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	414290	A. BUILDING ______ B. WING ______	1/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BELTLINE	2320 E BELTLINE SE GRAND RAPIDS, MI 49546

(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 Skld Beltline was surveyed for a combined annual recertification and abbreviated survey from 1/9/24-1/12/24. Intakes included: MI00140361, MI00141497, MI00141942. Census 125	F0000		
F0558 SS= D	Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for 1(Resident #105) of 2 residents reviewed for accommodation of needs resulting in the resident's inability to call for staff assistance with the potential for unmet care needs. Findings include: Resident #105 Review of an "Admission Record" revealed Resident #105 was originally admitted to the facility on 11/14/22 with pertinent diagnoses which included difficulty in walking and muscle weakness. Review of Resident #105's "Care Plan" revealed, " (Resident #105) is at risk for falls r/t (related to)	F0558	F Tag 558 Resident #105 had a psychosocial follow-up by Social Services to ensure accommodation needs and preferences were met. All residents in the facility have the potential to be affected. An audit was completed on all residents residing in the facility to ensure that resident call lights were within reach. All staff will be re-educated on the call light policy by 02/06/2024 to ensure call lights are within reach. The Administrator/designee will conduct random audits on five residents weekly, times four weeks, and then monthly after that, times three months, or until substantial compliance has been maintained to ensure residents' call lights are within reach. The results 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 02/06/2024	2/6/2024

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

Electronically Signed | | 01/29/2024

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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	left-sided paralysis and expressive aphasia (difficulty producing speech) r/t MVA (motor vehicle accident). Date initiated: 11/15/22...Interventions...Be sure call light is within reach, provide cueing and reminders for use as appropriate due to level of cognition. Date initiated: 4/12/23..." Review of Resident #105's "Care Plan" revealed, (Resident #105) has a communication and/or comprehension concern r/t Receptive Aphasia and expressive aphasia due to TBI (Traumatic brain injury). She does nod her head yes and no appropriately. Dated initiated: 3/2/23... Interventions: Ask yes/no questions in order to determine the resident's needs..." During an observation on 1/10/24 at 3:14 PM, Resident #105 was sitting in her bed waving her arms and yelling out. This writer entered the room and asked Resident #105 if she needed help. Resident #105 nodded her head yes. It was noted that Resident #105's call light was hanging from a pole in the room and out of Resident #105's reach. This writer asked Resident #105 if she could reach her call light, she nodded her head no. During an interview on 1/11/24 at 11:07 AM, Licensed Practical Nurse (LPN) "AA" reported that Resident #105 did use a call light when she needed assistance from staff. During an interview on 1/11/24 at 11:16 AM, Certified Nursing Assistant (CNA) " Y" reported that Resident #105 did use her call light when she needed assistance from staff.		and for sustained compliance after that.	
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	F0578	F Tag 578 Resident #228 had a review of his healthcare treatment decisions to ensure the advance directive was completed and documented in	2/6/2024

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	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 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: Based on interview and record review, the facility failed to obtain a resident's advanced directive (Code status) for 1 resident (R228) of 25 residents		the medical record. All residents in the facility have the potential to be affected. An audit was completed to ensure that advance directives were completed and documented in the medical record and any concerns identified were addressed. By 02/06/2024, facility-licensed nursing staff and the Social Services Department were re-educated on the advance directive policy and ensuring that residents make their own treatment decisions and complete their own documentation regarding advance directives. The Director of Nursing/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 proper advance directive documentation is signed by the resident. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Director of Nursing will ensure substantial compliance is attained through this plan of correction by 02/06/2024 and for sustained compliance after that.	

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reviewed for advanced directives resulting in the potential for failing to follow the resident's code status wishes.

Findings include:

According to the Admission Record, R228 was admitted on 1/8/2023 with diagnoses that included acquired absence of right leg, diabetes mellitus, hypertension, and chronic kidney disease.

During an interview on 1/11/2024 at 10:30 AM, R228 stated, "No one has asked me what I wanted for code status when I was admitted." It was noted during conversations, the resident was alert, oriented (person, place, time, date, and why he was at the facility), and able to hold a sensical conversation with humor.

During an interview and record review on 1/11/2024 at 1:30 PM, Social Worker (SW) "U" stated when reviewing R228's medical records, "It was brought to my attention today, that (R228's) code status was not done. The admission nurse usually does advance directives."

During an interview on 1/11/2024 at 3:20 PM, Director of Nursing (DON) "B" stated, "The facility's goal is to obtain code status immediately. I did not know (R228's) code status was not done until today. It is important to have the code status to follow a resident's wishes. The time to look for it (code status) is not during an emergency."

Review of R228's Order Summary did not have documentation of code status.

Review of R228's Progress Notes from 1/8/2024 21:12 (9:12 PM) through 1/9/2024 00:00 (midnight) did not have documentation of code

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	status. Review of facility policy, "Advance Directives" Updated 03/22/2021, reported, "It is the policy of this facility to ...Provide written information to residents at time of admission regarding ...Their right under State Law to accept or refuse medical treatment and the right to formulate Advance Directives such as the Natural Death Act, Durable Power of Attorney for Health Care Decision, or living will, in accordance with the Resident Self Determination Act ...PROCEDURE ...Upon Admission ...Designated staff will review and explain the specified State Law addressing Advance Directives options and Life Sustaining Treatment with the resident and/or representative ...Staff will provide the resident and/or representative with information regarding advance care planning which will address types of Advance Directives, treatment options and refusal of treatment ...Information will be reviewed and the resident and/or representative will be asked to sign and acknowledge that they have received the information on Advance Care Planning ...An Advance Directive form (as provided by the healthcare facility) shall be completed with resident and/or legal representative to verify treatment options as well as code status ...Appropriate information will be added to Physician Order Sheet (POS) ...Discussion of Advance Directives and treatment options/refusals will be addressed in appropriate chart documentation as well as care planned during the admission process, as indicated ...The facility shall maintain copies of all Advance Directives ..."			
F0580 SS= D	Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the	F0580	F Tag 580 Resident #99 was reassessed for changes in condition on 02/06/2024, and the notification of changes policy was followed.	2/6/2024

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	resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:		All residents have the potential to be affected by this practice. An audit using a 72-hour progress note was completed to ensure the attending physician and family/responsible person for residents with a change in condition were notified and documented in the medical record, and any concerns identified were addressed. By 02/06/2024, Licensed Nurses were re-educated on the Change in Condition-Reporting Policy to ensure the attending physician and family/responsible party is notified when a resident experiences a change in condition, and there is appropriate documentation of this notification in the medical record. The Director of Nursing/designee will conduct random audits on five residents' weekly times four weeks and then monthly after that times three months or until substantial compliance has been maintained to ensure documentation of notification to the resident's attending physician and family/responsible party in the medical record on change of condition. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Director of Nursing will ensure substantial compliance is attained through this plan of correction by 02/06/2024 and for sustained compliance after that.	

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Based on interview, and record review, the facility failed to notify the responsible party of a change in resident condition in 1 of 25 residents (R99) reviewed for notification of changes, resulting in the resident representative not being made aware of a dental abscess resulting in the lack of ability to participate in timely medical decision-making.

Findings include:

According to the Minimum Data Set (MDS), dated 12/16/2023, R99 was cognitively impaired with a score of 5/15 on his BIMS (Brief Interview Status). Diagnoses included Alzheimer's disease, dementia, and depression. Section J-Pain Management reported the resident had not been on a scheduled, PRN (as needed), or non-medication intervention for pain management regimen in the last 5 days of the quarterly OBRA quarterly review. Section L-Dental did not have documentation regarding R99's dental status.

