STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	5/9/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE CARE OF BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Pinnacle Care of Battle Creek was surveyed for a re-visit survey on 05/09/2024. Census=46	F0000		
F0561 SS= D	Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure resident choices were honored for one of three residents (Resident #4) reviewed for choices resulting in feelings of no self-worth, frustration, and distress.	F0561	F561 Element #1 Administrator received call from Resident #4's guardian on 5/21/24 regarding the resident's desire to transfer. Guardian stated she does not want to transfer the resident at this time. A letter from the guardian confirming these wishes were added to resident's EMR. Element #2 The facility has determined that all residents have the potential to be affected by the deficient practice. The social worker/designee will query interview-able residents at the facility for self-determination and will notify resident guardians as needed. Element #3 The Resident Rights Policy was reviewed and deemed appropriate by the QAPI Committee on 5/24/2024. Facility Staff will be re-educated and tested on Resident Rights by 6/6/2024. Staff will not be allowed to work until education and testing are completed. Element #4 The Social Service Director/Designee will conduct random audits of 3 residents 3 x weekly for 4 weeks for discharge planning.	4/22/2024

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

Electronically Signed | 05/26/2024

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	Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated 3/29/24, revealed Resident #4 (R4) was admitted to the facility on 12/15/23 with diagnoses that included overactive bladder, major depressive disorder, adjustment disorder with anxiety, and vascular dementia. Review of the same Minimum Data Set (MDS) revealed R4 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). In an observation and interview on 5/8/24 at 2:59 PM, R4 was seated in his wheelchair while watching television. R4 was easily conversant, understood, and answered questions appropriately. During the interview, R4 expressed that he wanted to be transferred to another facility and had requested this multiple times for months. R4 reported that he has no friends in this building, and one of the reasons he requested a transfer is because he would love the opportunity to gain meaningful friendships with other residents in another facility. R4 stated that he would like to go to a facility in the Holland area, however, R4 has a guardian and stated that he was informed that the guardian was aware of this request. When asked if there had been any follow up or discussion regarding his request to transfer, R4 stated that there has been no discussion. R4 stated that he has never met his guardian but feels that his guardian is awful. R4 said "I know he or she has a lot of responsibilities, but I would love the opportunity to speak with them for even five minutes so that they could hear my reasoning and talk to me about what I want. My guardian does not consider me as an individual and won't let me have a life of my own and allow me to chose things that are meaningful to me". Review of a Nurses Note dated 3/14/24 at 8:45		Results of the audits will be reported to QAPI monthly. The Administrator is responsible for sustained compliance. The Compliance Date is 6/6/2024	

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	AM revealed" IDT [Interdisciplinary] team met to discuss plan of care for resident, resident has expressed wanting to move to Holland. Reviewed homes in Holland with resident. Guardian states he frequently asks to move. Left additional voicemail for [Guardian name] to set up dc [discharge] care conference." Review of the Care Conferences for R4 revealed that resident had not had a Care conference since 12/19/23. Review of a Nurses Note dated 4/22/24 revealed "this nurse called guardian and left voicemail asking id guardian would like resident to start medication recommendation from [Behavioral Health Service] ...this nurse also reminded guardian that resident is stating that he would like to change facilities." Review of a Nurses Note dated 4/23/24 at 10:58 AM revealed "Guardian left voicemail for this nurse last night stating that guardian consents to [Behavioral Health Recommendations and immunizations]. Guardian requested this nurse call her back for clarification regarding resident wanting to move facilities. This nurse returned phone call and received guardians voicemail ...". Review of a Nurses Note dated 4/25/24 at 12:08 PM revealed "Resident guardian has not returned this nurses phone call. This nurse left another voicemail for guardian to return phone call regarding residents request to move facilities." In an interview on 5/8/23 at 3:56 pm, Unit Manager "D" verified that she was the nurse that created the nurses note regarding R4's request to change facilities. Unit Manager "D" stated that she had not made any further attempts since 4/25/24, aside from today, to contact R4's guardian and the facility had not held a care			

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	conference to discuss R4's request to transfer to a different facility.			
F0565 SS= E	Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F0565	F565 Element #1 The First grievance form, related to call lights and showers, staff is currently answering call lights in a timely manner and giving showers as scheduled. The grievance form was signed and dated by the facility staff and the council president to reflect the complaint was addressed to the resident's liking. The Second grievance form related to showers, the staff is giving showers as scheduled. The Grievance form was signed and dated by the facility staff and resident council president to reflect it was addressed to the residents liking. The Third grievance form related to the bowel and bladder, resident was put on bowel and bladder schedule. The grievance form was signed and dated by the facility staff and the council president to reflect the complaint was addressed to the resident's liking. The Fourth grievance form related to the resident's walker, resident was put on restorative program. The grievance form was signed and dated by the facility staff and the council president to reflect the complaint was addressed to the resident's liking. The Fifth grievance form related to waters, staff educated on passing waters. Managers are assisting with water pass. The grievance form was signed and dated by the facility staff and the council president to reflect the complaint was addressed to the resident's liking. The Sixth grievance form related to the call lights, staff is answering call lights timely and	4/22/2024

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	Based on interview and record review, the facility failed to act promptly on grievances reported in resident council meetings and provide responses to grievances in seven of seven residents, as reported during a confidential resident council interview, in a total sample of 30 residents. During a private resident council meeting on 05/09/24 at 10:00 AM, 14 residents were in attendance. Group identified as an anonymous group. Group commented that the grievance/ complaint process had not been resolved as stated in the plan of correction dated 04/22/2024. Residents who filed complaints/concerns prior to the plan of correction date remains unresolved. Writer reviewed seven complaint/grievance documents were not resolved. Record review revealed a resident council meeting was held on 04/12/24 at 2:00 PM. Old business discussed was showers, waters, and call lights. Acceptance of old business was marked no. Details included no call lights and ice waters. Under new business, call lights and ice waters were written in again. First complaint/grievance form identified call lights are not being answered in a timely fashion and not receiving showers regularly dated 04/15/24. Section for facility response was blank. Corrective action to be taken was to place a sign in residents' room for a reminder of shower days. Documentation to be completed for showers. Activity Director will conduct a call light audit. Bottom of form signed and dated by facility staff. No follow up, audit or residents' signature to show it was addressed to their liking. Second grievance/complaint form reported not getting showers regularly dated 04/15/24. Under section how can we address your issue? Getting showers on shower days. Bottom of first page		managers are assisting. The grievance form was signed and dated by the facility staff and the council president to reflect the complaint was addressed to the resident's liking. Element #2 The facility has determined that alert and oriented residents have the potential to be affected by the deficient practice. The facility will query interview-able residents for grievances by 6/6/2024. Element #3 The Grievance, Call Lights, and Staffing Policy has been reviewed and deemed appropriate by the QAPI Committee on 5/24/2024. The Administrator and Facility Staff will be reeducated and tested by the nurse consultant on the Grievance Policy by 6/6/2024. Element #4 The Activity Director will conduct random audits of 3 residents 3 x weekly for 4weeks for Grievances. Results of the audit will be reported to monthly QAPI. The Administrator is responsible for sustained compliance. The Compliance Date is 6/6/2024.	

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	signed and dated by facility staff for 04/15/24. Under facility response, staff to document when resident does/does not receive a shower. Corrective action to be taken, sign placed in residents' room as reminder. Resident will be reapproached if refuses. Date resolution letter by; facility staff, no date, no resident signature. Bottom of the form signed by facility staff and dated 04/17/24. No follow up, audit or residents' signature to show it was addressed to their liking. Third grievance/complaint form with concern: resident would like to be put on a bowel and bladder schedule. Woke up every two hours especially through the night dated 04/12/24. Bottom of the first page was signed and dated by facility staff. Under facility response, resident asked to be places on a B&B retraining program. Under corrective action to be taken, resident placed on a B&B program. Date resolution letter signed and dated by facility staff on 04/12/24, Facility staff also signed and dated the bottom of the second page on 04/15/24. No follow up, audit or residents' signature to show it was addressed to their liking. Fourth grievance/complaint form with concern: resident wants his walker dated 04/15/24. Under how can we address your issues? Give him back his walker. Facility staff signed and dated the bottom of the first page 04/15/24. Under facility response, resident is a regular walker. Under corrective action to be taken, resident is unsafe to ambulate and guardian is wanting resident to follow facility recommendations. Resident to be placed on restorative program. Date resolution letter: signed by a facility staff but not dated. At the bottom of the second page, the facility staff signed and dated it for 04/17/24. No follow up, audit or residents' signature to show it was addressed to their liking.			

