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 _____	11/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Evergreen Health and Rehabilitation Center was surveyed for an Abbreviated survey on 11/15/23. Intakes: MI00139080, MI00139462, MI00139532, MI00139962, MI00140397, MI00140548, MI00140611, MI00140683 Census = 150	F0000		
F0578 SS= D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the	F0578	F578 ELEMENT 1 It is the practice of the facility to timely obtain, acknowledge and ensure a resident's choice for health care decision making prior to petitioning for a third party guardian. Resident 807 court hearing was cancelled and the DPOA paperwork is within resident medical record. ELEMENT 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Those residents' have been assessed and reviewed to ensure that residents choice for health care decision making is completed prior to petitioning for a third party guardian. ELEMENT 3 The Interdisciplinary Team reviewed the policy and procedure Decision Making Capacity Policy and deemed it appropriate. Current residents who have a third party guardian were reviewed and no deficiencies were noted. The Social workers will be educated on the Decision Making Capacity policy with emphasis on ensuring a residents choice for health care decision is completed	12/8/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/04/2023

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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	facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: This citation pertains to intakes: MI00140611 and MI00140683. Based on observation, interview, and record review, the facility failed to timely obtain, acknowledge and ensure a resident's choice for health care decision making prior to petitioning for a third party guardian for one (R807) of one resident reviewed for resident rights, resulting in expressions of extreme frustration, distress, fear of loss of autonomy and the increased potential for further denial of the resident's right for self-determination under a reasonable person concept for a resident who had appointed a family member as their legal representative prior to the deterioration of their health condition. Findings include: Review of a complaint filed to the State Agency read in part, "I should file a petition for guardianship of my (age omitted) year old (relationship omitted) (blind with dementia). In Aug. 2023, I called the court and made plans to file the petition. Prior to going to court, I called (facility name omitted). The social worker informed me that they scheduled a representative to go to court to file the petition on my behalf...I got a notice via mail that the petition filed was for		prior to petitioning for a third party guardian. Education will be completed by December 7, 2023. ELEMENT 4 The Admin/designee will complete random audits three times a week for 4 weeks, then once a week for 4 week to ensure the resident choice for heath decisions is completed prior to petitioning for a third party guardian. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date: 12/8/2023	

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	the facility (facility name omitted) to have unrestricted guardianship of my (relationship omitted)...saying that our family was unreachable though one of us is present, visiting my (relationship omitted) everyday". Review of a second complaint filed to the State Agency read in part, "The court sent someone unannounced to the facility to see (name of R807) as they needed to verify that (relationship omitted) had no family present and willing to assume the care for him. They saw that the family was involved and present. The court went against the guardianship (facility name omitted). There are concerns that (facility name omitted) is seeking guardianship...was attempting to get guardianship over (name of R807) and did not notify the family and were attempting to restrict and strip the family from (name of R807)". Review of the clinical record revealed R807 was originally admitted to the facility on 11/10/22. R807 was hospitalized after their initial admission and most recently they were readmitted back into the facility on 11/7/23. R807's admitting diagnoses included hemiplegia (stroke), dementia, glaucoma, legal blindness, and dysphagia (difficulty with swallowing). R807 was receiving their nutrition through PEG (Percutaneous Endoscopic Gastrostomy) tube. (PEG tube is a tube placed surgically into the stomach to receive nutrition directly through the stomach when there is difficulty swallowing or when oral nutrition is inadequate.) According to a Minimum Data Set (MDS) assessment dated 8/18/23, R807 had severely impaired cognition, and was dependent on staff assistance with their mobility and activities of daily living (ADLs) such as mobility in bed, eating, bathing, and toileting.			

