STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634021	A. BUILDING _____ B. WING _____	3/14/2024

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

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F0000 SS=	INITIAL COMMENTS Evergreen Health And Rehabilitation Center was surveyed for an Abbreviated survey on 3/14/24. Intakes: MI00142846, MI00143149, MI00142861, & MI00143213. Census= 159.	F0000		
F0658 SS= E	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00142846 Based on interviews and record reviews the facility failed to ensure professional standards of nursing practice was provided by the nursing staff to administer pain medications as directed by the physician for one (R801) of three residents reviewed for pain. Findings include: Review of a complaint submitted to the State Agency (SA) documented concerns of the facility staff to have failed to administer R801's pain medication as directed by the physician. Review of the medical record revealed R801 was admitted to the facility on 10/27/23 with diagnoses that included: malignant neoplasm of cervix, abscess of vulva and acute kidney failure. A Minimum Data Set (MDS) assessment dated 11/2/23, documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact	F0658		

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

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	cognition and required staff assistance for Activities of Daily Living (ADLs). Review of a "Physician Team - H&P (history & physical) dated 10/29/23 at 8:08 AM, documented in part " ... diagnosed with stage 3C adenocarcinoma of the vulva status post 6 cycles of cisplatin and radiation therapy ... Currently, she is complaining of pain in the right knee and difficulty ambulating ..." Review of a Physical Medicine and Rehabilitation (PM&R) note dated 10/30/23 at 12:15 PM, documented in part " ... states that her pain is uncontrolled. She states that taking pain medication four time daily does improve this ... Pain: Currently uncontrolled. We will schedule the patient's Norco every six hours with as needed every eight hours. Also add gabapentin (medication) ..." Review of a Physician Team - Progress Note" dated 11/1/23 at 12:18 PM, documented in part " ... continues to complaint of tenderness in peri area around wounds. She states it is painful to sit and had difficult time with therapy. Discussed with PM&R and Norco scheduled q4h (every 4 hours) and will discuss gabapentin dosing ..." Review of a PM&R note dated 11/1/23 at 5:58 PM, documented in part " ... continues to state that her pain is uncontrolled. She is requesting to go up to every four hours for Norco which I was agreeable to ..." Review of a PM&R note dated 11/8/23 at 11:34 AM, documented in part " ... states that her pain is uncontrolled this morning, but she has not gotten her medications ..." Review of a PM&R note dated 11/13/23 at 1:48 PM, documented in part " ... complain of			

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	increased pain this morning; however, they did miss her morning medication. Once she did receive this, her pain improved back to baseline ..." Review of the November 2023 Medication Administration Record (MAR) documented the following pain medication " ... Hydrocodone-Acetaminophen Tablet 5-325 MG (Milligram), Give 1 tablet by mouth every 4 hours for pain ..." This medication was not administered by the facility nursing staff on the following dates: 2 AM dose- 11/4, 11/7, 11/8, 11/9, 11/12 & 11/13 6 AM dose- 11/8 & 11/13 6 PM dose- 11/8 & 11/13 Review of the medical record revealed no documentation on why the resident's pain medication was not administered at the above time and dates. Review of a care plan titled " ... Risk for impaired comfort" documented the following intervention in part " ... Administer pain medication as ordered ..." On 3/12/24 at 2:01 PM, the Director of Nursing (DON) was interviewed and asked why R801's pain medication was not consistently administered as prescribed by the physician and the DON stated they would look into it and follow back up. On 3/13/24 at 8:55 AM, the DON returned for a follow up interview and stated they could not find documentation on why the pain medication was not administered, however stated they recently educated the nurses on medication administration.			