Further review of R99's MDS Admission Assessment dated, 6/19/2023, reported that the resident did have tooth fragments or missing natural teeth (edentulous), broken natural teeth, mouth or facial pain, discomfort, or difficulty with chewing, or that the resident was unable to be examined.

During an observation and interview on 1/9/2024 at 12:00 PM, R99 was sitting on his bed. The lower left side of his face appeared swollen. R99 stated, "My tooth hurts."

During a telephone interview on 1/9/2024 at 12:00 PM, Guardian "III" stated, "No one at the facility is working with me. The facility does not tell me anything. They do not tell me when they change medications or anything."

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	During an interview on 1/11/2024 at 11:30 AM, Guardian "III" stated, "The social worker is to get ahold of me about (R99). I have not talked to her since September 2023. They (referring to the facility) do not give me information. The only person that told me (R99) is having tooth pain is my uncle when he called me on Tuesday (1/9/2024). No staff has called me to tell me (R99) has another infected tooth. The staff was to call me and let me know what they are going to do for him and again no one is calling. Not the nurses or the social worker." During an interview and record review on 1/11/2024 at 1:39 PM, Social Worker (SW) "U" stated, "About 7 weeks ago the prior social worker left employment with the facility and I became the social work director. I know the guardian is new to (R99). ISW reviewed R99's medical chart, stating, "On 12/24/2023, a nurse manager spoke with R99's guardian at the nurse desk regarding resident's care. That is the last documentation (R99's) guardian was contacted. I have not the time to look into all the residents and their needs."			
F0623 SS= E	Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)	F0623	F Tag 623 Residents #48 and #115's transfers/discharges in the last 30 were reviewed to ensure an appropriate written reason for the transfer/discharge and that the Ombudsman was notified. Resident #72 no longer resides at the facility. Residents who are transferring/discharging have the potential to be affected by this practice. An audit was completed on residents who have transferred/discharged to the hospital in	2/6/2024

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	(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency		the past 30 days to ensure appropriate written reason and notification of the transfer/discharge. The Ombudsman was notified of the transfer/discharge, and any concerns identified were addressed. By 02/06/2024, the Social Services Department was re-educated on submitting the monthly transfer/discharge log to the Ombudsman. The Admin/Designee will conduct random audits on five residents who transferred/discharged weekly, times four weeks, and then monthly after that, times three months, or until substantial compliance has been maintained to ensure appropriate written reason and notification of the transfer/discharge. The Ombudsman was notified of the transfer/discharge. The results will be presented to the QAA committee for review and consideration of further corrective actions.	

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	responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a written reason and/or give notifications of the transfer/discharge for 3 residents (#48, #72, & #115) reviewed for hospitalizations/transfers/discharges, resulting in the Long-Term Care Ombudsman not being notified of transfers/discharges and the potential for residents and/or family being un-informed of the reason for transfer/discharge.			

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Findings include:

Resident #48

Review of Resident #48's "Electronic Medical Record" (EMR) revealed: "Progress note: on 7/6/2023 " Resident #48 was transferred to the "Emergency Room" (ER) for " Acute Care Transfer...Observations and Assessment (Reason for Transfer): (Resident #48) hypotensive/dizzy post unwitnessed fall.

Medical Provider Notification and Orders: (send to) ER for evaluation.."

Review of Resident #48's "Electronic Medical Record" (EMR) revealed: "Progress note: on 7/20/2023 " Resident #48 was transferred to the "Emergency Room" (ER) for " Acute Care Transfer...Observations and Assessment (Reason for Transfer): (Resident #48) abnormal vital signs: hypotensive, tachycardic, febrile, hypoxia...Actual Transfer Time, Transfer Location and Transportation Route: transferred at 0815 by (Emergency Medical Services) EMS via stretcher.."

Resident #72

Review of Resident #72's "Electronic Medical Record" (EMR) revealed: "Progress note: on 1/2/24 at 13:32....Resident #72 was transferred to the "Emergency Room" (ER) for "Acute Care Transfer...Observations and Assessment.."

Review of Resident #72's "Electronic Medical Record" (EMR) revealed: "Progress note: on 12/4/23 at 13:32....(Resident #72) was transferred to the "Emergency Room" (ER) for altered mental status...."

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	Resident #115 Review of Resident #115's "Electronic Medical Record" (EMR) revealed: "Progress note: on 10/2/2023 at 10:17....(Resident #115) was transferred to the "Emergency Room" (ER) for "Acute Care Transfer...Observations and Assessment...." In an interview on 1/11/24 at 10:32 AM., Local "Ombudsman" (Omb) "BBB" reported the local ombudsman's office and herself (Omb "BBB") have not received the required monthly "Emergency Transfer/Discharge" information from the facility or "Social Worker" (SW) responsible for sending the information to her (Omb "BBB") since last year "from May 2023 to present day (1/11/24) this information has not been sent to the ombudsmans office..." In an interview on 1/11/24 at 12:29 PM., Nursing Home Administrator (NHA) "A" reported the "Social Worker" (SW) was responsible for sending monthly notifications of transfers/discharges/hospitalizations to the local ombudsman. NHA "A" reported the Social Worker who was responsible no longer works at the facility, and was not completing the notifications to the ombudsman for quite some time. NHA "A" reported she was unaware this was not being completed until last week.			
F0644 SS= D	Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the	F0644	F Tag 644 The PASARRs and annual level II screenings of residents #66, #76, and #105 were reviewed to ensure they were current and complete. All residents have the potential to be affected by this practice. An audit was completed to ensure that all	2/6/2024

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	PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure annual PASARR assessments were completed timely for 3 residents (Resident #66, #76, and #105) of 5 residents reviewed for PASARR, resulting in the potential for residents to not meet their highest practicable psychosocial well-being. Findings include: Resident #66 Review of an "Admission Record" revealed Resident #66 admitted to the facility on 11/27/2020 with pertinent diagnoses which included depression, anxiety, and adjustment disorder. Review of a "Minimum Data Set" (MDS) assessment for Resident #66, with a reference date of 12/21/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 11, out of a total possible score of 15, which indicated Resident #66 was moderately cognitively impaired. Review of Resident #66's "OBRA PASARR Correspondence", dated 11/19/2021, revealed "...The recipient may be admitted to or remain in the nursing facility and receive mental health services. Further PASARR Level II Evaluations		PASARRs and annual level II screenings were current and complete and that any concerns identified were addressed. By 02/06/2024, the Social Services Department was re-educated on the timely PASARRs and level II annual screening review requirements. The Admin/Designee will conduct random audits on five residents weekly, times four weeks, and then monthly after that, times three months, or until substantial compliance has been maintained to ensure PASARRS and annual level II screenings are current and complete. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Director of Nursing will ensure substantial compliance is attained through this plan of correction by 02/06/2024 and for sustained compliance after that.	

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	(Annual Resident Reviews) are not required... This does not alter the nursing facility's requirement for completing the annual Level I (DCH-3877)..." Further review of the electronic medical record revealed no annual Level I (DCH-3877) completed in 2023. In an interview on 1/11/2024 at 9:10 AM, Nursing Home Administrator (NHA) "A" reported the facility was aware PASARR evaluations were behind and they were working to complete these. Resident #76 Review of an "Admission Record" revealed Resident #76 was a male, with pertinent diagnoses which included: mild cognitive impairment and psychotic disorder with delusions. On 1/10/24 at 1:08 PM, Resident #76's medical record was reviewed for evidence of facility coordination with OBRA (Omnibus Budget Reconciliation Act) for Preadmission Screening and Annual Review (PASARR) Level II screening. A review of a document dated 9/12/22 from "State of Michigan Department of Health and Human Services" for Resident #76 revealed, "To Whom It May Concern: (OBRA Representative name omitted) completed an OBRA Level II Evaluation on the above-named individual and made the recommendation on placement and services. Based on the information provided by this agency, The State of Michigan Department of Health and Human Services made the following ...If the above-named individual remains in the nursing facility, a Level II Evaluation is needed by September 11, 2023."			