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	An initial observation was completed on 11/14/23, at approximately 10:35 AM. R807 was observed in their bed with their eyes closed. R807's private duty care giver ("J") (arranged and privately paid by R807's family) was sitting at their bedside. During this observation an interview was completed with R807's private duty care giver. Private duty care giver "J" was queried on who they were and what their role was. Care giver "J" reported that they were a private care giver appointed by the R807's family. Care giver "J" reported that they had been coming in to assist R807 for approximately a year. Care giver "J" also reported that they were coming four to five days/week for four hours, usually in the morning, and R807's spouse would usually come in the afternoon. Care giver "J" also reported that they were assisting in providing care for R807 while they were at the facility. A review of R807's Electronic Medical Record (EMR) revealed an admission agreement document dated 11/10/23 and 12/08/22 signed by R807's spouse. The admission agreement also included consent to immunizations/vaccines signed by R807's spouse. Further review of R807's EMR revealed a Durable Power of Attorney (DPOA) for Healthcare and Finances, executed by R807, that designated R807's son as their first agent and the daughter as their second agent to advocate and honor their wishes. This document was executed by R807 on 11/27/18 to have their children as their advocates/legal representatives to honor their wishes. Further review of R807's EMR also revealed a physician certification form initiated on 5/26/23, initiated approximately six months after initial admission to the facility. The form revealed that R807 was not competent to participate in medical treatment, care, and custody decision making. The form also had a check box that read "If the resident has executed a Durable Power of			

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	Attorney for Medical Decision-Making or has designated a Patient Advocate in compliance with state regulations, that DPOA or Patient Advocate is now in effect". The form was signed by the physician on 6/1/23. Review of R807's social work assessment and progress notes included an initial social work assessment dated 11/14/23 that documented R807's BIMS (Brief Interview for Mental Status - a cognitive exam) score was "0", which indicated severe cognitive impairment. The section of the assessment which addressed legal papers of authority was incomplete, with no boxes checked. Another social work assessment completed on 12/7/22 documented, "Patient presents as alert and oriented x 1 with confusion...Patient has a BIMS score of 0/15, indication of severe memory impairment. Social work has reviewed advance directive and current full code status which are appropriate at this time. No DPOA on file and family not interested in documents at this time. Patient's son is applying for Medicaid as plan B to remain in the facility". This social work assessment did not address any need for advocating for a guardianship for R807, and noted the family was not interested in DPOA at that time. The documentation did not explain what it meant by family not interested as R807's family had a valid DPOA document at that time. Review of a social work progress note dated 1/3/23 read, "SW (social work) spoke with resident and family to review Advance Directives. Continue FULL CODE status per their wishes". This note did not explain who it meant by "their wishes" as they did not have any legal document on R807's EMR during this time frame. Review of a social work progress note dated			

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	1/5/23 read, "SW emailed son and spouse to see if anyone had DPOA or guardianship of resident in place...discussed importance of it and reasoning behind it. Discussed guardianship process in case there was none in place". The note revealed that this discussion was done via e-mail. On 11/14/23 at approximately 3:00 PM, the Director of Social Work (Staff "K") was requested to provide a proof of this e-mail communication. Staff "K" reported this was handled by a different social work staff member who no longer worked at the facility and did not have any proof of communication. Review of a social work progress note dated 1/26/23 read, "SW called RP (Responsible Party) to make her aware related to guardianship process. Voiced understanding. She will look into it ...". Review of a quarterly social work assessment dated 2/22/23 read in part, "Guardianship was discussed with wife on 1/26/23, followed up on 2/22/23 in which she states that she is still considering it ...Resident has supportive family who participates in care discussions. Social work obtained input from resident/family...". Review of a quarterly social work assessment dated 5/19/23 read in part, "Guardianship has been discussed with spouse multiple times. Facility will initiate capacity evaluation and petition for guardianship. Caregiver states the spouse has her own medical issues currently and son (name omitted) would be the best candidate. VM (voicemail) left for son (name omitted) ...Resident has supportive family who participates in care discussions". Review of a social work progress note dated 5/23/23 read, "patient's son called the writer back			

