STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634021	A. BUILDING _____ B. WING _____	8/7/2024

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

(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 Evergreen Health And Rehabilitation Center was surveyed for a Recertification survey on 8/7/24. Intakes: MI00145640. Census= 143	F0000		
F0550 SS= E	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required	F0550	F550 ELEMENT 1 It is the practice of the facility to provide an environment that promoted and enhanced residents' dignity. R42, R73, and R85 have been interviewed and assessed to ensure the environment promotes and enhances residents dignity. Nurse K has received education on providing feeding assistance in a proper manner. Nursing staff has been educated on intervening when family members attempt to feed other residents. ELEMENT 2 Residents that currently reside in the facility on Anna s Place have the potential to be affected by this cited practice. Those residents have been interviewed and assessed to ensure the environment promotes and enhances residents dignity. Any deficiencies were corrected immediately with education provided to staff. ELEMENT 3 The Interdisciplinary Team reviewed Dignity policy and deemed it appropriate. Current staff have been educated on the policy and procedure dignity with emphasis on knocking and announcing prior to entering residents rooms, sitting when assisting a resident with feeding, and intervening when family members attempt to feed other residents.	9/17/2024

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

Electronically Signed | 08/26/2024

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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	under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide an environment that promoted and enhanced residents' dignity for multiple residents, including three (R42, R73, and R85) of residents reviewed for dignity. Findings include: According to the facility's policy titled, "Dignity" dated 9/21/23: "...Residents will be treated with dignity and respect at all times...Residents' private space and property are respected at all time...Staff are expected to knock and identify themselves before entering residents' rooms...Demeaning practices and standards of care that compromise dignity are prohibited...Staff are expected to treat cognitively impaired residents with dignity and sensitivity..." On 8/5/24 from 9:00 AM to 11:30 AM, multiple observations included nursing staff entering the rooms of residents on Anna's Place (a secured unit) without knocking, announcing themselves prior to entering the room, or waiting of acknowledgment from the residents to enter. Additional dignity concerns were observed		ELEMENT 4 The DON/designee will complete random audits three times a week for 4 weeks, then once a week for 4 weeks to ensure the environment promotes and enhances residents dignity with emphasis on knocking and announcing prior to entering residents rooms, sitting when assisting a resident with feeding, and intervening when family members attempt to feed other residents. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance.	

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	during the lunch meal on 8/5/24 which included: At 12:56 PM, Nurse 'K' was observed standing while providing feeding assistance to R85 who was seated in a gerichair recliner in the dining room. There were several empty chairs nearby that were available to use. At approximately 1:00 PM, the family member of R42 was observed standing while at the end of the table and feeding the R42. This family member was then observed to state to R73 (who was directly across from R42 at the end of the table), "You look like you haven't had a crumb of food in years, right?". During this time, the family member was observed to touch their clothing, hair, and table multiple times. This family member was then observed to begin to feed both R73 and R42 at the same time. There was no use of hand sanitizer or washing of hands by this family member in between assisting the two residents with their lunch meal. Additionally, although nursing staff were present, no one was observed to intervene or address this family member's actions. On 8/7/24 at 8:45 AM, an interview was conducted with Nurse Manager (NM 'N'). When asked about the observations during the lunch meal on 8/5/24, NM 'N' reported they had been made aware and also observed the same in regard to Nurse 'K'			

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	standing while feeding. They were also informed of the multiple observations of nursing staff entering the rooms without knocking, acknowledging prior to entering and they reported staff should absolutely be knocking and announcing before entering the rooms. R42 Review of the clinical record revealed R42 was admitted into the facility on 7/1/20, readmitted on 8/30/20, signed onto hospice on 11/21/23 with diagnoses that included: Alzheimer's disease with late onset, adult failure to thrive, unspecified severe protein-calorie malnutrition, and anorexia. According to the Minimum Data Set(MDS) assessment dated 5/31/24, R42 had severe cognitive impairment. Review of the resident's plan of care included, "...Announce self when entering room and explain all procedures...Assistance needed with feeding, may fluctuate day to day...EATING: 1 person assist as needed..." R73 Review of the clinical record revealed R73 was admitted into the facility on 2/10/21 and readmitted on 2/23/21 with diagnoses that included: cerebral palsy, bipolar disorder, metabolic encephalopathy, unspecified severe protein-calorie malnutrition, and			

