STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634560	A. BUILDING _____ B. WING _____	5/8/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS SKLD Bloomfield Hills was surveyed for an Abbreviated survey on 5/8/24. Intakes: MI00144323, MI00144086, MI00143871, MI00143743, MI00143687, MI00143635, MI00143598, MI00143440, MI00143426, MI00143391, MI00142885, MI00142866, MI00142758, MI00142560, MI00142461, MI00142366, and MI00141863 Census = 126	F0000		
F0600 SS= G	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00142885, MI00142866, MI00142560, and MI00142461. Based on observation, interview, and record review, the facility failed to protect three (R810, R808, and R809) residents' rights to be free from physical and verbal abuse by staff and residents.	F0600	F600 Abuse Resident # 810 continues to reside in the facility with no s/s of physical injury or psychosocial distress or discomfort. The facility followed its policy regarding abuse/neglect/reporting and ensuring resident safety. Resident was seen by the social worker for psychosocial follow up with no distress noted. Resident medical record was reviewed with physician involvement if applicable, to ensure that resident has appropriate interventions and plan of care in place for the protection of not only this resident, but of the rights and the safety of others. Care plans were updated to reflect any changes. Resident voices that she feels safe in the facility. Resident has impaired cognitive status and does not recall incident. CNA E was immediately suspended from the facility s/p incident, policy followed, and CNA no longer works at the facility. Education was also promptly initiated on the abuse policy which included how to interact with residents with behaviors.	6/4/2024

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

Electronically Signed | 05/31/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Findings include: A review of a complaint submitted to the State Agency revealed an allegation that a staff member (Certified Nursing Assistant - CNA 'E') slapped R810, it was observed by facility, and on camera. A review of a second complaint submitted to the State Agency revealed that R810 was assaulted by CNA 'E' while seated in a wheelchair. A review of a Facility Reported Incident (FRI) submitted to the State agency revealed it was reported that CNA 'E' physically abused R810 and it was witnessed by staff. On 5/7/24, an onsite investigation was initiated. On 5/7/24 at 12:28 PM, R810 was observed sleeping on her bed. R810 did not respond when name was called. A review of a police report dated 1/29/24 revealed they were dispatched to the facility on 1/29/24 at 3:23 PM for a report of assault. The police report documented, "The caller stated that a worker at the facility assaulted a patient." The police report noted that the former Administrator of the facility (Administrator 'M') was interviewed by police. The following was documented, "(Administrator 'M') advised that (Housekeeper 'F')...witnessed an assault today. (Housekeeper 'F') informed (Administrator 'M') that she saw an assault occur on the second floor in the hallway. (Administrator 'M') reviewed video footage and found the assault that (Housekeeper 'F')		Resident # 808 continues to reside in the facility with no s/s of physical injury, psychosocial distress, and voices feeling safe in the facility. Resident was seen by the social worker for psychosocial follow up. Resident declined offer to transfer off the unit he currently resides. Residents medical record was reviewed to ensure appropriate interventions and plan of care is in place for the protection of not only this resident, but of the rights and safety of others. Resident will be offered behavioral health services and physician will follow up for medication review and adjustment if needed. Resident # 809 continues to reside in the facility with no s/s of physical injury or psychosocial distress. Resident voices feeling safe in the facility. Resident declined offer to transfer off of current unit that he is residing. Resident's behavior tracking and monitoring tool was updated to include resident specific behaviors as expressed by the staff/residents. Resident is also being followed by behavior health services. Resident was seen by the social worker for psychosocial follow-up. Resident medical record was reviewed to ensure appropriate interventions and plan of care is in place for the protection of not only this resident, but of the rights and safety of others. Physician will follow up for medication review and adjustment if needed. All residents have the potential to be affected by this concern. An audit was completed via resident interviews and observations to identify any concerns with residents related to physical/verbal abuse and neglect. No concerns were identified.	

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	had witnessed... ...The video shows (R810) sitting in her wheelchair in the hallway by herself. A care worker at the facility (CNA 'E') is seen walking from the bottom of the video screen towards (R810). As (CNA 'E') steps next to (R810's) wheelchair, (CNA 'E') attempts to grab (R810's) hand. (R810) flinches and recoils her hand backwards so that (CNA 'E') cannot grab it. (CNA 'E') then strikes (R810) in her mouth with her left hand. (CNA 'E's) hand was open when she struck (R810)..." The police report included a summary of their interview with CNA 'E' which revealed CNA 'E' came to the police station with attorneys and the following was noted, "...(CNA 'E') explained that there are some very combative patients at (facility name). (CNA 'E') said the resident listed as the victim in my report wasn't her patient and wasn't sure of her name...(CNA 'E') did know (R810) liked to wander and wasn't allowed out of her area because she was combative...Before the incident, (CNA 'E') said staff had told her (R810) couldn't be allowed on her floor/wing. Somehow, (CNA 'E') was alerted that (R810) was trying to leave her area. (CNA 'E') went to the back of (R810's) wheelchair to pull her away from door, but (R810) was too strong. Then (CNA 'E') tried to push the wheelchair, but (R810) started spitting. (CNA 'E') said (R810) spit on her hand and at her. (CNA 'E') described (R810) as 'carrying on.' Then (CNA 'E') demonstrated what appeared to be a swatting motion with her left hand. (CNA 'E') said her action was a knee-jerk reaction... ...Summary between the video and (CNA 'E's) statement: (CNA 'E') stated that (R810) was 'carrying on' and was very strong. (CNA		An audit was completed of all resident medical records for any documented behaviors that have not been reported so that appropriate follow-up by SW, the physician and psych services can occur. Any residents identified will be reviewed by the physician and referred to psych services if appropriate. The DON/Um/designee in collaboration with social work will review the electronic dashboard daily in am clinical meeting for any triggered resident behaviors, alerts and/or documentation for review to ensure that residents with behaviors are followed up timely for appropriate interventions. Any resident identified with behavior concerns will be discussed and followed up weekly during IDT Behavior Meeting to ensure appropriate plan of care and interventions are active and in place for those residents. By 6/04/24 current staff will be educated on the “Resident Rights-Abuse and Neglect” policy which will focus on resident’s rights to be free of physical and verbal abuse and neglect. This will include how to handle residents with behaviors, monitoring, documentation and reporting of resident behaviors so that concerns can be addressed in a timely manner. By 6/04/24the policy for abuse/neglect will be reviewed with resident council members to ensure residents know when/who to report any concerns with staff and or resident behaviors and allegations of abuse/neglect so that any concerns can be addressed by facility leadership. The Administrator/designee in collaboration	

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	'E') also stated she tried moving (R810) by pulling and pushing the wheelchair. The video showed that (CNA 'E') never tried pushing or pulling (R810's) wheelchair. (R810) smacks (CNA 'E's) hand when (CNA 'E') tries to grab her hand, but it doesn't do anything physically that is combative. I cannot tell if (R810) spit at (CNA 'E') when she is grabbing (R810's hand)...Status: Sent to (county prosecutor's office) to review for charges of Vulnerable Adult Abuse on (CNA 'E')..." It was further documented in the police report that on 2/16/24, the county prosecutor issued "Vulnerable Adult Abuse 4th Degree" and "Assault and Battery" charges on CNA 'E'. On 2/29/24, CNA 'E' was arraigned at the court. A review of a "Narrative Report" written and signed by Housekeeper 'F' revealed, "...I witnessed a nurse slap a elderly women <sic> in a wheelchair across her face. Onec <sic> the nurse notice I witnessed it she immediately ran over to me and started apologizing several times. I immediately walked over to the elderly patient and ask if she was ok. The patient shook her head no and started pointing at the nurse who slap her across her face..." A review of the facility's investigation revealed a summary that documented Housekeeper 'F' reported on 1/29/24 that she witnessed CNA 'E' slap R810 in the face. It was noted that R810 could not be interviewed due to her cognitive status. The Administrator and Director of Nursing (DON) reviewed the video for that area and confirmed that the incident occurred. It was documented that abuse was substantiated.		with clinical services and social work will provide focused oversight, observation and guidance to the staff to ensure residents remain free from physical/verbal abuse and neglect. The Administrator/designee will conduct random audits through interview and observation on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure staff adherence to policy and procedures to ensure residents are free from verbal and physical abuse and neglect. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 6/04/24 and for sustained compliance thereafter	

