure continuity of decision making. In the event that the son wishes to continue as guardian, he will be able to apply at that time. The facility currently has a full-time medical	11/6/2023

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	facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:		records clerk on staff. The policy for processing resident medical record request was reviewed by the RNC, Administrator, Director of Nursing and medical records clerk and is appropriate. The medical records clerk will follow the process of processing medical record request, which includes the final review of the resident medical record by the Director of Nursing and Regional Nurse Consultant prior to sending to the requested party. This process will be triple checked by the RNC prior to the medical record clerk releasing requested medical records. The Administrator met with Doctor R to discuss the physician's methods of entering information/progress notes into the resident's medical record and to review the policy for HIPAA and privacy. Education was given on ensuring the documentation of residents in the electronic medical record is accurate, completed, and timely. All residents have the potential to be affected. An audit was performed of all medical record requests for the past 60 days to ensure no other residents had other residents' medical information mixed with their records. An audit was completed of all residents' medical records in the facility to ensure that no other residents medical records were mixed together or entered into the wrong medical record by the providers. By 11/06/23 facility providers will be educated on the policy for HIPPA and privacy, specifically documentation in the resident's medical record to ensure accuracy, complete and timeliness of residents' documentation. The DON/designee will conduct random	

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	This citation pertains to Intake MI00137216 Based on observation, interview, and record review, the facility failed to ensure accurate, complete, and timely documented medical records for five residents (R#'s 336, 440, 636, 438, and 96) of five residents reviewed for accurate, complete, and timely documented records, resulting in Health Insurance Portability and Accountability Act (HIPAA) violations of privacy and the potential for additional privacy violations. Findings include: A review of a facility provided policy titled, "Documentation" adopted 7/11/18 that read, "...All services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care..." R440 and R336 On 10/11/23 at 12:05 PM, a review of R440's clinical record revealed they admitted to the facility with diagnoses that included: pressure ulcers, seizures, major depressive disorder, and presence of a colostomy. It was further noted R440 had one pressure ulcer to their right ankle.		audits on 5 residents medical records weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure documentation in the resident medical record is accurate and complete and there are no violations of HIPAA, other residents' information in the medical record. The RNC will conduct audits on any/all requested medical records weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that medical records do not obtain other residents information. The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/06/23 and for sustained compliance thereafter.	

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	A review of R440's Physician's progress notes entered into the record by Dr. 'R' was conducted and revealed a note dated 1/25/23 at 11:33 PM that read, "...Note Text: Patient: (R336)...111/78 (blood pressure)...foley (urinary catheter) remains intact...1. Cerebral infarct (stroke). 2. Left hemiparesis...5. recent hospitalization secondary to sepsis..." It was further discovered the note documented the presence of three pressure ulcers (injuries involving the skin). Documentation in R440's clinical record did not indicate they ever had a urinary catheter, suffered a stroke, had left sided hemiparesis, were hospitalized due to sepsis or had three pressure ulcers. Continued review of R440's progress notes entered into the record by Dr. 'R' on 2/2/23 at 11:59 AM read, "...111/78...foley (urinary catheter) remains intact...1. Cerebral infarct (stroke). 2. Left hemiparesis...5. recent hospitalization secondary to sepsis..." It was noted this progress note also referenced the same three pressure ulcers as the note dated 1/25/23. A progress note entered into R440's record by Dr. 'R' on 2/16/23 at 11:52 AM read, '...foley remains intact...1. Cerebral infarct. 2. Left hemiparesis...5. Recent hospitalization secondary to sepsis..." It was noted this progress note also referenced the same three pressure ulcers as the note on 2/2/23 and 1/25/23.			

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	Progress notes entered into R440's clinical record by Dr. R dated 2/28/23, 3/7/23, 3/17/23, 3/28/23, 3/31/23, were also reviewed and referenced the foley catheter, the stroke, the left hemiparesis the hospitalization due to sepsis, and the three pressure ulcers, despite these things not being a clinical picture of R440. On 10/11/23 at 12:31 PM a review of R336's clinical record revealed they admitted to the facility with diagnoses that included: stroke, severe sepsis, and pressure ulcers. It was further discovered they had left sided hemiparesis due to the stroke, had a foley catheter, had been hospitalized due to sepsis, and had the three pressure ulcers documented in Dr. 'R's notes contained in R440's clinical record. On 10/12/23 at 2:25 PM, an interview was conducted with Dr. 'R' regarding numerous progress notes for R336 documented in R440's chart. Dr. 'R' said they did not start their documentation in the electronic medical record (e-MAR), they used "Google Docs" to document their assessment then they moved the note from from "Google Docs" over to the facility's e-MAR program, and they, "must have crossed over the notes". When asked why this happened numerous times, Dr. 'R' said, "It was just a mistake." They were then asked if it was the facility policy to use "Google Docs" and they said it was not. R96			