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	unspecified intellectual disabilities. According to the facility's MDS assessment dated 6/21/24, R73 had severe cognitive impairment. Review of the resident's plan of care included, "...EATING: 1 person assist...Encourage resident to join small dining for meals..." R85 Review of the clinical record revealed R85 was admitted into the facility on 1/3/22 and readmitted on 4/4/22 with diagnoses that included: Alzheimer's disease, dementia with other behavioral disturbance, legal blindness, and adult failure to thrive. According to the MDS assessment dated 7/12/24 documented R85 had severe cognitive impairment. Review of the resident's plan of care included, "...assist w (with)/feeding as indicated...EATING: 1 person assist..."			
F0555 SS= D	Right to Choose/Be Informed Attendg Physician §483.10(d) Choice of Attending Physician. The resident has the right to choose his or her attending physician. §483.10(d)(1) The physician must be licensed to practice, and §483.10(d)(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in	F0555	F555 Element 1 It is the practice of the facility to ensure choice of an attending physician is honored. R288 has been interviewed and physician choice has been updated. Dr. F has been educated on the process and residents right to have an attending physician of their choice.	9/17/2024

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	paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment. §483.10(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(d)(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options. §483.10(d)(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure choice of an attending physician was honored for one (R288) of three residents reviewed for choices. Findings include: On 8/5/24 at 10:30 AM, R288 was observed lying in bed. A sign announcing "Contact Precautions" was posted on the door and a isolation cart was observed in the hallway immediately outside R288's room which contained personal protection equipment (PPE) including isolation gowns and gloves.		Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Residents that currently reside in the facility have been interviewed to ensure the choice of attending physician is honored. Face sheets updated with the residents choice of attending physician. Element 3 The Interdisciplinary Team reviewed the Facility Admission Contract, with emphasis on the residents right to choose his or her attending physician and deemed it appropriate. Licensed nurses and current Physicians have been educated on the Facility Admission contract, with the emphasis on the residents right to choose his or her attending physician. Element 4 The DON/designee will interview 5 residents a week for 4 weeks, then every week for 4 weeks to ensure resident choice of attending physician is honored. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance.	

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	R288 was asked about care at the facility. R288 explained their doctor, Dr. "F", had come in the day before, but was touching their PICC (peripherally inserted central catheter) line and the dressing over the wound on their foot without gloves... when they told Dr. "F" to put on gloves, Dr. "F" "got an attitude" about wearing gloves. R288 also explained they had told Dr. "F" they did not want them as their doctor anymore. Review of the clinical record revealed R288 was admitted into the facility on 7/29/24 with diagnoses that included: diabetes, cellulitis and acute kidney failure. According to a Brief Interview for Mental Status (BIMS) exam dated 7/30/24, R288 scored 14/15 indicating intact cognition. Review of R288's progress notes revealed a Physician Team - H&P (health and physical) note dated 8/4/24 at 4:08 PM that read, "Patient refused exam". On 8/7/24 at 9:13 AM, Dr. "F" was interviewed by phone and asked about R288. Dr. "F" explained they were not wearing gloves, they wanted to see the PICC line, but R288 would not let them touch it, then they noticed a bandage on R288's foot, so they tried to move the blanket, but R288 yelled at them for not wearing gloves. Dr. "F" was asked if they were aware R288 was in Contact Precautions. Dr. "F" explained they normally enter the room and does an evaluation of what supplies they would need, then exits the			

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	room to gather the supplies, then they would put on a gown and gloves to do the examination and look at the wound. Dr. "F" was asked if R288 had said they did not want them as their doctor. Dr. "F" explained R288 was upset and had "fired" them, but that they were going to see them that day to see if they had calmed down. On 8/7/24 at 9:32 AM, the Director of Nursing (DON) was interviewed and asked if a resident did not want to see their doctor again, could they get a different doctor. The DON explained they had several doctors at the facility and a resident could change doctors at any time. The DON was informed R288 had told Dr. "F" they did not want them as their doctor, and Dr. "F" had agreed R288 had told them, but they had said they were going to see them anyway. The DON explained she would talk to R288 and facilitate a different doctor if that was what they wanted. When asked if Dr. "F" should have informed the facility that R288 had "fired" them, the DON agreed Dr. "F" should have informed them. Review of the facility's Admission Contract dated 11/2017 read in part, "...The resident has the right to choose his or her attending physician... If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility shall honor that choice..."			
	Choose/Be Notified of Room/Roommate	F0559	F559	9/17/2024