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	A review of a letter sent to CNA 'E' on 4/2/24 revealed the State Agency intended to revoke her nurse aide certificate due to the abuse allegation. A review of CNA 'E's personnel file revealed an "Employee Termination Form" dated 2/1/24 that documented, "Reason for Termination...Abuse - Employee slapped a resident in the face..." On 5/7/24 at 12:21 PM, a phone interview was attempted with Housekeeper 'F'. Housekeeper 'F' was not available for interview prior to the end of the survey. On 5/7/24 at approximately 10:00 AM, Human Resources (HR) Director 'A' reported CNA 'E's employment at the facility was terminated due to slapping a resident. On 5/7/24 at 12:40 PM, an interview was conducted with the current Administrator at the facility who is also the Abuse Coordinator. The Administrator did not work at the facility at the time of the physical abuse by CNA 'E' toward R810 and was not aware that is occurred. On 5/7/24 at 1:25 PM, a review of the video footage of the incident on 1/29/24 was conducted in the presence of the Administrator and the DON. In the video, CNA 'E' approached R810 who was seated in a wheelchair in the hallway. CNA 'E' attempted to grab R810's right hand and R810 swatted CNA 'E's hand away. Then CNA 'E' smacks R810 across the mouth using an open hand. A review of R810's clinical record revealed			

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	R810 was admitted into the facility on 5/21/21 with diagnoses that included: bipolar disorder, anxiety disorder, and dementia. A review of a Minimum Data Set (MDS) assessment dated 11/25/23 revealed R810 had severely impaired cognition and exhibited physical and verbal behaviors and rejected care at times. R808 and R809 A review of a Facility Reported Incident (FRI) revealed an allegation of resident-to-resident physical abuse involving R808 (perpetrator) and R809 (victim) that occurred on 2/10/24 at 9:45 AM. On 5/8/24 a record review revealed R808 was admitted to the facility on 7/23/23 with diabetes, neuropathy (nerve damage affecting the hands and feet), heart disease, and chronic obstructive pulmonary disease (COPD). A Brief interview mental status (BIMS) score evaluated in February 2024 revealed a score of 15/15 indicating R808 was cognitively intact. Clinical record review of R809 revealed readmission to the facility on 7/22/23 with a diagnosis of diabetes, pancreatitis, bipolar, dementia, anxiety, dysphagia (difficulty swallowing), and a Percutaneous Endoscopic Gastrostomy (PEG) Tube (surgically placed tube into the stomach to deliver nutrition). A BIMS score evaluated in February 2024 revealed a score of 9/15 indicating R809 was moderately cognitively impaired.			

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	On 5/8/24 at 10:30 AM, R809 was interviewed and immediately referred to R808 as a "hot head" R809 recalled the event and stated he was in his wheelchair and R808 just came up and hit him in the back of the neck. R809 stated that it was a hard hit, did not result in any trauma, but it hurt at the time. R809 further stated that R808 announces R809 is not allowed in the activities room and tells him he is not welcome. On 5/8/24 at 10:40 AM, Licensed Practical Nurse (LPN) "Q" stated R809 frequently is hostile to other residents, swears, steals food from the delivery cart, from other residents' trays, and is "not well liked" by other residents. On 5/8/24 at 11:00 AM, R808 recalled the FRI and replied that he and R809 used to be roommates and never got along with each other. R808 stated they were separated and are on opposite ends of the building and that R809 frequently swears at other residents and is always stealing food off resident trays. R808 stated on the day of the incident, R809 was in his wheelchair blocking the pathway and R808 told him to "move" R808 responded "fuck you" at which time R809 acknowledged hitting R808 in the back of the head. On 5/8/24 at 2:51 PM, The Director of Nursing (DON) and Regional Nurse Consultant "G" indicated the statement made			

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	by LPN "Q" regarding R809 was new information, and the DON and "G" were unaware of the behaviors. The DON and "G" indicated the staff need to document such behaviors and will follow up with the staff. On 5/8/24 at 4:41 PM, An interview with staff witness to the incident Certified Nurse Assistant (CNA) "R" recalled walking towards the second-floor nutrition room and overheard R808 say "move" and R809 replied "Fuck You" CNA "R" walked towards the corner by the elevators and confirmed observation of R808 hitting R809 in the back of the head. A review of a facility policy titled, "Abuse and Neglect", updated 3/24/23, revealed, in part, the following: "It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse...Abuse defined as the willful infliction of injury...intimidation or punishment with resulting physical harm, pain or mental anguish...Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm..."			
F0625 SS= C	Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on	F0625	F 625 Notification of Bed Hold Resident # 803 currently resides in the facility	6/4/2024

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	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: This citation pertains to intake: MI00143743. Based on observation, interviews, and record reviews the facility failed to provide a written copy of the bed hold notification to the resident's representative, upon transfer to the hospital for one (R803) of four residents reviewed for transfers/discharges. Findings include: Review of a complaint submitted to the State Agency (SA) documented in part, " ... Resident was transferred to the hospital on 3/15/2024. Guardian was not notified prior to hospital transfer nor was the bed hold policy provided ... Family visited the resident's room on 4/1 (2024) and the resident's belongings have been removed from the room. Family was not given any		and had not suffered any ill effects as a result of this concern. All residents have the potential to be affected by this concern. An audit was completed of all residents for bed hold policy notification that was discharged to the hospital within the past 30 days to ensure that the policy was given/explained. Any resident/RP identified as not having the policy was given Bed Hold policy. The DON/designee will ensure that copies of the bed hold policy are on each unit for the nurses to send with resident at time of transfer to the hospital with family notification/documentation. By 6/4/24, Licensed nurses will be educated on the Bed Hold Policy with emphasis on ensuring that a copy of the policy is sent with resident upon discharge to the hospital and family notified. The DON/unit managers/designee will review resident discharges to the hospital during daily am clinical for bed hold policy compliance. The DON/designee will audit the medical records of discharged residents weekly x4 weeks and then monthly x3 months or until substantial compliance has been maintained to ensure the facility bed hold policy is being completed. The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions.	

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	notification prior to removing belongings or after ..." On 5/8/24 at approximately 2:30 PM, R803 was observed lying on their back in bed sleeping. R803 was observed to have a pink tie-dyed shirt with a green comforter covering their lower body. R803 did not open their eyes to verbal stimuli and continued to sleep. Review of the medical record revealed R803 was initially admitted to the facility on 5/10/23, a readmission date of 4/9/24, with diagnoses that included: Chronic kidney disease (Stage 4), gastrostomy, epilepsy, and neuromuscular dysfunction of bladder. Review of the progress notes revealed on 3/15/24 at 9:39 AM, the Director of Nursing (DON) documented a change of condition note. Further review of the progress notes revealed the resident was sent to the hospital for decreased urine output coupled with an acute kidney injury. Review of the medical record revealed no documentation of the bed hold notice to have been provided to R803's representative. Review of a facility policy "Bed Hold Policy" (no date), documented in part " ... Facility must provide a copy of this policy to the resident and an immediate family member or legal representative before and when a resident is transferred for hospitalization ..." On 5/8/23 at 3:13 PM, the DON was interviewed and asked the facility's protocol on issuing residents who transfer out to the hospital the bed hold notice to the resident and/or resident representative and the DON stated the Admissions department would take care of that and notify the family and/or family representative		The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 6/4/24 and for sustained compliance thereafter.	

