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	614010	A. BUILDING _____ B. WING _____	4/17/2024

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CHRISTIAN CARE NURSING CENTER	2053 S SHERIDAN DRIVE MUSKEGON, MI 49442

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F0000 SS=	INITIAL COMMENTS Christian Care Nursing Center was surveyed for a Recertification survey on 4/17/2024. Intakes: 143182, 143699 Census=47	F0000		
F0578 SS= D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident	F0578		

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

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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	representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Advanced Directives were documented and communicated sufficiently to reflect the code status of 1 resident (Resident #19), out of 13 residents reviewed for Advanced Directives, resulting in the potential failure to carry out a resident's medical treatment decisions. Findings: Resident #19 (R19) Review of an "Admission Record" reflected R19 originally admitted to the facility on 8/10/2020, and readmitted to the facility after a hospitalization on 11/14/2023 with diagnoses that included vascular dementia. Review of a facility "Medical Treatment Decisions of Resident" form signed by Resident #19's responsible party, witnesses and the Medical Director (MD) ""N" on 3/11/24 reflected "I have been informed in writing, in language I understand, of my rights and all rules and regulations to make decisions concerning medical care, including the right to accept or refuse treatment and the right to formulate and to issue Advanced Directives to be followed if I become incapacitated. In the absence of an advanced directive I understand that any and all life sustaining measures may be used. I may revoke			

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	any and all of my decisions at any time." The form reflected that R19 did NOT wish to have cardiopulmonary resuscitation (CPR). Review of orders in the "Electronic Medical Record" (EMR) did not reflect a code status had been ordered for R19, indicating R19 was a "Do Not Resuscitate" (DNR). R19's code status was not reflected on the resident "Profile". During an interview on 4/17/24 at 2:10 p.m., the Director of Nursing (DON) confirmed R19 did not have an order reflecting R19's Advanced Directives and wish to be a DNR. The DON reported that without an order, it would not be easy for the staff to quickly identify what actions to take in the event R19 was discovered in cardiac arrest. The DON said the facility had recently conducted an audit of each resident's code status and R19 "must have been missed".			
F0582 SS= D	Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not	F0582		

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	covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide notification of planned discontinuation of coverage for Medicare Part A services for 2 residents (Resident #1 and #40) of 3 residents reviewed for this requirement, resulting in the loss of the right to appeal the determination and the potential for unforeseen obligation and hardship.			

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	Findings: Review of a "SNF (Skilled Nursing Facility) Beneficiary Notification Review" form completed by the facility reflected Resident #1 received "Medicare Part A Skilled Services" from 2/8/2024 through 3/27/2024. According to the form, the facility initiated the discharge from Medicare Part A Services when benefit days were not exhausted. The areas on the form indicating that notice of the planned discontinuation (Form CMS-10055 and Form CMS-10123) was provided or other circumstances impacted the notification (resident discharged from the facility and did not receive non-covered services; resident initiated discharge) were not completed. Review of a "SNF (Skilled Nursing Facility) Beneficiary Notification Review" form completed by the facility reflected Resident #40 received "Medicare Part A Skilled Services" from 3/26/2024 through 4/9/2024. According to the form, the facility initiated the discharge from Medicare Part A Services when benefit days were not exhausted. The areas on the form indicating that notice of the planned discontinuation (Form CMS-10055) was provided or other circumstances impacted the notification (resident discharged from the facility and did not receive non-covered services; resident initiated discharge) were not completed. In an interview on 4/17/2024 at 12:07 AM, Admissions Director "O" reported the facility Minimum Data Set (MDS) nurse responsible for completing the notification forms recently quit. Admission Director "O" was unable to provide the required forms for Resident #1 and Resident #40. In an interview on 4/17/2024 at 12:25 PM, the Director of Nursing (DON) reported forms CMS-			

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	10055 and CMS-10123 were required to notify residents of coverage ending. The DON reported form CMS-10055 was not assigned to another staff member when the MDS nurse recently quit. In an interview on 4/17/2024 at 12:30 PM, the Nursing Home Administrator (NHA) reported the facility had an outside agency MDS nurse covering the facility that was not completing the required notifications.			
F0657 SS= D	Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F0657		

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	review, the facility failed to revise the Plan of Care for one Resident (R10) with displays of behaviors affecting others. Findings: Review of the medical record reflected R10 was admitted to the facility 8/27/23 with diagnoses that included a History of Stroke, Hemiplegia (weakness or paralysis on one side of the body), and Dementia. Review of the Minimum Data Set (MDS) dated 2/14/24 reflected a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated that R10 was moderately cognitively impaired. Review of section B of this MDS reflected R10 understands and is understood. On 4/15/24 at 12:15 PM an observation was conducted of the noon meal service at the Faith Hall dining area. Eleven residents were present with most seated either in chairs or wheelchairs at a long rectangular table. R10 sat in a wheelchair at the head of this rectangular table with R12 in a wheelchair on the side corner of the table to his right. R10 was talking to staff and the surveyor in a loud, gregarious, and teasing manner. No other residents were engaged in conversation. R10 continued to talk without interruption to staff who were preparing residents for the meal. When the first tray was passed at 12:25 PM R10 directed his conversation to R12. R12 was observed to not look at R10 unless giving a one-word answer to his questions. R12 often ignored the questions but R10 would continue to talk to her. This persisted throughout the meal. On 4/16/24 at 8:33 AM the morning meal service was observed. R10 was again seated at the head of the table and R12 was again sitting to the right of R10 at the side corner of the table. R10 was speaking loudly to CNA staff as they attend to the			

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	needs of the other residents. R12 was not making eye contact with R10 and not speaking to him when he spoke to her. On 4/17/24 at 8:14 AM at the Faith Dining area R10 and R12 were seated as observed during previous meal services. Certified Nurse Aide (CNA) "D" reported that R10 "is sometimes bothersome" to other residents stating, "he's a talker". CNA "D" reported "we have to tell him sometimes to tone it down ...we do it with a great deal of humor". On 4/17/24 at 11:52 AM an interview was conducted with R12. R12 acknowledged that she sits by R10 at meals. R12 stated that R10 "does make a rude remark from time to time". R12 was asked if staff hear these rude remarks. R12 stated that if staff hear a rude comment staff will "keep him in line". R12 reported that she was "glad" she was asked about this. On 4/17/24 at 10:35 AM an interview was conducted with Assistant Director of Nursing (ADON) "A" and Social Worker (SW) "T" in the office of the ADON. ADON "A" reported when R10 admitted to the facility (8/27/23) the Resident's daughter told her R10 has a "different sense of humor". The ADON reported that "the church ladies (other residents) don't appreciate" his sense of humor. ADON "A" reported R10 was "talked" to about this by his daughter. ADON "A" and SW "T" were asked if this known behavior is addressed in the plan of care for R10. SW "T" reported no information was found in the medical record that identified or addressed this behavior. Review of the current Care Plan for R10 did not reveal any "bothersome" behaviors had been identified. No guidance was found in the Care Plan or in the medical record on how staff were to address a known behavior in a manner to preserve			