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	Fifth grievance/complaint for with concern: Waters. Under when did the problem or incident accrue? Brought up in resident council, dated 04/12/24. Bottom of first page signed and dated by facility staff for 04/12/24. Under facility response, resident c/o not getting waters. Corrective action to be taken, residents receive water at the start of each shift. Management in agreement to assist with waters throughout the day. Date of resolution, facility staff signed and dated for 04/15/24. Bottom of second page was signed and dated by facility staff for 04/15/24. No follow up, audit or residents' signature to show it was addressed to their liking. Six grievance/complaint form with concern: call lights. When did the problem or incident occur? Brought up in resident council dated 04/12/24. Under how we can we address your issue; answer call lights timely. Bottom of first page signed and dated by facility staff for 04/12/24. Under facility response, resident's c/o call lights. Corrective action to be taken, Activity Director performing call light audits. Date resolved signed by facility staff and dated 04/15/24. No follow up, audit or residents' signature to show it was addressed to their liking. Record review revealed a Survey Plan of Correction AD Hoc resident council meeting on 04/12/24. Under question section, written in no questions asked or concerns. Small talk from residents, unrelated to policies and survey. Record review revealed the residents (38) that do not attend resident council meetings were asked a single question, "Do you have any concerns that need to be addressed? Answered with a yes or no response. During this same resident council meeting on 05/09/24, anonymous residents shared they were			

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	afraid of retaliation if they complained. They also stated they would get less care than they are already receiving. Call lights were brought up again, adding how can they check the call light response time, when the lights are not even working. When asked how they make there needs known, they shared they just start yelling out until someone comes in their room. During an observation on 05/09/24 at 10:30 AM of staff going room to room handing out new bells to use for call lights. During an interview with Activity Director (AD) "J" stated she takes the residents concern to the stand down meeting with all departments at the end of the day. She will read them off and give them to the department responsible for them. AD "J" stated she had not ever had residents sign off on the grievance/complaint form showing the complaint resolved. Asked how she knows the grievance/complaint had been resolved. AD "J" stated when she gave it to the department, she assumed it was taken care of. Writer asked AD "J" how she tracked the resolution and she stated she had a binder that she kept all the resident council concern forms in. Writer asked AD "J" why the staff were handing out bells this morning. AD "J" stated that the call lights were not working. Writer asked AD "J" so the complaints of long wait time for the call lights to be answered, was the call lights even working? AD "J" stated she thought so. During an interview on 05/09/24 at 1:08 PM, Former NHA "B" stated they held an Ad Hoc meeting for resident council on the survey plan of correction. Writer asked for an agenda and signature sheet. Former NHA "B" stated that AD "J" had it. During an interview on 05/09/24 at 1:10 PM, AD			

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	"J" stated she did not know what an ad hoc meeting was, and she didn't have anything related to that. Record review revealed a new document provided for a Resident Council Ad Hoc Meeting dated 04/12/24. The document had four residents' names written on the bottom of the page. Also had under questions, that no questions or concerns were voiced. During an interview on 05/09/24 at 1:15 PM, UM/LPN "D" stated she always signs the grievance/complaint forms because she is the one that follows up on them. UM/LPM "D" also stated her signature meant she did what was asked of her. Also stated she doesn't know who fills the complaint so she can not follow up on them.			
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 covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in	F0582	F582 Element #1 Facility notified Resident #14's guardian by phone and certified mail on 5/10. Element #2 The facility has determined that all residents with a qualifying hospital stay and Medicare Part A benefit days available have the potential to be affected by the deficient practice. An Audit was conducted on current residents who were admitted in the past six months, and corrective actions, if needed will be completed by 6/6/2024. Element #3 The Advance Beneficiary Notices Policy was reviewed and deemed appropriate by the QAPI Committee on 5/24/2024. The	4/22/2024

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	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 ensure the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) included estimated cost of items and services for which the resident may be charged for one resident (#14) of one resident reviewed for Beneficiary Notification. Findings Included: Resident #14 (R14)		Administrator will reeducate the BOM, DON, MDS Coordinator, Unit Managers, Social Services on the Policy by 6/6/2024. Element #4 The BOM/Designee will conduct random audit of 3 residents weekly for 4 weeks to verify that notices were issued timely and appropriately. Results of the audits will reported to monthly QAPI The Administrator is responsible for sustained compliance The Compliance Date is 6/6/2024.	

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	Review of the medical record revealed R14 was readmitted 07/12/2023, on Medicare Part A services. R14's last covered day under Medicare Part A services was 10/05/2023, and she remained at the facility. R14's Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN) reflected " ...Beginning on 10/06/2023, you may have to pay for this care if you do not have other insurance that may cover costs ..." The care listed was Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST). There were no additional services listed, nor any potential cost for items for services for which R14 may have been financially responsible. Review of the facilities "Statement of Deficiencies and Plan of Correction" from the recertification survey, conducted 03/19/2024, stated " ... resident #14 Guardian will be notified via telephone of the resident's last covered day, omission and corrective action by 04/22/2024." Review of R14's medical record did not demonstrate that R14's Guardian had been notified via telephone or in writing of R14's last covered day, omission and corrective action had been conducted by 04/22/2024. During an interview on 05/09/2024 at 10:50 a.m. former Nursing Home Administrator (NHA) "B" explained that she was unable to provide documentation of notification to F14's Guardian or explain who was responsible for placing the telephone call to R14's Guardian, as stated in the facilities Plan of Correction (POC), that was to be completed by 04/22/2024. NHA "B" could not explain why the facility had not notified R14's Guardian as stated in the facility POC.			
F0625	Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and	F0625	F625	4/22/2024

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SS= D	return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to notify the resident and /or the resident's representative of the facilities policy for bed hold for one resident (#507) of two reviewed for hospital transfer. Findings Included: Resident #507 (R507) Review of the medical record demonstrated R507was admitted to the facility 11/17/2023 with diagnoses that included end stage renal disease, atrial flutter, atherosclerotic heart disease		Element #1 Resident #507 no longer resides at the facility. Element #2 The facility has determined that all residents have the potential to be affected by the deficient practice. The nurse manager or designee will complete an audit for signatures on the Bed Hold Policy for discharged residents in the last 30 days. Any records found to be without a signature will be updated by 6/6/2024. Element #2 The facility has determined that all residents have the potential to be affect by the deficient practice. Element #3 The Bed Hold Policy was reviewed and deemed appropriate by the QAPI Committee on 5/24/2024. Nursing staff will be educated and tested on The Bed Hold Policy by 6/6/2024. Element #4 The nurse manager or designee will conduct an audit of discharged residents in the last 30 days, 2x weekly for 4 weeks. This audit will ensure bed hold policies were signed. Results of the audit will be brought to monthly QAPI. The Administrator is responsible for sustained compliance. The Compliance Date is 6/6/2024.	