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	of the facility's bed hold policy. When asked where the facility documents that a bed hold policy has been provided, the DON stated they would look into that and follow back up. The DON was then asked why R803's representative was not notified of the bed hold policy for their transfer to the hospital on 3/15/24, the DON replied that the Admissions personnel had just resigned, however would look into it, and follow back up. No further explanation or documentation was provided by the end of the survey.			
F0658 SS= E	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake# MI00142366 Based on observation, interview and record review the facility failed to ensure resident's medications were stored securely, administered as ordered and documented according to professional nursing standards for five (R802, R804, R812, R813 and R816) out of sixteen residents reviewed for professional standards. Findings include: A Complaint was filed with the State Agency (SA) that alleged a resident did not receive their pain medication and was told by Staff that their pain medication had been given to other residents. R812	F0658	F 658 Professional Standards of Nursing Resident # 812 no longer resides in the facility. Residents # 802, 804, 813 did not suffer any ill effects as a result of the findings of medication at the bedside. All medication items were removed and properly stored per the mediation storage policy. Resident # 816 no longer resides in the facility. The tube feeding container was removed from the room and properly discarded. All residents have the potential to be affected by this citation. Room to room rounds were completed on every resident to ensure there were no medications and unnecessary tube feeding left at the bedside/rooms of residents. There were no further findings. Resident #804 mother was called by the unit manager to inform her of the medication	6/4/2024

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	A review of R812's clinical record documented the resident was admitted to the facility on 1/17/24 with diagnoses that included: aftercare following joint replacement surgery. The resident initial assessment indicted the resident was cognitively intact. A review of the resident's Medication Administration Record (MAR) noted that that the following controlled substance/narcotic medications were administered on 1/18/24: Morphine Sulfate Extended Release 15 MG (milligrams) give 1 tablet by mouth every 12 hours for pain. Given on 1/18/24 at 9:00 AM (signed by Nurse "H") and 9:00 PM (signed by Nurse "I"). Oxycodone 20 MG give 1 tablet by mouth every 12 hours for moderate to severe pain. Given on 1/18/24 at 9:00 AM (signed by Nurse "H") and 9:00 PM (signed by Nurse "I"). On 5/8/24 at 10:55 AM, an interview was conducted with the Director of Nursing (DON). The DON was asked as to whether R812 received their ordered pain medication as noted on the MAR. The DON reported that the medication had been ordered upon the resident's admission to the facility but had not yet arrived and the nurses needed to obtain the medication from their "backup" box. The DON further reported that they had determined that Nurse "I" did not provide the medication (Morphine and Oxycodone) to R812 on 1/18/24 at 9:00 PM as noted in the MAR. When asked if Nurse "H" provided the medication (Morphine 15 MG and Oxycodone 20 mg) at 9:00 AM as noted in the MAR, they replied that to their knowledge the resident did receive the medication. A request was made to provide documentation		administration policy and that residents cannot have medications left at the bedside. Unit managers were educated on daily clinical duties including room to room rounds and observations and reporting findings daily to the Director of Nursing. The unit manager/designee will observe tube feeding hanging that is not per the resident order and medications left at bedside when conducting daily rounds on the unit. Any instances noted will be addressed immediately by the Director of Nursing. By 6/04/24 licensed nurses will be educated on the policy of administration of medication, with emphasis on ensuring that no resident medications are left, and no tube feeding is hanging that is not per the order. Education was immediately initiated on 5/7/24. DON/designee will randomly audit 5 residents' room during rounds weekly times 4 weeks and then monthly times 3 months or until substantial compliance has been maintained to ensure that resident medications are not left at the bedside and no tube feeding is hanging in a resident room that is not per the order. The results will be presented to the QAA committee for review and consideration of further corrective action. The DON will be responsible for assuring substantial compliance is attained through this plan of correction 6/04/24and for sustained compliance thereafter.	

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	that the controlled substance medications were pulled from the backup box by Nurse "H" on 1/18/24 at 9:00 AM as noted in the MAR. The only document provided by the facility was a form titled, "Transaction by Employee and Witness " that noted Morphine 15MG was pulled by Nurse "H" and witnessed by Nurse "J" on 1/19/24 at 8:39 AM as it was noted that Nurse "I" never gave the medication. No documents were provided as requested for the date 1/18/24 by the end of the Survey. A phone interview was conducted with Nurse "I" on 5/8/24 at approximately 2:55 PM. When asked about the medication that was noted as given in R812's MAR, Nurse "I" reported that they checked it was given in error as it was a very busy evening. It should be noted that Nurse "I" no longer works at the facility. A phone interview was conducted with Nurse "H" on 5/8/24 at approximately 2:49 PM. When asked if they recalled providing (Morphine 15 MG and Oxycodone 25 MG) to R812 on 1/18/24 and whether the medications were signed out and witnessed by nursing staff, they indicated that they recalled pulling the medication from the "backup box" but the resident refused the medication and left the facility. A follow-up interview with the DON was conducted on 5/8/24 at approximately 3:42 PM. The DON was again asked if they were able to locate documentation that the narcotics were removed from the "back-up box" as it was identified that Nurse "H" administered the medication. The DON was not able to locate any documentation to ensure the medication was pulled. R804 and R816			

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	On 5/7/24 at approximately 9:27 AM, during an interview with R804, an enteral feeding bag dated 5/2/24 was observed hanging from a feeding tube pole near R816's bed. Next to the feeding tube pole was a bedside table. On the table were two boxes of prescription medication, Labetalol Hydrochloride injection (a beta-blocker that is used to control blood pressure in severe hypertension) and Mupirocin Ointment 2% (an antibiotic ointment). On the top of a chest of drawers in between R804 and R816's bed were two packages of generic cold and flu medications. R804 was asked about the medications located in their room. R804 reported that they had a roommate (R816) that went to the hospital about four days ago and could not verify if they took the medications on their own. As for the two packages of cold and flu medication, R804 stated that a family member brought them in for them to use when needed. On 5/7/24 at approximately 9:45 AM, Nurse "J" was queried as to the facility protocol pertaining to medications left unlocked in residents' rooms. Nurse "J" noted that medications should not be left in residents' rooms. Nurse "J" entered into R804 and R816's room and stated that R816 was sent to the hospital and was not sure why the medications remained in the room. As for the cold and flu medications, Nurse "J" again noted that they should not be in room. A review of R804's clinical record noted the resident was admitted to the facility on 3/22/24 with diagnoses that included pressure ulcers stage III and type II diabetes. The resident has been noted as having a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact cognition). There was no documentation in the resident's record for an order of cold and flu medication. Further there was no documentation that noted they could self-administer any			

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	medication. A review of R816's clinical record noted that the resident was initially admitted to the facility on 5/2/24 with diagnoses that include dementia and type II diabetes. The resident was discharged to the hospital on 5/3/24 as such documentation was limited. There was no documentation that noted the resident was able to self-administer medications. R802 On 5/7/24 at approximately 10:05 AM, R802 was observed lying in bed. The resident was alert and could answer some questions asked. The resident was observed to have red crusty areas on the left side of their face and in the left ear. On the bedside table was a box of Ketoconazole Cream (an antifungal medication) 2 %. When asked about the medication, the resident was not able to provide an answer as to how it is used. A review of R802's clinical record revealed the resident was initially admitted to the facility on 2/3/21 with diagnoses that included: schizoaffective disorder, bipolar disorder and type II diabetes. The resident was noted to have a BIMS score of 15/15. There was an order dated 2/29/24 for Ketoconazole Cream 2% to be applied topically two times per day for candidiasis. Per the resident's MAR the medication was administered by nursing staff. There was no documentation in R802's record that noted the resident could self-administer the medication. On 5/7/24 at approximately 3:43 PM, Nurse "N" was asked why the Ketoconazole Cream 2% was left in R802's room and whether they had an order to self-administer the cream. Nurse "N" reported			