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F0559 SS= D	Change §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide appropriate notice in a dignified manner of a room change for one (R289) of one resident reviewed for room changes. Findings include: On 8/5/24 at 11:11 AM, R289 was observed lying in a bed different than the room census provided by the facility. R289 was asked about being in that particular room. R289 explained their room had been changed that morning, it was the third room they had been in, and they had only been there four days. Review of the clinical record revealed R289 had been admitted into the facility on 8/1/24 with diagnoses that included: open wound of abdominal wall, prostate cancer and chronic kidney disease. According to a Brief Interview for Mental Status (BIMS) exam dated 8/2/24, R289 scored 13/15 indicating intact cognition.		Element 1 It is the practice of the facility to provide appropriate notice in a dignified manner of a room change. R289 has been notified in a dignified manner with no concerned voiced. Element 2 Residents that currently reside in the facility that require a room move have the potential to be affected by this cited practice. Those residents□ charts have been reviewed to ensure appropriate notice in a dignified manner has been completed. Any deficient practice has been corrected. Element 3 The Interdisciplinary Team reviewed the policy and procedure Notification of Room/Roommate Change and deemed it appropriate. Licensed nurses have been educated on the policy and procedure of Notification of Room/Roommate Change with emphasis providing appropriate notification in a dignified manner of a room change. Element 4 The DON/designee will complete random audits three times a week for 4 weeks, then every week for 4 weeks to ensure the facility is providing appropriate notification in a dignified manner of a room change. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance.	

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	Review of R289's census revealed upon admission, R289 was in Room 421. On 8/3/24, R289 was moved to Room 419, then on 8/5/24 R289 was moved to Room 417, their current room. On 8/6/24 at 1:05 PM, R289 was observed lying in bed and asked about their room changes. R289 explained they had been admitted (8/1/24) into one room, then was moved to a different room on Saturday (8/3/24) then at 2 o'clock in the morning that night (8/4/24) staff came and told them they had to change rooms, but did not say why...R289 asked why they had to change rooms, but staff told R289 they did not have to tell them the reason, they were a guest...R289 said even if they were a guest, they knew they had basic rights, but staff told them the room change was not part of their rights...R289 asked the staff if they had to call their lawyer because they knew they had rights. R289 was asked when they had moved to their current room. R289 explained staff came again that morning (8/5/24) and told them the reason for the room change, so they agreed to it. R289 was asked if staff had told them the reason for the room change at 2:00 AM, would they have agreed to the room change. R289 explained they definitely would have moved as it was explained to them that it had been a mistake to be put in that room, and it was for health reasons to be moved. When asked if they knew the name of the staff that wanted to move them at 2:00			

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	AM on 8/4/24, R289 explained there had been four staff members, and they did not know their names. On 8/6/24 at 4:21 PM, the Director of Nursing (DON) was interviewed and informed of the conversation with R289. The DON explained she had been told R289 had refused to be moved on 8/4/24, but then agreed to be moved on 8/5/24, but did not know the specifics. When asked if R289 should have been told the reason for the move, especially at 2:00 AM, the DON agreed R289 should have been told the reason. On 8/6/24 at 4:47 PM, Licensed Practical Nurse (LPN) "D" was interviewed and asked about the attempting to change R289's room at 2:00 AM on 8/4/24. LPN "D" explained she did tell R289 the reason for the room change, but R289 wanted specific information about the reasons, and were told they could not give specifics, R289 threatened to call their attorney. Review of a facility policy titled, "Notification of Room/Roommate Change" dated 4/18/23 read in part, "...The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed...Discuss possible room or roommate changes with the Interdisciplinary Team. Ensure room or roommate changes meet the CMS (Centers for Medicare & Medicaid Services) guidelines prior to proceeding with the change...Discuss			

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	the change with the resident and/or the resident's representative including the reason for the change. Provide the resident or representative with the printed notification form..."			
F0563 SS= F	Right to Receive/Deny Visitors §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by:	F0563	F563 Element 1 It is the practice of the facility to ensure unrestricted, 24-hour visitation for residents. The admission packet has been updated and visiting hours have been removed. Resident council meeting was held and updated the residents on unrestricted, 24-hour visitation. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Residents that currently reside in the facility and family members have been notified that visitation is unrestricted and 24-hour visitation is available. Element 3 The Interdisciplinary Team reviewed the F563- right to receive/deny visitors. All staff have been educated on the F563-right to receive/deny visitors with emphasis on unrestricted, 24-hour visitation for residents. Element 4 The DON/designee will complete 5 random interviews every week for 4 weeks, then every other week for 4 weeks to ensure that we offer unrestricted, 24-hour visitation for residents. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance.	9/17/2024