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A review of Resident #76's medical record revealed no subsequent Level II Evaluation had been completed.

In an interview on 1/11/24 at 9:20 AM, Social Worker (SW) "U" confirmed that no subsequent OBRA Level II Evaluation had been completed for Resident #76 in 2023 but that there should have been one completed. SW "U" reported the social worker who had been licensed and responsible for coordinating the "PASARR"s no longer worked at the facility. SW "U" reported she had conducted audits of the "PASARR"s and discovered that they were not being done as required. SW "U" reported after that discovery, the facility made a plan to get the required "PASARR"s completed moving forward but at the present time, they were not up to date on the required evaluations.

Resident #105

Review of an "Admission Record" revealed Resident #105 was originally admitted to the facility on 11/14/22 with pertinent diagnoses which included difficulty in walking and muscle weakness.

Review of Resident #105's " Preadmission Screening (PAS)/Annual Resident Review Level 1 Screening dated 7/11/22 revealed, " Resident #105 was listed as Hospital Exempt Discharge with the following the criteria: 1. Resident #105 was being admitted after a hospital stay, and 2. required nursing facility services for the condition for which he/she received hospital care and 3. was likely to require less than 30 days of nursing services..."

Review of Resident #105's record did not reveal a Level I Screening (PAS)/Annual Resident Review for the year of 2023.

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	In an interview on 1/10/2024 at 1:18 PM, Social Worker "U" reported annual PASARR evaluations were not completed in 2023 for Resident #66 or Resident #105. Review of Resident #105"s "OBRA PASARR Correspondence" dated 8/10/22 revealed that "Based on a review of the available information, the recipient (Resident #105) does not meet criteria for a serious mental illness, developmental disability, intellectual disability, or related condition under the PASARR provisions but may have a less than serious mental illness. The recipient (Resident #105) may be admitted to or remain in the nursing facility and receive mental health services... This does not alter the nursing facility ' s requirement for completing the annual Level I (DCH-3877) or reporting significant changes to the CMHSP or their contract agency..."			
F0660 SS= D	Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary	F0660	F Tag 660 Resident #128 no longer resides at the facility. Residents who are discharged have the potential to be affected by this practice. An audit was completed on residents who planned to be discharged in the past 30 days to ensure an appropriate and accurate discharge plan of care. Any concerns identified were addressed. By 02/06/2024, the Social Services Department and IDT team were re-educated on the discharge planning policy. The Admin/Designee will conduct random audits on five residents with a planned discharge in the next two weeks, weekly times four weeks, and then monthly after that times	2/6/2024

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	team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment		three months or until substantial compliance has been maintained to ensure they have an appropriate documented discharge plan and plan of care in place. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Director of Nursing will ensure substantial compliance is attained through this plan of correction by 02/06/2024 and for sustained compliance after that.	

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preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:

This citation pertains to intake MI00141497.

Based on interview, and record review, the facility failed to implement an effective discharge planning process and complete an accurate discharge plan of care in 1 of 2 residents (R128) reviewed for discharge, resulting in the resident being discharged without planned housing or medical care.

Findings include:

During an interview on 1/04/2024 at 3:14 PM, Complainant "JJJ" stated, " (R128) did not have discharge papers or a discharge plan when he came here. He is an older man and would die on the streets if he had no other place to go. When (name of facility) discharged him, he had to walk across 4 lanes of a very busy divided road (name of a State of Michigan highway) while using a walker. He then used every cent of money he had on a hotel room. The manager from that hotel called us (name of a transitional housing for homeless men). (R128) came with no medications, no clothes, no doctor; just came with the clothes on his back and a walker. He was told

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by the facility his insurance days were up. My facility has taken other residents from them with discharge paperwork and medications. I have no idea why they did not call this time for (R128).

He was so beyond himself because he spent one night at a homeless shelter and did not feel safe there. He needs medications and is going to need long term care. He is super skinny, has eczema, a lot of arthritis with a lot of pain. He thought he was going to live at the facility when he was admitted there and was surprised he was let go."

During an interview on 1/11/2024 at 1:30 PM Social Worker (SW) "U" stated, "I started working with (R128) after he got his notice of not meeting level of care, LOCD. He received that on 10/4/2023 with a discharge date of 11/4/2023. He was very independent and took LOAs (leave of absence) on his own. On May 11, 2023, when Covid waivers were lifted, the facility had to do new LOCD reviews and he did not meet requirements for long-term care. He had history of alcohol abuse, fatty liver, and polyosteoarthritis and walked with a walker. He ended up going to the hotel across the street. It is a busy divided 4-lane road. It was on a weekend. The former facility social worker worked with him to get on an apartment list. But nothing was followed through with that person. (R128) told me he did not want to go to the homeless shelter. On November 4 (2023) I was the On-Call manager and was in the facility. He gave me a list of apartments that he got from the former social worker, and he thought we were sending him to one of those that day. No housing was set up for him. I told him if he had money, he could get a hotel room. I gave him a shelter resource list and he would have to find someplace to go. His last date was that day (11/4/2023) he could be in the facility, and it was a weekend. He had to leave the facility." SW "U" reviewed R128's medical records stating, "His discharge instructions said

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	he could not have home health care due to no permanent address. There was no PCP (primary care provider) appointment made for him. He was to call a doctor within 2 weeks of discharge. The facility gave him a LOA pass to reserve a hotel room and he did not come back. He did not get discharge medications. A progress note from a nurse did not mention he got medications. The PA (physician's assistant) can prescribe medications but (R128) did not have a pharmacy to call medications to. He was taking medications for pain, inflammation, BPH, Magnesium, Melatonin, medication for GERD, Zinc, and Miralax (for constipation). The former social worker should have found housing for him. He had nowhere to go. He was such a nice man. He did not have anywhere to go." According to the Minimum Data Set (MDS), 8/20/2023, R128 was cognitively intact with a score of 13/15 on his BIMS (Brief Interview Mental Status), was independent in walking but did not attempt to walk 10 feet on uneven surfaces due to medical condition or safety concerns. His diagnoses included GERD (gastroesophageal reflux disease), BPH (benign prostatic hyperplasia), arthritis, primary nondisplaced neck and radius fracture, and joint replacement.			
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F0684	F Tag 684 Residents #70 and #110 had a neurological assessment completed to ensure there has not been a change in condition related to a history of falls. Resident #110 had an assessment completed by the attending provider related to a weight loss referral from the registered dietician. Residents who have had an unwitnessed fall or a fall resulting in a head injury have the	2/6/2024