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	R10's dignity and social effervescence while ensuring a pleasant dining experience of other residents.			
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 observation, interview, and record review, the facility failed to ensure professional standards of quality were followed for 1 resident (Resident #38) of 13 residents reviewed for professional standards of quality, resulting in the potential for residents to not meet their highest practicable physical, mental, and psychosocial well-being. Findings include: Review of an "Admission Record" revealed Resident #38 admitted to the facility on 1/6/2024 with pertinent diagnoses which included chronic obstructive pulmonary disease and heart failure. Review of a "Minimum Data Set" (MDS) assessment for Resident #38, with a reference date of 2/9/2024 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #38 was cognitively intact. Review of Resident #38's "Physician's Orders" revealed an order for a Lidocaine External Patch started 1/7/2024 and stopped 4/16/2024 with directions to apply to Resident #38's right upper	F0658		

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	back. In an interview on 4/17/2024 at 9:30 AM, Licensed Practical Nurse (LPN) "L" reported the previous week Tuesday or Wednesday she placed Resident #38's Lidocaine patch on his right upper arm instead of his right upper back because Resident #38 requested that she place in on his right upper arm. LPN "L" reported she did not contact the physician to discuss the location change or request an updated order. In an interview on 4/17/2024 at 12:56 PM, the Director of Nursing (DON) reported Resident #38's Lidocaine patch order directed the patch to be placed on his right upper back and not his arm. The DON reported LPN "L" should not have placed the patch on Resident #38's upper arm without an order from the physician. In an interview on 4/17/2024 at 1:00 PM, the Nursing Home Administrator (NHA) reported Resident #38's should have been placed according to the Physician Order on the right upper back and not on his arm. Review of "Employee Coaching", completed 4/17/2024 with LPN "L", revealed "...Detailed Descripton... Applied lidocaine patch to an area other than the ordered placement... Corrective Action... 1-Place patch where ordered... 2-Obtain order for different location if it is patients request..." Review of facility policy/procedure "General Medication Administration", revised 3/31/2022, revealed "...Medications must be administered in accordance with orders..."			
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	F0684		

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	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: Based on interview and record review, the facility failed to ensure admission orders were thoroughly reviewed and transcribed accurately, and pertinent physical assessment findings recognized and promptly addressed for 1 resident (Resident #49) out of 3 closed records reviewed, resulting in two hospitalizations due to missed orders and failure to address a change in condition in a timely manner. Findings: Resident #49 (R49) Review of an "Admission Record" reflected R49 admitted to the facility on 3/21/2024 with diagnoses that included sepsis, localized edema, atrial fibrillation, sick sinus syndrome, atrial flutter, pulmonary hypertension, high blood pressure, acute embolism and thrombosis of unspecified deep veins of lower extremity, muscle weakness and bladder neck obstruction. Review of a hospital "After Visit Summary" dated 3/21/2024 (the day R49 admitted to the facility) reflected "Instructions: Patient (R49) has been having labile INR (international normalization ratio, a measure of how long it takes for blood to clot) measurements. He typically takes warfarin (a blood thinning medication) 5 mg (milligrams)daily but suspect			

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	he will need lower dosing for now. His INR was 2.8 on 3/19 and warfarin 2.5 mg was given which raised his INR to 3.5 on 3/20. No dose was given on 3/20 and his INR was 3.2 today on discharge. He will need daily INR monitoring until he reaches a more steady state." (Normal range for PT is 11-35 seconds. INR of 0.8 to 1.1) Review of a hospital "Encounter Summary" dated 3/21/2024, scanned into the facility Electronic Medical Record (EMR) on 4/7/2024 reflected a "Discharge Summary" which included "Continue daily weights and strict I & O (intake and output), Continue PO (oral) Lasix (a diuretic) 20 mg daily. Review of the facility "History and Physical" (H & P) report dated 3/27/2024 written by Medical Director (MD) "N" reflected R49 had a "Past Medical History" of congestive heart failure (CHF), warfarin induced coagulopathy, history of recurrent DVT (deep vein thrombosis) and bladder outlet obstruction status post Foley catheter. The H & P also noted R49 had "labile INRs". "Review of Systems" reflects R49 felt his weight has been stable, MD "N" noted "lower extremity edema". "Physical Exam" findings indicate "Lungs are clear to auscultation ... He (R49) had trace to +1 pretibial edema, but he also had edema extending up to his posterior thighs bilaterally." The "Assessment and Plan" reflects,."Recommend routine follow-up with cardiology. He has significant lower extremity edema. Recommend increasing his furosemide (Lasix, a diuretic) from 20 mg a day to furosemide 40 mg a day. Recommend rechecking a basic metabolic profile in approximately 10 days. Continue Coumadin (warfarin) 5 mg at bedtime. Recommend weekly protimes (PT) and as needed. INR checked on 3/25/2024 was 2.81 ...". Review of the March 2024 "Medication			

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	Administration Record" (MAR) and "Treatment Administration Record" (TAR) did NOT reflect R49 was being weighed as ordered in the discharge summary. Weekly protimes were ordered as per MD "N" recommendation despite hospital discharge instructions directing daily PT/INR monitoring. Review of a "Dietary Note" dated 3/28/2024 reflected "Continue to monitor weight", however, no frequency for weight monitoring was indicated. Review of a "Health Status" note dated 3/30/2024 reflected, " ...Resident wanted his oxygen level checked. Lungs sounds are clear but dim bilaterally, O2 (oxygen) is 93% on RA (room air). Resident stated he just likes to have it checked because he feels short of breath once in a while but not right now. Reassured resident we are happy to do that and his O2 level is good. Will inform oncoming nurse and continue to evaluate." Review of a "Health Status" note dated 3/31/2024 reflected, " ...Resident noted with edema to bilateral hands and legs, resident states this is an ongoing issue, does receive routine Lasix." The note references edema in R49's hands, which is a progression from the physical exam noted by MD "N" on 3/27/2024. Review of a "Health Status" note dated 4/1/2024 reflected the weekly scheduled PT/INR lab had not been drawn. The nurse notified the provider who ordered the lab to be drawn the following lab day which was scheduled for three days later. No adjustments were made to R49's dose of blood thinning medication. Review of an "IDT Note" (Interdisciplinary Team) dated 4/2/2024 reflected R49 was at the			