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	that it should not have been left in the resident's room. R813 On 5/7/24, a clinical record review revealed R813 was admitted to the facility on 9/22/21 for history of a stroke resulting in left hemiparesis (unable to move left side of body), requiring a suprapubic catheter (tube surgically placed into the bladder to remove urine), chronic kidney disease, hypertension, enlarged prostate, and a psychiatric history of depression. A brief Interview for Mental Status (BIMS) conducted on 4/22/24 revealed R813 scored a total of five indicating severe cognitive impairment. On 5/7/2024 at 11:40, upon initial introduction, R813 was observed in a contracted position lying in bed watching television, orientated, and conversing appropriately. On the bedside table, a large clear bottle, half full of a blue colored liquid was observed and further identified as GaviLyte (an oral medication given to cleanse the bowel) and a bottle of Ammonia Lactate lotion (used to treat dry, scaly, skin conditions) R813 indicated both medications have been sitting on the table for a "long" time. R813's assigned nurse Licensed Practical Nurse (LPN) "B" came to the room and when questioned about the medications, LPN "B" acknowledged that both medications should not have been left and removed from R813's bedside table. Further observation of the GaviLyte bottle revealed the medication was dispensed on December 11, 2023. On 5/8/24 at 2:45 PM, The Director of			

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	Nursing (DON) acknowledged medications are not been to be left at the bedside and indicated that the staff had informed the DON of the findings prior to our discussion. Review of the facilities Medication Access and Storage Policy Adopted 07/11/2018 states " ...It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications ..."			
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: This citation pertains to Intake: MI00142560, MI00144323 Based on observation, interview and record review, the facility failed to administer a pre-procedural medication per physician orders for one resident (R813) resulting in termination of a diagnostic procedure. Findings include:	F0684	F 684 Quality of Care Resident # 813 did not suffer any ill effects as a result of this concern. The physician cancelled the order for colonoscopy s/p resident refusal to consume prep medication. Resident is currently receiving medication per the physician order and any follow up visits to the GI clinic will be scheduled per the physician order. All residents have the potential to be affected by this concern. All resident medical records were audited for scheduled procedures requiring medical preparation for the residents. None are currently ordered. The licensed nurse, upon confirming an order entered by a physician in the resident medical record will notify the DON and ward clerk of medical orders requiring prep and document in the resident medical record the procedure, reason/diagnosis, and order of the physician.	6/4/2024

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	On 5/7/24, a clinical record review revealed R813 was admitted to the facility on 9/22/21 for history of a stroke resulting in left hemiparesis (unable to move left side of body), requiring a suprapubic catheter (tube surgically placed into the bladder to remove urine), chronic kidney disease, hypertension, enlarged prostate, and a psychiatric history of depression. A Brief Interview for Mental Status (BIMS) conducted on 4/22/24 revealed R813 scored a total of five, indicating severe cognitive impairment. On 5/7/2024 at 11:40 AM, upon initial introduction, R813 was observed in a contracted position laying in bed watching television, orientated, and conversing appropriately. On the bedside table, a large clear bottle, half full with a blue colored liquid was observed and further identified as GaviLyte (an oral medication given to cleanse the bowel) and a bottle of Ammonia Lactate lotion (used to treat dry, scaly, skin conditions) R813 indicated both medications have been sitting on the table for a "long" time. R813's assigned nurse Licensed Practical Nurse (LPN) "B" came to the room and when questioned about the medications, LPN "B" acknowledged that both medications should not have been left and removed from R813's bedside table. Further observation of the GaviLyte bottle revealed the medication was dispensed on December 11, 2023.		The unit managers/designee will follow up with the licensed nurses to ensure that residents requiring prep/procedural medication prior to a procedure are carried out as ordered prior to the date of the procedure. Any resident refusals to consume ordered prep medication will be communicated to the physician immediately for further instruction/guidance. By 6/04/24 Licensed nurses will be educated on the medication administration policy with emphasis on ensuring the orders for medication prep for residents prior to a procedure are administered and documented as ordered. If a resident refuses or cannot complete a ordered prep, the physician and guardian will be notified for further instruction, and it will be documented in the resident medical record. The DON/designee will audit residents with orders for prep related procedures weekly x4 weeks and then monthly x3 months or until substantial compliance has been maintained to ensure that residents have completed their ordered prep/procedural medication as ordered. The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 6/04/24 and for sustained compliance thereafter.	

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	Record review revealed on 12/6/23 a physician ordered Golytetly Oral Solution (GaviLyte is the generic version) with specific instructions to drink 8 Ounces (Oz) every 15-20 minutes until gone and stools are clear. Further review the Medication Administration Record (MAR) revealed documentation this medication was administered on December 12, 2023, by LPN "D". On 5/8/24 at 8:58 AM, the Director of Nursing (DON) was interviewed and informed of the medications left at R813's bedside. The DON was further informed that the half full container of GaviLyte medication has been left at the bedside since December 2023 and was documented that staff administered on 12/12/23. The DON was unable to locate results from the procedure scheduled on 12/13/24 and provided the follow up order from the gastrointestinal physician and revealed the scheduled colonoscopy procedure was aborted due to poor preparation. Review of the facility's Medication Administration Policy adopted 07/11/2018, updated 12/19/2019 stated " ...It is the policy of this facility that medications shall be administered as prescribed by the attending physician ..."			
F0686 SS= G	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the	F0686	F686 Pressure Ulcers	6/4/2024

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	comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00143440. Based on observation, interviews, and record reviews the facility failed to ensure the facility staff consistently identified worsening of pressure wounds, accurately assessed/identified pressure wounds, and timely/accurately implemented treatment for pressure wounds for one (R803) of one resident reviewed for wound care, resulting in an infection to the left heel wound that required intravenous (IV) antibiotics. Findings include: Review of a complaint submitted to the State Agency (SA) documented concerns of proper wound care for R803. On 5/8/24 at approximately 2:30 PM, R803 was observed lying on their back in bed sleeping. R803 was observed to have a pink tie-dyed shirt with a green comforter covering their lower body. R803 did not open their eyes to verbal stimuli and continued to sleep. Review of the medical record revealed R803 was initially admitted to the facility on 5/10/23 with a		Resident #803 was assessed by the wound consultant and/or clinical wound team to ensure her wounds are thoroughly and consistently assessed, identified, treatment orders were implemented and changed as ordered and properly documented by the Wound doctor/ Practitioner. Resident is currently being followed by the wound care provider with treatments administered per providers order, and residents care plan updated accordingly. All residents have the potential to be affected. Residents with wounds were assessed by the wound consultant and/or clinical wound team to ensure wounds are thoroughly and consistently assessed, treatment orders were implemented and changed as requested by the Wound Nurse Practitioner, treatments administered per provider's order. A skin sweep was performed on all residents to ensure that there are no new or worsening skin concerns. Any alterations identified in residents' skin will have physician and family notification and treatments implemented per the physician orders. By 6/04/24 the Nurses and CENA's will be educated on "Skin Monitoring and Management Policy" specifically to ensure thorough and consistent skin assessments are completed upon admission, readmission, PRN, with a change in condition, wounds care is administered and documented per policy, notification of the physician and guardian/RP of new or worsening wounds with documentation and interventions implemented per residents' plan of care. DON/designee will randomly audit 5 residents	

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	readmission date of 4/9/24, with diagnoses that included: Chronic kidney disease (Stage 4), gastrostomy, epilepsy a neuromuscular dysfunction of bladder. Review of a "Nursing Admission Screening/History" dated 5/10/23 at 6:10 PM, documented no skin impairments. Review of an admission Nursing note documented in part " ... has L (left) posterior calf stage III (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole-rolled wound edges are often present. Slough and/or eschar may visible but does not obscure the depth of tissue loss) ... measuring 9.0x1.5x0.2 ... R (right) posterior calf stage IV (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) ... measuring 2.3x0.7 ... sacral stage IV ... measuring 8.5x13.5.1.5 ... Resident as fungal rash to mid back ..." Review of a "Braden scale for predicting pressure sore risk" dated 5/10/23, documented "Very High Risk" with a score of 9.0. Review of the physician orders on 10/5/23, documented a treatment for cleansing of the left heel with normal saline, then apply betadine gel to wound bed and pad with abd (abdominal dressing)/kerlix, three times a week and prn (as needed) was ordered, however a start date was not noted. Review of the medical record revealed no documentation of a wound identified to the left heel or the characteristics of the wound to the left heel. Review of a physician order, documented to		with wounds weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure wounds are thoroughly and consistently assessed, treatment orders were implemented and documented per order, treatments administered per providers order, clinical staff implemented interventions to prevent and heal pressure ulcers per the plan of care and residents with wounds are being followed by the wound care provider and assessed for skin management. The results will be presented to the QAA committee for review and consideration of further corrective actions. The ADM will be responsible for assuring substantial compliance is attained through this plan of correction by 6/04/24 and for sustained compliance thereafter.	