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	134140	A. BUILDING _____ B. WING _____	5/9/2024

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	(damage or disease in the hearts major blood vessels), weakness, anemia, insomnia, hypertension, chronic obstructive pulmonary disease (COPD), malnutrition, anxiety, hyperlipidemia (high fat content in blood), constipation, and type 2 diabetes. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/06/2024, revealed R507 had a Brief Interview for Mental Status (BIMS) of 14 (cognitively intact) out of 15. During observation and interview on 05/08/2024 at 01:52 p.m. R507 was observed sitting up in his wheelchair at the side of his bed. R507 explained that he had been recently transferred to the hospital on 05/04/2024 and on 04/23/2024. He explained that he had returned to the facility after he was treated in the hospital. R507 was asked if he had received a facility "bed hold" at the time of his discharge or within 24 hours of his discharge. R507 explained that he had not received a facility "bed hold" and could not explain the purpose of the facility "bed hold" document. Review of R507 medical record demonstrated that he had been discharged from the facility 05/04/2024 and had returned the same day. The medical record also demonstrated that he had been discharged 04/23/2024 and returned on 04/27/2024. R507's medical record demonstrated a document entitle "Bed Hold Policy provided upon Transfer" which had been completed on 05/04/2024 and 04/23/2024. Both "Bed Hold Policy provide upon transfer" documents demonstrated the statement "Policy has been provided to the Resident/Responsible Party " and was marked as yes. Review of the medical record did not demonstrate a signed copy of the facility "Bed Hold Notice" for either dates of discharge. In an interview on 05/08/2024 at 01:55 p.m.			

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	Licensed Practical Nurse (LPN) "G" explained that when a resident is discharged to the hospital it is necessary to send a "packet" with the resident. LPN "G" demonstrated a blank "packet", which included a document entitled "Transfer/Discharge Checklist" which demonstrated a line that stated "Bed Hold Form". LPN "G" could not explain if the "Bed Hold Form" was presented to the resident and signed at that time of discharge or if a copy was placed in the resident medical record. LPN "G" could not explain if a signed copy of the "Bed Hold Form" was placed in a residents medical record. In an interview on 05/08/2024 at 02:02 p.m. Assistant Director of Nursing (ADON) "E" explained that when residents are discharged to the hospital the nursing staff complete a check list for items that should be sent with the resident. She demonstrated that one of the listed documents was to be the "Bed Hold Form". ADON "E" was asked if it was facility policy to have the resident sign the bed hold and if that document was to be placed in the medical record. ADON "E" did not know if was the facility policy. Review of facility policy entitled "Bed Hold Notice Upon Transfer", implementation date of 06/01/2023 and last date reviewed 11/20/2023, demonstrated# 2 "In the event of an emergency transfers of a resident, the facility will provide within 24 hours written notice of the facilities bed-hold policies, as stipulated in the State's plan". The same policy also demonstrated #5 which stated, "The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or residents representative in the resident's file". During an interview on 05/08/2024 at 03:09 p.m. Nursing Home Administrator (NHA) "A"			

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	explained that a facility "Bed Hold Form" was sent with a resident when discharged to the hospital. He explained that there is occasion that a resident could not sign because of immediate transfer and that the nurse would sign the document. NHA "A" was asked to review the facility policy entitled "Bed Hold Notice Upon Transfer" and asked to explain who was responsible for completion of providing written notice within 24 hours and who was responsible for obtaining a signed and dated copy to be placed in the medical record, as stated in #2 and #5 of the policy. NHA "A" did not know who was responsible. NHA "A" could not explain why a signed copy of the facility "Bed Hold Form" was not present in R507's medical record.			
F0656 SS= D	Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F0656	F656 Element #1 A Care Plan for Depression including non-pharmacological interventions, medication side effect monitoring, and monitoring for depressive episodes and symptoms was added to Resident #4's comprehensive care plan. Resident #29's comprehensive care plan was updated with a list of hospice disciplines and frequency of those disciplines' visits. Element #2 The facility has determined that residents that require Hospice service and residents with a dx of Depression have the potential to be affected by the deficient practice. Director of Nursing/designee completed an audit for all resident care plans that receive Hospice service and resident with a dx of Depression care plan were reviewed. Any	4/22/2024

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	recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement comprehensive Care Plans for two (Resident #4, #29) of 3 reviewed for Care Plans, resulting in the potential for unmet care needs. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated 3/29/24, revealed Resident #4 (R4) was admitted to the facility on 12/15/23 with diagnoses that included overactive bladder, major depressive disorder, adjustment disorder with anxiety, and vascular dementia. Review of the same Minimum Data Set (MDS) revealed R4 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).		concerns were addressed immediately with additional updates, revisions will be corrected by 6/6/2024 Element #3 The Comprehensive Care Plan policy was re-reviewed and deemed appropriate by the QAPI Committee on 5/24/2024. All MDS Assessments will be done quarterly and with any significant change in status. IDT Team will review and revise care plans. The IDT will receive educated on reviewing and revising care plans for residents requiring hospice service and residents with a diagnosis of Depression to ensure this deficient practice does not recur. Element #4 The Director of Nursing or designee will audit 25% of the facility residents MDS reviews weekly x 4 weeks. Results of the audits will be reported to QAPI Monthly. The administrator is responsible for sustained compliance. The Compliance Date is 6/6/2024.	

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	In an observation and interview on 5/8/24 at 2:59 PM, R4 was seated in his wheelchair while watching television. R4 was easily conversant, understood, and answered questions appropriately. R4 reported that he was having a "really great day" because a staff member kindly offered to assist R4 outside so that he could enjoy the weather. When asked how his mood had been lately, R4 stated that he gets lonely and down at times, however, the opportunity to spend time outside greatly increased his mood. R4 also stated that he would love to have more opportunities to go outside when the weather is nice, as well as attending outings. Review of the Care Plan revealed R4 did not have a Care Plan for Depression which resulted in any type of intervention for monitoring and managing depressive symptoms. In an interview on 5/8/23 at 3:56 pm, Unit Manager "D" stated that she would expect there to be a Care Plan for R4 to include non-pharmacological interventions, medication side effect monitoring, and monitoring for depressive episodes and symptoms. Resident #29 (R29) Review of the medical record demonstrated R29 was admitted to the facility 10/08/2018 with diagnoses that included hemiplegia (paralysis) and hemiparesis (muscle weakness or partial paralysis) affecting left dominate side, type 2 diabetes, malnutrition, apraxia (difficulty with skill movement), weakness, chronic right hip pain, edema, depression, constipation, hearing loss, hypertension, and cerebral infarction (stroke). Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/13/2024, revealed R29's Brief Interview for Mental Status (BIMS) score was 99			

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	(interview incomplete) related to unable to answer questions and complete testing. During observation and attempted interview on 05/07/2024 at 10:56 a.m. R29 was observed lying down in bed. When attempted to interview R29 he motioned for this surveyor to leave the room. Review of R29's medical record demonstrated a physician order written 12/09/2023, which stated "Hospice to eval (evaluate) and treat". Review of the plan of care revealed the problem statement, "I have elected hospice services". The interventions listed in the plan of care did not list what hospice disciplines where to be included in the plan of care or the frequency of those disciplines' visits. The Plan of care did not demonstrate that any adjustments past the dates of 12/09/2023. Review of the facilities "Statement of Deficiencies and Plan of Correction" from the recertification survey, conducted 03/19/2024, stated "Resident ... #29, Comprehensive Assessments will be reviewed, revised, completed by 04/22/2024". In an interview on 05/07/2024 at 11:15 a.m. Assistant Director of Nursing (ADON) "E" explained that R29 had been receiving hospice services and currently those services continued. ADON "E" was asked to review R29's plan of care and to explain what disciplines were provided to the resident and the frequency of those services. ADON "E" explained that what disciplines and the frequency of those services were not listed on R29's plan of care. She could not explain why the facility had not updated R29's plan of care since 12/09/2023. ADON "E" could not find any "comprehensive assessment that had been reviewed, revised, and completed by 04/22/2024" as stated in the facilities "Statement of Deficiencies and Plan of Correction" from the recertification survey,			

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	conducted 03/19/2024. ADON "E" explained that she was of the opinion that the facility had not updated R29's plan of care for hospice services and was not currently compliant with the previous plan of correction that was to be completed by 04/22/2024.			
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 review, the facility failed to update care plans for three (R#11, R12 and R38) of four residents reviewed for care plan revision from a total sample of 30 residents.	F0657	F657 Element #1 Resident #s R11, R12, and R38's care plans have been reviewed, updated, and completed on 5/14/24. All current MDS Assessments will be evaluated by the nursing manager/Designee for development and implementation of Comprehensive Care Plans by revised by 6/6/2024. Element #2 The facility has determined that all residents have the potential to be affected by the deficient practice. the facility will review all residents care plans that reside at the facility to ensure compliance with care plan revisions by 6/6/2024 Element #3 The Comprehensive Care Plan Policy was reviewed and deemed appropriate by the QAPI Committee on 5/24/2024. All current MDS Assessments have been evaluated by the Director of Nursing/Designee for development and implementation of comprehensive Care Plans. The IDT team will review and revise care plans on going. The nursing management team will be educated and tested on adding interventions to Care Plans in the event a new problem is	4/22/2024