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	facility for IV (intravenous) antibiotics, physical and occupational therapy. The note indicated "His (R49's) biggest barrier is endurance and SOB (shortness of breath). Resident does have pulmonary hypertension diagnosis. Alternative options are being considered at this time. Will follow up in next week's Medicare meeting." The note did not specify any "alternative options". Review of a "Health Status" note dated 4/2/2024 reflected, " ...(R49's) Transfers are stand pivot with x2 EA (extensive assist). He needs EA assist (sic) with both upper and lower body dressing as he is very deconditioned, and caution needed with the PICC (peripherally inserted central catheter) line. He is not able to ambulate at this time and can barely stand long enough for staff to complete hygiene post toileting ...". Review of a "Health Status" note dated 4/3/2024 at 11:51 a.m. reflects, "(R49) is swollen around his groin area and his hands, C/O (complains of) SOB, went and asked MD "N" to look at him." Review of R49s "Weight Summary" accessed from the EMR reflected on 3/21/2024 R49 weighed 167.0 pounds. On 4/3/2024 at 1:59 p.m. R49 weighed 191.4 pounds, a 24.4-pound gain in 13 days. Review of a "Health Status" note dated 4/3/2024 at 4:38 p.m. reflected, "Resident was seen by provider today r/t (related to) fluid retention. Labs and medications reviewed. Catheter placement adjusted is patent and draining. Provider gave new orders with verbal instruction if resident declines or does not seem to be improving to call provider or on-call and send resident to hospital ...". Weekly weights were ordered at this time, as well as increased dose of diuretic (Lasix) medication." (The diuretic was increased to twice daily).			

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	Review of a "Health Status" note dated 4/3/2024 at 9:05 p.m. reflected R49 continued to have edema to hands and groin and was started on 1 liter of supplemental oxygen via nasal canula (NC) for a pulse oximetry reading of 88%. The note indicated R49 had 200 milliliters of urine output. Review of a "Health Status" note dated 4/4/2024 at 1:14 p.m. reflected, "Bladder scan completed a pt (patient, R49) had such low urinary output on MN (midnight) shift. 20 cc (cubic centimeters) found to be in bladder mid am (morning) ...Pt did ask to have O2 on ...O2 @ 2L (liter) per NC applied. He does have firm edema up to mid torso." The note does NOT indicate the physician was notified of the increased need for supplemental oxygen or progressive edema. Review of a "Health Status" note dated 4/4/2024 at 6:41 p.m. reflects, "Resident sent to (Hospital) ER (emergency room) per doctor's order for critical labs. PT 82.3 INR 8.53. All appropriate parties notified." Review of a "Health Status" note dated 4/5/2024 at 4:17 a.m. reflected R49 returned from the ER at 2:15 a.m. after getting a dose of Vitamin K (to help clot blood) and IV lasix. Review of a "Health Status" note dated 4/5/2024 reflected, "Resident seen by PCP (primary care provider) for acute visit on 4/4/2024. Review of a "Health Status" note dated 4/7/2024 at 11:20 a.m. reflected, "This pt admitted on 3-21 with a wt. (weight) of 167. He was on Lasix 20 mg daily, on 3/29 his Lasix increased to 40 mg daily. On 4/3 his wt. was 191.4 and his Lasix was increased to 40 mg BID (twice a day). Today his wt. is 193.6 His lungs are fairly CTA (clear to auscultation), but quite diminished. He states he			

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	is more tired than he has been in a long time. He has firm edema up to the nipple line. I placed a call to the on-call Dr. (name of provider) who instructed me to send him to the hospital to be admitted for diuresis. He is now on 2L O2 per NC. This is new over the past couple days." Review of the "Weight Summary" reflected R49 weighed 193.6 pounds on 4/7/2024 at 7:55 a.m., indicating he had gained an additional 2 pounds since his weight on 4/3/2024, for a total weight gain of 26.6 pounds in 17 days at the facility. During an interview on 4/16/2024 at 1:53 p.m., Assistant Director of Nursing (ADON) "A" was asked about R49 course of stay at the facility. ADON "A" said that she was not involved in completing admissions at the facility, Registered Nurse (RN) "B" was. ADON "A" reviewed the concerns identified in the clinical record and said it was concerning that weights had not been monitored for R49 and no physician notification had been done despite documented changes in R49's condition (SOB/use of supplemental O2/increased edema/low urine output). During an interview on 4/16/2024 at 2:00 p.m., the Director of Nursing (DON) was asked if she had reviewed R49's clinical record due to his unplanned hospitalizations. The DON said she had not reviewed the clinical records. ADON "B" explained the concerns that had been identified due to the surveyor review. The DON said that it would be a good idea to review the clinical record of residents who discharge to the hospital to evaluate for areas of improvement and to prevent hospitalizations in the future. During an interview on 4/17/2024 at 8:13 a.m., Registered Nurse (RN) "B" reported she completes most of the admissions at the facility. RN "B" said that the facility gets a packet of			

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	information from the hospital, and she makes sure that the packet matches what is in the chart via (name of hospital EMR) which the facility has direct access to. According to RN "B", she did not see the order for daily PT/INR laboratory draws. RN "B" said she did not see that hospital providers recommended daily weights or strict input and output monitoring. During an interview on 4/17/2024 at 9:08 a.m., MD "N" said that upon admission, R49's heart failure was not a top priority, and he did not see an order for daily weights or strict I & O and did not order weight monitoring. MD "N" said that monitoring strict I & O is just "not done" in Long Term Care because of the inaccuracy and resident access to fluids. According to MD "N", he did not note the hospital discharge instruction to monitor PT/INR daily for R49. MD "N" said he was very concerned about R49's PT/ INR and was very worried about the missed lab draw for PT/INR on 4/1/2024. MD "N" reported he has not been happy with the current laboratory provider and had spoken to the facility about getting a contract with another lab even before the missed PT/INR lab for R49. MD "N" said that R49 was a very sick person, and his fluid retention/edema was compounded by other diagnoses which was why the resident was still in the hospital as of the date of the interview on 4/17/2024. Review of a hospital "History and Physical" dated 4/7/2024 reflects, "(R49) was referred to into the emergency department today due to progressive weight gain, noting a weight of 196 pounds, and a previous weight of 167 pounds on 3/21/2024. Patient seen by primary care at (facility) noting increased peripheral edema, Lasix increased from 20 mg to 40 mg. Patient also describes shortness of breath with activity and orthopnea (discomfort when breathing while lying down flat)...In the emergency department, patient was noted to have clinical evidence of anasarca (extreme			