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	Based on interview and record review, the facility failed to ensure unrestricted, 24-hour visitation for residents. This deficient practice had the ability to affect all 143 residents in the facility. Findings include: On 8/6/24 at 10:30 AM, during a resident council meeting with the State Agency, several anonymous residents reported that the facility's visitor hours ended each night at 8:00 PM with the front door being locked at that time, and were announced overhead. Twelve residents were present and each resident reported not knowing that they were allowed to have visitors outside of the hours of 8:00 AM and 8:00 PM. On 8/7/24 at 1:10 PM, an interview was conducted with the Administrator. When queried what the facility's visitor hours were, they responded 8:00 AM to 8:00 PM with the front door locking at 8:00 PM each day, which is announced overhead. When queried if the residents were aware that they had the right to have visitors outside of the 8:00 AM to 8:00 PM timeframe, the Administrator chose not to "speak" for what the residents were aware of. The Administrator mentioned there may be visitor hours listed in the facilities admission packet. When asked if there was a script that was followed each night when announcing the end of visitor hours, the Administrator deferred to the Business Office Manager (BOM).			

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	634021	A. BUILDING _____ B. WING _____	8/7/2024

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	When the BOM was queried about the overhead announcements, they reported that beginning at 7:45 PM each night, there is a series of announcements made announcing the end of visitor hours and informing residents and visitors that visiting hours end at 8:00 PM and the front door will be locked at that time. A visitor policy was requested from the facility, however the Administrator responded that they did not have a formal visitor policy. Review of the first page of the admission packet provided by the facility revealed, in large bold print and in all capital letters "VISITATION 10 AM TO 7:45 PM DAILY. LOBBY DOOR LOCKS AT 8PM".			
F0578 SS= D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii)	F0578	F578 Element 1 It is the practice of the facility to execute a Do-Not-Resuscitate (DNR) Advance Directive order per the residents/guardians wishes. R128 no longer resides in the facility. Element 2 Residents that currently reside in the facility that wish to be a Do-Not-Resuscitate (DNR) have the potential to be affected by this cited practice. Residents that currently reside in the facility charts have been reviewed to ensure Advance Directives are in place and Do-Not-Resuscitate wishes have been executed per the facility□s policy. Any deficiencies have been corrected immediately. Element 3	9/17/2024

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	This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to execute a Do-Not-Resuscitate (DNR) Advance Directive order for one resident (R128) reviewed of two residents reviewed for Advance Directives. Findings include: Clinical record review revealed R128 was admitted from the hospital to the facility on 7/23/24. R128 required rehabilitation from right toe gangrene (death of body tissue due to lack of blood flow or infection). R128's medical history included diabetes, hypertension, end stage renal disease and		The Interdisciplinary Team reviewed the Advanced Directive policy and deemed it appropriate. Nursing staff and Social Work department have been educated on the Advanced Directive policy with emphasis on executing a Do-Not-Resuscitate (DNR) Advance Directive order per the residents/guardians wishes. Element 4 The Social Work Director/designee will complete random audits three times a week for 4 weeks on five residents, then every week for 4 weeks on five residents to ensure that Do-Not-Resuscitate (DNR) Advance Directive order are executed per the residents/guardians wishes. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance.	

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	required peritoneal dialysis (removal of waste products via the lining inside the belly as a natural filter for blood). A Brief Interview of Mental Status (BIMS) score totaled 14/15 indicating R128 was cognitively intact. On 7/29/24, a review of the health care conference summary held on 7/29/24 at 2:00 PM documented Advance Directives were reviewed and R128 expressed their choice of DNR code status. The facility documented the DNR form was completed by R128 and awaiting physician signature and order. On 8/6/24 at 12:49 PM, an interview with Corporate Social Services "B" confirmed the facility failed to implement R128's wishes of a DNR code status and remained a full code for the duration of R128's residency at the facility. On 8/6/24 at 1:12 PM, Social Services "B" provided the DNR form signed by R128, dated 7/29/24, stated the physician signed and dated the form 8/6/24. Social Services "B" was aware R128 was discharged from the facility at the time the physician signed.			
F0624 SS= D	Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.	F0624	F624 Element 1 It is the practice of the facility to ensure a safe and collaborated discharge. R29 no longer resides in the facility. Element 2 Residents that currently reside in the facility	9/17/2024