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	stating that he would be open for guardianship...". Further review of social work progress note reveals that a capacity form was sent to the R807's son on 7/10/23. An additional progress note dated 8/16/23 revealed that facility had referred the resident to an external entity to petition for guardianship. It must be noted that during this entire time frame R807 had a DPOA document, executed in 11/27/18. Family of R807 (spouse or children) were unaware and they were not educated that they did not need guardianship if they had a DPOA in place. On 11/14/23 at approximately 11:15 AM, an interview was completed with the complainant. When asked if they recalled whether the facility requested a copy of the DPOA documents via email or phonecalls as noted in the progress notes and they reported they had not. They further reported they were not aware that the family did not need the guardianship if they had an active DPOA, and no one had educated or explained any of this. The complainant reported that the facility had requested the family to get the guardianship and they were willing to get the guardianship (when there was no need for one). The Complainant reported that although they lived out of state, they visited once every two to three weeks, and they drove over 30,000 miles/year to assist their parents. The complainant also reported that R807's spouse visited the resident several days every week, and the family also paid for a private caregiver for R807. The Complainant reported that when they were in town they had spoken with a facility social worker and had notified the facility that they were in the process of going to court to get their guardianship as requested by the facility. The Complainant reported that they were notified by the facility staff member that the facility would send someone a representative on the family's behalf			

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	for guardianship and family did not need to go to court. The Complainant reported that R807's spouse and children were shocked when they had received the letter from the court that the facility was requesting a third-party to have guardianship and reported that R807 would have been extremely upset with this whole situation if they understood what had happened. The Complainant reported they had reached out to the speak with the social worker many times after the court situation and they were unsuccessful, and they had reported their concerns to administrator. Review of the guardianship documents provided by the facility revealed a publication of notice of hearing from the Probate court read that the notice for guardianship hearing that was scheduled for 10/11/23 was sent out on 9/13/23. Additionally, the facility had received a copy of the DPOA that indicated it had been scanned into the resident's EMR on 9/23/23. On 11/14/23 at approximately 4:30 PM, during an interview with the Administrator, it was confirmed the DPOA document was scanned in on 9/23/23 and that R807's EMR did not have any documentation or explanation as to why the facility had not provided this information to the third-party agency or explain to the family the unnecessary need to pursue guardianship with the existing DPOA and capacity forms already in place. The facility failed to follow-up and intervene timely, and a guardian Ad Litem was appointed. A review of the report by Guardian Ad Litem (GAL) dated 10/4/23 read in part, "Petitioner (from the third-party guardianship agency) alleges that (R807 name) is unable to make or communicate informed, decisions because of a mental deficiency and physical disability. Specifically, Petitioner alleges that he has			

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	multiple medical diagnoses that impairs cognition including dementia and requires assistance with his basic daily needs. Petitioner further alleges that he attempted to contact with (names and relationships omitted) without success and is requesting that a third-party professional guardian be appointed...". (It must be noted that R807 had a spouse visiting the facility several times a week and one of their children from out of town was visiting every two to three weeks since admission into the facility.) The GAL report further read, "On September 26, 2023, I went to (facility name omitted) to meet with (R807's name). Upon arrival to his room, (spouse name omitted) was present, and I explained the purpose of my visit as GAL. She had apparently just received service of the petition and was shocked and upset that it had been filed. She stated that she was at the facility every day to visit with her husband since he was admitted there in December 2022. She also contacted her (relationship omitted) by phone during my visit. He also expressed surprise at the filing of the petition at the request of the facility...Although (name omitted) resides in (location omitted) he usually travels to Michigan every 2-3 weeks to assist his (relationship omitted) with his (relationship omitted) care at the facility...Subsequently, (name omitted) gave me a copy of the executed POA documents and I have attached them hereto. I also attempted to contact the facility social worker however to date that has been unsuccessful.". The recommendation from the GAL read, "Based on the facts and circumstances as outlined above and after review of the duly executed POA documents, I recommend that the Court deny the petition at this time". (It must also be noted the R807's EMR did not have the documentation/the petition that was filed by third part guardianship agency on behalf of the facility and the GAL			

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	report.) On 11/14/23 at approximately 3:00 PM, an interview was completed with Staff "B". When queried on the facility's process and follow up on obtaining legal documents such as DPOA, guardianship information for residents with BIMS score of 0, Staff "B" reported that they would complete an initial assessment, typically within five days of admission and if residents had cognitive impairments, they would follow up with families to request if they any DPOA or guardianship. Staff "B" was queried on what had happened with R807 and why they were referred to a third-party agency to petition for guardianship, given the resident's supportive family and they reported that they had documented all the follow up with the spouse and son. Staff "B" was queried if they had sent any official notification from the facility before they were pursuing a third-party guardianship, Staff "B" reported that they did not send any official notification and it is not their facility policy to send official notifications when they were pursuing third party guardianship for the residents. Staff "B" reported some the family communication for R807 was handled by a different social work staff member who no longer worked at the facility, and they did not have any proof of communication. Staff member reported that R807 was referred to a third-party agency for guardianship on 8/15/23. Their last official communication with the family was in July 2023. Staff "B" was queried why the facility did not follow up with the third-party guardianship petitioner representing the facility to notify that the facility had the DPOA documents, and no further explanation was offered.			