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	Findings include Resident #11 (R11) Review of the medical record reflected R11 was an initial admission to the facility on 05/31/2017 and readmitted on 07/10/24. Diagnoses of Bipolar Disorder, Alzheimer's, Fibromyalgia, Chronic pain, and muscle weakness. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/12/2024, revealed R11 had a Brief Interview of Mental Status (BIMS) of 06 (severely impaired) out of 15. Under section G0110, Activities of Daily Living (ADL) Assistance reveals R11 requires extensive assistance of 2 staff and a mechanical lift and total dependent on all care. During an interview and observation on 05/07/24 at 10:00 AM, R11 stated "I am here", as she was finishing her breakfast in bed while watching TV. Observation of R11 picking at her skin on her chest and arms. Visible bright red areas and scabs up and down her arms and across her chest. R11 stated she doesn't get out of bed anymore. She prefers to do activities in her room and watch TV. Stated her bones are getting old and doesn't support her very well anymore. Record review revealed that R11 had care planned, under interventions, skin inspection. "I need you to inspect my skin and observe for redness, open areas, scratches, cuts, bruises and report changes" date initiated 06/15/17. Had not been revised or updated since 06/15/2017. Record review revealed under the care plan task: Monitor-skin observation, that during the last 3 weeks, no visible skin redness, scratched,		noted by the nursing manager/Designee by 6/6/2024. Element #4 The Director of Nursing/Designee will audit 25% of the facility resident's care plans weekly x 4 weeks to ensure care plan are reviewed and revised. Results of the audits will be reported to QAPI monthly. The Administrator is responsible for sustained compliance. The Compliance Date is 6/6/2024.	

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	discoloration, skin tears or open areas were marked. Also revealed that no new skin conditions were identified by marking the option, no. Record review revealed that R11 had care planned, under interventions, "Follow your skin management program" date initiated 06/01/2017. Review of the physician's orders did not reveal an order for a skin management program. Also under physician's orders, there was an order for Triamcinolone Acetonide (steroid cream) topical cream for skin disorders that was ordered on 03/06/24 and discontinued on 04/19/24. Record review revealed that R11 had care planned, under interventions, administer psychotropic medications as ordered by physician. "Observe me for side effects and effectiveness" Date initiated 05/09/2019. Revision dated 07/10/2023. Also, under interventions were "Review my behaviors/interventions and alternative therapies attempted and their effectiveness". Date initiated 05/09/2019. Revision date of 07/10/23. No alternative therapies were listed out on the care plan. Order for antipsychotic medication monitoring was discontinued on 12/11/2022. During an observation on 05/09/24 at 08:00 AM, R11 was eating breakfast in her bed with the TV on, curtain pulled for privacy and the TV was on. Arms and chest had visible redness and scabs up and down her arms and chest. Record review revealed the redness and scabs were not identified on the skin monitoring task sheet, nor was the care plan updated to include the new open areas. Resident #38 (R38)			

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	Review of the medical record reflected R38 was an initial admission to the facility on 12/06/2021. Diagnoses of Alzheimer's, Senile Degeneration of brain, Psychotic Disorder with Delusions. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/14/2024, revealed R38 had a Brief Interview of Mental Status (BIMS) of 00 (severely impaired) out of 15. Under section G0110, Activities of Daily Living (ADL) Assistance reveals R38 requires extensive assistance with care provided, independent with ambulating, and total dependence on bathing. During an interview and observation on 05/07/24 at 08:20 AM, R38 was observed sitting on the floor, leaning forward in the common area of the secured unit. R38 was wearing his soft helmet during this time. Physical Therapy Assistant (PTA) "L" assisted R38 up off the floor and directed him to the table and chair and assisted him down in the chair. PTA "L" stated that R38 does not site down for very long as he likes to walk all over the unit. R38 soon stood up and started walking in the hallway. PTA "L" stated R38 is care planned to sit on the floor as well as do activities on the floor. During an interview and observation on 05/07/24 at 08:45 AM, Therapy Director/ PTA "M" stated R38 is no longer on therapy services due to him being on hospice services. Record review revealed R38 had a fall on 05/02/24 and obtained an abrasion on his forehead. Order obtained to clean the abrasion on his forehead and cover it with a band aid. Record review revealed R38's care plan had not been updated or revised to include any new interventions related to the fall on 05/02/24. The last revision to the care plan under focus; for			

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	"history of falls r/t imbalance and stoop. I at times will sit or lay down on the floor and crawl around on the floor" was on 04/29/2022. During an interview on 05/07/24 at 3:50 PM, Unit Manager (UM/LPN) "D" stated she would have expected the care plan to be updated from the fall on 05/02/24. UM/LPN "D" stated the MDS nurse does most of the updates on the care plans. UM/LPN "D" and stated R38 is care planned to be on the floor. Also stated that the change in one of his medication dosages, Risperdal 1 milligram (mg) in the morning and 1.5 mg at bedtime should have been updated on the care plan too. During this same interview UM/LPN "D" stated she was not aware that before the plan of correction date, that all care plans needed to be reviewed and updated. Also stated that she thought she could update care plans as she was auditing them, after the plan of correction date. Resident #12 (R12) Review of the Face Sheet and Minimum Data Set (MDS) dated 2/28/24, revealed R12 was admitted to the facility on 1/25/23 with diagnoses that included insomnia, depression, dementia, and psychosis. Review of the same Minimum Data Set (MDS) revealed R12 scored 5 out of 15 (cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). In an observation and interview on 5/7/24 at 3:59 pm, R12 was observed in her room watching television in her bed. R12 was interactive and discussed the weather and her previous job. R12 was dressed in a very worn and thinned hospital gown. Review of the Physician Orders for R12 revealed			

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	that R12 was prescribed Zyprexa 7.5 milligrams (mg) on 4/25/24 and prescribed an additional dose of Zyprexa 15 MG on 4/26/24. Review of R12's Care Plan revealed a Focus area which stated "I am on an anti-psychotic medication (Seroquel) r/t [related to] unspecified psychosis and depression. Further review of the Physician Order's revealed that R12 did not have an active order for Seroquel. In an interview on 5/8/24 at 3:58 PM, Unit Manager "D" stated that the Care Plan should have been updated to reflect the current and accurate anti-psychotic medication order.			
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide intervention for bowel constipation for one Resident (Resident #12) of three residents reviewed for quality of care. Review of the Face Sheet and Minimum Data Set (MDS) dated 2/28/24, revealed Resident #12 (R12) was admitted to the facility on 1/25/23 with	F0684	F684 Element #1 Resident #12 had bowel movements on 5/1, 5/2, 5/4, 5/5, 5/6, 5/7, and 5/10, and currently does not need to be put on bowel protocol. An Xray of resident #12s abdomen was done on 5/23/24 and results were normal with no signs of impaction. Staff will monitor the UDA board daily for resident #12 alerts. Element #2 The facility has determined that all residents have the potential to be affected by the deficient practice. The nurses will assess all residents with an alert on the clinical dashboard in PCC related to no bowel movement and initiate the facility protocol at the facility by 6/6/2024.	4/22/2024