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	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a safe and collaborated discharge for one (R29) of three residents reviewed for discharge. Findings include: On 8/5/24 at 9:40 AM, R29 was observed in the bathroom unassisted. R29's spouse was in the room waiting for them to return from the bathroom. R29 stated that they would like a surveyor to return once they were finished getting ready for the day. At 10:00 AM, this surveyor returned to the room, R29 was sitting in the wheel chair with their left leg elevated on the bed. Their spouse was sitting in a chair across the room. R29 was interviewed and asked how was their current stay at the facility, and stated, "It has not been good" and explained that they were getting discharged today (8/5/24). R29's spouse interjected and stated, "Well, we don't know because social work came in and stated that we might not be getting discharged due to a fall (that R29 had that morning around 9:05 AM)." R29's spouse explained that the facility called them on Friday 8/2/24 to state that R29 would be discharged on Monday 8/5/24. R29's spouse stated, "Hence, why I have packed up her room and have her all ready to go, and now they are saying we are not leaving. So, we do not know what is going on but either way if they are making		that will be discharged have the potential to be affected by this cited practice. Those residents have been reviewed with care conferences scheduled with the IDT to ensure a safe and collaborated discharge. Any deficiencies have been corrected immediately. Element 3 The Interdisciplinary Team reviewed the Transfer and Discharge Policy and deemed it appropriate. Nursing staff and Social Work department have been educated on the Transfer and Discharge policy with emphasis on ensuring a safe and collaborated discharge including holding a care conference. Element 4 The Social Worker Director/designee will complete random audits three times a week for 4 weeks on five residents, then every week for 4 weeks on five residents to ensure a safe and collaborated discharge is in place for discharging patients including the completion of a care conference. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance.	

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	[R29] stay, we will stay but if they are discharging her then we will leave." R29 stated that it (their discharge) had just been an "unorganized mess" and that they just wanted to go home and stated, If they are not going to render any services, then I can sit at home and do the same thing." R29 and their spouse was then asked did the facility hold a care conference (a conference updating the resident and resident's representative of the plan of care for the resident)with them and they both said, "No". R29's spouse asked this surveyor what a care conference consisted of. R29 stated that the only person who had talked to her from the facility was the social worker on the day after admission and that Friday (8/2/24). A record review revealed that R29 was admitted to the facility on 7/18/24 with a diagnosis of type two diabetes, repeated falls, and generalized anxiety disorder. R29 had a brief interview for mental status score of 15, indicating an intact cognition. On 8/6/24 at 9:00 AM, R29 was observed in bed resting. R29 was asked how they were. R29 explained that they were still in pain from the fall and that they had been vomiting since yesterday and that their head and their hip were still hurting. On 8/7/24 at 10:13 AM, R29 and their spouse were interviewed. R29's spouse explained that they had received a call from the facility and was told that R29 was ready to be			

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	discharged. R29's spouse continued to explain that they were already on the way to the facility so that was okay (to discharge her then). The spouse stated that when they arrived to the facility around 9:30 AM, "another lady" came into the room and told them that we were not being discharged. On 8/7/24 at 11:33 AM, R29 and their spouse were observed going towards the exit with items in their hands. R29 waved this surveyor over to walk towards door with them where R29 then stated, "This place is a crap show. A nurse just came in the room and said we were discharged so we are leaving. But it is so unorganized!" R29 stated that there was no "continuous care" and no one knows what's going on in each department. The Director of nursing (DON) saw R29 and their spouse talking to this surveyor and came into the conversation and asked R29 if she knew who she was. R29 replied "Yes, you are the DON but what did you want?" The DON asked them where they were going and R29 stated, "I have been discharged". The DON replied, "No, you have not. There was no homecare set, no follow up appointments or anything, you need to go back to your room so we can set this up for you." R29 stated, "You all need to get your shit together because this is unacceptable, and if you are going to send me to my room I do not need a psychiatrist! I am competent, you all are just not collaborating with each other and it has confused me!"			

