STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	394160	A. BUILDING _____ B. WING _____	2/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF WESTWOOD	2575 N DRAKE ROAD KALAMAZOO, MI 49006

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F0000 SS=	INITIAL COMMENTS Medilodge of Westwood was surveyed for an Abbreviated survey from 2/7/24 - 2/15/24. Intakes: MI00136843, MI00137001, MI00137006, MI00137198, MI00139439, MI00139676, MI00139914, MI00140233, MI00141496, MI00141758, MI00141830. Census=80	F0000		
F0600 SS= D	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00140233. Based on interview, and record review, the facility failed to protect the residents right to be free from staff to resident verbal abuse in 1 of 4 residents (Resident #207) reviewed for abuse, resulting in the potential for a decline in physical, mental, and psychosocial well-being. Findings include:	F0600	Element 1 Resident 207 no longer resides in the facility. CENA was immediately suspended pending investigation and terminated upon completion of investigation. Resident was interviewed at the time and no ill effects per resident. Social Service did follow up with the resident and stated content with care with no further concerns identified. Facility reported the allegation to MiFRI. Element 2 Residents that are in the facility have the ability to be effected. Residents who are alert and oriented with BIMS 8 or higher were interviewed for allegations of abuse. If allegation identified, allegation will be reported per CMS guidelines. Residents with BIMS below 8 will receive a skin and pain assessment. Residents with identified concerns related to abuse will be reported per CMS guidelines. Element 3 The Administrator and DON reviewed the Abuse policy and deemed it appropriate. Policy reviewed at QAPI.	2/19/2024

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

Electronically Signed | 03/05/2024

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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	Review of an "Admission Record" revealed Resident #207 was originally admitted to the facility on 9/28/23, with pertinent diagnoses which included: overactive bladder and history of falling. Review of a "Minimum Data Set" (MDS) assessment for Resident #207, with a reference date of 10/3/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #207 was cognitively intact. Review of Resident #207's "Kardex (care guide)" indicated that she required assistance of 1 person for toileting and transfers. Review of Resident #207's "Alleged Abuse Incident Report" dated 10/4/23 at 10:00 PM revealed, "...Resident reports that CENA (certified nursing assistant) came into her room and stated "If you press that call light one more time, I am going to take it away from you." Resident is able to give a physical description of CENA and what she was wearing but is not able to recall her name. Immediate action taken: Through investigation and review of schedule, it was determined that (Certified Nursing Assistant (CNA) "Z") was the CENA providing care to resident at the time of the alleged abuse. (CNA "Z") was immediately placed on suspension pending investigation...At the conclusion of the investigation it was substantiated...(CNA "Z") was terminated..." In an interview on 2/8/24 at 3:54 PM, Resident #207 reported that she had an overactive bladder and needed to use the bathroom frequently when she resided at the facility. Resident #207 reported that she had to wait long periods of time for her call light to be answered, and frequently staff would complain and say that she had just been in		Staff educated on abuse policy including verbal and misappropriation. Allegations of abuse will be immediately reported and thoroughly investigated. Element 4 The administrator/ designee will audit 5 staff members per week to ensure understanding of abuse and reporting for 4 weeks then monthly thereafter. The administrator/ designee will audit 5 residents per week to ensure no abuse allegations for 4 weeks then monthly thereafter. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Administrator is responsible for compliance.	

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	the bathroom. Resident #207 reported that one night around 10:00 PM, she had her call light on to use the bathroom and a CNA came into her room and stated, "...if you don't stop this I am gonna take it away from you..." Resident #207 reported that after the incident, she was afraid to press her call light because she didn't know what kind of treatment she was going to get, and that was the "last straw"; she discharged home soon after the incident. In an interview on 2/8/24 at 11:45 AM, Registered Nurse (RN) "N" reported on 10/4/23 CNA "Z" came to her "fit to be tied" and upset, requesting that RN "N" go and help Resident #207. RN "N" reported that CNA "Z" said that Resident #207 was making her crazy. RN "N" told CNA "Z" to go take a break and that RN "N" would assist Resident #207. RN "N" reported that when she entered the room, Resident #207 was hysterical, complaining of pain and requesting to use the bathroom. RN "N" reported that CNA "Z" had a hard personality, and that she believed that CNA "Z" had told Resident #207 that she was going to take away her call light. In an interview on 2/13/24 at 2:54 PM, Speech Therapist (ST) "RR" reported that she was working with Resident #207 on 10/5/23 when she reported that a CNA had threatened to take away her call light the night before. ST "RR" stated, "...it definitely heightened her anxiety...she had an anxious undertone...she was worrying about not getting help when she needed it..." ST "RR" reported that in her experience, Resident #207 was cognitively intact and competent. ST "RR" reported the allegation to NHA immediately. In an interview on 2/13/24 at 12:30 PM, CNA "Z" reported that on 10/4/23 Resident #207 had pressed her call light a lot, but that she did not recall any issues. CNA "Z" reported that she did			

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	not have any stress during her shift and was not frustrated with Resident #207, nor did she threaten to take away her call light. In an interview on 2/13/24 at 4:37 PM, DON reported that on 10/4/23 CNA "Z" was not happy and got upset that DON was helping answer call lights for her assigned residents. DON reported everyone knew CNA "Z" had a bad attitude and if a resident knew CNA "Z" was working they would say, "oh no." In an interview on 2/13/24 at 9:10 AM, CNA "W" reported that CNA "Z" was very loud, residents complained that they didn't like the way she treated them, and CNA "Z" always complained about the resident assignment that she had. Review of CNA "Z's" "Performance Improvement Form" dated 10/11/23 revealed, "...Employee is being discharged due to violation of code of conduct #1. Violating the rights of residents and patients including abuse, neglect..." Review of a facility policy "Abuse, Neglect and Exploitation" last revised 1/10/24 revealed, "...Prevention of Abuse, Neglect and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse...B. Identifying, correcting, and intervening in situations in which abuse...is more likely to occur...C. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect...H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors..."			
F0602	Free from Misappropriation/Exploitation §483.12 The resident has the right to be free	F0602	Element 1	2/19/2024

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SS= D	from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake # MI00141758. Based on interview, and record review, the facility failed to prevent the misappropriation of controlled resident medications in 2 of 5 residents (Resident #212 and #201) reviewed for misappropriation of property, resulting in loss of resident's pain medication, and the potential for uncontrolled pain and discomfort. Findings include: Resident #212 Review of a "Minimum Data Set" (MDS) assessment for Resident #212, with a reference date of 11/12/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #212 was cognitively intact. Review of Resident #212's "Medication Administration Record (MAR)" revealed orders for Percocet (narcotic pain medication) 10-325 mg one pill to be given as needed every 4 hours for pain. The record indicated that 47 of 48 doses had been administered between the hours of 8:00 AM and 11:00 PM for December 2023, and 1 dose had been documented as administered at 3:18 AM on 12/26/23 by RN "II".		Resident 212 remains in the facility, and has no ill effects from the deficient practice. Resident 212 received medication at next scheduled time which was at 0925 with a follow up pain level of 1. Nurse identified was suspended pending investigation on 12/26/23. Resident 201 no longer resides in the facility. Resident 201 was discharged on 1/28/24. Deficient practice occurred on 12/26/23 at 4am. Resident 201 received pain medication at next scheduled time which was at 1324 on 12/26/23 with follow up pain level of zero. Nurse identified was suspended pending investigation on 12/26/23. Element 2 Residents have the potential for drug diversion and are at risk to be affected by the deficient practice. Residents who are alert and oriented with BIMS 8 or higher were interviewed to ensure receiving medication. Residents who report not receiving medications will have an investigation initiated. Residents with BIMs less than 8 will have a PAINAID completed and concerns identified will be investigated to ensure receiving medications per order. Element 3 The Administrator and DON reviewed the Controlled Substance and Accountability policy and deemed it appropriate. Policy reviewed at QAPI. Licensed Nurses educated on the Controlled Substance and Accountability policy	