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	cleanse left lateral heel with normal saline, then apply betadine gel onto wound bed, pad with abd/secure with kerlix, to be done three times a week and prn was ordered on 10/12/23 and started. This order was implemented a week after the initial physician's order on 10/5/23. Review of the progress notes documented the following in part: On 10/12/23 L heel DTI (deep tissue injury-Intact skin with localized area of persistent non-blanchable deep red, maroon, or purple discoloration due to damage of underlying soft tissue). On 11/3/23 open area to left heel On 11/13/23 L heel DTI deteriorating with 100% eschar Review of the November 2023 Medication Administration Record (MAR)/ Treatment Administration Record (TAR) documented the following treatment: Betadine Eternal Solution, Apply to L heel topically every day shift for wound care cleanser with ns (normal saline), apply betadine-soaked gauze or ointment, cover with ABD (abdominal) and kerlix 3x week and PRN (as needed). This order was supposed to be applied on 11/4/23, however was not and documented as applied on 11/5 and 11/6/23 and not applied again on 11/7/23. Review of a Wound Consultation dated 11/9/23, documented the following in part " ... Lateral Heel is a Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed ... wound encounter			

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	measurements are 2.5cm (centimeters) length x 2.5cm width with no measurable depth, with an area of 6.25 sq (square) cm ... The wound margin is undefined Wound bed has 76-100% eschar. The wound is deteriorating ... Left, Lateral Heel ... Wound Cleansing- Normal Saline, Primary Dressing- Medihoney/Manuka Honey, Secondary Dressing ABD pad, Kling/kerlix, Dressing Chage Frequency- PRN, 3x per week ..." Review of the physician orders and TAR/MARS for November 2023, revealed the treatment to the left heel did not start as directed by the wound clinician until 11/14/23, five days after the wound clinician changed the treatment. Review of a Wound Consultation note dated 12/7/23, documented the following in part, " ... " ... Lateral Heel is a Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed ... wound encounter measurements are 4.5cm length x 3.4cm width, with an area of 15.3 sq cm. There was no drainage noted. The wound margin is undefined Wound bed has 76-100% eschar. The wound is stable ..." Review of the progress notes revealed R803 was transferred to the hospital on 12/8/23 for a PEG (Percutaneous Endoscopic Gastrostomy) tube replacement, however the resident was admitted to the hospital. Review of the hospital records revealed the following: Review of a surgical wound consultation dated 12/10/23 at 9:57 AM, documented the following in part, " ... She was found to have multiple wounds on nursing admission skin assessment ... This patient is known to our service ... wounds			

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	634560	A. BUILDING _____ B. WING _____	**5/8/2024**

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	last evaluated by our service on 10/30/23 ... was treated with ... bilateral heel wounds with non-sting barrier wipes ... Left heel. (Unstageable pressure injury- Full-thickness skin and tissue loss in which the extent of tissue damage withing the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar)- present on admission ... Measurements: 6cm x 7.5cm. Unable to determine the wound depth. Base: Open, moist, tan/black necrotic base. Drainage: There is moderate creamy ... The wound is malodorous (unpleasant offensive odor) ... Right heel. (Deep tissue injury)- present on admission. Measurements: 2.5cm x 2.2cm. Unable to determine the wound depth. Base: Area of purple/black non-blanching intact skin ... Xerotic (dry scaly appearance skin) surrounding skin with no erythema ..." Review of an "Infectious Disease" consultation dated 12/11/23 at 9:51 AM, documented in part " ... ABT (antibiotic) management, wounds/urine ... Although all wounds show progression, L heel wound is most severe. It is unstageable, with necrotic base and malodorous discharge ... Will do XR (x-ray) of L foot. Considering progression of wound and active drainage, suspecting osteomyelitis of calcaneus. Will likely start empiric treatment for osteomyelitis even if XR negative due to severity of wound ... Limiting antibiotics prior to podiatry evaluation for possible L heel debridement is best to ensure proper deep wound cultures, However low threshold to restart antibiotics if clinically deteriorating ..." Review of a "Podiatry Consultation" dated 12/11/23, documented in part " ... Reason For Consultation: Infected left heel wound ... It is a soft boggy eschar with malodorous serous drainage emanating from the periphery of this wound ... A deep tissue injury is noted on the right heel. It is an area of purplish-black			

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	discolored skin that is nonblanchable. The skin is intact ... On the posterior aspect of the left heel, there is a soft, boggy eschar formation noted. It is an unstageable pressure wound. It measures 5.6 cm x 7.5 cm. There is a malodorous serous drainage emanating from the periphery of this soft, boggy eschar formation ... I applied 5% topical lidocaine anesthesia to this area x20 minutes. I then sharply excisionally debrided the necrotic, soft, boggy eschar formation in the posterior aspect of the left heel using a sterile #10 blade utilizing aseptic technique. An underlying stage IV pressure wound is noted. There was necrotic, slough tissue, and devitalized subcutaneous tissue at this area ... the bone itself was soft. It is most likely infected ... Post-excisional wound debridement measurements 5.9 cm x 7.5 cm deep to the level of the calcaneus bone ..." This indicated the facility staff and wound team failed to identify the worsening of R803's left heel wound and failed to identify the development of the right heel wound. The was no documentation of the facility staff to have informed R803's representative of the worsening of left heel wound or the development of the right heel wound. Review of the medical record documented R803 was re-admitted to the facility on 12/18/23. Review of the readmission nursing assessment dated 12/18/23 at 5:56 PM, documented in part " ... Decubitus ulcer of sacral region, decubitus ulcer of right leg, pressure injury right heel, decubitus ulcer of R&L (right and left) ischium ..." The assessment failed to identify the left heel wound. Review of the physician orders revealed no treatment implemented for the left or right wound			

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	heels until two days later on 12/20/23. Review of the December 2023 MAR/TAR documented the following in part, " ... Triad Hydrophillic Wound Dress External Paste (Wound Dressings) Apply to Bilat (bilateral) heels topically every shift for wound treatment. Cleanse with wound cleanser remove excessive residual Triad before application. Apply thick layer of Triad ointment to cover bilat heel wounds. Cover with dry flat 4x4 gauze and secure with kerlix and medipore tape ..." Started on 12/20/23. Review of a Wound Consultation dated 12/21/23, documented in part, " ... Left, Lateral Heel is a Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed ... wound encounter measurements are 6cm length x 6.5cm width, with an area of 39 sq cm. There was no drainage noted. The wound margin is undefined Wound bed has 76-100% eschar. The wound is stable ... Orders ... Cleansing- Normal Saline ... Dressing- Medihoney/Manuka Honey ... Secondary Dressing- ABD pad, Kling/kerlix ... Frequency- PRN, 3x per week ..." The right heel wound was not identified or assessed. This indicated the Wound Consultation was not an accurate assessment as the left heel wound was diagnosed as a Stage IV wound at the hospital and review of the medical record revealed the resident was currently on Intravenous (IV) antibiotics for the left heel wound infection (for 38 days) at the facility. Review of the December 2023 MAR/TAR documented the treatment as directed by the wound clinician on 12/21/23 was not implemented as directed.			