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	On 10/11/23 the medical record for R96 was reviewed and revealed the following: R96 was initially admitted to the facility on 11/13/20 and had diagnoses including Schizoaffective disorder and Vascular dementia. A review of R96's MDS (minimum data set) with an ARD (assessment reference date) of 8/15/23 revealed R96 needed assistance from facility staff with their activities of daily living. A review of R96's EMR (electronic medical record) profile page revealed R96's son was reported to be their court appointed legal guardian. A review of R96's "Letters of guardianship" court papers in their record indicated R96's guardianship expired on 11/12/21. No updated guardianship papers were present in the record that indicated R96 had a current court appointed legal guardian. On 10/12/23 at approximately 2:46 p.m., Social Worker "K" (SW "K") was queried regarding the expired guardianship paperwork in R96's record and if R96's son was still their legal guardian since the documentation in the record indicated the guardianship expired on 11/12/21 and they reported that they thought R96's son was still the legal guardian but did not have current guardianship documentation. SW "K" was queried why they did not have the updated legal paperwork in the record and they indicated the last correspondence they had			

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	with R96's son pertaining to guardianship was in February 2023 and they had not follow-up with them since that time. No updated/active legal guardianship paperwork for R96 was provided before the end of the survey. R438 & R636 A complaint was filed with the State Agency on 5/31/23 that alleged in part, "...asked for a copy of the resident's medical records and ended up getting information on another resident mixed in with his records..." Review of the closed record revealed R438 was admitted into the facility on 3/31/23 with diagnoses that included: Guillain-Barre syndrome (disorder in which the immune system attacks the nervous system), diabetes and tracheostomy status. An Admission Nursing Assessment dated 3/31/23, documented R438 was totally dependent on staff for all ADL's. According to a Brief Interview for Mental Status (BIMS) evaluation dated 3/31/23, R438 was cognitively intact. On 10/11/23 at 11:57 AM, Medical Records (MR) "R" was interviewed and asked about the process for release of medical records. MR "R" explained when a request for medical records is made, it is forwarded to the legal department, if it is approved, she then compiles the requested records and either mails it or emails it per the requestor's			

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	preference. MR "R" was asked for a copy of R438's medical record that was sent. MR "R" explained she had not been Medical Records Coordinator at that time, but would look for it. On 10/11/23 at 1:00 PM, MR "R" explained she could not find the copy of R438's medical records sent. On 10/11/23 at 1:02 PM, the Administrator was asked for a copy of R438's medical records that were sent. Review of a copy of R438's medical records sent by email revealed an 160 page document, however, starting on page 115, the document included a referral from a local hospital for R636. These 45 pages included R636's name, address, phone number, insurance information, laboratory results, diagnoses and detailed medical information. On 10/11/23 at 2:50 PM, the Administrator and the Regional Nurse Consultant (RNC) were interviewed and asked about the process of sending out medical records. The Administrator explained after the records were compiled, they were sent to either the RNC or the Director of Nursing (DON) to ensure all the requested components were included. The RNC was asked if she had reviewed R438's medical record before it was sent. The RNC explained she had not reviewed it. When informed that R636's referral to the facility had been included with			

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	R438's medical record, both the Administrator and the RNC said that should never happen and would look into the matter. On 10/12/23 at approximately 8:30 AM, the RNC explained the records had not been reviewed by herself or the DON before they had been sent out. Review of a facility policy titled, "Health, Insurance, Portability and Accountability Act (HIPAA)" dated 7/11/18 read in part, "...Communications with or about residents involving PHI (protected health information) will be private and limited to those who need the information in order to provide treatment, payment, and health care operations. These may be verbal, written or even electronic communications, and only those who need to know should have access to the information communicated... PHI is any information, including demographic information, which identities an individual and meets any or all of the following criteria: Is created or received by a health care provider, health plan, employer, or health care clearinghouse. Related to past, present, or future physical or mental health or condition of an individual. Describes the past, present, or future payment for the provision of health care to an individual..."			
F0847	Entering into Binding Arbitration Agreements §483.70(n) Binding Arbitration Agreements If	F0847	The arbitration agreement has been reviewed with resident #4 and #110 to ensure they have	11/6/2023

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SS= E	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 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).		a clear understanding of the agreement. All residents have the potential to be affected by this occurrence. An audit was conducted to identify residents admitted in the last 60 days. The facility administrator/designee met with each resident and/or responsible party who signed the arbitration agreement and still resides in the facility to review the arbitration agreement and ensure they had a clear understanding of the agreement. The administrator/designee met with the resident council to review the arbitration agreement and ensure they had a clear understanding of the agreement. By 11/06/23 the administrator in training (AIT) will be educated by the facility administrator on the admission packet, which included but was not limited to the arbitration agreement and ensuring while having the admission packets signed to ensure residents and/or responsible parties had a clear understanding of what they were signing. The administrator/designee will conduct random interviews on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the residents are aware of the arbitration agreement and have a clear understanding of the agreement. The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 11/06/23 and for sustained compliance thereafter.	