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	No further explanation or documentation was provided by the end of the survey.			
F0684 SS= G	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00142846. Based on interview and record review the facility failed to ensure staff timely identified a worsening of condition and communicated a change of condition with the nursing staff and physician staff for one (R801) of three residents reviewed for a change of condition. Findings include: Review of a complaint submitted to the State Agency (SA) documented concerns of the facility to have failed to assess a change of condition with R801 in a timely manner. Review of the medical record revealed R801 was admitted to the facility on 10/27/23 with diagnoses that included: malignant neoplasm of cervix, abscess of vulva and acute kidney failure. A Minimum Data Set (MDS) assessment dated 11/2/23, documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition and required staff assistance for Activities of Daily Living (ADLs).	F0684		

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	Review of a "Physician Team - Discharge Note" dated 11/17/23 at 1:33 PM, documented in part " ... Notified by staff that was <sic> found to have low Spo.(oxygen level) 77% (normal is 90-100%) on room air. She was placed on NR (non-rebreather) at 15L (liters) and Spo2 87%. HR (heart rate) 124, RR (respirations) 8-14. Orders for breathing treatments. No improvement with oxygenation and stat labs and CXR (chest x-ray) ordered. IVF (intravenous fluids) started as well. BP (blood pressure) retaken 104/55. Given lack of improvement and acute change in condition, decision made to call 911 and she was transferred to hospital for further eval. (evaluation) discussed with nursing management as well as DON (director of nursing)." Review of the medical record revealed a 94/44 BP documented on 11/15/23 at 11:11 AM and again at 11:32 AM. Review of the November 2024 Medication Administration Record (MAR) documented despite the 94/44 BP, staff administered multiple hypertensive (high blood pressure) medications such as amlodipine besylate 10 mg (milligram), lisinopril 40 mg and metoprolol tartrate 25 mg. There was no documentation of the nursing staff to have notified the physician of the low blood pressure. On 11/15/23 at 3:19 PM, a "Physician Team - Progress Note" documented the following, " ... Notified by pts (patients) daughter hat she has not been eating well and has lost weight ..." Review of a Physical Therapy note dated 11/15/23, documented in part " ... Pt (patient) has difficulty remaining on task, req (required) freq (frequent) vc (verbal cues) for re direction Freq breaks taken ... Pt exhibiting increased confusion			

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	on this date; telling PTA (physical therapist assistant) about the "fire" last night, and how she was "so scared I wouldn't be able to get to my walker." Pt reported "standing outside". Pt hyper verbal with increased confusion req constant re direction for task initiation and to remain on task ..." This note was documented by Physical Therapist Assistant (PTA) "A". Review of the medical record revealed there was no documentation of the therapy staff to have communicated the change in condition from the resident's baseline to the nursing staff or the physician. The resident started to have a decreased appetite and a change in mental status that was not collaboratively identified by the facility staff and relayed to the physician team, resulting in R801 to have been transferred to the hospital for the worsening of their change of condition two days later. Review of a facility policy titled "Change of Condition" (Issue Date: 12/13/23) documented in part " ... An acute change in condition is a clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional status ... Acute changes of condition can occur abruptly, over several hours, or over several days ... Notification to the licensed nurse regarding a change of the resident's condition may come from the resident themselves, a visitor, or facility staff ... Any facility staff that notices a change in the resident's condition should notify the licensed nurse for further evaluation ..." Review of the hospital records, "Emergency Medicine" note dated 11/17/23 at 12:20 PM, documented in part " ... Admitting Diagnosis Severe sepsis ... chief complaint of altered mental status ... For the past 2 days, she has been steadily declining. She is less interactive and not eating as much as normal ... Tachycardia present ... Labial			

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	wound was purulent, with a very foul smell ... She is lethargic and confused ..." R801 was then started on IV antibiotics by the emergency room medical team. Review of the medical record revealed no documentation of the facility staff to have identified a purulent and foul smelling labial wound prior to the hospitalization. On 3/12/24 at 11:17 AM, PTA "A" was interviewed and asked about the change of condition identified with R801 on 11/15/23, PTA "A" replied they wanted to review their notes for that resident and follow back up. Shortly after, PTA "A" returned and confirmed R801 did have a change of condition from their baseline. PTA "A" stated R801 had increased confusion. PTA "A" was asked who they reported the change of condition to, and PTA "A" stated they could not remember who they reported it to and did not document it, however they stated they always report change of conditions to the nursing staff. On 3/12/24 at 1:01 PM, the DON was interviewed and asked about the low bp and change of mental status not collaboratively communicated and identified by the facility staff and communicated to the medical team to timely identify a change of condition and worsening of, the DON stated they would look into it and follow back up. On 3/13/24 at 8:55 AM, a follow up interview was conducted with the DON. The DON stated they talked to PTA "A" and educated them on communicating a change of condition to the nursing staff. The DON stated they were unable to identify the nurse that PTA "A" stated they reported R801's change of condition to on 11/15/23. The DON stated they were reeducating all of their departments.			