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	diagnoses that included insomnia, depression, dementia, and psychosis. Review of the same Minimum Data Set (MDS) revealed R12 scored 5 out of 15 (cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). In an observation and interview on 5/7/24 at 3:59 PM, R12 was observed in her room watching television in her bed. R12 was interactive and discussed the weather and her previous job. R12 was dressed in a very worn and thinned hospital gown. Review of R12's Bowel Elimination Task revealed R12 was marked for "No Bowel Movement" for the dates of 4/29/24, 4/30/24, and 5/1/24. Review of the undated policy titled "Pinnacle Healthcare Bowel Protocol" revealed "Nursing staff must go to the "Clinical Dashboard" and view the alerts daily. If there is an alert for now [sic] BM [bowel movement] for 3 days, nurses are to initiate "Bowel Protocol". The Physicians have a standing order for "Bowel Protocol" which can be found under the residents orders. It is as follows: MOM [Milk of Magnesia]: Give 30 cc [cubic centimeter] by mouth every 24 hours as needed for constipation. If no results in 8 hours see the Dulcolax Suppository order. Dulcolax Suppository: Insert I application rectally every 24 hours as need for constipation. If no results in 8 hours see the Fleets Enema order. Fleets Enema: Insert 1 application rectally every 24 hours as need for constipation. If no results in 8 hours, notify the PCP [primary care provider].		Element #3 The Incontinence/ bowel protocol Policy was reviewed and deemed appropriate by QAPI Committee on 5/24/2024. The nursing staff received educated on the Incontinence/ bowel protocol policy by 6/6/2024, and reviewing the UDA board to ensure this deficient practice does not recur. Element #4 The Clinical team will review the Clinical Dashboard in PCC 3x weekly x4 for Alerts related to no BM in 3 days to ensure compliance. Any concerns will be addressed with reeducation and results forward to the QAPI committee monthly. The Director of Nursing will be responsible for sustained compliance. The Compliance Date is 6/6/2024.	

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	Review of R12's Physician Orders reflected the Bowel Protocol as needed orders of Milk of Magnesia, Dulcolax suppository, and Fleet Oil Enema were active as of 4/3/24. Review of the April and May Medication Administration Order for R12 revealed that the as needed bowel protocol orders were not administered. In an interview on 5/7/24 3:59 PM, Unit Manager "D" explained that when a resident does not have a bowel movement for three days, the alert to initial the Bowel Protocol will be displayed on the clinical dashboard. The nurse is instructed to check the Clinical Dashboard daily, and follow up with alerts as needed. Regarding R12's absence of a bowel movement for three days, Unit Manager "D" stated that the Bowel Protocol, starting with the Milk of Magnesia, should have been initiated for R12.			
F0740 SS= D	Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow up on behavioral health services recommendations for	F0740	F740 Element #1 Facility has followed up and initiated behavioral health services recommendations for Resident #4. Facility notified the MD and MD gave order to DC the medication. Element #2 The facility has determined that residents who receive behavioral health services have the potential to be affected by the deficient practice. Behavior health services will provide a list of all current orders and recommendations and facility will follow up by 6/6/2024	4/22/2024

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	one (Resident #4) out of three reviewed for behavior health services resulting in Resident #4 not receiving the necessary behavioral health services to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Review of a Psychiatric Progress Note dated 3/20/24 revealed R4 reported that his mood was "low, just low." R4 agreed to feeling more sad lately and per the progress note, the staff endorsed seeing the same. Toward the bottom of the Psychiatric Progress Note was a section indicating the plan for R4. The plan reflected "start sertraline (Zoloft-an antidepressant) 25 mg (milligrams) at hour of sleep. Additionally, a note stating "continuing recommending discontinuing Oxybutynin XL (medication for the treatment of overactive bladder) due to anticholinergic effects (Common central anticholinergic adverse effects include headache, impaired memory, reduced cognitive function, behavioral disturbances, anxiety, and insomnia) which can negatively affect cognition. Review of a Psychiatric Progress note dated 4/7/24 stated "Continue recommending discontinuting Oxybutinin XL [sic] due to anticholinergic effects with can negatively affect cognition." Further review of the Psychiatric Progress Notes revealed that the initial recommendation to discontinue Oxybutynin XL was made on 2/7/24. Review of the Physician Orders revealed that R4 was still being administered Oxybutynin XL. Review of the Progress Note section revealed no acknowledgement or discussion regarding the recommendation to discontinue Oxybutynin XL.		Element #3 The Behavioral Health Services Policy was reviewed and deemed appropriate by the QAPI Committee on 5/24/2024. Staff will be educated and tested on the Behavioral Health Policy by 6/6/2024. Nursing managers and social worker will be educated on following up on behavior health reccomendations. Staff will not return to work until education and testing is completed. Element #4 The social worker or designee will audit 25% of residents weekly x 4 weeks for behavioral health services recommendations. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for sustained compliance. The Compliance Date is 6/6/2024.	

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	In an interview on 5/8/23 at 3:56 pm, Unit Manager "D" verified that she was familiar with R4. When asked why the medication recommendations were not followed up timely, Unit Manager "D" stated that she had pulled all of the Psychiatric Progress Notes from March until current in attempt to get R4's orders in good standing, however, did not see the recommendation of discontinuing the Oxybutynin XL.			
F0761 SS= D	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: During observation of the South Boarder medication cart on 5/09/2024 at 10:33 AM it was observed that the following medications and	F0761	761 Element #1 No resident was citated in the deficient practice. Element #2 All expired meds have been removed from the carts on 5/9/2024. All other medications have been dated, labeled, and stored properly. All medical supplies were audited for expiration dates on 5/13/2024. Element #3 The facility Policy on Label & Storage of Drugs and Biologicals was reviewed and deemed appropriate by the QAPI Committee on 5/24/2024. All nursing staff and central supply will be educated and tested on the Label & Storage of Drugs and Biological policy by 6/6/2024 by nurse managers. No nurses will return to work until education and testing is completed. Element #4	4/22/2024

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	blood glucose test strips did not have a date when the medication was open placed on the container of medications: Two boxes of Artificial tears, one blood glucose testing strip bottle, Trelegy Ellipta inhaler, Nystatin External Powder, Albuterol Sulfate Aerosol inhaler, Fluticasone Suspension, and Haloperidol 2 milligrams (mg). During observation of the South Boardwalk medication cart on 5/09/2023 at 10:46 AM it was observed that the following medications and blood glucose test strips did not have a date when the medication was open placed on the container of medications: one blood glucose testing strip bottle, one vial if Humalog insulin, and one vial of Insulin Glargine. On an interview on 5/09/2024 at 12:10 PM, Unit Manager "D" stated that all medications and test strips should be labeled with an open date. Based on observation, interview, and record review the facility failed to ensure expired medications in three out of three medication carts were removed from the carts, and medications were correctly stored and labeled. Findings Included: During an observation on 5/9/2024 at 10: 36 AM, the medication cart on the north unit was observed to have a medication cup in the top drawer that contained five pills, was not dated, and was not labeled with the resident's name. During the observation Registered Nurse (RN) "N", prior to opening the medication cart top drawer, stated that she had Resident #12's (R12) medication in the top drawer of the medication cart, because R12 had left to go attend a meeting. RN "N" said R12 had been sitting at a table in the dining room, and pointed to a table directly		Nurse managers will audit the nursing carts and supply rooms 3 x weekly for 4 weeks and then weekly x 2 weeks to ensure proper label and storage of Drugs and Biologicals. Results of the audits will be reported to QAPI. The Director of Nursing is responsible for sustained compliance. The Compliance Date is 6/6/2024	

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	behind her and the medication cart. RN "N" said she had went to give R12 her medications while she was sitting at the table, but R12 was taken to the meeting, and was in a hurry as she went to give her the medications, so she did not give R12 her medications. Five pills were observed to be in a medication cup that was not labeled with R12's name, and there was no date on the medication cup. RN "N" stated that she should have wasted the pills (discarded), and then pulled R12's medications again when R12 was available. RN "N" further stated that the pills were not to be discarded into the sharps container (container on the medication cart where needles are discarded), but were to be put in the the drug buster (liquid that deactivates and destroys the medication) canister that was in the supply room. RN "N" said she had was not able to leave the dining room to put the pills into the drug buster container. because she was the only staff member in the dining room with residents. The bottom drawer on the medication cart was opened, and a container of drug buster was observed in the drawer. RN "N" said she could have destroyed the pills in that drug buster container. The medication cart was in the dining room. In an interview on 5/9/2024 at 1:15 PM, Licensed Practical Nurse (LPN) "D" who was the north unit Unit Manager, stated that the pills should have been destroyed by placing them into the drug buster container that was in the fourth drawer of each medication cart, and then new pills taken out and administered to the resident when available. LPN "D" said she provided education to the nurses on proper medication storage, dating, and labeling, but said she did not education all nurses because she could not get ahold of them all, and did not educate nurses who only worked casually (as needed).			