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	Based on observation, interview, and record review, the failed to 1.) perform neurological checks after falls for 2 (Resident #110 and #70) of 25 sampled residents, and 2.) ensure that a provider assessment was completed when requested by the Registered Dietician for 1 (Resident #70) of 25 sampled residents reviewed for quality of care resulting in the lack of assessment, monitoring, and documentation and the potential for the worsening of a medical condition and the delay in treatment. Findings include: Resident #110 Review of an "Admission Record" revealed Resident #110, was originally admitted to the facility on 11/9/22 with pertinent diagnoses which included muscle weakness and difficulty in walking. Review of Resident #110's " eINTERACT SBAR Summary for Providers" note dated 1/8/24 revealed, "Situation: The change in condition/s reported on this CIC evaluation are/were: Fall...Outcomes of physical assessment: no information was entered. Positive findings reported on the resident/patient evaluation for this change in condition were: Mental Status Evaluation: no changes observed. Functional Status Evaluation: Fall. Behavioral Status Evaluation: no information entered. Respiratory Status Evaluation: no information entered. Cardiovascular Status Evaluation: no information entered. Abdominal/GI Status Evaluation: no information entered. GU/Urine Status Evaluation: no information entered. Skin Status Evaluation: no information entered. Pain Status Evaluation: Does the resident/patient have pain? no		potential to be affected by this practice. An audit was completed of all residents who had fallen in the past 30 days to ensure neurological assessments were completed on all unwitnessed falls or falls with a head injury. Any concerns identified were addressed. Residents who have experienced weight loss have the potential to be affected by this practice. An audit was completed on all residents who have experienced weight loss in the past 30 days, and the results will be reviewed to ensure that the registered dietitian's recommendations have been followed. By 02/06/2024, Licensed Nurses were educated on the fall policy and neurological evaluation policy to ensure residents who have had an unwitnessed fall or fall resulting in a head injury have neurological evaluations completed per policy and documented in the medical record. By 02/06/2024, the registered dietician was educated on the nutrition monitoring and management program and ensured that any recommendations were appropriately communicated to the IDT team for appropriate follow-up. The DON/Designee will conduct random audits on five residents who have experienced a fall in the past two weeks weekly times four weeks, and then monthly after that times three months or until substantial compliance has been maintained to ensure neurological evaluation has been completed per policy on all unwitnessed falls or falls that resulted in a head injury.	

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	information entered. Neurological Status Evaluation: Nursing observations, evaluation, and recommendations are: none. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: neuron (sic) B. New Testing Orders: No Testing Orders: no information entered. C. New Intervention Orders: no information entered..." Review of Resident #110's " Post Fall Assessment" revealed, " ...Previous interventions: none. New interventions: none. Fall checklist....Y. Initiated neurological assessment for an unwitnessed fall or fall resulting in head injury? Yes..." During an interview on 1/11/24 12:12 PM, Unit Manger (UM) "DDD" reported that Resident #110 had a fall on 1/8/23. UM "DDD" reported that Resident #110 was found on the floor in his room on his back. UM "DDD" reported that nurses were responsible for completing the neuro assessment form and giving it to her. UM "DDD" reported that the nurse missed completing the neuro assessment and she did not have the form for review. During an interview on 1/11/24 at 2:47 PM, Registered Nurse (RN) "CCC" reported that she was the nurse caring for Resident #110 when he fell on 1/8/24. RN "CCC" reported that Resident #110 fell out his wheelchair in his room. RN "CCC" reported that she thought she had completed and documented neurological assessments on a neurological assessment form, but she could not report where she placed the form or why the facility did not have the form to review. Review of the facility's "Fall Policy" dated 7/11/2018 revealed, " Policy: It is the policy of		The DON/Designee will conduct random audits on five residents who have had weight loss in the past 30 days, weekly, times four weeks, and then monthly after that, times three months, or until substantial compliance has been maintained to ensure the registered dietitian recommendations have been completed. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Director of Nursing will ensure substantial compliance is attained through this plan of correction by 02/06/2024 and for sustained compliance after that.	

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this facility to evaluate extent of injury after a fall, prevent complications and to provide emergency care. Procedure: ...5. Initiate neurological checks for any fall where a resident hit his/her head or for any unwitnessed fall..."

Review of Resident #110's "Weights" revealed that Resident #110's weight had decreased from 165.4 pounds to 153.4 pounds from 11/1/23 to 1/10/24.

Review of Resident #110's " Nutrition/Weight" note dated 11/30/23 and documented by Registered Dietician (RD) "L" revealed, "(Resident #110) Resident triggering for weight loss, but not significant per nutrition standards... (Resident #110) continues with a regular diet, mechanical soft texture. He is now dependent for feeding. (Resident #110) reports an "alright" appetite. Intakes fair to good, average of 78.9%. Attempted to obtain preferences, the only change (Resident #110) requested was adding chocolate milk to his meals. Weekly weights in place for monitoring until weight stabilizes. Referral sent to PA (physician assistant) and MD (medical doctor) for further evaluation. Weight alert cleared. RD (Registered Dietician) to continue monitoring, will make adjustments as needed..."

During an interview on 1/11/24 at 10:44 AM, RD" L" reported that she did place a referral for one of the facility providers to assess Resident #110 due to his triggered weight loss. RD" L" reported that the providers would typically follow up with the resident within a few days from the referral. RD "L" reported that she was not sure if any provider had followed up with Resident #110. RD "L" reported that the she would typically check to ensure the resident had been assessed by the provider within a week, and that she had missed this for Resident #110.

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During an interview on 1/11/24 at 2:01 PM, Physician Assistant (PA) " EEE" reported that she did receive a request from RD "L" to evaluate Resident #110 for weight loss due to his weight loss. PA "EEE" reported that Resident #110 was not assessed by her or any other provider in the facility for his weight loss after RD "L" had requested on 11/30/23.

Resident #70

Review of an "Admission Record" revealed Resident #70 admitted to the facility on 1/29/2019 with pertinent diagnoses which included alzeheimer's, cerebral infarction, and repeated falls.

Review of a "Minimum Data Set" (MDS) assessment for Resident #70, with a reference date of 10/19/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 4, out of a total possible score of 15, which indicated Resident #70 was severely cognitively impaired.

In an observation and interview on 1/9/2024 at 1:40 PM in Resident #70's room, Resident #70's right eye was bruised and discolored. Resident #70 reported he lost his balance recently and fell while walking to the sink. Resident #70 reported he struck his eye on his wheelchair when he fell.

Review of Resident #70's electronic medical record on 1/11/2024 at 9:57 AM revealed no documentation of a recent fall or bruising of right eye. Further review revealed the last documented resident fall took place on 12/8/2023.

In an interview on 1/11/2024 at 10:32 AM, Certified Nursing Assistant (CNA) "X" reported she noticed Resident #70's black eye. CNA "X" reported he told her he fell out of bed the prior day when she was not working and struck his eye

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	on the chair. In an interview on 1/11/2024 at 10:36 AM, Licensed Practical Nurse (LPN) "HH" reported she noticed Resident #70's right eye bruise today and discussed this with LPN Unit Manager "V". In an interview on 1/11/2024 at 10:39 AM, LPN Unit Manager "V" reported she discovered Resident #70's eye injury on 1/8/2024 and disussed this with the team at the morning meeting. LPN Unit Manager "V" reported Resident #70 told her he struck his eye on his wheelchair and told others that he had fallen. LPN Unit Manager "V" reported she notified family and the Physician's Assistant of the event, but neurological checks were not completed. LPN Unit Manager "V" reported neurological checks should have been completed and stated, "That's on me." In an interview on 1/11/2024 at 10:56 AM, Director of Nursing (DON) "B" reported the team discussed Resident #70's eye injury on Monday or Tuesday but failed to follow up. DON "B" reported neurochecks should have been completed after this head injury.			
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:	F0695	F Tag 695 Resident #91's BiPAP was cleaned and stored per the physician's order. All residents utilizing BiPAP have the potential to be affected. All residents with a BiPAP were audited to ensure it was being cleaned and stored per physician orders, and any concerns identified were addressed. By 02/06/2024, Licensed Nurses were educated on cleaning and storing the BiPAP	2/6/2024

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Based on observation, interview, and record review, the facility failed to clean and store BiPAP (bilevel positive airway pressure) equipment (a treatment used for sleep apnea - pressurized air is provided through a mask to prevent collapse of the airway) according to the physician's order for 1 resident (Resident #91) of 1 resident reviewed for respiratory care, resulting in an increased potential for respiratory infection and respiratory distress.