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F0686 SS= G	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake(s): MI0014286, MI00143149, MI00142861 & MI00143213. Based on observation, interview, and record review the facility failed to ensure pressure wounds were identified (R801), assessed and monitored by physicians/wound clinicians consistently if at all (R's 801 & 804) , implement effective treatment for identified wounds timely (R803), implement preventive interventions (R802) for four (R's 801, 802, 803 & 804) of four residents reviewed for wounds, resulting in R801 to have developed an unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) coccyx/sacrum wound, R802 to have developed a Deep Tissue Injury (DTI- Intact skin	F0686		

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	with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue), R803 to have developed a Stage III (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled wound edges are often present) coccyx wound and R804 to have developed and unstageable left heel wound. Findings include: R801 R801 was admitted to the facility on 10/27/23 with diagnoses that included: malignant neoplasm of cervix, abscess of vulva and acute kidney failure. A Minimum Data Set (MDS) assessment dated 11/2/23, documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition and required staff assistance for Activities of Daily Living (ADLs). Review of a nursing "Admission" evaluation dated 10/27/23 at 7:22 PM, documented in part " ... Clinical Evaluation Integumentary (Skin) ... Does the resident have any skin abnormalities? No ..." Review of a Braden assessment (at tool used to identify a resident's risk for pressure ulcer development) dated 10/27/23 at 4:45 PM, documented a score of 15, which indicated "At Risk". Review of a "Skin - Total Body Evaluation" dated 11/13/23 at 10:35 PM, documented in part " ... wound in <sic> the coccyx. Treatment completed bed bath given ..." Review of the November 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no implemented treatment for the R801's identified			

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	coccyx wound. Review of the medical record revealed no assessments of the physician notification/follow up and monitoring of the identified coccyx wound. Review of a "Skin - Total Body Evaluation" dated 11/16/23, documented in part " ... coccyx wound noted ..." Review of the medical record revealed R801 was transferred to the hospital the next day on 11/17/23 for a change of condition. Review of the hospital records revealed the following: A photograph of the wound taken on 11/17/23 at 11:26 PM, revealed a large unstageable wound that covered the left and right aspects of the sacrum area. A "Surgical Wound Care Consult Note" dated 11/18/23 at 10:23 AM, documented in part " ... Reason for consult: To evaluate the patient's sacral wound ... The patient was found on nursing admission skin assessment to have a sacral wound ... Sacrum (Open unstageable sacral pressure injury) ... Measurements: 11 cm (centimeters) x 14 cm. Unable to determine the entire wound depth ... Base: The centermost aspect of the wound with yellow/tan necrotic base. The outermost aspect of the wound with an open, moist, pale pink and yellow slough mixed base. The wound base has areas of both partial and full thickness tissue loss, with scattered areas of pink hypopigmented scarring present along the outer edges ... Minimal serosanguinous drainage ... wound is slightly malodorous ..." On 3/12/24 at 10:48 AM, the Director of Nursing			