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	generalized edema or massive edema). BNP (Brain Natriuretic Peptide, a measure of heart function) is elevated 785 (normal range for BNP is less than 100 picograms per milliliter pg/mL). Chest x-ray shows progressive pulmonary edema with increasing bilateral pleural effusions."			
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 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:	F0690		

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	Based on interview and record review, the facility failed to ensure a resident did not experience bowel incontinence and/or complications from constipation for 1 resident (Resident #34), out of 13 residents reviewed, resulting in diarrhea and subsequent constipation when the facility did not implement appropriate bowel monitoring and protocols. Findings: Resident #34 (R34) Review of an "Admission Record" reflected R34 admitted to the facility with diagnoses that included displaced intertrochanteric fracture of right femur, subsequent encounter for routine healing, dementia, depression, high blood pressure, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and unsteadiness on feet. During an interview on 4/12/2024 at 9:44 a.m., R34's Power of Attorney (POA) "Q" reported that R34 had "half a colon" and did not use laxatives prior to admitting to the facility. POA "Q" said that the facility was administering laxative daily for over a week at the facility which resulted in R34 having severe diarrhea. POA "Q" informed the facility that R34 did not take laxative but used "Imodium" (an anti-diarrhea medication). According to POA "Q", R34 was then given far too much Imodium causing severe constipation. Review of the March 2024 "Medication Administration Record" (MAR) reflected R34 was ordered "Senna-Plus (a laxative) Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) Give 1 tablet by mouth at bedtime for constipation-Start Date-3/06/2024 - D/C date - 3/13/2024." The MAR reflects R34 was given the laxative			

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	every evening from 3/6/24-3/12/24. Review of a "Dietary Note" dated 3/12/2024 at 10:35 a.m. indicated " ...Bowels show recent diarrhea/loose stools. ... Continue to monitor B/M ..." Review of a "Health Status" note dated 3/21/2024 at 1:10 p.m. reflects "(POA "Q") has had numerous conversations with several staff members about pts (R34's) medications. Specifically, her Imodium. Earlier in pts stay here, daughter wanted Physician to give an order for Imodium as she would give it at home. Daughter is pts caregiver. Daughter is now concerned that she is getting too much. I did page the provider who told me to change Imodium to PRN (as needed). Also, to give a dose of MOM (Milk of Magnesium). Pt has therapy today, and because of this MOM will be given after therapy leaves today. This was discussed with (ADON). One time order placed to be given between 4-6 today." Another order on the March 2024 MAR reflected, "Imodium A-D Oral Tablet 2 MG (Loperamide HCl) Give 1 tablet by mouth four times a day for Antidiarrheal/loose stools-Start Date-3/12/2024-D/C date-3/22/2024." During an interview on 4/17/2024 at 10:45 a.m., RN "H" reported that the facility has a "Bowel Protocol", and the third shift nurse runs a "bowel report" that shows what residents have not had a BM in three days. The first shift nurse then implements to bowel protocol as needed. RN "H" said that CNA's report issues with BMs to the nurse as needed as well as documents each BM in the clinical record. Review of a facility "Bowel Protocol", undated, reflects, "If Res (resident) is with NO BM (bowel			

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	movement) in 3 days, give 2 Dulcolax tabs (total 10mg). If NO results from 2 tabs in one more shift, then Dulcolax suppository; If Res with NO results from SUPP (suppository), give Fleets ENEMA; If no results from ENEMA, 1st shift to call DR on day 5; Always contact doctor for refusals." During an interview on 4/17/24 at 10:55 a.m., CNA "S" reported she was familiar with R34 and had cared for her during her stay. CNA "S" reported that at one point during R34's stay at the facility, she personally assisted R34 to the toilet 5 times for diarrhea one morning. CNA "S" said the aides are expected to document each bowel movement and also report the abnormalities to the charge nurse. Review of a "Follow Up Question Report - B&B (Bladder and Bowel) Elimination" report for the date range 2/17/2024-4/17/2024 reflected that R34 had a "Large" bowel movement on 3/9/24, 3/10/24, 3/11/24, a large BM and another medium BM 3/12/24, and a "Medium" BM on 3/13/2024. R34 did not have a bowel movement from 3/14/2024-3/24/2024 at 1:59 p.m. (a total of 11 days without a BM). An instance of R34 having 5 loose or watery stools in one morning was not reflected on the BM report, calling into question how well the CNAs were documenting resident bowel and bladder results. During an interview on 4/17/2024 at 12:45 p.m., the Director of Nursing (DON) reported that the Imodium order was not entered into the record correctly and should have been a PRN rather than scheduled. The DON also indicated that there were nurses who did not run the bowel report, resulting in R34 going 11 days without a bowel movement. The DON said that a medication error report had been completed and the nurses who did not run the bowel report had been educated,			

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	however, not all staff had been educated about the bowel medications and bowel protocol expectations.			
F0756 SS= E	Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as	F0756		

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	evidenced by: Based on interview and record review, the facility failed to implement and maintain a process to ensure pharmacy monthly medication reviews and recommendations were reviewed and acted upon by the attending physician for five facility Residents (R2, R24, R30, R42, and R9) resulting in pharmacy recommendations not being reviewed and the potential for unnecessary medication to be administered. Resident #2 (R2) Review of the medical record reflected R2 was admitted to the facility 12/4/23 with diagnosis that included Fractures with Multiple Other Trauma and Depression. Review of the EMR for R2 reflected Pharmacy Notes (Pharmacy Review) entered 12/20/23 and 1/24/24. Both entries reflected "Consultant Pharmacist Monthly Review ... Recommendation (s): Non-Significant Recommendation to Physician". The EMR did not reveal how these "Recommendation(s)" were conveyed to the Physician and related documentation was not located in other areas of the EMR. Resident #24 (R24) Review of the medical record reflected R24 was admitted to the facility 3/8/24 with diagnoses that included Cardiorespiratory Conditions and Diabetes Mellitus Review of the EMR Progress Notes for R24 reflected an entry on 3/13/24 of Pharmacy Notes (Pharmacy Review). The entry reflected "Consultant Pharmacist Monthly Review ... Recommendation(s): Non-Significant			