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	In an interview on 2/9/24 at 12:15 PM, Resident #212 reported that she did not take Percocet during the night. Resident #212 reported that on the night of 12/25/23 into 12/26/23, she was awake all night long watching movies, and did not request or receive any pain medication from Registered Nurse (RN) "II". Resident #212 reported that RN "II" had been in her room earlier that evening and had been acting strange. In an interview on 2/9/24 at 9:00 AM, RN "I" reported that on 12/26/23, she was taking over the B hall medication cart from RN "II", and that RN "II" couldn't stand still, she was not making sense, and was making unusual movements with her mouth during report. RN "I" reported that RN "II" had counted and signed the narcotic count sheet herself, so RN "I" decided to repeat the narcotic count behind RN "II". While performing narcotic count, RN "I" had discovered that RN "II" documented Percocet had been administered during the night to Resident #212, so RN "I" checked in with Resident #212 to make sure that she was feeling ok, since she did not normally take pain medication during the night; Resident #212 denied having pain during the night, and/or taking Percocet. Review of RN "II's" employee file, included onboarding documents from 2015 and 2023, and no documents related to discipline and/or termination of employment for 2015 or 2023. In an interview on 2/8/24 at 4:12 PM, NHA reported that RN "II" had been previously employed at the facility in 2015, and then again for a very short time in 2023 (11/21/23-12/31/23), that there were no documents available related to her resignation and/or termination in 2015, and that RN "II" had voluntarily resigned on 12/31/23. NHA denied having any knowledge of RN "II" having disciplinary actions in 2015 and		Narcotic Diversion when identified will be reviewed immediately and investigated. Element 4 The administrator/ designee will audit 10 residents weekly related to ensuring receiving medications x 4 weeks then monthly thereafter. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Administrator is responsible for compliance.	

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	that she did not have any disciplinary actions during her time with the facility in 2023, but would print RN "II's" resignation letter for this surveyor to review. In an interview on 2/9/24 at 9:51 AM, RN "II" reported that she resigned from the facility in December 2023, after being suspended pending an investigation of medication records. RN "II" reported that the facility did not tell her what the concern was about, and after a few days with no communication, she decided to resign. In an interview on 2/9/24 at 10:09 AM, Regional RN (RRN) "NN" reported that she had been notified on 12/26/23 at approximately 8:00 AM by RN "I" of a narcotic diversion concern; RN "II" had documented the administration of Percocet to Resident #212 at 3:18 AM on 12/26/23, but the resident had reported that she did not request or receive the medication. RRN "NN" reported that the concern was discussed in morning meeting with NHA, and then an investigation was started. RRN "NN" interviewed several staff members that reported RN "II" had been fidgety, and acting strange during her shift from 12/25/23 at 10:00 PM-12/26/23 at 6:00 AM. RRN "NN" reported that Resident #212 was alert, oriented and competent. When RRN "NN" interviewed Resident #212, she had denied receiving Percocet at 3:18 AM on 12/26/23, as it had been documented by RN "II". RRN "NN" reported that she called RN "II" in for an interview on 12/26/23 at approximately 3:00 PM (7 hours after the allegation) regarding the allegation, and then placed her on suspension pending the full investigation. RRN "NN" did not request that RN "II" complete a drug test. Prior to the completion of the investigation, on 12/31/23, RN "II" resigned, therefore RRN "NN" did not investigate any further. RRN "NN" reported that there was no proof that RN "II" had misappropriated Resident #212's Percocet. This			

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	surveyor requested the investigation file for review. Review of the "Investigation File" provided by NHA included a performance improvement form for RN "II" dated 12/26/23 for "possible drug diversion", and witness statements from RN "II" dated 12/26/23 at 3:00 PM, RN "I" dated 12/26/23 at 2:40 PM, LPN "J" on 12/27/23, CNA "VV" on 12/27/23, & LPN "G" on 12/27/23. There were statements from Resident #212, and #201, indicating that they had not received the medication that RN "I" documented having administered on 12/26/23. There were narcotic count sheets from 6 additional residents that had received narcotics during RN "I's" shift from 12/25/23 at 10:00 PM-12/26/23 at 6:00 AM, along with the residents' witness statements. Two of the six witness statements from residents were not completed, and the remaining four indicated that the residents were not able to recall whether they received the medication or not. The file did not include witness statements from RN "Q" that had reported off on second shift with RN "II" on 12/25/23, and/or RN "Y" that received report and counted narcotics with RN "II" on 12/26/23 for "C" hall. The file also did not include a witness statement from Unit Manager (UM) "DD". In an interview on 2/9/24 at 11:23 AM, NHA reported that RN "II" was not required to drug test per facility policy related to the allegation of narcotic drug misappropriation on 12/26/23. NHA reported that she had interviewed Unit UM "DD" who had performed narcotic count with RN "II" on 12/26/23, and UM "DD" did not have a concern with how RN "II" was acting, therefore there was no grounds to drug test. (see below for UM "DD's" interview) NHA reported that RN "II" did not appear under the influence on 12/26/23 at 3:00 PM when she was brought into the facility to be interviewed. NHA reported that the fact that residents had reported that they did			

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	not receive their narcotic medications was hearsay, and because all of RN "II's" documentation was in place, there was no proof that medications had been misappropriated. NHA reported that because RN "II" had already left the facility when the allegation was made, they were not able to request that she be drug tested. In an interview on 2/9/24 at 2:11, UM "DD" reported that she had worked on 12/26/23, the day that the narcotic diversion allegation occured, but had arrived after RN "II" had gone home for the day. UM "DD" reported that there was only one day (unknown) that she had worked with RN "II"; RN "II" was all over the place on that day, and UM "DD" could see in her eyes that she was tired. UM "DD" reported that that was the only time she had worked with RN "II", because RN "II" worked third shift and UM "DD" worked first shift. UM "DD" reported that she had not provided a witness statement to NHA related to RN "II's" actions or condition on 12/26/23, but had discussed RN "II" with NHA prior to 12/26/23 due to staff complaints that RN "II" had appeared to be working while under the influence of drugs or alcohol. In an interview on 2/9/24 at 12:46 PM, RN "Q" reported that at the end of her shift (second shift) on 12/25/23 she gave report to RN "II" and stated, "...she was hyper all the time, but that specific day was unusal..." RN "Q" reported that RN "II" was in a big hurry and was not listening to report, and that RN "II" kept saying things like, "...ok, ok, keep going, keep going..." In an interview on 2/9/24 at 1:26 PM, Staff Member "JJ" reported that she had observed RN "II" on 12/25/23 at 6:00 AM acting like she was high on drugs, and extremely nervous. Staff Member "JJ" reported that she informed NHA and former DON about her concerns, and they			

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	told her that there was nothing they could do because the nurse had already left the facility. Staff Member "JJ" reported that RN "II" worked again the next day (third shift), and then was suspended. In an interview on 2/8/24 at 11:15 AM, Licensed Practical Nurse (LPN) "E" reported that she had worked with RN "II" on third shift (date unknown), and had noticed that she was moving very fast, rocking back and forth, her mouth was twisted, her nose was red and she would disappear for 30-45 minutes at a time. LPN "E" reported that she notified Facility Staff (JJ) and NHA, but was told that there was nothing that the facility could do about it, because LPN "E" had already left the facility. LPN "E" reported that RN "II" quit a few days later, after being suspended for suspected narcotic diversion. LPN "E" reported that it was not typical for Resident #212 to take pain medications during the night. In an interview on 2/9/24 at 1:41 PM, LPN "H" reported she had expressed concerns about RN "II" being under the influence of drugs or alcohol while working, to the NHA and DON on multiple occasions. LPN "H" reported that there were several times when RN "II" could not hold a conversation, and couldn't keep her eyes open at work. In an interview on 2/13/24 at 11:51 AM, RN "Y" reported they took over the "C" hall medication cart from RN "II" on 12/26/23 at 6:00 AM, and recalled that RN "II" was frantic all the time, and seemed strung out. RN "Y" reported that Resident #212 did not normally request pain medications during the night, and that it would be unusual for her to receive Percocet at 3:18 AM. Review of "Narcotic Shift Count" documents for 12/25/23-12/26/23 (third shift), indicated that RN			