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	On 11/14/23 at 4:30 PM, an interview was completed with the Administrator. When queried why the facility had pursued appointment of a third-party guardian when R807 had a supportive family who were very involved in their care, the Administrator reported that they were involved later, after the petition was filed and further agreed that R807's family was very involved and supportive. When queried on the current facility process, why the family of R807 was not notified prior to pursuing third party guardianship, and why the guardianship process was not terminated when the facility had valid DPOA documents of R807's EMR, the Administrator reported that they had opportunities in their current facility processes and they would review and revise their process. The Administrator also reported that the intent of the referral for guardianship was to assist the family, and there had been lapse in communication on the facility end. (It must be noted that R807 had a supportive family with a valid DPOA in EMR and did not need a guardian as mentioned above. It must also be noted the R807's EMR did not have any documentation on guardianship petition that was filed by third party guardianship agency on behalf of the facility and the GAL recommendations to the court. These documents were provided by the complainant.) A facility provided document titled, "Resident Rights Under Michigan Public Health Code", dated 11/20/17, read in part, "Residents of this facility have the right to a dignified existence, and to communicate with individuals and representatives of choice. The facility will protect resident rights as designated below using the federal Nursing Home Reform Law enacted in 1987 in the Social Security Act. The law requires nursing homes to "promote and protect the rights of each resident" and places a strong emphasis on individual dignity and self-determination".			

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	A facility provided document titled, "Decision-Making Capacity Policy", dated 11/21/20, read in part, "If the resident has Durable Power of Attorney (DPOA) or Patient Advocate paperwork established, the DPOA or Patient Advocate paperwork will be activated if the resident is deemed incompetent by two physicians. A copy of the paperwork will be uploaded to the resident's medical record. If the resident has no legal paperwork in place, the social worker will speak to the resident's family member and/or emergency contact about applying for guardianship through the probate court system. The social worker should document these conversations or attempts at conversations in the resident's medical record. If the family member and/or emergency contact is not interested in obtaining guardianship or fails to obtain guardianship, the facility, or contracted vendor, should petition the probate court system for a court appointed guardian. Once the family or court-appointed guardian is approved, a copy of the guardianship paperwork will be uploaded to the resident's medical record".			
F0658 SS= E	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake MI00139462 Based on interview and record review the facility failed to ensure narcotic medications were documented as administered per professional standards for one (R802) of one resident reviewed	F0658	F-658 ELEMENT I It is the practice of the facility to ensure narcotic medications are documented as administered per professional standards. Resident 802 is no longer at the facility. Resident 802 MAR and Controlled substance (C2) records were reviewed. Nurses who did not complete proper documentation were immediately re-educated on: Importance to document on C2 form and MAR when administered PRN narcotic medications and on the facility “documentation policy”. ELEMENT 2	12/8/2023