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	Recommendation to Physician". Like the previous review, the EMR did not reveal how this "Recommendation(s)" was conveyed to the Physician nor was other documentation found in the EMR. On 4/17/24 at 2:01 PM the Director of Nursing (DON) was asked to provide the Pharmacy recommendations and the Physician's response to the recommendations for R2 and R24. The DON reported the recommendations sent by the pharmacist are not available and indicated the Physician has not reviewed the recommendations for R2 and R24.. Resident #30 (R30) Review of an "Admission Record" revealed Resident #30 admitted to the facility on 3/3/2023 with pertinent diagnoses which included Alzheimer's disease, anxiety, and depression. Review of Resident #30's "Pharmacy Notes" revealed monthly pharmacist reviews with non-significant recommendations to the physician on 11/17/2023 and 2/14/2024. Physician follow up documentation to recommendations could not be found in the electronic medical record. Resident #42 (R42) Review of an "Admission Record" revealed Resident #42 admitted to the facility on 9/19/2023 with pertinent diagnoses which included Alzheimer's disease, anxiety, and right sided Hemiplegia (paralysis affecting one side of the body). Review of Resident #42's "Pharmacy Notes" revealed monthly pharmacist reviews with non-significant recommendations to the physician on 11/17/2023 and 1/24/2024. Physician follow up			

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	documentation to recommendations could not be found in the electronic medical record. In an interview on 4/17/2024 at 1:45 PM, the Director of Nursing (DON) reported monthly pharmacist recommendations have not been followed up with by the facility since she was hired in November. The DON reported the pharmacy had been sending these to her but she just found out they were going to a spam folder and that there was no system or process in place to review pharmacist recommendations. Resident #9 (R9) Review of a facility "Admission Record" indicated R9 admitted to the facility on 1/23/24 with diagnoses that included infection and inflammatory reaction due to indwelling urethral catheter, type 2 diabetes, and chronic kidney disease, stage 4 (severe). The record indicated R9 was allergic to Cephalexin (an antibiotic), Codeine (a narcotic), Hyrocodone (a narcotic), Lisinopril (an ACE inhibitor, used to treat high blood pressure and heart failure), Celebrex (a non-steroidal anti-inflammatory drug, NSAID), Flagyl (an antibiotic) and NSAID's. Review of a "Pharmacy Note" dated 1/24/24 at 12:00 p.m. reflected "Consultant Pharmacist Monthly Review ... Recommendation(s): Non-significant Recommendation to Physician" Review of a "Pharmacy Note" dated 3/13/24 at 3:38 p.m. reflected "Consultant Pharmacist Monthly Review ... Recommendation(s): Non-significant Recommendation to Physician" Review of the entire "Electronic Medical Record" (EMR) including "Miscellaneous" documents did not reflect any evidence of the pharmacy recommendations or physician follow-up.			

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	During an interview on 4/17/24 at 1:01 p.m., the Assistant Director of Nursing (ADON) "A" reported that she did not have any information about pharmacy recommendations and would follow-up if she was able to provide any additional information. Pharmacy recommendations for R9 and the Pharmacy Medication Regimen Review policy were requested from ADON "A" at this time. Documentation regarding pharmacy recommendations pertaining to R9 were not received from the facility prior to the survey exit conference on 4/17/24 at 4:15 p.m.			
F0758 SS= D	Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to	F0758		

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	14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to attempt gradual dose reductions of psychotropic medications and ensure PRN (as needed) psychotropic medications were limited to 14 days for 2 residents (Resident #30 and #42) of 5 residents reviewed for unnecessary medications, resulting in the administration of unnecessary medications and the potential for residents to not meet their highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #30 Review of an "Admission Record" revealed Resident #30 admitted to the facility on 3/3/2023 with pertinent diagnoses which included Alzheimer's disease, anxiety, and depression. Review of Resident #30's "Pharmacy Notes" revealed monthly pharmacist reviews with non-significant recommendations to the physician on 11/17/2023 and 2/14/2024. Physician follow up documentation to recommendations could not be			

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	found in the electronic medical record. Review of Resident #30's active "Physician Orders" on 4/17/2024 at 2:10 PM revealed Resident #30 was currently prescribed psychotropic medications including sertraline, trazodone, and quetiapine fumarate. Further review of the electronic medical record revealed no documentation that gradual dose reductions (GDR) were attempted or that risks versus benefits were considered. Review of Resident #30's Pharmacist recommendations documented on a "Note To Attending Physician/Prescriber", dated 11/17/2023, revealed "...(Resident #30) is currently taking the following psychoactive medications... trazodone... quetiapine... sertaline... She is due for a dose reduction evaluation at this time... Please evaluate if a dose reduction would be appropriate at this time... If a GDR is contraindicated, please consider writing a risk vs. benefit statement documenting the clinical rationale for no reduction..." Review of Resident #30's Pharmacist recommendations documented on a "Note To Attending Physician/Prescriber", dated 2/14/2024, revealed "...(Resident #30) is currently taking the following psychoactive medications... trazodone... quetiapine... sertaline... She is due for a dose reduction evaluation at this time... Please evaluate if a dose reduction would be appropriate at this time... If a GDR is contraindicated, please consider writing a risk vs. benefit statement documenting the clinical rationale for no reduction..." In an interview on 4/17/2024 at 1:45 PM, the Director of Nursing (DON) reported monthly pharmacist recommendations have not been followed up with by the facility since she was			

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	hired in November. The DON reported the pharmacy had been sending these to her but she just found out they were going to a spam folder and that there was no system or process in place to review pharmacist recommendations. In an interview on 4/17/2024 at 2:35 PM, the DON reported she reviewed Resident #30's medical record and was unable to find GDR documentation and did not believe that they had been completed or addressed. Resident #42 Review of an "Admission Record" revealed Resident #42 admitted to the facility on 9/19/2023 with pertinent diagnoses which included Alzheimer's disease, anxiety, and right sided Hemiplegia (paralysis affecting one side of the body). Review of Resident #42's "Pharmacy Notes" revealed monthly pharmacist reviews with non-significant recommendations to the physician on 11/17/2023 and 1/24/2024. Physician follow up documentation to recommendations could not be found in the electronic medical record. Review of Resident #42's "Physician's Orders" revealed an order for Ativan (psychotropic medication used for anxiety) Oral Tablet 0.5 MG, directed to take 1 tablet by mouth every 8 hours as needed, started 2/9/2024 and with no end date. Review of Resident #42's Pharmacist recommendations documented on a "Note To Attending Physician/Prescriber", dated 11/17/2023, revealed "...(Resident #42) is currently taking the following psychoactive medication... lorazepam (generic for Ativan) 0.5mg every 8 hours as needed for anxiety... Current guidelines now state that a resident may			