Findings include:

Review of an "Admission Record" revealed Resident #91 admitted to the facility on 8/23/2022 with pertinent diagnoses which included obesity, chronic obstructive pulmonary disorder, and obstructive sleep apnea.

Review of a "Minimum Data Set" (MDS) assessment for Resident #91, with a reference date of 11/13/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 11, out of a total possible score of 15, which indicated Resident #91 was moderately cognitively impaired.

Review of Resident #91's active "Physician's Order", started 8/3/2023, revealed "...Cleanse BiPAP equipment... Wash with warm soapy water and rinse in AM, leave out to dry for nighttime use... Once dry cover and place inside drawer..."

In an observation and interview on 1/9/2023 at 1:25 PM in Resident #91's room, Resident #91's BiPAP mask was resting uncovered and dry on his bedside table. Resident #91 reported his mask is often left out by staff.

In an observation on 1/10/2023 at 8:36 AM in Resident #91's room, Resident #91's BiPAP mask was sitting on his bedside table uncovered and

and following physician orders. BIPAP-CPAP-Competency Validation was completed.

The DON/Designee will conduct random audits on five residents utilizing a BiPAP weekly, times four weeks, and then monthly after that, times three months, or until substantial compliance has been maintained to ensure the BiPAP is being cleaned and stored per physician orders.

The results will be presented to the QAA committee for review and consideration of further corrective actions.

The Director of Nursing will ensure substantial compliance is attained through this plan of correction by 02/06/2024 and for sustained compliance thereafter.

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	dry. In an interview on 1/11/2024 at 11:00 AM, Licensed Practical Nurse (LPN) "O" reported BiPAP masks were cleaned on night shift when taken off and left out on the bedside table. LPN "O" checked the phyicician's order and reported the order was to wash the mask and store it covered in the bedside drawer. In an observation and interview on 1/11/2024 at 11:05 AM in Resident #91's room, Resident #91's BiPAP mask was sitting on his bedside table uncovered and dry. Resident #91 reported his mask was not washed that morning and was always stored out on the table and not in his drawer. Resident #91 reported his mask was washed about once a week. In an interview on 1/11/2024 at 11:16 AM, LPN "O" reported she did not wash Resident #91's mask that day. LPN "O" reported she did not cover Resident #91's mask or store it in the drawer. In an interview on 1/11/2024 at 11:23 AM, Director of Nursing (DON) "B" reported BiPAP masks should be washed and then stored covered in the drawer after they are dry, per the physician's order.			
F0697 SS= D	Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F0697	F Tag 697 Resident #99 was assessed to ensure his pain had been assessed, identified, addressed, and resolved. The plan of care will be updated for specific dental pain management. All residents have the potential to be affected. All residents were audited to ensure their pain	2/6/2024

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	Based on observation, interview, and record review the facility failed to ensure adequate pain monitoring and management for 1 resident (R99) of 25 residents reviewed for pain management, resulting in unrelieved dental pain that impacted the resident's eating and functional status of life. Findings included: According to the Minimum Data Set (MDS), dated 12/16/2023, R99 was cognitively impaired with a score of 5/15 on his BIMS (Brief Interview Status). Diagnoses included Alzheimer's disease, dementia, and depression. Section J-Pain Management reported the resident had not been on a scheduled, PRN (as needed), or non-medication intervention for pain management regimen in the last 5 days of the quarterly OBRA quarterly review. Section L-Dental did not have documentation regarding R99's dental status. Further review of R99's MDS Admission Assessment dated, 6/19/2023, reported that the resident did not have tooth fragments or missing natural teeth (edentulous), broken natural teeth, mouth or facial pain, discomfort, or difficulty with chewing, or that the resident was unable to be examined. Review of R99's Care Plans did not have a resident-specific plan of care for dental-specific pain management. During an observation and interview on 1/9/2024 at 11:58 AM, R99 was sitting in his bed visiting with Family Member (FM) "FFF" while talking on speaker phone with his Guardian "III". Guardian "III" stated, "(R99) took antibiotics for 7 days for his mouth. He has an infected tooth; I think it is a left molar." FM "FFF" observed R99 with Surveyor. R99 sat himself to the edge of his bed, opened his lunch tray, and ate all the ice		was adequately assessed, identified, and resolved; any concerns identified were addressed, and care planned. By 02/06/2024, Licensed Nurses were educated on the pain management policy and how to adequately assess pain, identify pain, follow up to ensure it is resolved, and develop a care plan for specific pain management. The DON/Designee will conduct random audits on five residents weekly for four weeks and then monthly after three months or until substantial compliance has been maintained to ensure that residents have adequately had their pain assessed, identified, and resolved. Their care plans have specific pain management. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Director of Nursing will ensure substantial compliance is attained through this plan of correction by 02/06/2024 and for sustained compliance thereafter.	

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cream while placing it in the right side of his mouth. The lower left side of his face appeared swollen. The resident did not eat any other of his food. R99 stated, "My tooth hurts. I cannot eat anything else."

During an observation and interview on 1/09/2024 at 12:34 PM, FM "FFF" went to the nurse's station to let CNA (certified nursing assistant) "EE" know (R99) could not eat because of a painful tooth. The CNA and LPN (licensed practical nurse) "O" went to observe the resident. CNA "EE" stated, "(R99) will not eat his banana. He has not been eating because of his tooth ache for the last week or so. He has complained to me for the past week, and I tell the nurse that is caring for him. He will eat soft foods, but he cannot eat anything else. He will take a protein shake or ice cream. He looks to be in pain." It was noted on R99's MAR/TAR 1/1/2024-1/31/2024 that antibiotics were not ordered or administered prior to this interview.

During an interview on 1/9/2024 at 12:43 PM, LPN "O" stated, "(R99) has not eaten in a week."

During an interview and record review on 1/10/2024 at 9:19 AM, Unit Manager (UM) "D" stated, "In November (2023) (R99) started having tooth symptoms and not eating. He has orders for PRN (as needed) Tylenol. The facility can monitor for pain and try to keep him comfortable." UM "D" reviewed R99's MAR/TAR for the months of November 2023, December 2023, and January 2024, stating, "It was documented that (R99) was only given Tylenol once in November."

During an observation and interview on 1/11/2024 at 10:30 AM, R99 was bed with his breakfast tray next to him set up, with sausage and eggs that were cut up. None of the solid food

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	had been eaten. Resident's left jaw appeared swollen compared to right. At the left corner of resident's mouth was a dried substance appearing to be bloody discharge. Resident was soft spoken, with eyes lowered. He touched his left jaw stating, "It hurts to eat and chew. I can't eat those eggs." During an interview on 1/11/2024 at 10:35 AM, LPN "LL" stated, "I am taking care of (R99) today. I did not know he had dental pain." During an interview on 1/11/2024 at 3:20 PM, Director of Nursing (DON) "B" stated, "He is being treating for dental pain with Tylenol. I'm looking at his notes and the nurses have not charted his pain, and he has not gotten any Tylenol since November 2023. I rely on documentation, and it is not there." Review of R99's Order Summary, 6/12/2023, revealed, "Tylenol (acetaminophen) (pain reducer) oral tablet 325 mg, give 2 tablets by mouth every 4 hours as needed for pain." Review of R99's Medication Administration Record/Treatment Administration Record (MAR/TAR) 1/1/2024-1/31/2024 revealed, "Tylenol Oral Tablet 325 mg (acetaminophen) give 2 tablets by mouth every 4 hours as needed for pain." It was noted the pain reducing medication had not been documented as administered from 1/1/2024 through 1/10/2024 at 14:34:18 ET (Eastern Time).			
F0790 SS= D	Routine/Emergency Dental Srvcs in SNFs §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an	F0790	F Tag 790 Resident #99 dental extraction services have been coordinated. All residents have the potential to be affected.	2/6/2024

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	outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to coordinate dental extraction services, for 1 resident (R99) of 1 resident reviewed for dental care, resulting in delayed dental services and treatment, on-going tooth pain, and an abscessed tooth. Findings include: According to the Minimum Data Set (MDS), dated 12/16/2023, R99 was cognitively impaired with a score of 5/15 on his BIMS (Brief Interview		All residents were audited to identify dental concerns; the facility will coordinate dental services for any identified problems. By 02/06/2024, Licensed Nurses and the Social Service Department were educated on the dental services policy and coordination of dental services. The DON/Designee will conduct random audits on five residents weekly, times 4 weeks, and then monthly after that, times 3 months, or until substantial compliance has been maintained to ensure care coordination for any resident requiring dental services. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Director of Nursing will ensure substantial compliance is attained through this plan of correction by 02/06/2024 and for sustained compliance thereafter.	