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F0812 SS= F	Food Procurement,Store/Prepare/Serve-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 properly date mark and discard food product. These conditions resulted in an increased risk of food borne illness that affected all residents who consume food from the kitchen in a current facility census of 46 residents. Findings include: On 5/7/24 at approximately 12:20 PM, observation of the 2-door reach in cooler adjacent to the tray line revealed a large opened package of bologna dated 4/30 - 5/30, an undated pan of lettuce, and an undated pan of sliced tomatoes. During interview at the time of observation, Dietary Manager, Staff H, confirmed that lettuce and tomatoes should be dated when they are prepared, and proceeded to discard the food	F0812	F812 Element 1 The opened package of bologna, the pan of lettuce and the undated pan of sliced tomatoes was discarded , lettuce and sliced tomatoes were discarded immediately. Element #2 The Dietary Manager performed an audit of food items to ensure no other foods were unmarked. Any concerns were addressed immediately. Element #3 The FoodProcurement/Store/Prepare/Serve-SanitaryPolicy, was re-reviewed and deemed appropriate by QAPI on 5/24/2024. Dietary Staff will be educated and tested on policy by 6/6/2024 by the Dietary Manager. No dietary staff will return to work until education and testing is completed Element #4 The Dietary Manager/Designee will audit 3x weekly for 4 weeks to ensure The department is compliant with FoodProcurement, Storage, Prep, Service and Sanitation. Results of the audit will be reported to monthly QAPI. The Administrator is responsible for sustained compliance. The Compliance Date is 6/6/2024.	4/22/2024

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	products. When asked about the opened bologna, Staff H referenced a paper chart taped to the cooler door that stated lunch meats could be kept for 30 days. Staff H further stated they would revise the chart and that it had been placed there by a previous manager. Review of the 2017 Food Code section 3-501.17 states: "(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-TO-EAT, 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."			
F0835 SS= F	Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure for all 46 residents, who resided in the facility, effective administration oversite of the facility's plan of correction for the survey dated 3/19/2024, and bringing the facility into compliance for 10 identified deficient practices. Findings Included:	F0835	F835 Element 1 F561 The social worker has performed an audit for all resident self-determination. The social worker has educated all staff for self-determination. The social worker conducted interviews with residents to determine if any resident or guardian has interest in another residence. The interviews were recorded on audit a form for compliance. F565 The social worker/designee conducted an audit to ensure interviewable resident were quired regarding grievances to ensure no other resident is affected by this deficient practice.	6/6/2024

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	Review of the facility's plan of correction (POC) for survey dated 3/19/2024 revealed that the POC was not completed by 4/22/2024, the facility's alleged POC date, nor by 5/9/2024 upon exit of the revisit survey for the following tags, F561, 565, 582, 625, 656, 657, 684, 740, 761, and 812. Further review of the facility's POC revealed: F561, the facility did not perform audits to monitor and ensure continued compliance for resident self-determination, and did not provide education for all staff. The facility's POC revealed that all residents were determined to have the potential to be affected by the deficient practice, however the facility did not assess all residents who resided at the facility for self-determination. F565, the facility identified per the POC that all residents had the potential to be affected by the deficient practice, however did not assess all residents who resided at the facility for grievances, and did not ensure seven residents who had grievances prior to the facility's POC date of 4/22/2024 were resolved. F582, did not correct Resident #14's advanced beneficiary notice from the previous survey findings dated 3/19/2024 per the facility's POC. F625, the facility did not conduct any audits to ensure continued compliance with bed hold notices per the facility's POC. F656, the facility did not correct Resident #4 and 29 comprehensive care plans from the previous survey findings dated 3/19/2024 per the facility's POC. F657, the facility did not review all residents care plans that resided at the facility to ensure		F582 Resident #14 advanced beneficiary notice was given on 5/10/24 The DON/Designee is currently conducting audits on resident transferring to the hospital to ensure the bed hold policy is followed. The audit is reviewed at morning report for compliance to ensure no other resident is affected by this deficient practice. F657 The MDS nurse reviewed and updated care plans for Resident #4 and R#29 to ensure no other resident is affected by this deficient practice. The Interdisciplinary Team reviewed and if needed, revised all resident care plans. An audit was initiated to ensure compliance to ensure no other resident is affected by this deficient practice. F684 An audit was conducted by the DON/Designee related to the facility bowel protocol. The Nursing Manager will audit the dashboard for Alerts PCC to ensure compliance regarding resident bowel protocol for compliance to ensure no other resident is affected by this deficient practice. F740 An audit was conducted on all resident who reside at the facility related to behavioral health services to ensure no other resident is affected by this deficient practice. All staff was Inservice on resident behavioral health services. F761 The DON educated 5 nurses related to medication storage. Nurses will receive education prior to working the unit to ensure no other resident is affected by this deficient practice.	

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	compliance with care plan revisions. The facility's POC revealed that all residents had the potential to be affected by the deficient practice. F684, the facility did not assess all residents who resided at the facility, and did not perform audits after 4/22/2024 to ensure continued compliance with the facility's bowel and bladder protocol. The facility's POC revealed that all residents had the potential to be affected by the deficient practice. F740, the facility did not assess all residents who resided at the facility, did not perform audits, and only educated three staff members to ensure compliance with behavioral heath services. The facility's POC revealed that all residents had the potential to be affected by the deficient practice. F761, the facility did not assure all nursing staff were educated, but rather only educated nine out of 13 nursing staff, to ensure compliance with medication storage. F812, the facility did not educate all dietary staff, but only the dietary manager was educated, however per the facility's POC the dietary manager was the one who was to provide all dietary staff the education. In an observation and interview on 5/7/24 at 11:11 AM, approximately four employees were observed in former Nursing Home Administrators (NHA) "B"'s office adding pages into the Plan of Correction (POC) binders. When queried if we could have them, former NHA "B" stated that they are "making sure everything is there." Former NHA "B" instructed the staff to "remove the sticky's." Several sticky notes were observed on the POC binder tags which stated "missing audits 2 weeks." Staff removed sticky notes from the POC binder, crumbed up into their fists, and		F812 Inservice was conducted for all dietary staff related to marking dates on ready to eat food products, Dietary staff will not be allowed to work in the kitchen before receiving education regarding dating/proper food storage to ensure no other resident is affected by this deficient practice. Element 2 The facility has determined that all residents have the potential to be affected by the deficient practice The facility has employed a Nurse consultant/Compliance coordinator to oversee the Federal Survey citations to assist the facility in maintaining continuous compliance. Element 3 The Policy related to Administrator was reviewed. The nurse consultant/Compliance coordinator educated the Administrator regarding the Federal Survey as it related to Administration. Element 4 The Administrator is responsible for sustained compliance. The Compliance Date is 6/6/2024.	

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	134140	A. BUILDING _____ B. WING _____	5/9/2024

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	exited the room. In an interview on 5/7/24 at 2:13 PM, former NHA "B" stated that the sticky notes were on the POC binders because she went through the binders on Friday and put sticky notes in the binders for nursing to review. When asked what was identified which required review from nursing, former NHA "B" stated "just things here and there... if information was missing." Former NHA "B" verified that she identified missing audits during her POC binder review. In an interview on 5/9/2024 at 1:15 PM, Licensed Practical Nurse LPN "D" stated she attended a QAPI meeting on 4/23/2024. LPN "D" said in the meeting it was discussed who was going to perform audits and the education. LPN "D" confirmed that on Tuesday 5/7/2024, when the state agency entered the facility for a revisit survey to the previous survey dated 3/19/2024, the facility's POC was not completed. LPN "D" said she provided the nursing education and was aware that all nurses were to be education for the POC, but stated she did not educate nurses who worked casually on an as needed basis, and was not able to get together nurses to educate them all. In an interview on 5/9/2024 at 2:58 PM, former Administrator "B" was not able to answer why all staff had not received education, and stated all staff should have all been educated for the corresponding deficiencies. Administrator "B" said she used the POC and policies and procedures to ensure compliance. Administrator "B" was asked how she assured all of the facility POC elements were completed, in which Administrator "B" stated by doing audits. Administrator "A" said the POC audits were not done nor completed, and she took responsibility for that.			