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	for professional standards resulting in the inaccurate representation of the amount given and the effectiveness of pain medications. Findings include: A complaint was filed with the State Agency (SA) that alleged in part that R802's record was inaccurate/false. Review of the closed record revealed R802 was admitted into the facility on 8/25/23 with diagnoses that included: fracture of left tibia, fracture of left fibula and multiple fractures of pelvis. According to the Minimum Data Set (MDS) assessment dated 8/13/23, R802 was cognitively intact and required the assistance of staff for activities of daily living (ADL's). Review of R802's pain care plan initiated 8/26/23 revealed an intervention that read, "Administer pain medication as ordered. Monitor for effectiveness." Review of R802's August 2023, September 2023 and October 2023 Medication Administration Records (MAR's) revealed an order with a start date 8/25/23 for Oxycodone 10 milligrams (mg), give 1.5 tablet by mouth every 6 hours as needed for pain. The order was discontinued 8/31/23 and a new order with a start date of 8/31/23 for Oxycodone 10 mg, give 10 mg by mouth every 4 hours as needed for pain. The MAR's revealed some days the Oxycodone was given four times a day, and some days none were given. Review of "CONTROLLED DRUG RECEIPT/RECORD/DISPOSITION FORM" (C2 Form) for R802's Oxycodone revealed the medication was removed from the supply of R802's medications multiple times daily. The directions on the form read, "Every dose must be accounted for and requires charting on the		All current facility residents who has order for PRN narcotic medications are at risk for inaccurate representation of the amount given and the effectiveness of pain medications. Those residents' have been reviewed to ensure narcotic medications are documented as administered per professional standards and make sure pain medications are effective and dosages are correct. ELEMENT 3 Facility "Documentation policy" was reviewed and deemed appropriate. All nurses were re-educated on facility "Documentation policy" with specific attention on importance to document on C2 form and in medication administration record (MAR) when administered PRN narcotic medication. Education completed by 11/30/23. ELEMENT 4 The DON/designee will complete random audits weekly for 4 weeks on five residents on each unit, then monthly for 4 weeks on five residents on each unit to ensure PRN narcotic medications are documented as administered per professional standards. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date: December 8, 2023	

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	Medication Administration Record." Reconciliation of R802's MAR's and the C2 Forms revealed the following discrepancies: 8/26/23 the MAR documented doses administered at 8:58 AM and 9:23 PM. The C2 Form documented the medication removed at 8:30 AM, 2:30 PM and 9:30 PM. In addition to the 2:30 PM dose not documented on the MAR, the wrong date of "8/24" was written on the C2 Form. 8/27/23 the MAR documented two doses at 4:50 AM and 10:53 PM. The C2 Form had four medications removed at 4:30 AM, 8:30 AM, 2:30 PM and 8:50 PM. 8/28/23 the MAR had one dose at 7:00 AM. The C2 Form had two removed at 6:55 AM and 11:30 PM. 8/29/23 the MAR was blank (indicating no doses given). The C2 Form had two removed at 9:53 (unknown if AM or PM) and 11:40 (unknown if AM or PM). 8/30/23 the MAR was blank. The C2 Form had two removed at 9:00 AM and 6:00 PM. 8/31/23 the MAR had one dose at 10:02 PM. The C2 Form had four removed at 1:00 AM, 9:00 AM, 5:00 PM and 10:00 PM. 9/1/23 the MAR had three doses at 3:01 AM, 10:09 AM and 9:03 PM. The C2 Form had four removed at 3:00 AM, 9:00 AM, (illegible time), 9:00 PM. 9/5/23 the MAR was blank. The C2 Form had two removed at 9:00 AM and 10:00 PM. 9/6/23 the MAR had one dose at 6:35 AM. The			

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	C2 Form had three removed at 6:30 AM, 9:00 AM and 8:00 PM. 9/7/23 the MAR was blank. The C2 Form had three removed at 9:00 AM, 3:00 PM and 10:00 PM. 9/11/23 the MAR was blank. The C2 Form had two removed at 9:00 AM and 5:00 PM. 9/13/23 the MAR and C2 Form both had three doses given, however the one medication removed had no date or time removed on the C2 Form. 9/14/23 the MAR had two doses at 2:26 PM and 11:44 PM. The C2 Form had three removed at 9:00 AM, 2:00 PM and 11:24 PM. 9/15/23 the MAR had two doses at 12:02 AM and 10:37 AM. The C2 Form had four removed at 4:00 AM, 9:00 AM, 4:00 PM and 9:35 PM. 9/16/23 the MAR had one dose at 11:23 PM. The C2 Form had two at (illegible time) and 11:20 PM. 9/17/23 the MAR had one dose at 2:15 PM. The C2 Form had two removed at 9:00 AM and 2:00 PM. 9/18/23 the MAR had two doses at 12:12 AM and 9:53 AM. The C2 Form had four removed at (re-written over) 12:15 AM, 9:00 AM, 2:00 PM and 10:00 PM. 9/19/23 the MAR and C2 Form both had two doses given, however neither medication had a time they were removed on the C2 Form. 9/20/23 the MAR had two doses at 2:00 PM and 9:23 PM. The C2 Form had three removed at 9:00			