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Status). Diagnoses included Alzheimer's disease, dementia, and depression. Section J-Pain Management reported the resident had not been on a scheduled, PRN (as needed), or non-medication intervention for pain management regimen in the last 5 days of the quarterly OBRA quarterly review. Section L-Dental did not have documentation regarding R99's dental status.

Further review of R99's MDS Admission Assessment dated, 6/19/2023, reported that the resident did not have tooth fragments or missing natural teeth (edentulous), broken natural teeth, mouth or facial pain, discomfort, or difficulty with chewing, or that the resident was unable to be examined.

Review of R99's Care Plans did not have a resident-specific plan of care for dental management.

During an interview on 1/09/24 at 11:58 AM, Guardian "III" stated, "(R99) has an infected tooth, I think it is a left molar."

During an observation and interview on 1/9/2024 at 12:00 PM, Family Member (FM) "FFF" observed R99 with Surveyor. R99 sat himself to the edge of his bed. The left side of his face appeared swollen. R99 stated, "My tooth hurts."

During an interview on 1/09/2024 at 12:43 PM, Licensed Practical Nurse (LPN) "O" stated, "(R99) has to be sedated to be seen by the dentist and that does not happen here. The facility is waiting for his guardian to make an appointment. She wanted to have the appointment closer to her."

During an interview and record review on 1/10/2024 at 9:19 AM, Unit Manager (UM) "D" stated, "(R99) has had a tooth abscess. He will not

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let the dentist look in his mouth he has to be sedated. In November he started having symptoms and not eating. The facility's PA (Physician's Assistant) wanted to do bloodwork on (R99) before antibiotics were ordered and the daughter did not want to wait so she took him to an Urgent Care. Their recommendation was a tooth extraction. The daughter said she wanted to find a place that would accept him. The scheduler at that time is not here anymore. That scheduler said she might be able to get him into a dental office that sedates. But that did not happen. She suggested the daughter try to find him a place. There is a new scheduler (Medical Records "GG") but we have not spoken about (R99). The scheduler is responsible to find a place to treat (R99)."

During an interview and record review on 1/10/24 at 10:05 AM, Medical Records "GG" stated, "I do central supply, stock supplies, and schedule for ancillary services including dental. I did not know anything about (R99) needing an appointment for dental extraction with sedation. He is not on my list. He does receive ancillary visiting dental services." Medical Records "GG" reviewed services available to facility residents stating, " I have one dental service that provides sedation that is not our current dentist. They accept Medicaid and our residents can go there. They are good about taking residents in but it may take a few months to get them in, but I have not had to ask if they will quickly take a resident with tooth abscess. As soon as I get an order from PA I can schedule an appointment (R99)."

During an interview on 1/10/2024 at 10:25 AM, ancillary Dentist (DDS) "OOO" stated, "(R99) is not on my list to be seen today. I am providing treatment to residents that are on the list from scheduling. I come to the facility to treat residents."

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During an interview on 1/10/2024 at 3:45 PM, Director of Nursing (DON) "B" stated, "In passing today, I told (Medical Records "GG") we would talk about getting (R99) a dental appointment."

During an interview on 1/10/2024 at 3:48 PM, Medical Records "GG" stated, "I have not seen (DON "B") all day. I've been in the back of the facility putting away supplies.

During an observation and interview on 1/11/2024 at 10:30 AM, R99 was sitting in his bed with a blanket over his head. He took the blanket off his head. R99's left jaw appeared swollen compared to his right jaw. At the left corner of resident's mouth was a dried substance appearing to be bloody discharge. Resident was soft spoken, with eyes lowered. He touched his left jaw stating, "It hurts to eat and chew."

During an interview on 1/11/2024 at 10:40 AM, LPN "L" stated, "I checked with nursing management and (R99's) family is to make an appointment with a dentist that does sedation."

During an interview on 1/11/2024 at 11:30 AM, FM "III" stated, "Facility staff told me the dentist comes to the facility to see (R99) and he refuses. Twice he had the infection in the same tooth. The facility is to find a dentist see him. (UM "D") told me the facility was going to find him a dentist that took his insurance and could see him. I have taken him to the Emergency Room (ER) for a tooth infection. The ER told me to talk to the facility to have it taken care of. The ER told me to tell the facility I wanted to have the tooth removed it. If the facility tells me he refuses I am to tell the facility I am his guardian and I want it pulled. The facility is not waiting on me for anything (referring to arranging a dental appointment for R99). I would take him, but the

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facility told me they were going to get (R99) an appointment."

During an interview and record review on 1/11/2024 at 1:39 PM, Social Worker (SW) "U" stated, "I heard yesterday, 1/10/2023, that (R99) needed a dental appointment. Prior to that I knew nothing."

During an interview and record review on 1/11/2024 at 3:20 PM, Director of Nursing (DON) "B" stated, "I looked into (R99's) medical chart and the medical records coordinator had retired. Medical Records "GG" took over about a month ago. He was seen by the ancillary visiting dentist, and they saw the root exposed. They said the tooth needed to be extracted. Ultimately, he needs the tooth out. The disconnect began with the former medical records that did not hand off her information to the new Medical Records "GG"."

Review of R99's Summary Report (dental appointment) dated 12/4/2023, reported the resident was seen and completed a comprehensive oral evaluation including radiographs (xrays) that revealed a retained root for tooth #14 (upper left molar).

Review of facility policy "Dental Services", adopted 7/11/2028, reported, "It is the policy of this facility to ensure routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care ...Routine and 24-hour emergency dental services are provided to our residents through a contract agreement with a licensed dentist ...Referral to community dentists or Referral to other health care organizations that provide dental services. A list of community dentists will be made available upon request ...Social services representatives

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	will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible ..."			
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: Based on observation, interview, and record review, the facility failed to ensure a resident received food in an appropriate texture to optimize intake and meet individual needs for 1 resident (R99) of 25 residents reviewed for food and drink, resulting in food being difficult to chew and decreased food acceptance. Findings include: According to the Minimum Data Set (MDS), dated 12/16/2023, R99 was cognitively impaired with a score of 5/15 on his BIMS (Brief Interview Status). Diagnoses included Alzheimer's disease, dementia, and depression. During an observation and interview on 1/9/2024 at 12:00 PM, Family Member (FM) "FFF" observed R99 with Surveyor. R99 sat himself up to the edge of his bed, opened his lunch tray. He opened an ice cream cup, place it in the right side of his mouth. The lower left side of his face appeared swollen. The resident did not eat any other food. R99 stated while placing his hand on the left side of his face, "My tooth hurts. I cannot eat anything else." During an observation and interview on 1/09/24	F0805	F Tag 805 The registered dietitian and speech therapist assessed resident #99 to ensure the food texture was appropriate for his needs. All residents with dental concerns have the potential to be affected. An audit was completed to ensure that the food texture was appropriate for their needs and that any concerns identified were addressed. The registered dietician/designee will conduct random audits and observations on five residents weekly, times four weeks, and then monthly after that, times 3 months, or until substantial compliance has been maintained to ensure the food texture is appropriate to meet their needs. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Director of Nursing will ensure substantial compliance is attained through this plan of correction by 02/06/2024 and for sustained compliance thereafter.	2/6/2024