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	(DON) was interviewed and asked about the skin assessments completed on 11/13/23 and 11/16/23 that identified the coccyx wound, with no follow up documented, no assessments of the sacral wound, no physician notification of the wound, no treatments implemented, or care plans implemented, and the DON stated they had a soft file on R801. The DON explained once the resident was admitted to the hospital the family called to question the DON about the sacral wound that they were not informed of. The DON stated after they investigated the situation. Review of an "Investigation report" provided by the DON documented the following in part, " ... Resident was sent to the hospital on 11/17/23. At the hospital resident noticed to have coccyx wound ... CONCLUSION: Resident is alert and able to make her needs known. Was favoring laying on her back in order to elevate(sic) pain and pressure from adenocarcinoma of the vulva. During stay at our facility resident developed wound on coccyx which was unavoidable due to resident medical condition. On 3/12/24 at 1:01 PM, the DON was reinterviewed and asked about their soft file and their conclusion of R801 sacral/coccyx wound to have been unavoidable. The DON was asked how they can conclude that it was unavoidable if the facility never implemented treatment to the area or had the wound monitored and assessed by a physician and the DON acknowledged the concern. The DON stated they had identified problems with the facility's wounds and had educated staff on the correct protocols and policies of the facility for skin impairments. No further explanation or documentation was provided by the end of the survey. R802			

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	Review of the medical record revealed R802 was admitted to the facility on 1/19/24 with diagnoses that included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, quadriplegia, gastrostomy status and heart failure. Review of a Physician Statement of Capacity for Medical Treatment and Decisions" revealed R802 lacked the capacity to make decisions regarding their medical affairs. Review of a nursing "Admission" dated 1/19/24 at 10:31 PM, documented in part " ... Clinical Evaluation Integumentary (Skin) ... Does the resident have any skin abnormalities? No ..." Review of a Braden assessment dated 1/19/24 at 10:28 PM, documented a score of 9.0, indicating "Very High Risk". Review of the medical record revealed the resident was transferred to the hospital on 2/3/24 for a change of condition. Review of the hospital records identified a DTI (deep tissue injury) to the right ear ..." Review of the medical record revealed no identification of the facility staff to have identified the DTI to R802's right ear. Review of the census revealed R802 was readmitted to the facility on 2/10/24. Review of the physician orders documented the following: "Helmet must be on when out of bed, every shift for Craniotomy (brain surgery) ..." order date 2/12/24.			

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	Review of the progress notes revealed the following: On 2/23/24 at 12:55 PM, a "Nursing" note documented in part " ... Opening to right ear. Resident wear helmet due to medical condition. Helmet is ill fitting and slide up and down when on. Family is aware of ill fitting helmet ... asked PCP (primary care physician) for a proper fitting helmet and never was given one ..." Review of the care plans revealed no preventive intervention in place to prevent the helmet opening to have developed. Review of a "Wound Rounds Note" dated 2/27/24 at 4:51 PM, documented in part " ... ear wounds ... noted to have right ear wound. Pt (patient) wears a protective helmet that is malfitting <sic>; slides across ears ... As a result, she has developed a wound on her right ear ... Right ear abrasion, 0.2 cm deep, scant drng (drainage), no cellulitis, base granular, Recommend Tx (treatment) apply foam dressing 3x/week. Review of the wound photo taken by the facility staff on 2/27/24 revealed an open wound to the right ear and the wound bed could not be visualized by the photo. On 3/13/24 at 1:28 PM, the DON was interviewed and asked how the facility staff failed to identify the development of the right ear wound, despite the hospital to have identified it during their hospitalization on 2/3/24 and why the facility did not but preventive interventions in place for the monitoring of the helmet against the residents skin and the DON responded the facility staff did not know that R802 was going to develop the right ear wound and as soon as they found out they addressed it.			

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	No further explanation or documentation was provided before the end of the survey. R803 Review of the medical record revealed R803 was admitted to the facility on 2/15/24, with diagnoses that included: acute kidney failure and diastolic heart failure. Review of a nursing "admission" assessment dated 2/15/24 , documented in part " ... Coccyx - redness ..." Review of a February 2024 MAR and TAR documented the following order implemented " ... PeriGuard external ointment ... Apply to Sacrococcyx & Groin topically every shift for incontinence ..." this order was implemented on 2/15/23. Review of a "Nursing" progress note dated 3/1/24 at 7:04 AM, documented in part " ...Resident coccyx area has openings with small amount of blood noted. Coccyx area cleansed and cream applied. Ordered a wound consult. Logged for dr (doctor) ..." Although worsening of the wound was identified on 3/1/24, the facility nurse continued the Periguard treatment and logged the assessment in the physician's book for them to review the next time the physicians came to the facility. Review of a care plan titled "Risk for Pressure Injury Formation ..." dated 2/16/24, documented the following intervention " ... weekly nursing skin evaluations with showers. Notify PCP (primary care physician) and wound care nurse of any skin changes ..." implemented 2/16/24.			