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	"II" was assigned to "C" hall and "B" hall medication carts. In an interview on 2/13/23 at 3:00 PM, NHA reported that she had received notification on 12/26/23 between 8:00 AM and 9:30 AM, that Resident #212 had reported that she had not received a dose of Percocet that RN "II" had documented as administered on 12/26/23 at 3:18 AM, and that staff were reporting that RN "II" had appeared to be working while under the influence of drugs during that time. NHA reported that she did not report the allegations to the state. NHA reported that she had also received a call from two other staff members on 12/25/23 concerned that RN "II" had been working while under the influence, but that it was purely hearsay and there were no residents saying that they were missing pills at that time. Resident #201 Review of a "Minimum Data Set" (MDS) assessment for Resident #201, with a reference date of 1/28/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #201 was cognitively intact. Review of Resident #201's "MAR" indicated that he received Oxycodone (narcotic pain medication) on 12/26/23 at 4:06 AM, administered by RN "II". The MAR indicated that the resident resided on "C" hall. Review of Resident #201's "Statement of Witness" dated 12/26/23 revealed, "I did not get any pain medication at 4 AM." In an interview on 2/14/24 at 3:28 PM , LPN "J" reported that she was surprised that the facility had rehired RN "II" after her previous incident of			

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	394160	A. BUILDING _____ B. WING _____	2/15/2024

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	narcotic diversion at the facility in 2015. LPN "J" reported that RN "II" always acted like she was high on a ton of caffiene, her eyes rolled back in her head, she disappeared for extended periods of time, and she frequently complained about being tired. RN "II" reported that Resident #201 was in constant pain and well aware of when/if he received his pain medication. Review of a facility policy "Determining reasonable suspicion for drug/alcohol use" last revised on 1/1/22 revealed, "...You should ask an employee to undergo a drug/alcohol test only if you have a reasonable suspicion" that he/she is impaired by drugs or alcohol while on the job...If a co-worker reports that an employee is behaving in an impaired manner, or smells of alcohol, you or another manager should observe the employee directly..."			
F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)	F0609	Element 1 Resident 212 remains in the facility, and has no ill effects from the deficient practice Resident #201 no longer reside in the facility. Element 2 Residents have the potential for drug diversion and are at risk to be affected by the deficient practice. Residents who are alert and oriented with BIMS 8 or higher were interviewed. If the resident reviewed was found to have met requirements to be reported for misappropriation related to medications, they will be reported to MIFRI. Element 3	2/19/2024

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	(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake # MI00141758. Based on interview and record review, the facility failed to implement policies and procedures for ensuring immediate reporting to the State Agency allegations of misappropriation of resident property (narcotics) and the investigation results to the State Agency within 5 working days, resulting in the potential for continued abuses to go unreported and for residents to not be protected from abusive individuals due to inaccurate investigations. Findings include: In an interview on 2/9/24 at 10:09 AM, Regional Registered Nurse (RRN) "NN" reported that she had been notified on 12/26/23 at approximately 8:00 AM by Registered Nurse (RN) "I" of a concern of narcotic diversion; RN "II" had documented the administration of Percocet (narcotic pain medication) to Resident #212 at 3:18 AM on 12/26/23, but the resident had reported that she did not request or receive the medication. RRN "NN" reported that the concern was discussed in morning meeting with NHA on 12/26/23, and then RRN "NN" began an investigation. RRN "NN" interviewed several staff members that reported that the nurse working third shift on 12/26/23, RN "II", had		The Administrator and DON reviewed the Abuse, Neglect and Exploitation policy and deemed it appropriate. Policy reviewed at QAPI. Education regarding reporting of misappropriation was given to the administrator by the RDO. Misappropriation will be reviewed immediately with reporting requirements identified in the SOM. Decision will be reviewed with governing body at the time of event. Element 4 The administrator/ designee will audit 5 risk management reports related to drug diversion weekly in the facility to ensure reporting requirements were met x 4 weeks, then monthly thereafter. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Administrator is responsible for compliance.	

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	been fidgety and acting strange during her shift. RRN "NN" reported that Resident #212 was alert, oriented and competent. When interviewed, Resident #212 had denied receiving Percocet at 3:18 AM on 12/26/23, as it was documented by RN "II". RRN "NN" reported that she called RN "II" into the facility for an interview on 12/26/23 at approximately 3:00 PM (6 hours after the allegation was reported) regarding the allegation, and then placed her on suspension pending the full investigation. Prior to the completion of the investigation, on 12/31/23, RN "II" submitted her resignation via email, therefore RRN "NN" did not investigate the concern any further. This surveyor requested the investigation for review. In an interview on 2/13/23 at 3:00 PM, NHA reported that she had received notification from RRN "NN" on 12/26/23 between 8:00 AM and 9:30 AM, that Resident #212 had reported that she had not received a dose of Percocet that RN "II" had documented as administered on 12/26/23 at 3:18 AM, and that staff were reporting that RN "II" had appeared to be working while under the influence of drugs during that time. NHA reported that she did not report the allegations to the state. NHA reported that she had also received a call from two other staff members on 12/25/23 concerned that RN "II" had been working while under the influence, but that it was purely hearsay and there were no residents saying that they were missing pills at that time. Review of a "Minimum Data Set" (MDS) assessment for Resident #212, with a reference date of 11/12/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #212 was cognitively intact. In an interview on 2/9/24 at 12:15 PM, Resident #212 reported that she does not take Percocet			

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	(narcotic pain medication) during the night. Resident #212 reported that on the night of 12/25/23 into 12/26/23, she was awake all night long watching movies, and did not request or receive any pain medication from Registered Nurse (RN) "II". Resident #212 reported that RN "II" had been in her room earlier that evening and had been acting strange. Resident #212 reported that RN "II" had brought 2 Tylenol in with her regular medications, and when the resident questioned what the pills were, RN "II" said that she had thought the resident had asked for them. Resident #212 reported that she had not requested any Tylenol or Percocet from RN "II". Review of Resident #212's "Medication Administration Record (MAR)" revealed orders for Percocet (narcotic pain medication) 10-325 mg one pill to be given as needed every 4 hours for pain. The record indicated that 47 of 48 doses had been administered between the hours of 8:00 AM and 11:00 PM during the month of December 2023, and 1 dose was documented as administered at 3:18 AM on 12/26/23 by RN "II". In an interview on 2/9/24 at 9:00 AM, RN "I" reported that on 12/26/23, she was taking over the medication cart from RN "II", and that RN "II" couldn't stand still, she was not making sense, and was making unusual movements with her mouth. RN "I" reported that RN "II" had counted and signed the narcotic count sheet herself, so RN "I" decided to repeat the narcotic count behind RN "II". While performing narcotic count, RN "I" had discovered that RN "II" documented Percocet had been administered during the night to Resident #212, so RN "I" checked in with Resident #212 to make sure that she was feeling ok, since she did not normally need pain medication during the night, and that was when Resident #212 denied having pain during the night, and/or taking Percocet.			

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	In an interview on 2/9/24 at 9:51 AM, RN "II" reported that she resigned from the facility in December 2023, after being suspended pending an investigation of medication records. RN "II" reported that the facility did not tell her specifically what the concern was about, and after a few days with no communication, she decided to resign. Review of the "Investigation File" provided by NHA included a performance improvement form for RN "II" dated 12/26/23 for "possible drug diversion", and statements from staff and residents. There were statements from Resident #212, and #201, indicating that they had not received the medication that RN "I" documented having had administered. There were narcotic count sheets and witness statement documents from 6 additional residents that had received narcotics during RN "I's" shift from 12/25/23 10:00 PM-12/26/23 6:00 AM. Two of those six witness statement documents did not include a resident's statement, and the remaining four indicated that the residents were not able to recall whether they had received the medication or not. Review of the facility "Abuse, Neglect, and Exploitation" policy dated 7/28/20 and revised 1/10/24 revealed, "Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes as required by state and federal regulations: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or			