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at 12:34 PM, FM "FFF" went to the 400-hall nurse's station to let CNA (certified nursing assistant) "EE" know (R99) could not eat because of a painful tooth. The CNA and LPN (licensed practical nurse) "O" went to observe R99. LPN "O" stated, "The facility has already treated his tooth. I gave him medicine this morning." The CNA stated, "He will not eat his banana. He has not been eating because of his tooth ache for the last week or so. He has complained to me for the past week, and I tell the nurse that is caring for him. He will eat soft foods, but he cannot eat anything else. He will take a protein shake or ice cream."

During an interview on 1/09/24 at 12:43 PM, LPN "O" stated, "(R99) has not eaten in a week."

During an observation and interview on 1/1/2024 at 10:30 AM, R99 was in bed with his breakfast tray next to him set up. The sausage and eggs were cut up. A glass of juice was empty. None of the solid food appeared eaten. R99's left jaw appeared swollen compared to right. R99 touched his left jaw stating, "It hurts to eat and chew. I can't eat those eggs. I want something sweet to eat." It was noted nothing sweet was on the tray.

Review of R99's Order Summary, 6/12/2023, reported the resident was on a regular diet-regular texture.

During an interview on 1/11/2024 at 3:20 PM, Director of Nursing (DON) "B" stated, "Dietary was told he is having issues chewing in morning meetings and to give easier foods to chew but I don't see it in his notes."

Review of R99's Baseline/Interim Care Plan, 6/13/2023, reported his diet order was a regular diet, regular texture, and thin liquids. Nutritional concerns had been identified on

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	evaluation/assessment, but none were listed. The focus and goal were a nutritional problem or the potential for nutritional problem related to medical conditions that affected intake. It was noted the medical conditions were not identified. Interventions to meet the goal included monitoring intake and record every meal, and report changes in consumption to nurse and/or dietician. Review of R99's Care Plan, Nutritional Problem or Potential Nutritional Problem (revision 12/28/2023), related to diagnoses that included Alzheimer's disease, with a history of variable/poor intakes with weight loss. The Goal was to maintain adequate nutritional status. Interventions to meet these goals included obtaining preferences frequently, offer alternatives at mealtime if dislike or intolerance of served items, serve diet as ordered, and the RD (registered dietician) was to evaluate and make diet change recommendations PRN (as needed). It was noted no dietary preferences were identified. Review of R99's Dietary Evaluation-Admission, 6/16/2023, reported the resident was to have regular diet texture, with no dislikes, but really liked dessert. Staff were to offer/provide alternatives as needed. Resident had natural teeth denying difficulty chewing/swallowing, and facility would continue to monitor intake. It was noted no further dietary evaluations had been completed. Review of R99's Dental Summary Report, 12/4/2023, reported the resident received a comprehensive oral evaluation, including radiographic images with missing 9 teeth (edentulous) (#s 1, 2, 9, 17-19, and 30-32) and a retained root (#14).			
	Resident Records - Identifiable Information	F0842	F Tag 842	2/6/2024

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F0842 SS= D	§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a		Resident #24 no longer resides at the facility. All residents have the potential to be affected. An audit of the MARs/TARs for the past seven days was conducted to ensure that no missed opportunities for documentation were missed and that any concerns were addressed. By 02/06/2024, Licensed Nurses were educated on the charting and documentation policy, specifically “holes” in the MAR/TAR. The DON/Designee will conduct random audits on five residents weekly, times 4 weeks, and then monthly thereafter, times 3 months, or until substantial compliance has been maintained to ensure no missed opportunities for documentation in the MAR/TAR. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Director of Nursing will ensure substantial compliance is attained through this plan of correction by 02/06/2024 and for sustained compliance thereafter.	

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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:

Based on interview and record review, the facility failed to maintain complete and accurate medical records in 1 (Resident #24) of 25 residents reviewed for accuracy of medical records, resulting in the potential for providers to not have an accurate picture of resident status and condition.

Findings include:

Review of an "Admission Record" revealed Resident #24 was a female, with pertinent diagnoses which included: hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), vascular dementia, and type 2 diabetes mellitus (a condition where the body is not able to properly use sugar from the blood).

Review of a "Physician's Order" for Resident #24 revealed, "Blue boot to right foot while in bed as tolerated every shift for DTI (deep tissue injury) Verbal Active Order Date 09/26/2023 Start Date 09/27/2023"

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	Review of Resident #24's MAR/TAR (Medication Administration Record / Treatment Administration Record) for October, 2023 revealed opportunities (check boxes) for documentation of application of the boot daily at 7 AM and 7 PM. Of the 62 "opportunities" (31 days x 2 times per day) for boot application in October, 4 check boxes were left blank (no documentation). Review of Resident #24's MAR/TAR (Medication Administration Record / Treatment Administration Record) for November, 2023 revealed opportunities (check boxes) for documentation of application of the boot daily at 7 AM and 7 PM. Of the 60 "opportunities" (30 days x 2 time per day) for boot application in November, 4 check boxes were left blank (no documentation). Review of Resident #24's MAR/TAR (Medication Administration Record / Treatment Administration Record) for December, 2023 revealed opportunities (check boxes) for documentation of application of the boot daily at 7 AM and 7 PM. Of the 62 "opportunities" (31 days x 2 times per day) for boot application in December, 3 check boxes were left blank (no documentation). Review of Resident #24's MAR/TAR (Medication Administration Record / Treatment Administration Record) for January 1 - January 10, 2024 revealed opportunities (check boxes) for documentation of application of the boot daily at 7 AM and 7 PM. Of the 20 "opportunities" (10 days x 2 times per day) for boot application in January, 2 check boxes were left blank (no documentation). Review of a "Physician's Order" for Resident #24 revealed, "Right Medial Heel wound: Cleanse			

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	with NSS/Wound cleanser. Apply betadine to 2x2, cover ABD, wrap with kerlix. right medial heel every night shift for DTI (deep tissue injury) Verbal Active Order Date 12/21/2023 Start Date 12/21/2023" Review of Resident #24's MAR/TAR (Medication Administration Record / Treatment Administration Record) for January 1 - January 10, 2024 revealed opportunities (check boxes) for documentation of ordered wound treatment to right medical heel daily at 7 PM. Of the 10 "opportunities" (10 days x 1 time per day) in January, 1 check box was left blank (no documentation). In an interview on 1/11/24 at 2:57 PM, "Director of Nursing" (DON) "B" reviewed Resident #24's MAR/TAR documentation with this surveyor and agreed that there was missed items, "holes" in the documentation but should not be. In an interview on 1/11/24 at 3:28 PM, "Nursing Home Administrator" (NHA) "A" reviewed Resident #24's MAR/TAR documentation with this surveyor and agreed that documentation was missing in some areas for the ordered interventions/treatments. According to Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing. "...High-quality documentation is necessary to enhance efficient, individualized patient care. Quality documentation has five important characteristics: it is factual, accurate, complete, current, and organized..." Accessed from: Kindle Locations 24106-24108). Elsevier Health Sciences. Kindle Edition.			
F0880	Infection Prevention & Control §483.80 Infection Control The facility must establish	F0880	F Tag 880 It is the practice of this facility to establish an	2/6/2024