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	not be on a PRN psychoactive for more than 14 days without re-evaluating it's necessity... Recommendation... Please evaluate the use of this medication and determine if it should continue on an "as needed" basis... If this medication is to continue on an as needed basis, please provide a Risk vs. Benefit statement and include a date when you will re-evaluate the use of this medication (END DATE)..." Review of Resident #42's Pharmacist recommendations documented on a "Note To Attending Physician/Prescriber", dated 1/24/2024, revealed "...(Resident #42) is currently taking the following psychoactive medication... lorazepam (generic for Ativan) 0.5mg every 8 hours as needed for anxiety... Current guidelines now state that a resident may not be on a PRN psychoactive for more than 14 days without re-evaluating it's necessity... Recommendation... Please evaluate the use of this medication and determine if it should continue on an "as needed" basis... If this medication is to continue on an as needed basis, please provide a Risk vs. Benefit statement and include a date when you will re-evaluate the use of this medication (END DATE)..." In an interview on 4/17/2024 at 1:45 PM, the Director of Nursing (DON) reported monthly pharmacist recommendations have not been followed up with by the facility since she was hired in November. The DON reported the pharmacy had been sending these to her but she just found out they were going to a spam folder and that there was no system or process in place to review pharmacist recommendations. In an interview on 4/17/2024 at 3:43 PM, the DON reported Ativan should not be ordered PRN with no stop date. Food Procurement,Store/Prepare/Serve-	F0812		

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F0812 SS= F	Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to: 1. Properly date mark and discard food product; 2. Properly store food product; 3. Ensure cleaning of food and non-food contact surfaces; 4. Air dry pots and pans; and 5. Minimize bare hand contact with ready to eat food. These conditions resulted in an increased risk of contaminated foods and an increased risk of food borne illness that affected 49 residents who consume food from the kitchen. Findings Include: 1. During an interview with Certified Dietary Manager (CDM) "M", at 9:25 AM on 4/15/24, it was found that potentially hazardous foods made in house are held for three days and commercially prepared products are generally held for seven days. Observation of the walk in cooler at this time found the following: an open package of honey ham with no date, a container of ham roll			

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	ups with no date, a container of beef tips and gravy with no date, an open saran wrapped package of turkey with no date, an open package of hot dogs with no date, a container of purred devil eggs dated 3/29 to 4/7, French onion dip dated 3/14 to 3/19, BBQ pork dated 4/7 to 4/12, Pizza sauce dated 4/7 to 4/12, Butternut Soup dated 3/6, and a pitcher of strawberry smoothie with no date. During the initial tour of the Faith kitchenette, at 10:45 AM on 4/15/24, observation of the refrigerator found a thickened dairy beverage open and dated for 3/29. During the initial tour of the Love Kitchenette, at 10:56 AM on 4/15/24, it was observed that a open container of thickened water was found with no date. A review of the manufacturer's directions state the item is good for "7 Days" after opening. According to the 2017 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. "(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is			

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	opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety ..." According to the 2017 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. "(A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) ..." 2. During the initial tour of the facility, at 9:50 AM on 4/15/24 (Monday), it was observed that boxes of food were found stored on the floor of the walk in freezer. When asked when the facility gets deliveries, CDM "M" stated they get them on Thursdays. According to the 2017 FDA Food Code section 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor.			

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	3. During the initial tour of the kitchen, at 9:57 AM on 4/15/24, observation of a clean utensil drawer containing metal spoons, found an increased accumulation of debris. When asked how often staff should be cleaning the drawers out, CDM "M" stated its done weekly. During the initial tour of the kitchen, at 10:01 AM on 4/15/24, observation of the main kitchen found an increased amount of accumulation on the inside top of the microwave. During the initial tour of the clean pots and pan drying rack, at 10:03 AM on 4/15/24, it was observed that three eighth pans were found stacked with white food debris and residue. During the initial tour of the Kitchenettes, starting at 10:45 AM on 4/15/24, it was observed that both microwaves were found to have an accumulation of debris with the Microwave in the Love Kitchenette showing pitted and chipping surfaces on the inside of the unit. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." 4. During an initial tour of the kitchen, at 10:02 AM on 4/15/24, it was observed that two quarter pans and three eighth pans were found stacked and stored wet with accumulation of water.			

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	According to the 2017 FDA Food Code section 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD ..." During an observation of the noon meal on 4/15/24 at 12:36 p.m., Certified Nurse Aide (CNA) "F" used her bare hands to fold a soft shell tortilla into a wrap for Resident #30 (R30) and encouraged the resident to eat. CNA "F" then went around the table and folded the soft shell tortilla being served into a wrap for Resident #14 (R14) and encouraged that resident to eat. According to the 2017 FDA Food Code section 3-301.11 Preventing Contamination from Hands. "(B) Except when washing fruits and vegetables as specified under §3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT ..."			
F0880 SS= F	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a	F0880		

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	minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will			

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	conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: ased on observation, interview, and record review, the facility failed to implement and maintain an effective Infection Control Program to include comprehensive surveillance of facility infections and education and implementation of infection control measures for one facility Resident (R9). Findings: Review of the facility policy titled Infection Prevention and Control Program last reviewed 1/23/24 reflected. "Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines." 1. The designated Infection Preventionist(s) is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases. 2. Surveillance: ... b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee.			

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CHRISTIAN CARE NURSING CENTER	**2053 S SHERIDAN DRIVE MUSKEGON, MI 49442**

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	On 4/16/24 at 2:52 PM an interview was conducted with Registered Nurse Infection Preventionist (IP) "B". IP "B" reported she received her IP certification in 2019 but is new to implementing and maintaining a comprehensive Infection Control program. IP "B" reported she does not currently receive memos for the Center for Medicare and Medicaid Services (CMS) or from Center for Disease Control (CDC). IP "B" acknowledged new Enhanced Barrier Precautions (EBP) information has been disseminated by CMS but has not reviewed these updates. IP "B" reported residents recommended to be on EBP are designated as such and staff are educated at the time of implementation of these precautions. IP "B" reported this education is not documented and no all-staff in-service has been conducted on the new EBP information. IP "B" was initially not able to verbalize the facility surveillance process but did convey that a monthly log with mapping of infections is maintained. IP "B" produced a binder separated by months of the year. IP "B" demonstrated the January 2024 log and mapping reflect the infections, antibiotic use, and a map of the resident's rooms with infections and their proximity to one another. IP "B" reported in January three residents with urinary tract infections (UTI) were identified and the rooms were close to each other. IP "B" reported she conducted staff education of perineal care and audited staff adherence to hand hygiene. However, the log displayed that no symptoms or culture results were documented for one resident with a UTI. The entry reflected that the antibiotic was initiated at the hospital prior to the resident's admission to the facility and continued by the facility without ensuring pertinent criteria was documented. IP "B" reported she was instructed that if the hospital initiates an antibiotic the facility just continues it and does not complete the facility protocol. Review of the log for February 2024 reflected eight facility infections which			