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	On 8/7/24 at 11:47 AM, an interview was conducted with the social worker (SW). They were asked what role they play in their discharge plan? The SW explained that she just took over R29's case and she was not 100 percent sure what happened (with the discharge). The SW explained that she was trying to "fix it from this point on". The SW was asked who informed the family of the discharge. The SW explained that she was not sure, that the social work director had resigned on 8/5/24. The SW stated, "I'm just trying to do what I can." On 8/7/24 at 1:00 PM, the facility had the resident petitioned to hospital for "psychiatric behaviors" that stated the resident was trying to "self harm." There was no additional information provided by the exit of survey.			
F0655 SS= D	Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social	F0655	F655 Element 1 It is the practice of the facility to implement a baseline care plan for tube feeding. R287 no longer resides in the facility. The baseline care plan was updated prior to R287 discharged. Element 2 Residents that currently reside in the facility that receive tube feeding have the potential to be affected by this cited practice. Those residents charts have been reviewed to ensure a baseline care plan is in place within 48 hours of admission to the facility. Any deficiencies have been corrected	9/17/2024

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	services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement a baseline care plan for tube feeding was provided to one (R287) of one resident reviewed for tube feeding. Findings include: Review of a facility policy titled, "Care Plan - Baseline" dated 8/25/23 read in part, "...It is the policy of the facility to develop a baseline plan of care to meet the resident's immediate health and safety needs for each resident within forty-eight (48) hours of admission... The baseline care plan includes instructions needed to provide effective, person-centered		immediately. Element 3 The Interdisciplinary Team reviewed the Care Plan-Baseline policy and deemed it appropriate. Nursing staff have been educated on the Care Plan-Baseline policy with emphasis on ensuring baseline care plans for tube feedings are completed within 48 hours of admission. Element 4 The DON/designee will complete random audits three times a week for 4 weeks on five residents, then every week for 4 weeks on five residents to ensure that baseline care plans are completed within 48 hours of admission. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance.	

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	care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident..." On 8/5/24 at 9:54 AM, R287 was observed sleeping in bed. Enteral nutrition (tube feeding) was being delivered via pump. Review of the clinical record revealed R287 was admitted into the facility on 8/3/24 with diagnoses that included: stroke, major depressive disorder and malnutrition. According to a Brief Interview for Mental Status (BIMS) exam dated 8/4/24, R287 scored 3/15 indicating severely impaired cognition. Review of R287's baseline care plan revealed no care plan for tube feeding. On 8/6/24 at 2:39 PM, the Director of Nursing (DON) was interviewed and asked if a resident receiving tube feeding should have a care plan for tube feeding. The DON explained there should be a care plan. When informed R287 had no care plan for tube feeding, the DON explained there should have been one from admission.			
F0658 SS= D	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as	F0658	F658 Element 1 It is the practice of the facility to ensure medications were accurately documented and orders written according to professional standards of practice. R27 medications was	9/17/2024

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	evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were accurately documented and orders written according to professional standards of practice for two (R27 and R287) residents. Findings include: R27 On 8/6/24 at 8:25 AM, as part of the Medication Administration task, Licensed Practical Nurse (LPN) "E" was observed to prepare seven medications for R27. LPN "E" crushed the medications and mixed them with applesauce. LPN "E" was observed to enter R27's room to give the seven crushed medications to R27. R27 refused to take the medications. LPN "E" was then observed to leave R27's room with the medications R27 had refused. On 8/6/24 at 9:05 AM, the medications LPN "E" had prepared were reconciled with R27's physician orders. All seven medications were marked as given by LPN "E". On 8/6/24 at 9:15 AM, LPN "E" was asked if she had gone back and given R27 their medications. LPN "E" explained she had not. When informed all the medications had been marked as given, LPN "E" explained she had marked them as done before R27 had refused them. LPN "E" was asked when		offered again and accepted during survey with nurse encouragement. LPN E has been educated on the process of signing out medications after medications have been administered. R287 no longer resides in the facility. R287□s order was clarified and updated prior to discharge. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Those residents□ charts have been reviewed and residents interviewed to ensure medications were accurately documented and orders written according to professional standards of practice. Any deficiencies have been corrected immediately. Element 3 The Interdisciplinary Team reviewed the Medication Administration and Physician, Practitioner Orders policy and deemed it appropriate. Nursing staff have been educated on the Medication Administration and Physician, Practitioner Orders policy with emphasis on ensuring medications were accurately documented after administration and orders written according to professional standards of practice. Element 4 The DON/designee will complete random audits three times a week for 4 weeks on five residents, then every week for 4 weeks on five residents to ensure that medications were accurately documented after administration and orders written according to professional standards of practice. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance.	