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	b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury; B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies."			
F0658 SS= D	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate post-fall assessment and monitoring for 1 (Resident #211) of 5 residents reviewed for falls, resulting in a delay of treatment for spinal fractures and the potential for unidentified neurological changes, when Resident #211 sustained an unwitnessed fall with reported head trauma, and staff did not implement spinal cord precautions (prevent movement of the spine) prior to transfer into bed, did not implement neurological checks and/or monitor vital signs. Findings include: Review of an "Admission Record" revealed Resident #211 was originally admitted to the	F0658	Element 1 Resident #211 no longer resides in the facility. Post fall assessment was not completed at the time of the incident on 1/29/24. Resident was transferred to the hospital on 1/30/24 and returned on 2/3/24 with a C-Collar in place. Resident was changed to a one person SBA for transfers. Resident care plan identifies resident at risk for falls and SBA for transfers. Element 2 Residents who are at risk for falling have the potential to be effected. Residents who fell in the last 30 days will be reviewed to ensure a post fall assessment was completed and accurate. If a fall assessment was not completed or accurate a new post fall assessment will be completed. Element 3 The Administrator and DON reviewed the Falls-Clinical Protocol policy and procedure	2/19/2024

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	facility on 1/17/24, with pertinent diagnoses which included: urinary tract infection, frequent falls, osteoporosis (condition in which bones become brittle and fragile), hypertension (high blood pressure), low back pain, hyponatremia (low sodium (electrolyte), and depression. Review of a "Minimum Data Set" (MDS) assessment for Resident #211, with a reference date of 1/23/24 revealed a Brief Inventory for Mental Status (BIMS) assessment score of 9/15 which indicated the resident was cognitively impaired. Section "GG" revealed Resident #211 required moderate assistance for toileting and transferring from one surface to another. Review of Resident #211's "Care Plan" revealed, "...Resident is at risk for falls/injury related to history of falls...recent UTI..." Date initiated 1/18/24." In an interview on 2/14/24 at 9:15am, Resident #211 sat supported in bed, wearing a neck brace. Resident #211 reported she fell at the facility but did not recall any specific information about the event. Resident #211 reported she had pain in her upper back. Resident #211 expressed fear of falling again and stated, "God forbid I should have to wear this neck brace forever". Review of a history and physical report from a local emergency room with a reference date of 1/30/24 revealed Resident #211 complained of back pain that was worse than her baseline level of pain. Review of a radiology report from a local hospital with a reference date of 1/30/24, revealed Resident #211 underwent a cervical spine computed tomography (CT) exam due to neck pain after the fall that occurred on 1/29/24, and was diagnosed with a cervical fracture.		and has deemed it appropriate. Policy reviewed at QAPI. Nursing staff educated regarding the Falls-Clinical Protocol policy. During clinical meeting managers will ensure the post fall assessment is completed. Element 4 The DON/ designee will audit 5 falls weekly x 4 weeks then monthly to ensure a post fall assessment which includes neurological assessment was completed and the post fall assessment is accurate. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Administrator is responsible for compliance.	

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	Review of a "Progress Note" written by Director of Nursing (DON) "B" on 2/5/24, revealed while at a local emergency room on 1/30/24, Resident #211 was diagnosed with an acute compression fractures of C7 (neck vertebrae) and T2 (chest vertebrae). Review of an "Incident Report" dated 1/18/24 revealed Resident #211 had an unwitnessed fall and was found sitting on the floor next to her bed. Review of Resident #211's "Un-Witnessed Fall Report" dated 1/29/2024 at 11:00 PM revealed, "Resident's roommate came out of their room stating that the resident was on the floor. This nurse and the aide on the hall went to assess the resident. Resident was found on the floor with her head towards the door and leg going towards her bed. The resident was lying with her head on a blanket. This nurse assessed the resident for any injuries. There was none obvious, but resident did state that she hit her head. This nurse and aide helped the resident to her feet and back into bed. Resident stated she was trying to go to the bathroom, but fell after taking a few steps. Vital signs T:97.8, P:95, R:16, B/P:120/64, 02 (oxygen):97. On call provider was notified and after talking to the DON it was decided to put the resident's bed against the wall. The resident agreed. After the bed was moved, the resident complained of some right elbow and shoulder pain 4/10. This nurse administered PRN (as needed) tylenol for the resident which was effective. After resident took tylenol, this nurse offered her to go to the bathroom. She stated she was fine and would stay in her bed. Immediate action taken: This nurse assessed the resident immediately. After initial assessment this nurse and aide helped the resident to her and took a set of vitals...Injuries observed at time of incident: Right iliac crest, right elbow. Level of pain: 4...Resident has some small bruised areas on the			

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	right elbow and right lower back. She stated that is was causing some pain...Resident has had falls before. Resident is encouraged to stay in bed and use call light if she needs assistance with going to the bathroom..." Review of Resident #211's "Progress Notes" dated 1/29/24 written by Nurse Practitioner (NP) "LL" revealed, "Telehealth...Resident had change of elevation (fall) when trying to walk unassisted to the bathroom. No injury noted does not take blood thinners. Vitals and (sic) reviewed and care team notified." In an interview on 2/14/24 at 12:59 PM, NP "LL" reported that she did not recall her phone conversation on 1/29/24 with the nurse regarding Resident #211's fall, and was not certain if the resident had hit her head. NP "LL" reported that when a resident has an unwitnessed fall, neurological checks and vital signs should be performed based on facility policy for a set period of time, regardless of if the resident reported having hit their head or not. NP "LL" reported that standard of care for an unwitnessed fall, is to complete a thorough assessment prior to moving the resident, then if no pain, injury, neurological and/or range of motion concerns, then transfering the resident with a hoyer lift is recommended, to avoid further injury by lifting and pulling. In an interview on 2/14/24 at 11:41 AM, NP "XX" reported that when a resident reports a fall and hitting their head, neurological checks and vital signs would be ordered for at least 24 hours; staff are expected to transfer the resident using a board or hoyer lift out of concern for head or neck injury. In an interview on 2/14/24 at 2:15 PM, NHA reported that for an unwitnessed fall, the facility policy is to only implement neurological checks if			

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	ordered by the provider, and the provider did not order neurological checks for Resident #211 after her fall on 1/29/24. NHA did not know if the provider was aware that Resident #211 had hit her head, and/or why neurological checks were not ordered. In an interview on 2/14/24 at 3:18 PM, Unit Manager (UM) "DD" reported that licensed nurses are expected to document on an initial fall assessment record, and then the follow-up assessments are triggered automatically so that the nurse is required to complete them. UM "DD" reported that there was no initial fall assessment record and no "neuro-check" documentation completed for Resident #211's fall on 1/29/24. In an interview on 2/14/24 at 3:28 PM, Licensed Practical Nurse (LPN) "J" reported that when a resident sustains an unwitnessed fall, staff should use a hoyer lift to help the resident off of the floor, and perform neurological checks to monitor and determine affects of the fall. In an interview on 2/14/24 at 10:36am Unit Manager (UM) "EE" reported if a resident has an unwitnessed fall and reports they hit their head, the facility staff should not move the resident until cleared to do so by a provider. UM "EE" reported implementation of "neuro-checks" (evaluation of a person's nervous system, vital signs, level of consciousness, motor strength, sensation, and mental status done at timed intervals for a pre-determined period of time) is a standard care practice after an unwitnessed fall. Review of a "Blood Pressure Summary" for Resident #211 revealed no documented blood pressure monitoring from 1/17/24-1/30/24. Review of a "Temperature Summary" for Resident #211 revealed no documented			

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	temperature monitoring from 1/17/24-1/30/24. At the time of exit, no documentation of "neuro-checks" for Resident #211 was provided. Attempts where made to contact Licensed Practical Nurse (LPN) "E" to discuss Resident #211's fall on 2/13/24 at 3:34pm and 3:37pm, again on 2/14/24 at 7:51am, and were not successful. LPN "E" completed the incident report for Resident #211's fall. Attempts where made to contact Certified Nursing Assistant (CENA) "ZZ" to discuss Resident #211's fall on 2/13/24 at 8:11am and 2/14/24 at 8:35am, and were not successful. CENA "ZZ" was assigned to care for Resident #211 at the time of her fall. Review of "Post-Fall Assessments" published by the American Association of Post-Acute Care Nursing 2021, revealed "Before a resident can be moved, the nurse must assess them for an injury to the spinal column ...signs of spinal fracture include: ...pain (may not be severe) ...tenderness ...if a spinal injury is suspected, stabilize the neck until EMS arrives. An assessment of neurological status, often called a "neuro check" should be done when a resident hits his or her head or if it is unknown if they hit their head (unwitnessed fall)." Review of a facility policy "Falls-Clinical Protocol" with a reference date of 11/2/23 revealed " ...Residents who have fallen and have been witnessed to hit their head, suspected to have hit their head, and all unwitnessed falls ...should have neurochecks (sic) per MD (physician) orders or protocol". Review of a facility policy "Fall Prevention Program" last revised 10/26/23 revealed, "...Each			