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	AM, 4:00 PM and 9:00 PM. 9/21/23 the MAR had two doses at 9:55 AM and 11:34 PM. The C2 Form had three removed at 9:00 AM, illegible time and possibly 9:30 PM. 9/22/23 the MAR had one dose at 9:46 PM. The C2 Form had two removed at 9:00 AM and no time documented. 9/23/23 the MAR had one dose at 9:23 PM. The C2 Form had two removed at 10:00 AM (crossed out, but counted down on the sheet) and 9:20 PM. 9/24/23 the MAR was blank. The C2 Form had one removed at 12:00 unknown if AM or PM. 9/26/23 the MAR was blank. The C2 Form had one removed at 8:43 PM. 9/29/23 the MAR was blank. The C2 Form had one removed at 8:00 PM. 9/30/23 the MAR had two doses at 1:23 AM and 9:47 AM. The C2 Form had four removed at 1:23 AM, 10:30 AM 2:00 PM and 7:00 PM. 10/1/23 the MAR had three doses at 8:25 AM, 2:39 PM and 7:21 PM. The C2 Form had five removed at 12:00 AM, 4:18 AM, 8:00 AM, 3:00 PM, and (illegible time). 10/2/23 the MAR had two doses at 2:34 AM and 8:38 PM. The C2 Form had three removed at 2:30 AM, 11:19 AM and 8:38 PM. 10/3/23 the MAR was blank. The C2 Form had three removed at 9:00 AM, 2:00 PM and (unknown time). Review of R802's progress notes revealed the			

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	Oxycodone doses that were documented on the MAR produced an Administration Note that documented R802's level of pain. There was also an additional Administration Note approximately one hour after that documented whether the pain medication was effective or not. On 11/14/23 at 3:00 PM, the Director of Nursing (DON) was informed of the discrepancies found between R802's MAR's and C2 Forms. The DON explained she would look into the matter. On 11/14/23 at 4:55 PM, Licensed Practical Nurse (LPN) "A" was interviewed and asked about the process of giving a narcotic medication. LPN "A" explained she first checked to see if the medication was due to be given, then she removes the medication from the locked narcotic box, documents the removal on the C2 Form, documents as given on the MAR and gives the medication to the resident. When asked if the medication could be just documented on the MAR or the C2 Form, LPN "A" explained it had to be on both the MAR and C2 Form. On 11/14/23 at 5:00 PM, LPN "B" was interviewed and asked about narcotic medications. LPN "B" explained she would check to see if there was an order for the medication, and if it was due to be given, then would document the resident's pain level and documented the medication on both the C2 Form and the MAR. When asked if it had to be documented on both the C2 Form and the MAR, LPN "B" said yes. On 11/14/23 at 5:10 PM, LPN "C" was interviewed and asked about narcotic medications. LPN "C" explained she would document pain level before, document on both C2 Form and MAR and document if the medication was effective or not after. When asked if the			

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	medication could just be on one, C2 Form or MAR, LPN "C" explained it had to be on both. On 11/15/23 at approximately 1:00 PM, the DON explained she had reviewed all the documentation and had determined there had been no diversion of narcotics, but the documentation of the medication was not correct, the C2 Form and the MAR should contain the same times and doses given. The DON was asked if there was any type of audit done on C2 Forms to reconcile them to the MAR's. The DON explained she does do random audits of narcotic medications, but had been at the facility for less than a month. Review of a facility policy titled, "Documentation Policy" undated, read in part, "...Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation... Write legibly... Record date and time of entry..."			
F0805 SS= D	Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake MI00139532, MI00139080 Based on observation, interview and record review, the facility failed to provide food in the prescribed texture/consistency for one (R803) of four residents reviewed for therapeutic diets,	F0805	F 805 Element 1 It is the practice of the facility to provide food in the prescribed texture/consistency. Resident 803 incorrect tray was removed and corrected. The correct meal/consistency tray was provided to Resident 803. Resident 803 was assessed, and no signs or symptoms of aspiration were noted. Element 2 Residents that currently reside in the facility that receive a pureed diet, have the potential to be affected by this cited practice. Those residents' have been reviewed to ensure the correct diet is being provided. Any deficient	12/8/2023