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	should medications be marked as given. LPN "E" explained they should not be marked until after they have been given. On 8/7/24 at 8:24 AM, the Director of Nursing (DON) was interviewed and asked when medications should be marked as given. The DON explained medications should only be marked as given after the resident takes the medication. R287 On 8/5/24 at 9:54 AM, R287 was observed sleeping in bed. Jevity 1.5 Cal (calorie) Enteral nutrition (tube feeding) was being delivered via pump at 65 ml/hr (milliliters per hour). Review of the clinical record revealed R287 was admitted into the facility on 8/3/24 with diagnoses that included: stroke, major depressive disorder and malnutrition. According to a Brief Interview for Mental Status (BIMS) exam dated 8/4/24, R287 scored 3/15 indicating severely impaired cognition. Review of R287's physician orders revealed an Enteral Feed order with a start date of 8/4/24 that read, "in the evening Up at 1800 (6:00 PM); down at 1400 (2:00 PM); 20 hours total". There was no specific type of tube feed formula or rate the tube feed was to be infused in the order. On 8/6/24 at 8:49 AM, R287 was observed			

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	sleeping in bed. No tube feed was being delivered to R287. On 8/6/24 at 10:51 AM, Registered Dietician (RD) "G" was interviewed and asked about R287's tube feed orders. RD "G" explained when a resident is admitted at night or on the weekends like R287 was, the nurse would call him and he would give a standard order or use what the resident had been receiving in the hospital until he could come and evaluate the resident's nutritional needs. RD "G" was asked if an order should be put in reflecting the specific type of tube feed formula and the infusion rate. RD "G" explained the order should be complete with all the required elements including the type of formula and the rate. RD "G" also explained the tube feed formula and rate were in a progress note. When asked if a progress note was sufficient for tube feed orders, RN "G" explained there needed to be an order for tube feed. Review of R287's progress notes revealed a Nursing note written by Registered Nurse (RN) "H" dated 8/3/24 at 8:17 PM that read in part, "Pt (patient) admitted...Jevity 1.5 to run at 65 ml/hr..." On 8/6/24 at 11:36 AM, RN "H" was interviewed by phone and asked about R287's tube feed orders. RN "H" explained she was the Midnight Manager and had been assisting with R287's admission and had written the admission progress note. RN "H"			

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	was asked if the type of tube feed and infusion rate should just be in a progress note. RN "H" explained the physician orders should be complete with the type of formula and infusion rate. Review of the facility's "Unit Charge Nurse (RN/LPN)" job description undated read in part, "...As a member of the interdisciplinary team, the unit Charge Nurse assumes responsibility and accountability for nursing services delivered to all residents of a designated unit for one shift..."			
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 has 2 Deficient Practice Statements. Deficient Practice Statement #1 Based on observation, interview and record review, the facility failed to provide wound care for two (R337 and R120) of two residents reviewed for nonpressure related wound	F0684	F684 Deficient Practice Statement #1 Element 1 It is the practice of the facility to provide wound care for non-pressure related wound care. R337 and R120 have been assessed and wound care has been provided per the physician order. Element 2 Residents that currently reside in the facility that receive wound care for non-pressure wound care have the potential to be affected by this cited practice. Those residents charts have been reviewed to ensure wound care order is in place and being provided per the physician order. Any deficiencies have been corrected immediately. Element 3 The Interdisciplinary Team reviewed the Skin and Wound Guidelines and deemed it appropriate. Nursing staff have been educated on the Skin and Wound Guidelines with emphasis on providing wound care for non-pressure related wound care per the physician order and not signing off treatments	9/17/2024