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	Review of a Wound Consultation dated 12/28/23, documented in part " ... 12/28: Patient returned back to the facility after being discharged from the hospital ... currently on IV ABX (antibiotics). New DTI noted to right heel ... Left, Lateral Heel is a Deep Tissue Pressure Injury ... 6.5 cm length x 6cm width, with no measurable depth, with an area of 39 sq cm. There is a Small amount of fresh blood drainage noted which ha no odor ... 51-75% eschar ... Right Heel is a Deep Tissue Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurement are 2.5cm length x 2.2cm width with no measurable depth, with an area of 5.5 sq cm ... Wound Orders ... Left, Lateral Heel ... Wound Cleansing- Normal Saline, Primary Dressing- Medihoney/Manuka Honey, Secondary Dressing- ABD pad, Kling/kerlix ... PRN, 3x per week ... Right Heel ... Wound Cleansing- Acetic Acid, Primary Dressing- Medihoney/Manuka Honey, Secondary Dressing- Bordered foam, Dressing Change Frequency- PRN, 3x per week ..." Review of the Physician orders, December 2023 MAR/TAR and January 2024 MAR/TAR documented did not implement the right and left heel wound orders as directed by the wound clinician. The previous "Triad Hydrophillic Wound Dress External Paste" order stayed implemented for both heels until it was discontinued on 1/4/24, two weeks after the order was originally changed by the wound clinician. Review of the January 2024 MAR/TAR revealed orders implemented on 1/6/24- Medihoney Gel to the right heel topically every Tuesday, Thursday, and Saturday. This was not wound order directed by the wound clinician. Further review revealed an order to the left hell for Medihoney every Tuesday, Thursday and Saturday implemented on			

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	1/6/24, which is also not the exact order as directed by the wound physician. This order was discontinued on 1/17/24 and new orders was not implemented until 1/20/24 for both the left and right heels, resulting in no treatment to the heels for three days. Review of a Wound Consultation dated 2/1/24, documented a "Unstageable Pressure Injury" to the right heel. Review of a Wound Consultation dated 2/29/24, documented a " ... Transfer of Care ..." for the right and left heel wounds. " ... Podiatrist that will be moving forward in managing patient's chronic wound. Wound care is signing off ..." No further wound assessments, consultations or follow-up care identified in the medical record. On 5/8/24 at 3:13 PM, the Director of Nursing (DON) and Wound Nurse (WN) "O" was asked to provide any documentation or consultation regarding R803's left and right heels from 2/29/24 when they were discharged from the wound consultant's services. Shortly after, WN "O" provided one consultation dated 3/11/24. Review of a " ... Foot Clinic & Wound Care Center" consultation dated 3/11/24, documented in part " ... Bilateral heel wounds - please apply Santyl to the black, necrotic, fibrotic tissue. Change dressings daily. If there is excess drainage, change dressing twice per day. Her heels must be floating at all times. They are not to leave the offloading boots. While in bed keep a pillow under her calf just above the wound to float heels from bed. If skin gets macerated, apply betadine to this area prior to dressing. Follow up next week ..." No other consultations from this Foot and Wound clinic were provided by the DON or WN "O" and no further consultations			

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	were identified in the medical record. Review of the medical record revealed on 3/15/24 the resident was transferred to the hospital for decreased urine output and acute kidney injury. Review of a Medical ICU (Intensive Care Unit) consult dated 3/15/24, documented in part " ... Bilateral heel wounds with necrotic eschar and mucopurulent discharge ..." Review of a Podiatry consult dated 3/18/24, documented in part " ... A 10.0 cm x 8.0 cm stage IV pressure wound is noted on the posterior aspect of the left heel. A 6.5 cm x 4.0 cm stage IV pressure wound is noted on the posterior aspect of the right heel ... Both wounds were tender to direct pressure as the patient did open her eyes when I was palpating the heel wounds and she was making facial gestures with pressure applied to both heels, even while being intubated ... A soft, boggy, black eschar formation was noted on the posterior aspect of both heels ... An extensive amount of malodorous purulent discharge was noted from the left heel stage IV pressure wound. Some serosanguineous drainage was noted from the right heel stage IV pressure wound ... They both extended deep to bone and calcaneus bone was exposed on the posterior aspect of each of the heels. Clinically, each of these wounds were considered to be actively infected due to the exposed calcaneus bone as well as the purulence and frank pus from the left heel wound ..." Review of the medical record revealed the resident was re-admitted on 4/9/24. Review of a Wound Consultation dated 4/16/24, documented a " ... Right Heel ... Unstageable Pressure Injury ..." Which was not an accurate assessment as the wound was already staged at a stage IV during their hospitalization.			

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	On 5/8/24 at 11:34 AM, WN "O" was interviewed and asked the facility's process on the ordering and implementation of the wound clinician wound orders and WN "O" explained they had started employment with the facility in February 2024, however they explained that they would complete wound rounds with the wound clinician weekly. Once completed with the rounds or after the resident's assessment they would order and implement the resident wound orders as directed by the wound clinician. WN "O" was asked why the wound orders were not implemented timely and accurately and asked about the inconsistent wound assessments. WN "O" stated they would check into it and follow back up. On 5/8/24 at 3:13 PM, the Director of Nursing (DON) was also, asked why the facility staff failed to identify the worsening of R803's heel wounds, timely/accurately implement the orders as directed by the wound clinician, and accurately and consistently completed wound assessments. The DON explained the facility employed a different wound nurse until about December 2023, when the previous wound nurse resigned. The DON stated the facility had recently been undergoing a big transition. The DON stated they would look into it and follow back up. At 5:34 PM, the DON returned and stated the Facility's Quality and Assurance program had identified skin concerns at the facility. The DON was asked if they had identified any skin concerns with R803 and the DON showed that resident R803 was picked up on one of the skin audits, however the staff documented no concerns. The DON was then asked if they felt their skin audits were effective considering the audit/staff did not identify the concerns of the skin impairments with R803 and the DON stated the audits are a concern and is currently still ongoing. No further explanation or documentation was			

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	provided by the end of the survey.			
F0690 SS= D	Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00143440. Based on observation, interviews, and record	F0690	F 690 B&B/Urinary Catheter new Resident # 803 currently resides in the facility and has a functioning indwelling catheter in place. All residents with an indwelling catheter have the potential to be affected by this citation. An audit was completed on all residents residing in the facility with indwelling catheters to ensure all were patent and functioning per the physician order. Competencies will be provided to licensed nurses on foley catheter insertion to ensure proper placement and functioning. By 6/04/24 the charge nurses will be educated on the policy of Indwelling catheter use and exchange, specifically ensuring upon assessment of catheters that they are properly functioning without concerns. The DON/designee will conduct random audits on 5 residents with indwelling catheters weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that residents with indwelling catheters are functioning properly. The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this	6/4/2024

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	reviews the facility failed to ensure an accurate placement of a urinary catheter foley for one R803 of two residents reviewed for a urinary catheter. Findings include: Review of a complaint submitted to the State Agency (SA) documented in part, " ... Resident's foley catheter was improperly inserted on 3/14/2024 and resident had to be transported to hospital on 3/15/2024. This is the 2nd time this has occurred ..." On 5/8/24 at approximately 2:30 PM, R803 was observed lying on their back in bed sleeping. R803 was observed to have a pink tie-dyed shirt with a green comforter covering their lower body. R803 did not open their eyes to verbal stimuli and continued to sleep. A urinary catheter bag was observed on the lower right side of the bed, draining clear yellow urine. Review of the medical record revealed R803 was initially admitted to the facility on 5/10/23, a readmission date of 4/9/24, with diagnoses that included: Chronic kidney disease (Stage 4), gastrostomy, epilepsy, and neuromuscular dysfunction of bladder. Review of a Nursing Note dated 3/14/24 at 7:14 PM, documented in part " ... Writer watched other nurse replace per NP (Nurse Practitioner) order 16 fr (French) catheter foley replaced with 15cc residual return. Resident tolerated procedure." Review of a Physician Services note dated 3/15/24 at 5:04 PM, documented in part " ... Per nursing staff, pt (patient) had minimal output x 1 day ago. Pt seen and examined today. Pt remains obtunded (having a reduced level of consciousness/alertness) w (with)/a subtle grunting noted ... Acute oliguria (low urine output)-new-limited urine output in the past 24		plan of correction by 6/04/24 and for sustained compliance thereafter.	