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	634021	A. BUILDING _____ B. WING _____	3/14/2024

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	Review of the medical record revealed R803 was examined by a physician on 3/3/24, however no documentation of an assessment of the coccyx area was documented. Review of the record revealed no documentation of a physician follow up regarding the wound identified on R803's coccyx area. Further review of the medical record revealed no care plan implemented for the coccyx wound. An additional review of the medical record revealed on 3/11/24, the facility uploaded a wound consultation dated 3/5/24, that documented the following in part, " ... Geriatrics Wound Consult ... consult regarding coccyx ... total area 8.7 x 6.0. The left side is open with yellow necrotic slough, the right side is open and dark granular tissue scant serosanguineous drainage no clinical evidence of infection ... Pressure ulcer of sacral region, unstageable ..." Review of the medical record revealed the resident was transferred out to an appointment and admitted to the hospital on 3/6/24. Review of the hospital records revealed the buttock wounds were identified upon admission and revealed a stage III buttock wound. On 3/12/24 at 10:31 AM, Wound Care Nurse (WCN) "E" was interviewed and asked the facility's protocol when a skin impairment is identified and WCN "E" replied they would assess the residents' skin impairment and implement the treatment they feel is sufficient for the skin impairment and document it in the doctor's log book so the skin impairment could be assessed. WCN "E" was asked to confirm that they would assess the area, implement what treatment they felt the resident should have with			

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	out getting an order directly from the physician? Or informing the physician of the skin impairment assessment? WCN "E" was asked to confirm that they are putting orders in the system for skin impairments without the physician's approval and WCN "E" declined to answer. On 3/12/24 at 2:23 PM, the DON was interviewed and asked why the nurse did not immediately notify the physician on 3/1/24 of the worsening of the coccyx wound instead of logging it in the physician book for the physician to review next time they came to the facility and the DON stated the nurse that identified the worsening of the wound on 3/1/24 was educated on the proper facility protocols when identifying worsening of a wound. On 3/13/24 at 9:19 AM, the DON and WCN "E" requested to talk to the surveyor to clarify WCN "E" statement regarding the implementation of treatment to a skin impairment without notifying the physician and writing it in the log book for the physician to review the next time they visited the facility. WCN "E" stated they go by the recommendations of the facility's policy that documented recommended treatments for skin impairments, both the DON and WCN "E" were asked if they were concerned that staff are implementing treatment from a policy recommendation, and not notifying the physician of the treatment that is being implemented under the physician's name and failing to timely report the skin impairment to the physician and the DON stated they understood the concern and will start education with their staff. No further explanation or documentation was provided by the end of the survey. R804			

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	Review of the medical record revealed R804 was admitted to the facility on 12/23/23 with diagnoses that included: palliative care, hemiplegia and hemiparesis following infarction affecting left non-dominant side and required staff assistance for all ADLs. Review of an "Admission" nursing evaluation dated 12/23/23 at 11:37 PM, documented in part " ... Clinical Evaluation Integumentary (Skin) ... Left lower leg (front) Scar ... Right lower leg (front) Scratches ... Back of head redness ... Right ear dark mold ..." Review of an admission Braden dated 12/24/23 at 12:15 AM, documented a score of 13, which indicated "Moderate Risk". Review of a "Nursing" progress note dated 1/9/24 at 11:17 AM, documented in part " ... Writer informed by staff with new noted skin issues, fluid filled blister to left heel ..." Review of a "Wound Rounds" consultation dated 1/16/24 at 4:44 PM, documented in part " ... seeing pt (patient) re (regarding) ... heel wounds ... Left heel unstageable ulcer, desiccating blood blister, ruptured with central eschar, 2.5 x 1.3 ..." On 3/13/24 at 3:50 PM, R804 was observed sleeping on their back in bed with family at bedside. R804's daughter explained the resident was on hospice and was currently declining and transitioning. Review of the medical record revealed no documentation of the left heel wound to have been monitored, assessed, or evaluated by the wound clinician since 1/16/24. On 3/13/24 at 2:27 PM, the DON was interviewed and asked why R804's left heel			