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	resulting in the increased potential for episodes of choking and aspiration to occur. Findings include: A complaint was filed with the State Agency (SA) that alleged in part, the facility did not provide the correct diet to R803. On 11/14/23 at 12:28 PM, R803 was observed sitting in a wheelchair eating lunch. The food on the tray appeared to be pureed. R803 was asked if they had difficulty swallowing. R803 said yes. When asked how was the food at the facility, R803 made a noncommittal sound. Review of the clinical record revealed R803 was admitted into the facility on 3/31/20 and readmitted 8/30/23 with diagnoses that included: dementia, diabetes and macular degeneration. According to the Minimum Data Set assessment dated 9/5/23, R803 had severely impaired cognition and required the extensive assistance of staff for activities of daily living (ADL's). Review of R803's physician orders revealed a diet order with a start date of 9/26/23 for puree texture, thin consistency (liquids) and assistance with meals. On 11/14/23 at 12:55 PM, Speech-Language Pathologist (SLP) "F" was interviewed and asked about R803's diet. SLP "F" explained she was new to the facility and had not had any interaction with R803 yet. On 11/15/23 at 8:40 AM, R803 was observed sitting in a wheelchair in their room eating breakfast. On the divided plate there appeared to be pureed sausage and a piece of French Toast with the crust cut into large pieces and covered in syrup. The meal ticket on the tray had an orange sticker that said "PUREED". The diet order listed "Pureed Texture" and was highlighted in yellow.		practice was corrected immediately. Immediate in-servicing was provided for the dietary staff on the day of the incident. Element 3 The Interdisciplinary Team reviewed the policy and procedure Facility Pureed Diet Plan and deemed it appropriate. The dietary staff have been educated on the Facility Pureed Diet Plan with emphasis on providing an accurate diet to the residents. In-services will be completed by December 7, 2023. Element 4 The ADMIN/designee will complete random audits three times a week for 4 weeks, then every week for 4 weeks to ensure residents that require a pureed diet receive the correct diet. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date: December 8, 2023	

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	Also highlighted in yellow was "No Straw" and "1:1 FEEDING ASSISTANCE". The list of items included, "BREAKFAST ITEMS: P Sausage Link - 2 each; S French Toast, Crustless - 1 slice". On 11/15/23 at 8:42 AM, Assistant Dietary Manager (ADM) "G" was interviewed, showed R803's meal ticket, and asked what S French Toast, Crustless meant. ADM "G" explained it meant the crust was cut off the piece of French Toast and it was pureed with liquid to create a slurry, so it was listed as S for slurry and the P was for puree. ADM "G" was asked to observe R803's breakfast tray in their room. Upon observing the tray, ADM "G" explained it was not correct, the French Toast was not the correct texture. At that time, ADM "G" walked out of the room and left the tray of food in front of R803, who was still eating. On 11/15/23 at 8:45 AM, SLP "F" was asked to observe R803's breakfast tray. Upon entering the room, R803 was spearing a piece of French Toast with a fork. SLP "F" asked R803 if they were having difficulty eating their breakfast. R803 said yes. SLP "F" explained to R803 she was going to take the tray and bring one back they would have an easier time eating and picked up the tray and removed it from the room. SLP "F" explained she was going to go to the kitchen and get a tray that had the French Toast slurry for the resident to eat. On 11/15/23 at approximately 1:00 PM, the Director of Nursing (DON) was interviewed and asked why, when R803's meal ticket from breakfast had an orange sticker saying puree and highlighted pureed texture, was the tray given to R803 with a whole piece of French Toast on it. The DON explained she had been told about breakfast, but R803 had not eaten any of the French Toast. The DON was informed R803 had a piece on their fork when SLP "F" was brought			

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	to their room. When asked who had cut the piece of French Toast and put syrup on it, the DON had no answer. Review of a facility document titled, "Facility Pureed Diet Plan" undated read in part, "...This diet consists of pureed, homogenous, and cohesive foods. Food should be "pudding-like". No coarse textures, raw fruits or vegetables, nuts, and so forth are allowed. Any foods that require bolus formation, controlled manipulation, or mastication (chewing) are excluded..."			