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	hrs (hours). No results found for renal US (ultrasound). Due to Oliguria coupled w/severe AKI (acute kidney injury) send to ED (emergency department) w/ for further Eva. (evaluation). Review of an EMS (emergency medical services) transport record dated 3/15/24 at 9:27 AM, documented in part " ... Upon arrival found pt (patient) laying supine in bed unresponsive to painful stimuli ... was called for no pt urine output for over a day. When staff rolled her to change her, we noticed pt's Foley catheter wasn't even place in her ..." Review of an "Emergency Medicine" consultation dated 3/15/24 at 9:53 AM, documented in part " ... presents to the ED from her skilled nursing facility with altered mental status ... Nursing staff stated that there was decreased urinary output. However, when EMS arrived the Foley was not even in place ..." Review of a "Medical ICU (Intensive Care Unit)" consult dated 3/15/24 at 12:00 PM, documented in part " ... new foley was inserted frank pus versus white-colored sediment was immediately expressed ..." On 5/8/24 at 3:13 PM, the Director Of Nursing (DON) was interviewed and asked about R803's urinary catheter that was observed by the EMS to have been incorrectly placed. The DON stated they would look into it and follow back up. On 5/8/24 at 5:32 PM, Nurse "P" (the nurse assigned to R803 on 3/15/24 when the resident was transferred to the hospital) was interviewed and asked if they could recall any issues/concerns with R803's foley catheter and Nurse "P" denied to have identified any concern/issues with R803's catheter before they were transferred to the hospital.			

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	At 5:34 PM, the DON returned and referred to the "Medical ICU (Intensive Care Unit)" consult dated 3/15/24 at 12:00 PM, documented in part " ... Per ER resident there was a Foley loose when patient presented; when new foley was inserted frank pus versus white-colored sediment was immediately expressed ..." No further explanation or documentation was provided by the end of the survey.			
F0697 SS= D	Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake #MI00142366 Based on interview and record review the facility failed to ensure a resident received ordered pain medication in a timely manner for one (R812) out of one resident reviewed for pain, resulting in a significant increase in pain (10/10). Findings include: A complaint was filed with the State Agency (SA) that alleged R812 did not receive scheduled pain medication and after telling the nurse they were in extreme pain, the nurse noted told them "honey you can make it through the night". A review of R812's clinical record documented the resident was admitted to the facility on 1/17/24 with diagnoses that included: aftercare following joint replacement surgery. The	F0697	F697 Pain Management R# 812 no longer resides in the facility. A medication error report was completed for the nurse signing out resident medication without administering. Nurse I was disciplined for not following the policy of medication administration. All residents in the facility have the potential to be affected and were assessed to ensure their pain was adequately assessed, identified, and addressed. Residents will continue to be assessed for pain upon admission, daily via pain score on the medication administration record, quarterly and as needed and any resident identified as having pain will receive pain medication per the physician order. By 6/04/24 Licensed nurses will be educated on the pain management and medication administration policy with emphasis on how to adequately assess and identify pain and administer pain medication per the physician's orders in a timely manner. Education will include utilizing the facility back up system for medication when a medication has not yet	6/4/2024

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	resident's initial assessment indicted the resident was cognitively intact. Continued review of R812's clinical record revealed, in part, the following: Medical Practitioner Note (1/18/24 at 6:38 PM): " ...Pt (patient) comes to this facility for rehab therapy and medical management. Pt. seen today and examined today. Pt reports knee pain 8/10 at bedside ...Continue Morphine and Oxycodone as ordered ...Morphine Sulfate ER Extended Release 15 MG give 1 tablet by mouth every 12 hours for pain ...Oxycodone Extended Release (ER) ...20 MG give 1 tablet by mouth every 12 hours for moderate to severe pain ...". Medical Practitioner Progress Note (1/19/24 at 6:50 PM) "Late entry ... Pt seen an examined today. Pt reports uncontrolled pain and current pain score of 10/10. Pt reports she is not receiving her proper pain meds ...Pt states that she is leaving when her sister arrives ... Case d/w (discussed with) nursing to administer pain meds ASA (as soon as) ...". A review of the resident's Medication Administration Record (MAR) noted that that the following controlled substance/narcotic medications were administered on 1/18/24: Morphine Sulfate Extended Release 15 MG (milligrams) give 1 tablet by mouth every 12 hours for pain. Given on 1/18/24 at 9:00 AM (signed by Nurse "H") and 9:00 PM (signed by Nurse "I"). Oxycodone 20 MG give 1 tablet by mouth every 12 hours for moderate to severe pain. Given on 1/18/24 at 9:00 AM (signed by Nurse "H") and 9:00 PM (signed by Nurse "I").		been received from the pharmacy, with administration of the medication and proper documentation. The DON/designee will conduct random audits on 5 residents receiving pain medication weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that residents are adequately assessed for pain with pain medication administered per the physician orders in a timely manner. The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 6/04/24 and for sustained compliance thereafter.	

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	634560	A. BUILDING _____ B. WING _____	5/8/2024

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	On 5/8/24 at 10:55 AM, an interview was conducted with the Director of Nursing (DON). The DON was asked as to whether R812 received their ordered pain medication as noted on the MAR. The DON reported that the medication had been ordered but had not yet arrived at the facility and the nurses needed to obtain the medication from their "backup" box. The DON further reported that they had determined that Nurse "I" did not provide the medication (Morphine and Oxycodone) to R812 on 1/18/24 at 9:00 PM as noted in the MAR. When asked if Nurse "H" provided the medication (Morphine 15 MG and Oxycodone 20 mg) at 9:00 AM as noted in the MAR, they replied that to their knowledge the resident did receive the medication. A request was made to provide documentation that the controlled substance medications were pulled from the backup box by Nurse "H" on 1/18/24 at 9:00 AM as noted in the MAR. The only document provided by the facility was a form titled, "Transaction by Employee and Witness " that noted Morphine 15MG was pulled by Nurse "H" and witnessed by Nurse "J" on 1/19/24 at 8:39 AM as it was noted that Nurse "I" never gave the medication. No documents were provided as requested for 1/18/24 by the end of the Survey. A phone interview was conducted with Nurse "I" on 5/8/24 at approximately 2:55 PM. When asked about the medication that was noted as given in R812's MAR, Nurse "I" reported that they checked it was given in error as it was a very busy evening. It should be noted that Nurse "I" no longer works at the facility. A phone interview was conducted with Nurse "H" on 5/8/24 at approximately 2:49 PM. When asked if they recalled providing (Morphine 15 MG and			

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	Oxycodone 25 MG) to R812 on 1/18/24 and whether the medications were signed out and witnessed by nursing staff, they indicated that they recalled pulling the medication from the "backup box" but the resident refused the medication and left the facility. A review of the facility policy titled, "Pain Management" (7/11/18) documented, in part: "Policy- It is the policy of this facility to provide an environment and programs that assist each resident to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being... Procedure: The resident will be assessed for pain...Management...Medications received, refused and response to medication will be documented on the MAR...".			
F0791 SS= D	Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must	F0791	F791 Dental Services Resident #802 was evaluated in the facility by the Dentist on 5/17/24 with pending appointment for teeth extraction. He is tolerating his diet without pain or concerns. All residents have the potential to be affected by this concern. An audit was completed by the ward clerk/designee on all residents' medical records to ensure that no resident was missing any new, follow up or pending Dental/ancillary appointments to be scheduled. The process was reviewed regarding the scheduling of residents' ancillary and outside appointments, to include providing the Director of Nursing/designee a weekly list of residents scheduled to go for an appointment	6/4/2024

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	have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake #'s: MI00143426 and MI00144086. Based on observation, interview and record review the facility failed to ensure resident's received timely dental services, including denture replacement and tooth extractions for one (R802) out of three residents reviewed for dental care. Findings include: Complaints were filed with the State Agency (SA) that alleged residents were not receiving dental care and dentures were not replaced timely. R802 On 5/7/24 at approximately 10:05 AM, R802 was observed lying in bed. The resident was alert and could answer some questions asked. When asked about care provided in the facility R802 reported that they needed to seek services outside of the facility and further noted that they needed to have two molars removed. When asked if their teeth caused pain, R802 reported they hurt at times. R802 also noted that their dentures were stolen and needed to be replaced.		so there can be timely follow up and to ensure that residents go to their appointments as ordered. The social worker/designee will review scheduled dental/vision/podiatry appointments with the clinical team daily to ensure that residents are seen per the physician order. Any services that require re-scheduling will be reviewed by the team, with the resident, physician and legal guardian/RP notified timely. The DON/designee will randomly audit 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that residents receive ancillary services per the physician orders. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained though this plan of correction by 6/04/24 and for sustained compliance thereafter.	