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	This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that two (R4 and R110) residents received a clear understanding of the facility's "Binding Arbitration" agreement prior to signing the document and ensure that facility staff had a clear understanding of the legal document. Findings include: During the entrance conference the facility reported that the "Binding Arbitration" was offered to all residents entering into the building. The facility provided a list of residents that had agreed to "Binding Arbitration" that included R4 and R110. Review of the facility "Binding Arbitration Agreement" was reviewed and documented, in part: " ...Except as otherwise expressly provided in any written agreement between the parties ....the parties agree that any and all claims and disputes arising out of or relating to Resident's stay ...will be resolved through the dispute resolution process ...Any covered claims not resolved by mediation will be settled by arbitration ...Residents understand that by agreeing to the dispute resolution process set forth in this Agreement, Resident is waiving Resident's rights to have any Covered Claims adjudicated in a court or other governmental tribunal, as well as Resident's right to have			

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	any Covered Claims presented to and decided by a jury ...". On 10/11/23 at approximately 10:00 AM, a Resident Council meeting was conducted with six residents that were noted a cognitively intact. The residents were asked if they had entered into binding arbitration agreements to resolve disputes and if so, how the agreements were explained to them by facility staff. All of the residents reported that they had no idea as to what binding arbitration was and believed that they did not or possibly would not sign the agreement. A review of R4 and R110 clinical record showed no documentation as to the Binding Arbitration agreement. On 10/12/23 at approximately 2:45 PM, the Administrator was asked as to the location of the signed agreements. The Administrator reported that the Administrator in Training (hereinafter AIT "U"), who was in the room during the interview, was currently responsible for working with newly admitted residents regarding the agreements. AIT "U" was interviewed as to how the process worked and their understanding of what the Binding Arbitration Agreement meant. AIT "U" reported that the Binding Arbitration Agreement is attached to the admission packet that is provided to residents and/or their representative. AIT "U" will then ask the residents/representatives to read over the documentation and they will			

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	sign electronically. AIT "U" was asked as to their understanding of what the Binding Arbitration Agreement meant and what if anything they explained to the residents/representatives. AIT "U" then stated that the document allowed residents to go through an Arbitrator to address a dispute and if they dispute could not be resolved, residents had a right to go through the court system to address their disputes. AIT "U" noted that he would provide the signed Arbitration Agreements for R4 and R110. On 10/12/23 at approximately 3:30 PM, the facility provided the signed Binding Arbitration Agreements for R4 and R110. An e-signature for R4 was made on 5/16/23 followed by a staff signature dated 5/25/23. R110 had an electronic signature dated 4/10/23 followed by a signature from AIT "U". Both R4 and R110 were interviewed and did not recall signing the documentation, nor had an understanding of document. R4 noted that they might consider signing the document, but noted they needed a better understanding. Review of R4's clinical record revealed the resident was admitted to the facility on 5/12/23 with diagnoses that included: paraplegia and neuromuscular dysfunction. A review of the residents Minimum Data Set (MDS) noted the resident had intact cognition.			

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	Review of R110's clinical record revealed the resident was admitted to the facility on 4/7/23 with diagnoses that included: heart failure, anxiety and renal failure. Review of the resident's MDS noted the resident had intact cognition .			
F0881 SS= E	Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to establish an antibiotic stewardship program that failed to establish an antibiotic stewardship program that included consistent implementation of protocols for appropriate antibiotic use. This deficient practice affected multiple residents (including R42, and R637) at the facility. Findings include: Review of a facility policy titled, "Antibiotic Stewardship" dated 7/11/18 read in part, "...training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall	F0881	R #42 had no adverse reaction related to the use of this antibiotic. R #637 had no adverse reaction related to the use of this antibiotic. R #73 had no adverse reaction related to the use of this antibiotic. All residents have the potential to be affected. All residents currently on antibiotic therapy were reviewed by the ICP nurse/designee for meeting the McGeers criteria for antibiotic usage, with benefits vs risk discussed with the physician and documentation to continue with antibiotic use or discontinue the antibiotic based on clinical findings. By 11/06/23 providers and extenders will be educated on antibiotic stewardship and the McGeers criteria for antibiotic usage with emphasis on ensuring that appropriate labs and diagnostics are ordered for a definitive diagnosis and supportive documentation is given for the ordering and use of antibiotics for residents. By 11/06/23 licensed nurses will be educated on the McGeers criteria for antibiotics and ensuring proper documentation of residents with signs and symptoms of infection, communicating lab and diagnostic findings to the physician or need for supportive labs and diagnostics based on resident symptoms to	11/6/2023