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	394160	A. BUILDING _____ B. WING _____	2/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF WESTWOOD	2575 N DRAKE ROAD KALAMAZOO, MI 49006

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	resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls...2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 3. The nurse will indicate the resident's fall risk and initiate interventions...6. When a resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment..."			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00137198. Based on observation, interview, and record review, the facility failed to provide scheduled showers/bathing for 2 (Resident #202 and Resident #203) of 3 residents reviewed for showers, resulting in the potential for skin irritation and breakdown and feelings of decreased dignity. Findings include: Resident #202 Review of an "Admission Record" dated 8/25/22 revealed Resident #202 was admitted to the facility with pertinent diagnoses that included: hemiplegia following a cerebral infarction (loss of movement on one side of the body following a	F0677	Element 1 Resident #202 was reviewed to ensure shower was completed. Shower was offered on 2/15/24 and refused. Shower offered on 2/19/24 and completed per preference. Resident #203 no longer reside in the facility Element 2 Residents who receive showers/bed baths have the potential to be effected. Residents were reviewed to ensure shower/bed bath are being completed per resident□s preference. If shower/bed bath was not completed the shower/bed bath will be completed on the next day. If resident refuses the refusal will be documented. Element 3 The Administrator and DON reviewed the ADL policy and procedure to include resident□s preference for showers/bed bath and has deemed it appropriate. Policy reviewed at QAPI. Education regarding completing showers/bed baths per resident preference will be	2/19/2024

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	stroke), repeated falls, major depressive disorder (persistent depressed mood with loss of interests and motivation). Review of a Minimum Data Set (MDS) assessment dated 12/24/23 revealed Resident #202 scored 14/15 on a Brief Inventory for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Section "GG" indicated bathing was not attempted with Resident #202 during the 14-day assessment period. Review of a "Care Plan" for Resident #202 dated 12/1/23 revealed focus/goal/interventions as follows: "Resident has behavior diagnosis ...refusing bathing. Goal: Resident will participate in care through next review. Interventions: Approach resident in calm manner, educate on need/benefit for personal hygiene, offer assistance." Review of a "Shower/Bath" tracking record for Resident #202 dated 1/11-2/2/24 revealed Resident #202 preferred bathing on Monday and Thursday. During the 3-week period, which afforded 7 opportunities based on the resident's preferred schedule for bathing, 1 shower, and 2 refusals were documented. During an observation on 2/7/24 at 2:25pm, Resident #202 was awake, lying in bed. The resident's hair was disheveled and oily, face unshaven with several days of facial hair growth present. In an interview on 2/7/24 at 2:26pm, Resident #202 reported staff did not ask him regularly if he wanted to shower. In an interview on 2/7/24 at 10:36am Family Member (FM) "UU" reported Resident #202		completed with nursing staff. Shower/bed baths scheduled per resident preference will be reviewed during clinical meeting. Element 4 The DON/ designee will audit 10 showers weekly x 4 weeks then monthly to ensure policy and procedure are followed. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Administrator is responsible for compliance.	

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	appeared unclean and had body odor at times during her visits. Resident #203 Review of an "Admission Record" dated 2/11/23 revealed Resident #203 was admitted to the facility with pertinent diagnoses that included: hemiplegia following cerebral infarction (loss of movement on one side of the body after a stroke), and depression. Review of a Minimum Data Set (MDS) assessment dated 2/17/23 revealed Resident #203 was dependent on staff to complete bathing. Review of a "Care Plan" for Resident #203, dated 5/1/23, revealed the following "focus/goal/interventions": "Focus: The resident needs activity of daily living assistance related to previous CVA (stroke) ...Goal: The resident will improve current level of function ...Interventions: provide sponge bath when a full bath or shower cannot be tolerated ...first shift Wednesday and Saturday". Review of a "Bath Report" for Resident #203 dated 3/11-4/24/23 revealed documentation of 5 baths during the 6-week period, a total of 5 baths during 14 scheduled opportunities. In an interview on 2/8/24 at 12:46pm, Family Member (FM) "TT" reported Resident #203 often appeared disheveled and unkempt, smelled of body odor when she resided at the facility. FM "TT" described Resident #203's hair as oily and matted throughout the resident's stay. FM "TT" reported the facility did not meet Resident #203's bathing needs. During an interview on 2/8/24 at 4:24pm, Nursing Home Administrator (NHA) "A"			

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	confirmed the facility had no additional information regarding showering/bathing for Resident #202 or Resident #203. In an interview on 2/9/24 at 9:04am, Certified Nursing Assistant (CENA) "AA" reported residents missed showers/bathing at times due to lack of time. In an interview on 2/7/24 at 1:04pm, Certified Nursing Assistant (CENA) "V" reported that since the facility no longer had "Shower Aides" who's primary job was to provide bathing to the residents, it had been difficult to ensure residents were bathed twice a week. According to Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 50742-50744). Elsevier Health Sciences. Kindle Edition. "...Personal hygiene affects patients' comfort, safety, and well-being. Hygiene care includes cleaning and grooming activities that maintain personal body cleanliness and appearance. Personal hygiene activities such as taking a bath or shower and brushing and flossing the teeth also promote comfort and relaxation, foster a positive self-image, promote healthy skin, and help prevent infection and disease..."			
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F0689	Element 1 Resident 201 no longer resides in the facility. On 12/9/23 date of incident resident pain medication was changed per resident request. No ill effects identified to the stump. Facility identified on 2/13/24 that resident was transferred with 1 person with Hoyer lift. CENA identified completing the transfer received one on one education regarding Hoyer lift must be completed with 2 staff.	2/19/2024

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	This citation pertains to intake #MI00141496 Based on interview and record review the facility failed to provide adequate supervision during a mechanical lift transfer for 1 (Resident #201) of 3 residents reviewed for falls, resulting in the potential for injury. Findings include: Review of an "Admission Record" dated 9/28/23 revealed Resident #201was admitted to the facility with pertinent diagnoses that included: acquired absence of right leg below the knee (11/29/23), acquired absence of left leg below the knee (11/15/22), peripheral vascular disease (condition in which blood flow is reduced to the extremities), chronic pain. Review of a Minimum Data Assessment (MDS) assessment dated 12/5/23 revealed Resident #201was dependent for transfers (helper provided all the effort). Review of a "Care Plan" for Resident #201, dated 9/29/23, revealed a focus/goal/approach of: "Focus/Goal/Interventions: Focus: Resident has an ADL self-care performance deficit, Goal: Resident's Activities of Daily Living needs will be met. Interventions: transfers with 2 person assist AND use of mechanical lift with large sling." Review of a "Kardex" care guide for Resident #201 revealed caregiver instructions: transfers: with 2 person assist AND use of mechanical lift with large sling. Review of a "Nursing Admission Evaluation" dated 11/29/23, section III revealed a "Fall Risk Evaluation" in which Resident #201 scored a 12,		Element 2 Residents who require use of a mechanical lift are at risk to be affected. Residents who require the use of a Hoyer lift were identified and to ensure 2 staff members are completing the Hoyer lift transfer. The Administrator and DON reviewed the Safe Lifting and Movement of Residents policy and has deemed it appropriate. Policy reviewed at QAPI. Element 3 Education regarding the Safe Lifting and Movement of Residents policy and procedure, including Hoyer lift. Residents who fell and use a Hoyer Lift will be reviewed during clinical meeting to ensure 2 staff completed the transfer Element 4 The DON/ designee will audit 5 Hoyer lift transfers weekly to ensure policy and procedure are followed x 4 weeks then monthly thereafter. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Administrator is responsible for compliance.	