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	included four cases of COVID 19 and one UTI. The log reflected that the "symptoms" box contained a zero for the resident with the UTI. The log reflected a culture obtained on 2/18/24 for this resident but the results section was blank. The mapping form in the February 2024 section was blank, therefore the location and proximity to each of the 4 COVID 19 cases is not evident. Despite the blank form in the binder IP "B" reported mapping had been done for February 2024 but this had not been provided by survey exit. Review of the log for March 2024 reflected six infections with one UTI which was without documented symptoms. IP "B" reported mapping was not done for March 2024. The policy provided by the facility titled "Infection Surveillance" last revised 1/1/24 was reviewed. The policy reflected: "Policy: A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections." And Policy Explanation and Compliance Guidelines: 1. The Infection Preventionist serves as the leader in the surveillance activities, maintains documentation of incidents, findings and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee ...". And "6. The facility will collect data to properly			

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	identify possible communicable diseases or infections among residents and staff before they spread ...". And "8. Monthly time periods will be used for capturing and reporting data. Line charts will be used to show data comparisons over time and will be monitored for trends." The lack of consistency in adhering to written infection control policy and protocols places at risk the ability of the facility to effectively manage and limit the onset and spread of infections. Resident #9 Review of a facility "Admission Record" indicated R9 admitted to the facility on 1/23/24 with diagnoses that included infection and inflammatory reaction due to indwelling urethral catheter, chronic venous hypertension (idiopathic) with ulcer of left lower extremity, and non-pressure chronic ulcer of other part of unspecified foot with unspecified severity. Review of a "Care Plan" initiated on 1/23/24 indicated R9 has a urinary catheter, pressure ulcer and required assistance with Activities of Daily Living (ADL) with a goal of remaining free of complications with the catheter or infections. An intervention added to the care plan for pressure ulcer on 1/25/2024 was "ENHANCED BARRIER PRECAUTIONS: Gown and Gloves for Direct Cares". An intervention added to the catheter and ADL care plan on 3/30/2024 instructed staff to "Use Enhanced Barrier Precautions for Catheter Cares" and "Use Enhanced Barrier Precautions with Direct Cares".			

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	During an observation and interview on 4/15/2024 at 11:15 a.m., signage on the door of R9 indicated the resident was on "Enhanced Barrier Precautions". The sign indicated providers and staff were to wear gloves and a gown for high contact resident care activities such as dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy and wound care: any skin opening requiring a dressing change. A tower of Personal Protective Equipment (PPE) that included gowns and gloves were behind the door of R9's room. During the observation on 4/15/2024 at 11:15 a.m., Certified Nurse Aide (CNA) "F" entered R9's room and asked her if she would like to get washed up and dressed for the day. R9 said yes and consented to the surveyor observing the cares. CNA "F" assembled her supplies and assisted R9 remove her sleeping gown and wash her upper body. CNA "F" then cleaned R9's catheter and lower body before assisting R9 dress in a fresh gown. CNA "F" wore gloves but did not don a gown for the procedure. During an follow-up interview on 4/15/24 at 2:00 p.m., R9 reported that the staff never don the PPE and she should ask them to get it out of her room. R9 did not know why the PPE was in her room and could not explain what Enhanced Barrier Precautions were or why it was required. Review of a policy "Enhanced Barrier Precautions" implemented 1/20/2024 reflected, "It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug resistant organisms. "Enhanced Barrier Precautions" refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be			

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	colonized with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices)." The policy indicated "a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions; b. All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions... ". The policy also indicated that residents and visitors would be educated about the requirement.			
F0881 SS= D	Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement antibiotic use protocols and a system to monitor antibiotic use for 1 resident (Resident #34) out of 5 residents reviewed for high-risk medications, resulting in the potential for antibiotic resistance, adverse reactions and/or complications from inappropriate antibiotic use. Findings: Resident #34 (R34) Review of an "Admission Record" reflected R34 admitted to the facility with diagnoses that included displaced intertrochanteric fracture of right femur, subsequent encounter for routine	F0881		

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	healing, dementia, depression, high blood pressure, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and unsteadiness on feet. Review of a hospital "After Visit Summary" dated 3/15/24 indicated R34 was seen in the hospital emergency department for "Multiple complaints from family, fall". R34 was diagnosed with "Acute cystitis without hematuria" (bladder infection without blood in the urine). Tests run at the hospital included a "Urinalysis with reflex microscopic" (a test to detect abnormalities in the urine). The summary indicated a urine culture was in progress. R34 was prescribed the antibiotic "Cephalexin (Keflex) 500 mg capsule - Take 1 capsule (500 mg total) by mouth 2 (two) times a day for 5 days." Review of a "Health Status" note dated 3/15/24 at 4:09 p.m. indicated R34 was sent to the hospital emergency department (ED) at the request of R34's responsible party for an evaluation of R34's eye. Review of a "Health Status" note dated 3/16/24 at 10:13 a.m. indicated R34 returned from the hospital ED at 8:30 p.m. (on 3/15/24) with a new diagnosis of UTI (urinary tract infection) with a culture and sensitivity (C&S) report pending. "No orders were sent with patient ... Will wait for C&S results from UA completed in ER. Resident denies urgency, burning or frequency. Will continue to monitor. PCP (Primary Care Physician) made aware." Review of a "Health Status Note" dated 3/16/24 at 11:19 a.m. reflected "Note text: Contacted on call, (name of on-call provider), about starting Keflex 500 mg 2x (two times)/day for 5 days and she stated that should be fine and to go ahead with prescription as stated from the hospital."			