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SS= E	and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The		infection prevention and control program (IPCP). DOR “NN, SW “U, RD “L, CNA “JJ”, and LPN “O” received education on appropriate PPE and hand hygiene when entering and exiting rooms under transmission-based precautions and providing meal service. The facility has ensured that all residents under transmission-based precautions have an infection control cart outside their door with appropriate PPE for facility staff. All residents have the potential to be affected. By 02/06/2024, all staff were educated on transmission-based precautions, specifically hand hygiene and appropriate PPE when entering and exiting the room and ensuring the infection control carts are appropriately stocked with PPE. DON/designee will randomly audit five staff weekly, times four weeks, and then monthly, after that, times three months, or until substantial compliance has been maintained to ensure hand hygiene when entering and exiting resident rooms and during meal service. DON/designee will randomly audit five staff weekly times four weeks and then monthly after three months or until substantial compliance has been maintained to ensure appropriate PPE is used when entering and exiting resident rooms under transmission-based precautions. DON/designee will randomly audit five residents under transmission-based precautions weekly for four weeks and then monthly after three months or until substantial compliance has been maintained to ensure they have infection control carts outside their	

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	hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow standards of practice and ensure 1.) proper hand hygiene was completed during meal services, as well as when staff entered and exited resident rooms which included "Transmission Based Precaution" (TBP) rooms for residents with infections including but not limited to Covid-19 2.) failed to ensure required PPE supplies/equipment were available to staff and visitors for use prior to entering TBP rooms, resulting in the potential for the introduction of infection, cross-contamination, and disease transmission. Findings include: During an observation on 1/09/24 at 2:08 PM in the hall outside of room 406 the hand sanitizer machine was not working properly. According to the Admission Record, R228 was admitted on 1/8/2023 with diagnoses that included acquired absence of right leg, diabetes mellitus, hypertension, and chronic kidney disease. During an observation and record review on		rooms and stocked with appropriate PPE. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Director of Nursing will ensure substantial compliance is attained through this plan of correction by 02/06/2024 and for sustained compliance thereafter.	

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	1/9/2024 at 2:10 PM, R228's door had signage stating, "Special Droplet/Contact Precautions In addition to Standard Precautions. Everyone must: Including visitors, doctors, and staff: clean hands when entering and leaving room. Wear mask Fit tested N95 or higher required when doing aerosolizing procedures. Wear eye protection (face shield or goggles) Gown and glove at door. Keep Door closed. Use patient dedicated or disposable equipment. Clean and disinfect shared equipment." Observed Director of Rehab (DOR) "NN", Social Work Director (SW) "U", and Registered Dietician (RD) "L" wearing N95 masks, don disposable gowns. None of the staff used hand sanitizer or donned gloves prior to entering the room. At 2:21 PM, the 3 staff exited R228's room. None of the staff changed out their N95 mask to a new, clean mask. DOR "NN", SW "U", and RD "L" stated, "We have been trained on PPE infection control for Covid. We saw (R228), he is a new admit. His roommate is on precautions because he is Covid positive. We did not use hand sanitizer before we donned our gowns because there was no hand sanitizer available outside the room. We did not don gloves before we entered the room because there were no gloves in the isolation cart. We did not put on clean masks or change masks when we went in the room or exited it." Observed the 3 staff walk down the 400 hall and through the facility. Observed directly across the hall a box of gloves sitting on the chair rail. During an observation and interview on 1/09/24 at 2:17 PM, Certified Nursing Assistant (CNA) "JJ", donned a disposable gown and gloves without using hand sanitizer or eye protection and entered room 410 that had Special Droplet/Contact Precautions" signage on the door. She was wearing a N95 mask she had on when entering the hall. Upon exiting the room, CNA "JJ" did not put on a new, clean N95 mask, stating, "I did not put on eye protection when I			

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entered the room or change my N95 mask." The CNA continued down the hall delivering waters to other residents.

During an observation and interview on 1/09/24 at 2:30 PM, Licensed Practical Nurse (LPN) "O" stated, "I was putting goggles in isolation carts because none of them had them. There is no hand sanitizer in isolation carts for room 412, 412, 409, and 410. They are Covid rooms. I have been trying to get clarification on isolation room precautions. It is not clear from management on how long residents need to be on isolation. The residents are asking too. When going into a Covid positive/special precautions room, staff should use hand sanitizer, don gown, gloves, eye protection, and wear a N95 mask. When exiting rooms, we are to change out masks and put a new one on."

During an observation and interview on 1/09/24 at 2:37 PM, CNA "JJ" entered room 411 a designated Special Droplet/Contact Precautions room, donning disposable gown, gloves, and eye protection with using hand sanitizer. Hand sanitizer was not available outside of the room. Upon exiting the room, she had doffed her gown and gloves, and used hand sanitizer that was just inside the door. She did not change out her N95 mask and entered room 410, a designated Special Droplet/Contact Precautions room. At 2:59 PM, the CNA exited the room wearing eye protection and a N95 mask. She did not change out her N95 mask. CNA stated, "I did not change out my N95 mask. I have not been told to change it out when exiting Covid positive rooms."

Observed on 1/09/24 at 3:08 PM, rooms 409, 410, 411, and 412 had Special Droplet/Contact Precautions signage on door. Rooms 409, 410, and 412 had isolation carts with no gloves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414290	A. BUILDING ______ B. WING ______	1/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BELTLINE	**2320 E BELTLINE SE GRAND RAPIDS, MI 49546**

(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
	During an observation on 1/09/24 at 3:12 PM, room 308 had Neutropenic Precautions signage on the door with no isolation cart outside of door. During an interview on 1/11/24 at 3:20 PM, Director of Nursing (DON) "B" stated, "I am the Infection Control Preventionist. When staff enter a Covid positive room you can wear the N95 mask you had on, but on exit you would doff it, put it in the garbage and don a new one." This is CDC (Centers for Disease Control) guidance which our policy matches. Staff has been trained to remove the N95 masks upon exiting a room. By not doing this it increases the transmission rate of Covid-19 to residents and themselves." During an observation on 1/9/24 at 3:01 PM, noted Rooms 504 and 505 each had signage on the room doors that read, "Special Droplet/Contact Precautions - In addition to Standard Precautions - Only essential personnel should enter this room - If you have questions ask nursing staff - Everyone Must: (including visitors, doctors, staff) Clean hands when entering and leaving room Wear face mask. Wear eye protection. Gown and glove at door. N95 Respirator. Keep Door Closed. Use patient dedicated or disposable equipment. Clean and disinfect shared equipment. Contact infection control prior to discontinuing precautions" There were plastic bins next to the doorways outside of both Rooms 504 and 505 that contained Personal Protective Equipment (PPE) supplies. A thorough search of both the said plastic "PPE" supply bins revealed that no N95 Respirators were present so that staff could doff their N95 and don a new one when exiting the rooms. In an observation on 1/9/2024 at 12:08 PM in room 618, Certified Nursing Assistant (CNA) "S"			

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	414290	A. BUILDING ______ B. WING ______	1/12/2024

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	passed a lunch tray to the resident in 618-1, retrieved a tray from the hallway cart without performing hand hygiene and passed a tray to the resident in 618-2, hands coming into contact with items on the resident's tray tables. CNA "S" then left the room and without performing hand hygiene took another tray from the cart in the hallway and entered another resident's room down the hall to set up another lunch tray. In an interview on 1/9/2024 at 12:57 PM, CNA "S" reported staff are required to perform hand sanitization in between every resident contact.			