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	"high risk" for falls. Review of "Discharge Summary" for Resident #20, dated 12/11/24, provided by a local acute care hospital revealed Resident #201 complained of pain to his right residual leg after "staff at the nursing facility dropped him" on 12/9/24. The injury site was "otherwise healing well", no evidence of fracture or dislocation. Review of an "Incident Report" dated 12/9/23 revealed Licensed Practical Nurse (LPN) "E" witnessed Resident #201 lying on the floor between his wheelchair and the legs of a mechanical lift on 12/9/23 at 7:18am. A small amount of blood came from the incision on his right residual leg and Resident #201 stated "he was dropped on his stump (residual leg) ...". In an interview on 2/8/24 at 11:08am, Licensed Practical Nurse (LPN) "E" reported she found Resident #201 lying on the floor between the legs of the mechanical lift with his head near the base of the lift. His wheelchair was facing him and parked at the end of the mechanical lift's legs. Certified Nursing Assistant (CENA) "SS" was the only other staff member present. LPN "EE" reported CENA "SS" transferred Resident #201 alone and "never should have done that". LPN "EE" reported that the facility policy was to use 2 staff members to transfer a resident with a mechanical lift, to maintain the resident's safety. LPN "EE" reported Resident #201 recently underwent surgical amputation of his right leg and did not demonstrate safety awareness skills at that point in his recovery. LPN "EE" reported a second staff member should have been present during the transfer. In an interview on 2/14/24 at 12:55pm, Certified Nursing Assistant (CENA) "SS" reported the facility policy required the use of 2 staff to			

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	complete mechanical lift transfers. CENA "SS" reported the use of 2 staff members during mechanical lift transfers was recommended for safety. When queried, CENA "SS" reported she could not recall specific information about Resident #201's fall on 12/9/23 but at times she completed mechanical lift transfers alone, rather than with the assist of another staff member. In an interview on 2/13/24 at 9:00am, Certified Nursing Assistant (CENA) "W" reported 2 staff members were required to transfer a resident using a mechanical lift. Review of a "Falls-Clinical Protocol" policy dated 11/2/23 revealed statements: "The MDS ...will be utilized to develop the comprehensive plan of care to minimize falls ...interventions to remember when developing the plan of care include ...proper use of mechanical lifts ...".			
F0690 SS= D	Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that	F0690	Element 1 Resident #211 no longer resides in the facility. On 1/29/24 resident was seen by the MD and urinalysis ordered. No note to push fluids was identified. Resident went to hospital on 1/30/24 and returned on 2/3/24 with Cipro ordered. On 2/5/24 note to encourage fluids. Element 2 Residents who currently have signs and symptoms of a UTI have the potential to be effected. Residents currently being treated for a UTI have the potential to be effected. Residents currently with signs and symptoms of a UTI or are being treated for a UTI were reviewed to ensure vital signs are completed. Residents identified as not having vital signs	2/19/2024

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	catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide appropriate monitoring and treatment for a resident experiencing symptoms of a Urinary Tract Infection (UTI), (confusion, painful and frequent urination, and cloudy urine with a strong odor) for 1 resident (Resident #211) out of 4 residents reviewed for urinary care, resulting in a lack of monitoring, a delay in the treatment of UTI (urinary tract infection), hospitalization, and the potential for sepsis (a life threatening complication of infection.) Findings include: Review of an "Admission Record" revealed Resident #211 was originally admitted to the facility on 1/17/24, with pertinent diagnoses which included: urinary tract infection, frequent falls, osteoporosis (condition in which bones become brittle and fragile), hypertension (high blood pressure), low back pain, hyponatremia (low sodium (electrolyte), and depression. Review of a "Minimum Data Set" (MDS) assessment for Resident #211, with a reference date of 1/23/24 revealed under the "Bladder and		completed staff completed and documented VS in the chart. Element 3 The Administrator and DON reviewed the Admission Process checklist. Process reviewed at QAPI. Nursing staff educated regarding the s/sx of UTI and initiating VS and pertinent charting. During clinical meeting managers will ensure the residents clinical record reflects documentation for monitoring and treatment of a UTI is completed. Element 4 The DON/ designee will audit 5 charts weekly x 4 weeks then monthly to ensure a documentation was completed for monitoring and treatment of residents with a UTI. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Administrator is responsible for compliance.	

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	Bowel" section that no toileting program had been attempted on admission because the resident was continent of urine. The answer under urinary continence indicated that Resident #211 was "occasionally incontinent (less than 7 episodes of incontinence)". Review of Resident #211's "Care Plan" revealed, "...Resident is at risk for falls/injury related to history of falls...recent UTI..." Date initiated 1/18/24." There was no care plan related to the resident's continent/incontinent status, and/or UTI monitoring. Review of Resident #211's "Bladder Elimination Record" on 2/15/24 indicated that staff had coded the resident as incontinent on 16 of the past 25 days documented. In an interview on 2/14/24 at 11:35 AM, Certified Nursing Assistant (CNA) "S" reported she cared for Resident #211 regularly and the resident had episodes of urinary incontinence since her admission. In an interview on 2/15/24 at 1:33 PM, Certified Nursing Assistant (CNA) "BB" reported she regularly cared for Resident #211 and noticed the resident had become more confused in the days prior to her hospitalization on 1/30/24. CNA "BB" also reported Resident #211 had episodes of urinary incontinence since her admission. Review of Resident #211's "Hospital Discharge Paperwork" from prior to admission to the facility indicated that the resident was admitted on 1/6/24 and discharged on 1/17/24. The discharge summary revealed, "Primary Diagnosis: COVID-19 infection, UTI, completed course of antibiotics during her hospitalization...recurrent falls..." In an interview on 2/14/24 at 4:12 PM, Registered			

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	Nurse (RN) "Y" reported that Resident #211 wore an incontinence brief, was incontinent, but would also sometimes use the toilet. RN "Y" reported that while toileting Resident #211 on 1/27/24, the resident complained of painful and frequent urination, and her urine was cloudy. RN "Y" notified the provider and obtained an order for a urine test to rule out a UTI. RN "Y" reported that he did not share his concerns with other nursing staff and CNA's (certified nurse assistants). RN "Y" reported that he did not alert staff to monitor Resident #211's vital signs, encourage fluids, offer cranberry juice, or increase supervision for a potential increased fall risk due to UTI. Review of Resident #211's "Vital Sign Record" revealed no documentation of any vital signs between 1/17/24-1/30/24. Review of Resident #211's "Fluid Intake Record" indicated that the resident drank approximately 15 ounces on 1/27/24, 8 ounces on 1/28/24, and 21 ounces on 1/29/24. There was no documented refusals. Review of Resident #211's "Progress Notes" written by Nurse Practitioner (NP) "MM") revealed, "...1/27/24...Telehealth (virtual visit)...Staff reports that the resident has painful urination and it is noted that the urine has a foul odor and is cloudy. Ordered a UA (urine test) with C&S (culture and sensitivity to determine effective treatment options) if indicated." There were no other progress notes until NP "LL" documented on 1/29/24 which revealed, "Telehealth...Resident had change of elevation (fall) when trying to walk unassisted to the bathroom. No injury noted does not take blood thinners. Vitals and (sic) reviewed and care team notified." In an interview on 2/15/24 at 7:55 AM, NP "MM"			

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	reported she was the on-call provider contacted on 1/27/24 regarding Resident #211's symptoms of a urinary tract infection. NP "MM" reported she was not told of Resident #211's increase in confusion, that the contacting nurse did not report specifically if the resident had a fever. NP "MM" reported she was told Resident #211's vital signs were "stable". NP "MM" reported the documentation provided by the facility did not indicate if the facility had completed a urine dip test. NP "MM" reported if the resident had a fever along with the other reported symptoms, the clinical protocol would have warranted the use of an antibiotic while awaiting test results. NP "MM" reported that she would have expected staff to monitor vital signs, increase supervision and encourage fluids as necessary, and that she would not order those things. NP "MM" reported she was not aware Resident #211 had been hospitalized for a severe urinary tract infection prior to her admission to the facility on 1/17/24. Review of Resident #211's "Emergency Department Hospital Records" revealed "...1/30/24 at 9:10 AM Chief Complaint: Hematuria (blood in urine) Pt (patient) BIB (brought in by) EMS (emergency medical services) from (facility). Complains of blood in urine starting today. Fall last night with cervical (neck) tenderness...Patient states she fell and is complaining of neck and back pain. She states she is also here because there is some bleeding coming from her pelvic area...The staff however notes that the patient had some pink tinge in her diaper. Patient has had a recent urinary infection...Physical Exam:...was found to have a temperature of 100.4...complains of neck pain...patients urine obtained by catheter was thick purulent and pink in color. Urine reveals evidence of significant infection...started on Rocephin (IV antibiotic) for urinary infection...Final Impression: Acute febrile illness, Urinary tract infection (acute), Fall, closed			