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	Administrator "B" stated she checked the POC binder on 5/3/2024 and had found that audits, and staff education had not been completed. Administrator "B" said on Monday 5/6/2024 she emailed staff for the POC documentation that was not in the POC binder. Administrator "B" said the facility POC was not completed by the facility's alleged POC date of 4/22/2024, because she did not get the documents from staff that she needed. Administrator "B" stated she understood that there was a concern with the effectiveness of the QAPI program and bringing the facility back into compliance by 4/22/2024. Furthermore, Administrator "B" stated that she had no QAPI meeting notes nor documents pertaining to monitoring the effectiveness of the facility's POC. Per Administrator "B", and record review of a sign in sheet, the only QAPI meeting that was held pertaining to the POC was on 3/26/2024, and only the facility's pertinent policies and procedures and the writing of the POC was discussed. Administrator "B" said she relied on staff to perform the POC correction activities they were assigned to, and provide the documentation to her, however did not provide the administrative oversite of the plan of correction and bringing the facility back into compliance with the deficiencies. During an observation and interview on 05/07/24 at 11:11am, this writer went into the Former NHA "B's" office requesting the plan of correction binders. Observation of 4 staff members sitting around the conference table putting documents in the binder, had several sticky notes marking missing items. Writer asked why they were putting documents in the binder after we had asked to see them. Former NHA "B" stated "We are double checking to make sure everything is in place." Observation of tabs and dividers flagged with missing items listed on the sticky notes. Writer picked up part of the binders while other surveyor picked up the rest as staff			

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	were pulling off the ticket notes not wanting survey team to read the notes regarding missing information. All binders were taken into the conference room with the whole team. It was at this time it was confirmed that the facilities alleged plan of correction was not complete.			
F0867 SS= F	QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the	F0867	F 867 ELEMENT #1 The facility has reviewed F561, 565, 582, 625, 656, 657, 684, 740, 761 and 812 for compliance. F561 The facility has conducted audits for self-determinations and continues to monitor residents for self-determinations. All staff was re-educated to ensure continuous compliance. F565 All interviewable residents residing at the facility were assessed for grievances if able to participate. All grievances were reviewed for a resolution and resident/ council president were involved with signing and dating the forms. F582 The advanced beneficiary notice for resident #14 was corrected. F625 The facility is currently ensuring that residents receive notices of the bed hold policy. The nurse manager conducts audits to ensure compliance. F656 The Care plan for Resident #4 and 29 are currently updated and revised with interventions related to the assessment. F657 The facility IDT has reviewed all resident's care plans to ensure compliance with revisions. F684 The facility has assessed all resident for bowel and bladder protocol and will continue to review the PCC Dashboard to ensure compliance. F740 The facility has review and assess all	6/6/2024

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	data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as		residents for behavioral health services and conducted education for staff to ensure compliance. F761 The facility nurses have been educated regarding medication storage and labeling to ensure compliance. The facility will not allow staff to work until properly trained. F812 The dietary manager has educated all staff regarding proper storage and labeling of food items. The facility will not allow staff to work in the department until educated related to food storage and labeling. Element #2 The facility has determined that all residents have the potential to be affected by the deficient practice The facility has reviewed the process for QA/QAPI and has employed a Nurse Consultant/Quality Assurance Coordinator to assist the facility with compliance related to the Survey Process and preventing citations using the QAPI process to identify deficient practice and implement corrective measure by using monitoring tools, feedback and data collection. The facility will meet monthly to ensure compliance. The Nurse Consultant/Quality Assurance Coordinator will assist with ensuring the QA program take actions at performance improvement and implementing actions to measure successful outcome related to resident care. Element 3 The Nurse Consultant/Quality Assurance Coordinator will educate the Administrator related to the importance of utilizing the QA/QAPI Program to maintain compliance.	

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	reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure, through the facility's Quality Assurance and Performance Improvement (QAPI) program, monitoring of corrective action for 10 deficiencies that were identified on the previous survey, dated 3/19/2024, were in compliance by 4/22/2024 the facility's alleged compliance date. Findings Included: Review of the facility's plan of correction (POC) for survey dated 3/19/2024 revealed that the POC was not completed by 4/22/2024, the facility's alleged POC date, nor by 5/9/2024 upon exit of the revisit survey for the following tags, F561,		Element 4 The Administrator is responsible for sustained compliance. The Compliance Date is 6/6/2024.	

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	565, 582, 625, 656, 657, 684, 740, 761, and 812. Further review of the facility's POC revealed: F561, the facility did not perform audits to monitor and ensure continued compliance for resident self-determination, and did not provide education for all staff. The facility's POC revealed that all residents were determined to have the potential to be affected by the deficient practice, however the facility did not assess all residents who resided at the facility for self-determination F565, the facility identified per the POC that all residents had the potential to be affected by the deficient practice, however did not assess all residents who resided at the facility for grievances, and did not ensure seven residents who had grievances prior to the facility's POC date of 4/22/2024 were resolved. F582, did not correct Resident #14's advanced beneficiary notice from the previous survey findings dated 3/19/2024 per the facility's POC. F625, the facility did not conduct any audits to ensure continued compliance with bed hold notices per the facility's POC. F656, the facility did not correct Resident #4 and 29 comprehensive care plans from the previous survey findings dated 3/19/2024 per the facility's POC. F657, the facility did not review all residents care plans that resided at the facility to ensure compliance with care plan revisions. The facility's POC revealed that all residents had the potential to be affected by the deficient practice. F684, the facility did not assess all residents who resided at the facility, and did not perform audits			

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	after 4/22/2024 to ensure continued compliance with the facility's bowel and bladder protocol. The facility's POC revealed that all residents had the potential to be affected by the deficient practice. F740, the facility did not assess all residents who resided at the facility, did not perform audits, and only educated three staff members to ensure compliance with behavioral heath services. The facility's POC revealed that all residents had the potential to be affected by the deficient practice. F761, the facility did not assure all nursing staff were educated, but rather only educated nine out of 13 nursing staff, to ensure compliance with medication storage. F812, the facility did not educate all dietary staff, but only the dietary manager was educated, however per the facility's POC the dietary manager was the one who was to provide all dietary staff the education. In an interview on 5/9/2024 at 1:15 PM, Licensed Practical Nurse LPN "D" stated she attended a QAPI meeting on 4/23/2024. LPN "D" said in the meeting it was discussed who was going to perform audits and the education. LPN "D" confirmed that on Tuesday 5/7/2024, when the state agency entered the facility for a revisit survey to the previous survey dated 3/19/2024, the facility's POC was not completed. LPN "D" said she provided the nursing education and was aware that all nurses were to be education for the POC, but stated she did not educate nurses who worked casually on an as needed basis, and was not able to get together nurses to educate them all. In an interview on 5/9/2024 at 2:58 PM, former Administrator "B" was not able to answer why all staff had not received education, and stated all			

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	staff should have all been educated for the corresponding deficiencies. Administrator "B" said she used the POC and policies and procedures to ensure compliance. Administrator "B" was asked how she assured all of the facility POC elements were completed, in which Administrator "B" stated by doing audits. Administrator "A" said the POC audits were not done nor completed, and she took responsibility for that. Administrator "B" stated she checked the POC binder on 5/3/2024 and had found that audits, and staff education had not been completed. Administrator "B" said on Monday 5/6/2024 she emailed staff for the POC documentation that was not in the POC binder. Administrator "B" said the facility POC was not completed by the facility's alleged POC date of 4/22/2024, because she did not get the documents from staff that she needed. Administrator "B" stated she understood that there was a concern with the effectiveness of the QAPI program and bringing the facility back into compliance by 4/22/2024. Furthermore, Administrator "B" stated that she had no QAPI meeting notes nor documents pertaining to monitoring the effectiveness of the facility's POC. Per Administrator "B", and record review of a sign in sheet, the only QAPI meeting that was held pertaining to the POC was on 3/26/2024, and only the facility's pertinent policies and procedures and the writing of the POC was discussed. Administrator "B" said she relied on staff to perform the POC correction activities they were assigned to, and provide the documentation to her, however did not provide the administrative oversite of the plan of correction and bringing the facility back into compliance with the deficiencies. Resident #14 (R14)			