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	A review of R802's clinical record revealed the resident was initially admitted to the facility on 2/3/21 with diagnoses that included: schizoaffective disorder, bipolar disorder and type II diabetes. The resident was noted to have a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact cognition). Continued review of R802's clinical record documented, in part, the following: (Name redacted) Dental Group (7/20/23): "R802 ...Delivered maxillary complete denture ...Encourage to wear denture ...". (Name redacted) Dental Group (8/10/23): "R802 ...Patient had crown #30 (bottom right molar) come off ...reveals non-restorable distal cervical decay. Informed patient #30 will need extraction by Oral Surgeon ...". (Name redacted) Dental Group (3/27/24)" "R802 ...Patient needs new upper dentures, states that his were stolen. #31 (bottom right molar) and #30 non-restorable decay into the pulp (nerves/blood tissue). Refer to OS (surgeon) for extractions and prior authorization sent for new dentures last ones delivered on 7/20/23). Following review of the Dental Group care in R802's record, no documents were found that indicated the residents dentures were stolen and/or the resident was scheduled for oral surgeon for extractions of teeth #30 and #31. On 5/7/24 at approximately 12:49 PM, a request for any IA (incidents/accident) reports and/or grievances for R802 was sent via e-mail. A grievance dated 10/11/23 was provided and documented, in part: "Date of Report: 10/11/23 ... Received by Social Worker(SW) "K" ...Name:			

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	R802 ...Describe Grievance or Satisfaction ...Social Worker received voicemail from resident reporting that the staff stole his dentures and took them to a pawn shop to sell them ...Investigation: SW spoke with Kitchen Manager and Housekeeping Director to inquire if dentures were found on tray or in laundry - both advised NO ...Resolution: BLANK ...Notifications: Date Resident Notified of Resolution: BLANK ...Administrator Signature: BLANK ...". On 5/7/24 at approximately 3:43 PM, a phone interview was conducted with SW "K". SW "K" was asked as to their role in ensuring ancillary services, including dental care, was provided to residents. SW "K" noted that they were responsible for ensuring in house ancillary services were provided. When asked about the grievance form dated 10/11/23 that alleged R802's dentures were stolen and appeared not to be completed with any resolution, SW "K" noted that they did not recall what was done. When asked about the dental recommendation on 8/10/23 and again on 3/27/24 that noted the resident needed two teeth extracted and reported that their denture was stolen, SW "K" reported that they do not schedule outside services and stated that it is the responsibility of Staff Scheduler "L" to ensure outside healthcare services are scheduled. SW "K" was asked as to their role in ensuring services are scheduled by Staff "L" as the Dentist notes indicate that an extraction was recommended on 8/10/23 and again over seven months later on 3/27/24. SW "K' again noted that they do not schedule those services and recommended talking with Staff "L". On 5/7/24 at approximately 4:00 PM, an interview was conducted with Staff "L". Staff "L" confirmed that they are responsible for scheduling outside services. Staff "L" was asked about R802's need to have two teeth extracted and follow-up denture replacement. They reported			

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	that they were aware that the resident needed to have their teeth extracted and needed their dentures replaced. When asked if anything had been scheduled, they reported that it was difficult to schedule the appointments as the resident needed to be taken by stretcher and due to their insurance coverage they needed to be sent to a specific oral surgeon. When asked to provide any documentation that they attempted to schedule the appointments, Nurse "L" reported that they did not have any documents that would indicate they attempted to schedule and/or if any appointments had been scheduled. Nurse "L" further indicated that they were also waiting for the residents Durable Power of Attorney (DPOA) to consent to the dental treatments. *It should be noted that R802 was noted as their own responsible party and had signed consent for psychoactive medication on 3/4/24. The facility policy titled, "Dental Services" was reviewed and documented, in part: "Policy: It is the Policy of this facility to ensure routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care... Routine and 24-hour emergency dental services are provided to our residents through... Selected dentists must be available to provide follow-up care.... Social Services representatives will assist residents with appointments, transportation arrangements and for reimbursement of dental services under the state plan...direct care staff will assist residents with denture care... If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink...and the reason for the delay. All dental services provided are recorded in the resident's medical record...".			

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F0880 SS= D	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F0880	F 880 Infection Control Resident # 801 did not suffer any harm as a result of this concern. Nurse B was given education and skilled competency on the policy of hand hygiene per policy and acceptable standards. All residents have the potential to be affected by this concern. Licensed Nurses were assessed for skilled competency for hand hygiene. By 6/04/24 licensed nurses will be educated on the policy for hand hygiene with emphasis on prior to and after providing care and procedures to residents to reduce the potential for transmission of infectious material. The DON/designee will perform random observations on nurses providing care to residents with specifics on nurses that provide trach care weekly x4 weeks and then monthly x3 months or until substantial compliance is maintained to ensure that nurses are following hand hygiene practices per policy. The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 6/04/24 and for sustained compliance thereafter.	6/4/2024

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	contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake: MI00144086. Based on observation, interview, and record review, the facility failed to perform hand hygiene consistent with accepted standards resulting in the potential for transmission of infectious material. Findings include: A review of Intake MI00144086 indicated the complainant was concerned about cross contamination with R801's tracheostomy tube (a medical device surgically inserted into a hole in the neck to help a person breath). "...The staff touch everything in the room and then provide trach care ..." Further concerns included toe fungus, and skin breakdown on the buttock area. The complainant was present at the facility on 5/7/24 and confirmed the allegations. On 5/7/24, A clinical record review revealed			

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	R801 was recently readmitted to the facility on 5/1/24 for a history of stroke with intracerebral hemorrhage (bleeding in the brain), required a tracheostomy related to impaired breathing mechanics, and a Percutaneous Endoscopic Gastrostomy (PEG) Tube (surgically placed tube into the stomach to deliver nutrition) due to dysphagia (inability to swallow) and is incontinent of bowel and bladder functions. On 5/7/24 at 12:45 PM, a skin assessment observation was performed with Registered Nurse (RN) "C". R801 was placed on his back in the bed, both shoes and socks were removed to expose both feet. RN "C" then separated the toes individually with gloved hands to allow visualization in between the surface areas. The toenails were observed pale yellow colored and thick. R801 was then rolled onto his right side and an incontinent brief was removed exposing the buttocks, RN "C" placed same gloved hands around the buttocks and revealed a moderate reddened rash like area. A comment was made to RN "C", once R801 was changed into a shirt, the area around the tracheostomy site would need to be observed. RN "C" proceeded to have R801 sit up and then manipulated around the tracheostomy area and removed the gauze covering the opening into the neck without changing gloves that were used when touching R801's feet and buttock areas.			

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	The complainant was present during the assessment and became upset at RN "C" when it was identified that gloves and hand hygiene were not performed in between touching the feet and buttocks prior to touching around the tracheostomy site. At that time, RN "C" removed gloves, and replaced with another pair and did not wash hands. On 5/8/24, at 2:40 PM, The Director of Nursing (DON) was informed of improper hand hygiene and acknowledged gloves should have been changed with hand hygiene after handling R801's feet and buttocks. The DON revealed that RN "C" is afraid of the complainant and probably was nervous hence why the hand hygiene was not performed. Review of the facilities policy Hand Hygiene Updated 3/24/22 states " ...It is the policy of this facility that hand hygiene be regarded as the single most important means of preventing the spread of infection ...Healthcare personnel should use an alcohol-based hand rub or wash with soap and water before performing an aseptic task or handling of invasive medical devices ..."			