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	nondisplaced fracture of seventh cervical vertebra (neck)..." Review of Resident #211's "Urinalysis with Culture & Sensitivity" (urine test to identify type of infection and proper treatment regimen) collected on 1/28/24, reported on 1/31/24 while resident was in the hospital indicated, pseudomonas (bacteria) infection, that would be best treated with Fosfomycin or Ciprofloxin (antibiotics). In an interview on 2/14/24 at 2:22 PM, Infection Preventionist (IP) "F" reported that Resident #211 admitted to the facility on 1/17/23 following hospitalization for a UTI. IP "F" reported that the facility policy is to obtain vital signs every shift for 3 days for new admits, but that Resident #211 only have vital signs documented once on 1/17/24 and then on 1/30/24 just prior to her transfer to the emergency room. IP "F" reported that she had been aware that Resident #211 had a urine test pending results on 1/28/24, and those results came back on 1/31/24 while the resident was in the hospital. IP "F" reported that a urine test was ordered because Resident #211 had increased confusion, painful urination, and frequent urination; these symptoms met the facilities criteria to begin antibiotics for a suspected UTI, but the provider did not order any medication. IP "F" reported that when a resident has a history of UTI sometimes the provider will order antibiotics with only one symptom of UTI present, and in this case Resident #211 met criteria on 1/27/24. IP "F" reported that the minimum care per standard of practice while awaiting the urine test results would be to monitor for worsening symptoms, monitor vital signs, encourage fluids, and offer cranberry juice, but that based on the documentation, none of those things were done. In an interview on 2/14/24 at 3:18 PM, Unit			

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	Manager (UM) "DD" reported that a UTI placed a resident at an increased risk for falls and sepsis. UM "DD" reported that the floor nurse would be expected to enter orders to push fluids, increase supervision, and communicate the concern to oncoming staff. UM "DD" reported that she was not made aware of Resident #211's signs and symptoms of UTI, and/or the pending urine test. In an interview on 2/15/24 at 9:27 AM, DON reported that residents that are newly admitted to the facility are expected to have vital signs obtained/recorded every shift for 72 hours and then weekly. DON reported that when a UTI is suspected, it would be important to increase monitoring of vitals signs, specifically temperature due to the threat of sepsis. In an interview on 2/13/24 at 2:41 PM, Licensed Practical Nurse (LPN) reported that obtaining vitals signs were the nurse's responsibility, but was challenging to complete due to the lack of equipment available in the facility; the vital signs equipment carts are not reliable and frequently have dead batteries. According to the facility policy "Infection Prevention and Control Program" last revised 12/27/23 revealed, "...Surveillance:...c. Licensed nurses participate in surveillance through assessment/evaluation of residents and reporting changes in condition to the residents ' physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections..."			
F0842 SS= D	Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an	F0842	Element 1 Resident #211 no longer resides in the facility. Residents admission record 1/18/24 did not indicate residents accurate fall risk. Residents fall risk evaluation was assessed and	2/19/2024

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	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 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		completed on 2/15/24 indicating risk and interventions required. Element 2 Residents who are at risk for falling on admission have the potential to be effected. Admissions in the last 30 days will be reviewed to ensure a fall risk assessment was completed and accurate. If the fall risk assessment was not completed or accurate a new fall risk assessment will be completed. Element 3 The Administrator and DON reviewed Falls-Clinical Protocol policy and procedure and has deemed it appropriate. Policy reviewed at QAPI. Nursing staff educated regarding the Falls-Clinical Protocol policy. During clinical meeting managers will ensure the fall admission assessment is completed/accurate. Element 4 The DON/ designee will audit 5 new admissions weekly x 4 weeks then monthly to ensure the admission fall assessment was completed and accurate. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Administrator is responsible for compliance.	

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	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 for 1 out of 14 residents (Resident #211) reviewed for medical records, resulting in inaccurate fall risk assessment and incomplete fall documentation, and the potential for facility staff and providers not having all of the pertinent information to care for residents. Findings include: Review of an "Admission Record" revealed Resident #211 was originally admitted to the facility on 1/17/24, with pertinent diagnoses which included: urinary tract infection, frequent falls, osteoporosis (condition in which bones become brittle and fragile), hypertension (high blood pressure), low back pain, hyponatremia (low sodium (electrolyte), and depression. Review of Resident #211's "Fall Risk Evaluation" dated 1/18/24 at 1:07 AM indicated a history of 1 -2 falls in the last 90 days with the last fall on 1/16/24, was independent and continent with toileting, no osteoporosis, no depression, no medications taken currently or within the last 7 days for antidepressant, or antihypertensive (blood pressure), and scored at a low-risk for falls.			

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	Review of Resident #211's "Physician Orders" indicated Amlodipine (for high blood pressure), Escitalopram (for depression), and Alendronate (for osteoporosis). It was noted that Resident #211's fall risk evaluation completed on 1/18/24 did not include these medications and/or conditions. In an interview on 2/15/23 at 11:13 AM, NHA reported that Resident #211's fall risk assessment completed on 1/18/24 was inaccurate and did not reflect the resident's actual health status. Review of Resident #211's "Un-Witnessed Fall Report" dated 1/29/2024 at 11:00 PM revealed, "Resident's roommate came out of their room stating that the resident was on the floor. This nurse and the aide on the hall went to assess the resident. Resident was found on the floor with her head towards the door and leg going towards her bed..." Review of Resident #211's "Initial Fall Assessment Record" revealed no assessment completed for 1/29/24. In an interview on 2/14/24 at 3:18 PM, Unit Manager (UM) "DD" reported that licensed nurses are expected to document on an initial fall assessment record, and then the follow-up assessments are triggered automatically so that the nurse is required to complete them. UM "DD" reported that there was no initial fall assessment record and no "neuro-check" documentation completed for Resident #211's fall on 1/29/24. UM "DD" reported that prior to 1/29/24, Resident #211 was at an increased risk for falls due to having a UTI, and also a previous fall on 1/18/24. UM "DD" reported that when staff identified that Resident #211 had signs and symptoms of a UTI on 1/27/24, there should have been interventions in place to increase supervision for fall			

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	prevention, but there was nothing documented and UM "DD" was not aware of the resident's symptoms. Review of Resident #211's "Skilled Daily" note dated 1/30/24 at 1:09 PM indicated, the resident was not receiving blood pressure medication, did not have any signs or symptoms of infection, no pain, and had no labs or tests ordered. In an interview on 2/15/24 at 10:45 AM, Unit Manager (UM) "DD" reported that Resident #211 should have daily "skilled" documentation, and did not have any nursing documentation between 1/26/24 and 1/30/24, there were also no nursing progress notes for that timeframe. UM "DD" reported that the skilled documentation on 1/30/24 was completed for 1:09 PM and the resident had been sent to the hospital approximately 4 hours earlier; the documentation did not accurately reflect Resident #211's status. Review of a facility policy "Falls-Clinical Protocol" with a reference date of 11/2/23 revealed " ...Residents who have fallen and have been witnessed to hit their head, suspected to have hit their head, and all unwitnessed falls ...should have neurochecks (sic) per MD (physician) orders or protocol". Review of a facility policy "Fall Prevention Program" last revised 10/26/23 revealed, "...Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls...2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 3. The nurse will indicate the resident's fall risk and initiate interventions...6. When a resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-			