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	community...If an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements: ...f. Indications for use..." Review of the facility's July 2023 infection control log book documented of the 36 antibiotic line listings, 12 of them did not meet criteria for antibiotic use. Including R637 receiving Ciprofloxacin 500 milligrams (mg) beginning 7/19/23. A progress note dated 7/18/23 at 5:46 PM by Nurse Practitioner (NP) "O" read in part, "...Pt (patient) seen and examined today. Pt reports persistent pain during urination x 3 weeks. Pt completed a 7 day course of Cipro on 7/10 for UTI (urinary tract infection)... Include Problems: 1. ...Acute dysuria (painful urination) - labile (changing or unstable) - restart Cipro 500 mg PO (by mouth) x 7 days..." No urinalysis (UA) or culture and sensitivity (C&S) tests were done prior to starting the antibiotic to ensure the presence of bacteria, and what antibiotic the bacteria were susceptible to. An additional progress note by NP "O" dated 7/25/23 at 5:57 PM read in part, "...Diagnosis/Status/Plan: 1. ...Acute diarrhea on chronic constipation-labile- Cipro DCd (discontinued) due to worsening diarrhea and Vancomycin started for ppx (prophylaxis) treatment of C-diff (Clostridioides difficile - infection of the large intestine)..." No laboratory text was done prior to starting the antibiotic to ensure the presence of C-diff. Review of R637's July 2023 and August 2023 Medication Administration		help ensure appropriate antibiotic use. The ICP nurse/designee will review the electronic dashboard daily for new resident orders for antibiotic to ensure that appropriate lab/diagnostic and documentation and diagnosis is in place per the physician and follow up with the physician when needed to further investigate residents on antibiotic therapy with no indication for use. ICP/DON/designee will perform random medical record audits on 5 residents receiving antibiotics weekly times 4 weeks and then monthly times 3 months or until substantial compliance has been maintained to ensure the protocol for appropriate antibiotic usage is being followed. The results will be presented to the QAA committee for review and consideration of further corrective action. The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 11/06/23 and for sustained compliance thereafter.	

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	Records (MAR's) revealed R637 received Vancomycin 125 mg four times a day for 10 days. Review of the facility's August 2023 infection control log book documented of the 42 antibiotic line listings, 22 of them did not meet criteria for antibiotic use. Including R42 receiving Macrobid 100 mg beginning 8/15/23 two times a day for seven days for a UTI when the signs and symptoms were documented as "change in mood, confusion, abd (abdominal) pain", and labs dated 8/9/23 showed "no colony". Review of the facility's September 2023 infection control log documented of the 36 antibiotic line listings, 22 of them did not meet criteria for antibiotic use. Including R73 receiving Keflex 250 mg three times a day for seven days for a UTI. Review of a progress note dated 9/19/23 at 4:16 PM by Certified Nurse Practitioner (CNP) "P" read in part, "...Patient is anuric (failure of the kidneys to produce urine) secondary to hemodialysis/ESRD (end-stage renal disease), complaint of bladder discomfort, malodorous foul-smelling urine, dysuria. Patient reports dizziness similar when she has urinary tract infection. She denies fever chills, denies lethargy, weakness is at baseline... ASSESSMENT/PLANS: #Bladder infection. Anuric, will start Keflex 250 mg 3 times a day x7 days..." No UA/C&S was performed prior to starting the antibiotic.			

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SKLD BLOOMFIELD HILLS	**2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304**

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	On 10/12/23 at 1:17 PM, an interview with Registered Nurse (RN) "M", who served as the facility's Infection Control Preventionist was conducted regarding the prescribing and administration of antibiotics for resident infections that did not meet McGeer's criteria. RN "M" explained the physicians and the extenders need to be sure they are including their rationales for the continued use of the antibiotic medications when a resident does not meet the criteria for antibiotic usage, and would try to reach out to the physicians and the physician's extenders about antibiotics for infections that did not meet criteria in an attempt to either discontinue the medications or have them justify a rationale for the use.			