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	wound had not been monitored or assessed by the wound clinician since 1/16/24 and the DON stated they would look into it and follow back up. On 3/14/23 at 9:31 AM, the DON returned and stated the nursing staff had been educated on wounds and could provide QAPI (Quality Assurance Performance Improvement) documentation of R804's wound to have been monitored. Review of the QAPI documentation provided revealed documentation of measurements of R804's left heel on 1/16/24, 1/24/24, 1/31/24, 2/6/24, 2/13/24, 2/20/24, 2/27/24, and 3/1/24. No additional physician wound assessments were provided. No further documentation was provided by the end of the survey.			
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00143149 & MI00142861. Based on interviews and record reviews the facility failed to ensure supervision for an appointment (appt) was provided for a resident who lacked capacity, one R802 of three residents reviewed for accidents. Findings include:	F0689		

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	Review of a complaint submitted to the State Agency (SA) documented concerns of the facility staff to have failed to accompany R802 to their medical appt and once found, R802's head helmet that's worn for medical purposes was found on the floor. Review of the medical record revealed R802 was admitted to the facility on 1/19/24, with diagnoses that included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, functional quadriplegia, gastrostomy, and anoxic brain damage. Review of a "Physician Statement of Capacity for Medical Treatment and Decisions" documented the resident lacked the capacity to make reasoned medical decisions and provide informed consent for their medical affairs, signed by the second physician on 2/1/24. Review of a "Physician Team - Progress Note" dated 1/22/24 at 2:27 PM, documented in part " ... On 11/6 she had hemicraniectomy (surgical procedure where a large flap of the skull is removed) on right side ..." The resident was status post a surgical procedure of their skull. This was the reason for the helmet worn by R802. Review of a "Nursing" note dated 2/26/24 at 9:34 AM, documented in part " ... out for doctor's appointment ..." On 3/12/24 at 1:33 PM, a telephone interview was conducted with Family Member (FM) "C". When asked about the appointment for R802 on 2/26/24, FM "C" stated they would usually ride on the van with R802 to all of their appointments. FM "C" stated for this particular appointment they walked into the room of R802, and the resident was not in the room. FM "C" then asked			

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	nursing staff where R802 was, and the staff stated R802 had left with the transportation personnel to their appointment. FM "C" asked the staff how they let R802 (a vulnerable resident who lacks capacity to make decisions for themselves) leave on a medical appointment alone. FM "C" stated they ran out of the building and sped to the doctor's office. FM "C" stated once at the doctor's office, they found R802 in the lobby in a geri chair by themselves with their medical helmet on the floor. FM "C" stated there was no personnel with R802 to provide supervision. FM "C" stated the whole incident was unbelievable and they filed a complaint with the facility's Director of Nursing (DON). On 3/13/24 at 9:35 AM, the DON was asked to provide all of grievances filed for or on the behalf of R802. Review of a "Receipt of Concern" form dated 2/27/24, documented FM "C" was upset that R802 was transported to the appointment without FM "C". The DON documented that all staff was educated and documented in part " ... Staff involved in above situation was educated on importance to have family member or facility staff accompany cognitively impaired pt (patient) to outside DR (doctor) appt. (appointment) ..." On 3/13/24 at 1:28 PM, the DON was interviewed and asked if R802 was able to speak or move their body and the DON stated thy resident could not. The DON stated it is not the facility's protocol to allow cognitively impaired residents with transportation staff to outside appointments without facility staff or a family member of the resident. The DON stated they re-educated all of their staff when the incident was reported to them by R802's family. No further explanation or documentation was			