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	fall assessment..." Review of the facility policy "Falls-Clinical Protocol" last revised 11/2/23 revealed, "...1. As part of an initial and ongoing resident assessment, the staff will help identify individuals with a history of falls and risk factors for subsequent falling. This will be accomplished by the following task;...Admission Evaluation Data Form, which includes the falls risk evaluation (for facilities with electronic health records (EHR) the assessments and forms identified in this protocol are completed in the EHR). This form is completed upon admission, quarterly, and with significant change in status. Information obtained from this assessment includes, but is not limited to vital signs, orientation, diagnoses, cognitive and communication abilities, behavioral symptoms, vision, hearing, skin conditions, foot/feet problems, ADL abilities, cardiovascular and circulatory status, GI status, bowel and bladder status, gait, balance, involuntary movements, ROM and sleep patterns, nutritional risk, medication considerations, devices and restraints, pain, falls risk/s, etc. The falls section (fall risk evaluation) is inclusive of; History of falls, cognitive status/behavioral symptoms, vision status, continence, mobility, balance, vital signs and orthostatic blood pressure evaluation, age, health conditions/risk factors, and medications. Staff will ask the resident and the caregiver or family about a history of falling. 2. Based on the assessment an initial plan of care will be developed and implemented to address identified risk. This will be revised as necessary. 3. The Minimum Data Set (MDS) and subsequent CAAs will be utilized to develop the comprehensive plan of care to minimize falls and injuries from falls. 4. Goals of the plan of care may include the interdisciplinary team, physician, resident and responsible party when possible...Clinical			

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	Protocol: 8. For an individual who has fallen, staff should attempt to define possible causes within 24 hours of the fall...Residents who have fallen and have been witnessed to hit their head, suspected to have hit their head, and all un-witnessed falls regardless of the resident's cognitive status should have neurochecks per MD orders or protocol. The Physician and Responsible party should be notified as soon as the resident is stabilized. Document findings in the resident's medical record or EHR per standard protocol. Complete the Fall Re-evaluation in EHR, to determine if there are new or additional risk factors and address as appropriate...An accident/incident report will be completed and forwarded to the DON.." According to "Legal and Ethical Issues in Nursing", by G. Guido (2006), "A major responsibility of all health care providers is that they keep accurate and complete medical records. From a nursing perspective, the most important purpose of documentation is communication. The standards for record keeping attempt to ensure, patient identification, medical support for the selected diagnoses, justification of the medical therapies used, accurate documentation of that which has transpired, and preservation of the record for a reasonable time period. Documentation must show continuity of care, interventions used, and patient responses. Nurses' notes are to be concise, clear, timely, and complete."			
F0921 SS= E	Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F0921	Element 1 No residents were identified. Element 2 Room 306 doorway was cleaned of dark liquid	2/19/2024

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	This citation pertains to intakes: MI00136843, MI00137001 Based on observation, interview, and record review, the facility failed to maintain general cleanliness of the premises including floor care (Rooms 402, 306, 102, 203, 205), cleaning of high contact surfaces, and resident personal and shared equipment, resulting in the potential for the spread of infection. Findings include: During an observation on 2/9/24 at 9:37am, the floor in the doorway of room 306 was soiled with a dried dark liquid, within room 306 the floor was soiled by a dried, darkened area of residue that measured 5' wide and extended from the door to bed. In an interview on 2/9/24 at 9:39am, the resident who resided in room 306, stated "my floor is dirty, and it bothers me. It's been like that since I came here" then pointed to a large, darkened area of residue on her room floor. The resident reported the environment was not home-like and felt unclean. In an interview on 2/7/24 at 10:36am, Family Member (FM) "UU" reported she brought cleaning supplies and cleaned the residents room herself during her visits because the room always appeared dirty. FM "UU" reported she mopped the floor and wiped down the high contact surfaces of the room during each visit because the cleanliness of the room was always lacking. FM "UU" reported the resident seemed to appreciate having his room cleaned and that she did so to reduce the risk of potential infection and to support the resident's psychosocial well-being.		and residue. Hallway near room 100 hall was cleaned of dried brown liquid. Hallway outside room 101 black liquid cleaned from floor. Room 102 brown liquid cleaned from floor. Room 110 brown liquid and dead insects cleaned from floor. Room 203 brown substance cleaned from floor. The exit door at the far end of 200 hall cleaned of yellow mucous substance. Wheelchair outside of room 112 unable to identify. Scale in alcove of 400 hall was cleaned of dust and debris and crumbs. The 12 gallon black trash can in private dining room was cleaned of substance. Residents in the facility have the ability to be affected. Resident room floors, bathrooms and common area floors audited to ensure floor care, trash cans cleaned and doors are clean. If audit identifies areas that are not cleaned the area will be cleaned. Resident wheelchairs audited to ensure clean. If audit identifies w/c is not clean staff will clean.	

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	During an observation on 2/9/24 at 9:09am, the hallway floor near to boiler room in the 100-hall was soiled with a dried brown liquid that measured 2"x6". The hallway floor outside room 101 had 30 droplets of dried brownish black liquid that extended across 9 floor tiles. The floor in room 102 had a dried brown liquid that covered 2 12"x12" tiles, a darkened path of dried debris extended from the door to the bed and measured approximately 12" in width. 4 dead insects and a dried brown liquid that measured 4"x8" were observed on the floor outside room 110. During an observation on 2/9/24 at 9:15am, the floor in room 203 was soiled by a dried brown substance in four locations, each approximately the size of a baseball. The exit door located at the far end of the 200 hall was soiled with a dried, yellow, mucous like substance that measured 1"x3". During an observation on 2/13/24 at 8:41am, the exit door located at the far end of the 200-hall remained soiled with a dried, yellow, mucous like substance that was approximately 3" in length. During an observation on 2/9/24 at 8:54am, an unoccupied blue resident wheelchair sat outside room 205. The wheelchair had dried white liquid in 4 spots on the footrest, along the edge of the leg supports. During an observation on 2/9/24 at 9:09am, an unoccupied blue resident wheelchair outside room 112, was soiled with a dried white substance along the right edge of the leg supports. Debris, crumbs, and flakes of dried skin were observed on the footrests, along with dried white liquid droplets on the right armrest. During an observation on 2/9/24 at 9:13am, a		Element 3 The Administrator and DON reviewed the Daily Patient Room Cleaning process and procedure and has deemed it appropriate. Policy reviewed at QAPI. The Administrator and DON reviewed the Resident Transport and Cleaning Policy and has deemed it appropriate. Policy reviewed at QAPI. Education regarding floor care and cleaning was provided to housekeeping staff. Education of nursing staff on cleaning w/c per schedule. During rounds daily staff will identify concerns with floor, door and w/c cleanliness and report to NHA/managers. Element 4 The NHA/ designee will audit random common area floors, weekly then monthly to ensure policy and procedures are followed. The NHA/ designee will audit 10 resident bathrooms weekly then monthly to ensure policy and procedures are followed. The NHA/ designee will audit 10 random doors weekly then monthly to ensure policy and procedures are followed. The NHA/ designee will audit the scale weekly then monthly to ensure policy and procedures are followed. The NHA/ designee will audit 10 trash cans weekly then monthly to ensure policy and procedures are followed. NHA/designee will audit 10 w/c per week x 4 weeks then monthly to ensure clean.	

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	wheelchair accessible resident scale located in an alcove on the 400-hall, was soiled with dust across the handrails, screen and standing platform. The standing platform was also covered with debris and crumbs. During an observation on 2/9/24 at 9:16am, a 12-gallon black trash can in the private dining room was soiled with a dried thick dark substance on the hand grip of the lid. A fingerprint was present in the dried substance. In an interview on 2/13/24 at 9:00am, Certified Nursing Assistant (CENA) "W" reported the floors and resident bathrooms were often soiled with debris and there was a lack of housekeeping being done. In an interview on 2/13/24 at 10:02am, former Director of Nursing (DON) "KK" reported the facility looked "dingy" and she often found resident bathrooms in unsanitary conditions, after housekeeping had serviced the rooms. Review of "Resident Council" minutes revealed the council voiced monthly concerns related to the cleanliness of the building in the last 4 months.		Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Administrator is responsible for compliance.	