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	Rational for starting R34 on the antibiotic despite not having any signs or symptoms of a UTI were noted. Review of the March 2024 "Medication Administration Record" (MAR) reflected R34 was given "Keflex Oral Capsule 500 MG (Cephalexin) Give 1 capsule by mouth two times a day for UTI for 5 Days -Start Date 3/16/2024" twice daily as ordered from 3/16/24-3/20/2024. Review of a pharmacy form "Antimicrobial Dosing Recommendation" dated 3/20/2024 (the same day R34 completed the 5 day course of antibiotic) indicated that R34's "Calculated Creatinine Clearance" (a measure of kidney function) was "33 ML/MIN" (milliliter/minute). The pharmacist did not recommend a dose adjustment. The form was signed by the provider on 3/26/2024, 6 days after R34 completed the antibiotic. Review of "Health Status" noted dated 3/22/2024 at 4:52 a.m., 3/24/2024 at 4:53 a.m., 3/27/2024 at 4:19 a.m. reflected the licensed nurse was documenting R34 is "currently on antibiotics for UTI" despite the completion of the order as reflected in the March 2024 MAR on 3/20/2024. Review of laboratory reported in the "Electronic Medical Record" (EMR) do not reflect evidence of a culture and sensitivity report or result. Review of a physician "Progress Note" dated 3/18/2024 documented by Medical Director (MD) "N" indicate R34 was seen as a follow-up after emergency room evaluation. The note references "Laboratory" results as follows: 3/15/2024: Urinalysis revealed specific gravity of 1.025, positive nitrite, 3-10 white blood cells per high-power field, 3+ bacteria and urine culture revealed greater than 100,000 g/mL (grams per			

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	milliliter) of E. coli. The E coli is pan sensitive (the organism is sensitive to all the antibiotics usually tested for potential treatment); 3/15/2024 BUN (blood urea nitrogen) 33, creatinine 1.01 with a GFR (glomerular filtration rate) of 55." The physical assessment indicated that R34 denied any signs or symptoms of a urinary tract infection. It is not clear where MD "N" got the laboratory results or culture and sensitivity report. Review of the entire EMR for R34 did not reflect a "UTI Protocol" form had been completed. During an interview on 4/16/24 at 2:52 p.m., Infection Control (IC) Registered Nurse (RN) "B" reported that because R34 was diagnosed with a UTI in the hospital ED, the UTI protocol was not done. According to RN "B", the physician accesses laboratory results in a hospital electronic health record and makes treatment decisions based on those results. RN "B" said the pharmacy calculates the creatinine clearance and adjusts the dose as necessary. RN "B" said that nurses can administer one dose of antibiotic without a creatinine clearance but must wait until pharmacy approves or adjusts the dose of antibiotic before a second and subsequent doses can be administered. At the time of this interview RN "B" contacted the pharmacy and asked why the creatinine clearance wasn't calculated for R34 until the fifth day of antibiotic administration. The pharmacy reported difficulty in obtaining from the facility the laboratory and patient values needed and subsequently had to obtain the data themselves. Review of a policy "Antibiotic Stewardship Program" dated 1/1/2024 reflected "It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the			

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	treatment of infections while reducing the adverse events associated with antibiotic use." The policy specified, "a. Medical Director - sets the standards for antibiotic prescribing practices for all healthcare providers prescribing antibiotics, oversees adherence to antibiotic prescribing practices, and reviews antibiotic use data and ensures best practices are followed; b. Director of Nursing - establish standards for nursing staff to assess, monitor and communicate changes in a resident's condition that could impact the need for antibiotics, use their influence as nurse leaders to help ensure antibiotics are prescribed only when appropriate, and educate front line nursing staff about the importance of antibiotic stewardship and explain policies in place to improve antibiotic use. ... 2. The Antibiotic Stewardship Program leaders utilize existing resources to support antibiotic stewards' efforts by working with the following partners: a. Infection Preventionist ... b. Consultant Laboratory ... c. State and Local Health Departments ... 3. Licensed nurses participate in the program through assessment of residents and following protocols as established by the program. 4. The program includes antibiotic use protocols and a system to monitor antibiotic use."			
F0947 SS= E	Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides	F0947		

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	providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure certified nursing assistants completed the required 12 hours a year of in-service training, resulting in the potential for inadequate and substandard quality of care for residents living at the facility. Findings include: Review of "Employee Online Inservice Training" competencies report, current 4/16/2024, revealed out of 30 Certified Nursing Assistants (CNA) listed on the report, 27 had not completed any of the assigned training's including body mechanics/ergonomics, fire safety prevention guidelines, HIPAA privacy/confidentiality, infection control & awareness, influenza awareness & prevention, pressure ulcers risk control, resident/client rights guidelines, sexual harassment awareness, violence in healthcare workplace, abuse, bloodborne pathogens, emergency and disaster procedures, end of life care, grievance filing guidelines, safety and incident reporting, care for dementia/alzheimers, CNA proficiency skills review, nutrition and hydration, kitchen sanitation, foodborne illness prevention, restraint free/fall prevention, medication effects on the elderly, customer service, OSHA's hazardous communications, slipstrips&fall prevention/employees, conflict resolution/effective communication, vital signs review, COVID-19 and hand washing, cleaning high touch surfaces, reacting to an active shooter, CDC COVID19 training for LTC, first aid review, and restorative care.			

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	In an interview on 4/16/2024 at 12:59 PM, Human Resources (HR) Director "P" reported it was her responsibility to pull reports to track whether staff were completing their online training. HR Director "P" reported most staff were behind on trainings and the competency report reads "OPEN" if the training had not been completed. HR Director "P" reported she was trying to work with staff to get caught up on training. In an interview on 4/16/2024 at 1:47 PM, CNA "R" reported she was aware she was behind on completing online annual in-service training. CNA "R" reported she was given access a couple weeks ago and planned to work on getting caught up. In an interview on 4/16/2024 at 1:42 PM, the Director of Nursing (DON) reported she was aware CNA's were behind on annual competencies and the facility was working on this. In an interview on 4/17/2024 at 1:20 PM, the Nursing Home Administrator (NHA) reported all staff on the competency report that read "OPEN" on a competency had not completed the training. The NHA reported the facility was aware that they were behind on Inservice online training and were working to get caught up. Review of facility policy/procedure "Nurse Aide Training Program", revised 12/29/2022, revealed "...This facility maintains an appropriate and effective nurse aide in-service training program for the purpose of ensuring the continuing competence of nurse aides... Each nurse aide shall be provided at least 12 hours of in-service training annually, based on his/her employment date... It is the responsibility of the employee to attend/complete mandatory in-service trainings to			

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	maintain employment status with the facility... Minimum training will include... Effective communication... Dementia management... Abuse, neglect, and exploitation prevention... Elements and goals of the facility's QAPI program... Resident Rights and facility responsibilities... infection prevention and control... compliance and ethics... safety and emergency procedures... behavioral health..."			