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	Review of the medical record revealed R14 was readmitted 07/12/2023, on Medicare Part A services. R14's last covered day under Medicare Part A services was 10/05/2023, and she remained at the facility. R14's Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN) reflected " ...Beginning on 10/06/2023, you may have to pay for this care if you do not have other insurance that may cover costs ..." The care listed was Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST). There were no additional services listed, nor any potential cost for items for services for which R14 may have been financially responsible. Review of the facilities "Statement of Deficiencies and Plan of Correction" from the recertification survey, conducted 03/19/2024, stated " ... resident #14 Guardian will be notified via telephone of the resident's last covered day, omission and corrective action by 04/22/2024." Review of R14's medical record did not demonstrate that R14's Guardian had been notified via telephone or in writing of R14's last covered day, omission and corrective action had been conducted by 04/22/2024. During an interview on 05/09/2024 at 10:50 a.m. former Nursing Home Administrator (NHA) "B" explained that she was unable to provide documentation of notification to F14's Guardian or explain who was responsible for placing the telephone call to R14's Guardian, as stated in the facilities Plan of Correction (POC), that was to be completed by 04/22/2024. NHA "B" could not explain why the facility had not notified R14's Guardian as stated in the facility POC. Resident # 29 (R29) Review of the medical record demonstrated R29			

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	was admitted to the facility 10/08/2018 and demonstrated a physician order written 12/09/2023, which stated "Hospice to eval (evaluate) and treat". Review of the plan of care revealed the problem statement, "I have elected hospice services". The interventions listed in the plan of care did not list what hospice disciplines where to be included in the plan of care or the frequency of those disciplines' visits. The Plan of care did not demonstrate that any adjustments past the dates of 12/09/2023. Review of the facilities "Statement of Deficiencies and Plan of Correction" from the recertification survey, conducted 03/19/2024, stated "Resident ... #29, Comprehensive Assessments will be reviewed, revised, completed by 04/22/2024". In an interview on 05/07/2024 at 11:15 a.m. Assistant Director of Nursing (ADON) "E" explained that R29 had been receiving hospice services and currently those services continued. ADON "E" was asked to review R29's plan of care and to explain what disciplines were provided to the resident and the frequency of those services. ADON "E" explained that what disciplines and the frequency of those services were not listed on R29's plan of care. She could not explain why the facility had not updated R29's plan of care since 12/09/2023. ADON "E" could not find any "comprehensive assessment that had been reviewed, revised, and completed by 04/22/2024" as stated in the facilities "Statement of Deficiencies and Plan of Correction" from the recertification survey, conducted 03/19/2024. ADON "E" explained that she believed the facility had not updated R29's plan of care for hospice services and was not currently compliant with the previous plan of correction that was to be completed by 04/22/2024.			

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	During an observation and interview on 05/07/24 at 11:11am, this writer went into the Former NHA "B's" office requesting the plan of correction binders. Observation of 4 staff members sitting around the conference table putting documents in the binder, had several sticky notes marking missing items. Writer asked why they were putting documents in the binder after we had asked to see them. Former NHA "B" stated "We are double checking to make sure everything is in place." Observation of tabs and dividers flagged with missing items listed on the sticky notes. Writer picked up part of the binders while other surveyor picked up the rest as staff were pulling off the ticket notes not wanting the survey team to read it. All binders were taken into the conference room with the whole team. It was at this time it was confirmed that the facilities alleged plan of correction was not complete.			
F0919 SS= E	Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to effectively maintain the facility resident call system effecting all residents on the South hall, resulting in the increased likelihood for delayed emergency response and/or negative resident outcomes. Findings include:	F0919	F919 Element #1 All resident room call lights are currently operating. Facility will sign a quote and pay the deposit by 6/6/2024 to have the south hall call-light system replaced Element #2 The facility has determined that residents on the south hall have the potential to be affected by the deficient practice. Element #3 The Call light System Policy was reviewed and deemed appropriate by the QAPI Committee on 5/24/2024. The Maintenance Department was re-educated on the Call light System and Repair by 6/6/2024.	4/22/2024

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	134140	A. BUILDING _____ B. WING _____	5/9/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE CARE OF BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 5/7/24 at approximately 12:40 PM, the bedside call button in Room 130 was tested. Upon pressing the button, a light was activated outside the door. Observation was then made of the nurse call panel located in the nurses station. A low audible sound could be heard but there was no visible light displayed on the panel. The toilet room call light of Room 130 was then tested, with the same results of no visible light displayed on the panel at the nurse station. On 5/7/24 at approximately 12:45 PM, the bedside call button in Room 136 was tested. Upon pressing the button, a light was activated outside the door. Observation was then made of the nurse call panel located at the nurses station. A low audible sound could be heard but there was no visible light displayed on the panel. On 5/7/24 at approximately 12:30 PM, during interview, when queried on the repairs made to the nurse call system, Director of Maintenance, Staff F, stated that an electrical company was working on solution. On 5/7/24 at approximately 3:30 PM, during interview with the Nursing Home Administrator, Staff A, they stated that the electrical contractor has the board functional but still needs to make repairs to the lights.		Element #4 The Maintenance Department/Designee will audit Call Lights System 3 x weekly for 4 weeks on both Units for proper functioning. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for sustained compliance. The Compliance Date is 6/6/2024.	
F0921 SS= F	Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the physical plant, including floor wall junctures and lighting, resulting in	F0921	F921 Element #1 The light fixture was replaced in the toilet room of Room #113 on 5/13/2024. The wall cover was installed in the visitor toilet room on 5/13/2024 Gaps in the North Hall between rooms 117 and 120, under the radiator near room 103 were repaired on 5/20/2024	4/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	5/9/2024

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	unsanitary and unsafe conditions for any residents residing in or traversing through the North Hall and open areas of the South Hall. Findings include: On 5/7/24 at approximately 12:50 PM, the over sink light in the toilet room of Room 113 was observed very dim and flickering. Interview at this time with Staff I was conducted. Staff I stated that the lighting "comes and goes". On 5/7/24 at approximately 1:00 PM, a hole approximately 6 inches by 12 inches was observed in the wall behind the toilet in the visitor toilet room. On 5/7/24 at approximately 3:00 PM, on the North Hall between rooms 117 and 120, and under the radiator near room 103, observed gaps at the floor/wall juncture of approximately an inch, between the floor and the cove base. Dirt and debris accumulation could be seen in the gaps. The cove base was observed missing at the exit door by room 114. On 5/7/24 at approximately 3:10 PM, on the South Hall between rooms 147 and 150, observed gaps of approximately an inch at the floor/wall juncture on both sides of the hall, and between rooms 121 - 124, and at all door frames. Dirt and debris could be seen in the gaps. During interview at this time, Staff F stated that he would repair the areas.		Missing cove base by exit door near room 114 was replaced on 5/20/24. Gaps in South Hall between rooms 147 and 150, on both sides of the hall, and between rooms 121 - 124, all door frames were cleaned and repaired on 5/20/2024. Element #2 The facility has determined that all residents have the potential to be affected by the deficient practice. Element #3 The Safe, Functional, Sanitary/ComfortableEnvironment Policy was reviewed and deemed appropriate by the QAPICommittee on 5/24/2024. The Maintenance Department and The Housekeeping Director will be reeducated on the policy by 6/6/2024. Element #4 The Maintenance Department/Housekeeping Director will audit 3 x weekly for 4 weeks for compliance of deficiencies listed in Element #1 for North & South Unit. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for sustained compliance. The Compliance Date is 6/6/2024.	