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	provided by the end of the survey.			
F0692 SS= D	Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00142846. Based on interview and record reviews the facility failed to obtain weights per the facility's policy for one (R801) of one resident reviewed for weight loss. Findings include: Review of a complaint submitted to the State Agency (SA) documented a concern of R801 to have had a significant weight loss while inpatient at the facility. Review of the medical record revealed R801 was admitted to the facility on 10/27/23 with	F0692		

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	diagnoses that included: malignant neoplasm of cervix, abscess of vulva and acute kidney failure. A Minimum Data Set (MDS) assessment dated 11/2/23, documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition and required staff assistance for Activities of Daily Living (ADLs). Review of the only documented weight obtained by the facility staff on 10/27/23 at 8:12 PM, documented 143.3 lbs (pounds). Review of the medical record revealed the resident was transferred to the hospital on 11/17/23 for a change of condition. Review of a facility policy titled "Weights" Issued on 5/3/22, documented in part " ... Residents are weighed upon admission and then weekly for a total of four weeks ..." The facility failed to obtain R801's weights according to the facility's policy, three additional weights were missed. On 3/12/24 at 2:01 PM, the Director of Nursing (DON) was interviewed and asked why R801's weight was only obtained on admission, without further weights obtained by the facility staff as directed in the facility's policy and the DON stated they would look into it and follow back up. On 3/13/24 at 8:55 AM, a follow up interview was conducted with the DON and the DON stated they are starting education with the facility staff. No further explanation or documentation was provided by the end of the survey.			
F0773	Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or	F0773		

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SS= E	obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00142846. Based on interviews and record reviews the facility staff failed to ensure labs were completed as ordered by the medical clinicians for one (R801) of three residents reviewed for a change of condition. Findings include: Review of a complaint submitted to the State Agency (SA) documented concerns of the facility to have failed to assess a change of condition with R801 in a timely manner. Review of the medical record revealed the following: A "Complete Blood Count" (CBC) report dated 11/1/23, documented a White Blood Cell (WBC) Count of 12.3, High, (normal range 3.3-10.7). A "Physician Team - Progress Note" dated 11/6/23 at 1:50 PM, documented in part " ... WBC 12.3, repeat labs ... consider UA (urinalysis) if leukocytosis (elevated WBC) persists ..."			

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	Review of the physician orders revealed multiple orders to repeat the CBC labs on the following dates: 11/5/23, 11/12/23, 11/15/23 & 11/17/23. Review of the medical record revealed no documentation of the CBC to have been repeated as directed by the medical clinician for the above dates. A Stat (immediate) CBC was drawn on 11/17/23 when the resident had an identified change of condition and was transferred to the hospital. R801's WBC was documented as 23.2, High, normal range 3.3-10.7. On 3/12/24 at 2:01 PM, the Director of Nursing (DON) was interviewed and asked why R801's CBC labs were not completed as ordered by the medical clinician on 11/5/23, 11/12/23 & 11/15/23 and the DON stated they would look into it and follow back up. On 3/13/24 at 8:55 AM, a follow up interview was conducted with the DON and the DON stated the facility was having trouble with the lab company services and was in the process of changing lab companies at the time. No further explanation or documentation was provided before the end of the survey. Review of a facility policy titled "Laboratory Results" (Issued: 8/18/23) documented in part " ... The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law ..."			
F0825 SS= D	Provide/Obtain Specialized Rehab Services §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-	F0825		

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	language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00143213. Based on interview and record review the facility failed to provide therapy services as ordered by the physician for one (R803) of two residents reviewed for rehabilitation services. Findings include: Review of a complaint submitted to the State Agency (SA) documented the facility failed to provide appropriate and adequate rehabilitation services. The complaint documented in part " ... Multiple times (R803) went 3 & 4 day stretches without PT (physical therapy) or OT (occupational therapy). When we brought this up, we were told they were "short staffed" & another time we were told that a "stomach bug had hit their PT staff ..." Review of the medical record revealed R803 was admitted to the facility on 2/15/24 with diagnoses that included: acute kidney failure and diastolic congestive heart failure.			

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	Review of the documents provided to that facility by the transferring facility noted the resident was transferred for extensive rehabilitation. Review of the physician orders documented the following orders: Rehab: Physical Therapy recommended for skilled treatment [5] times a week until 3/21/24, Start date: 2/19/24. Review of a "Physical Therapy (PT) Evaluation & Plan of Treatment" for the certification period of 2/16/24-3/11/24, documented in part " ... Frequency: 5 time(s)/week, Duration: 25 day(s), Intensity: Daily ... Patient Goals: to get better and return home. Potential for Achieving Rehab Goals: Patient demonstrates good rehab potential as evidenced by high PLOF (Prior Level Of Functioning) Therapist accepting transfer of Plan: PT (physical therapist)/PTA (physical therapist aide) will be assigned ..." Further review of the PT evaluation documented the goals the PT staff would focus on while working with R803. Review of the PT encounter notes revealed R803 was seen by therapy staff only twice the second week and three times on the third week of their inpatient stay, with two to three days passing without being seen by the PT staff . Rehab: Occupational Therapy recommended for skilled treatment [5] times a week until 3/11/24. Review of a "Occupational Therapy OT Evaluation & Plan of Treatment" for the certification period of 2/16/24 - 3/11/24, documented in part " ... Frequency: 5 time (s)/week, Duration: 25 day(s), Intensity: Daily ... Patient Goals: Goal is to return home with spouse and temporary assist if/as needed. Potential for Achieving Rehab Goals ... demonstrates good			

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	rehab potential as evidence by high PLOF, recent onset, good cognition, strong family support, ability to learn new information and able to make needs known ... Therapist Accepting Transfer of Plan ..." Further review of the OT evaluation documented the goals the OT staff would focus on while working with R803. Review of the OT encounter notes revealed R803 was seen by therapy staff four times within the first week and two times in the third week of their inpatient stay. On 3/13/24 at 12:45 PM, Therapy Director (TD) "B" was interviewed and asked why R803 was not seen by the PT and OT staff five times a week as ordered by the physician for rehabilitation services and TD "B" gave an example that if the resident was seen by the OT three times one week and seen by PT twice the same week it satisfies therapy services for the resident for that week. The physician orders were reviewed with TD "B" who acknowledged the orders documented for both OT and PT to be provided five times a week, however TD "B" was adamant that the OT and PT encounters combined satisfied therapy services. On 3/13/24 at 1:36 PM, the Director of Nursing (DON) was interviewed regarding R803 to not have received the five days weekly of PT and OT rehabilitation as documented in the physician's order and the DON replied that it was a concern for them as well and will be following up with the therapy director. Review of a facility policy titled "Physician Involvement in the Plan of Therapy" (Issue Date 7/27/15), documented in part " ... therapists will perform evaluation and treatment of patients only under the direction of the physician ... Following the evaluation, the therapist will immediately develop a Plan of Treatment ... and given to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634021	A. BUILDING _____ B. WING _____	3/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	physician for approval signature ..." Review of a facility policy titled "Recommendations by Ancillary Services" (Issue Date 1/30/24) documented in part " ... treatment rendered to a patient will be in accordance with the specific or standing orders signed by the licensed physician ... The Rehab Clarification order for recommendation of treatment will include the frequency and duration as recommended by the therapist ... recommendations will be entered into the EMR (electronic medical record) ... The recommendation then becomes a physician order when noted signed electronically by the physician ... When a resident requires a changed in frequency and/or extended duration the therapist will communicate with the physician using a Rehabilitation Clarification Order ..." Review of the medical record revealed no Rehabilitation Clarification Order implemented to change the frequency of therapy services for R803. No further explanation or documentation was provided by the end of the survey.			