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	care. Findings include: R337 On 8/5/24 at 9:15 AM, R337 was observed lying in bed resting. R337 was asked how their stay at the facility had been. R337 stated that they were in pain and that someone needed to change their wound dressings but they (the facility) had not done so. R337 stated, "There is an area on my butt that they have not changed yet." R337 stated that the abdominal wound had started to stink and proceeded to show this surveyor the abdominal wound. There was blood and drainage from the wound that had a mild odor. A record review revealed that R337 was admitted to the facility on 8/3/24 with the diagnosis of hyperlipidemia, type two diabetes and mild protein deficit. R337 had a brief interview for mental status score of 15, indicating an intact cognition. A further review of the record revealed that R337 received orders for treatment for surgical wound to gallbladder in the hospital paper work. On 8/6/24 at 12:00 PM, the wound care (WC) nurse was interviewed and asked about the process of new admissions who come in with surgical wounds. The WC explained that there is supposed to be orders in once the admission is completed and the nurses would call the doctors for treatment orders if they		until the treatment is completed. Element 4 The DON/designee will complete random audits three times a week for 4 weeks on five residents, then every week for 4 weeks on five residents to ensure that wound care for non-pressure related wounds have been provided. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Deficient Practice Statement #2 Element 1 It is the practice of the facility to follow up on a Physician consult appointment. R128 no longer resides in the facility. Element 2 Residents that currently reside in the facility that have physician consult appointments have the potential to be affected by this cited practice. Those residents□ charts have been reviewed to ensure physician consult appointments follow up has been received. Any deficiencies have been corrected immediately. Element 3 The Interdisciplinary Team reviewed the Physician and Practitioner Orders policy and deemed it appropriate. Nursing staff have been educated on the Physician and Practitioner Orders policy with emphasis on following up on physician consult appointment. Element 4 The DON/designee will complete random audits three times a week for 4 weeks on five residents, then every week for 4 weeks on five residents to ensure follow up has been	

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	were unable to speak to the doctor and the orders would remain until wound care rounds on the resident. The WC explained that they would normally follow orders from the hospital paper work. WC nurse was asked if R337 should have wound care orders. The WC clarified that there were no orders for wound care currently and there should have been some. R120 On 8/5/24 R120 was observed sitting in a wheel chair in their room. R120 had a wound vac in place as well as a hand dressing dated 7/31/24. When R120 was asked about the care they received while at the facility, R120 stated its pretty decent but anywhere you go you would be able to tell the people who love doing what they do and the ones who love to get a pay check. R120 was asked when was the last time the facility changed their hand dressing. R120 stated it was changed on the date that was written on the bandage (07/31/2024). R120 stated, "It's supposed to be completed 3 times a week." A record review revealed that R120 was admitted to the facility on 7/19/24 with the diagnosis of sepsis, pressure ulcers stage 3, and hyperlipidemia. R120 had a brief interview for mental status of score of 15, indicating an intact cognition. A further review of the record revealed that in the medication administration record (MAR) the hand dressing was marked off as being		completed for physician consult appointments. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance.	

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	completed on 08/02/2024. On 8/6/24 at 12:00 PM, the WC nurse was asked how the treatment was marked off as being completed on 8/2/24, when the bandage on R120's hand was dated for 7/31/24 and that R120 confirmed that was the last time it was completed. The WC nurse stated, "I am not for sure as I did not do that wound. The floor nurses are responsible for (R120) wounds outside of the wound vac. The Director of Nursing interjected and stated that the nurse (Nurse "R) who clicked off on the treatment was in the facility today would have them come and speak with this surveyor. Nurse "R" was why did she sign off on a treatment that had not been completed, Nurse "R" stated, "It must have been a miscommunication (between her and WC)" and explained that she did not complete the treatment. No addition information was provided by the exit of survey. Deficient Practice Statement #2 Based on interview and record review, the facility failed to follow up on a Physician consult appointment for one resident (R128) of one reviewed for physician consults, resulting in the potential for missed or delayed new orders and treatments. Findings include:			

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	Clinical record review revealed R128 was admitted from the hospital to the facility on 7/23/24. R128 required rehabilitation from right toe gangrene (death of body tissue due to lack of blood flow or infection). R128's medical history included diabetes, hypertension, end stage renal disease and required peritoneal dialysis (removal of waste products via the lining inside the belly as a natural filter for blood). A Brief Interview of Mental Status (BIMS) score totaled 14/15 indicating R128 was cognitively intact. On 8/6/24 at 4:38 PM, The Director of Nursing (DON) was questioned of a progress note dated 7/30/24 that the daughter took R128 to a doctor's appointment and no documentation of an after-visit summary was identified. The DON acknowledged the process for outside appointment was "not done correctly" and acknowledged the facility did not follow up on the physician consult. On 8/6/24 at 4:45 PM, The facility's policy on coordination of care for outside appointments was requested and not received by end of the survey.			
F0686 SS= D	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers	F0686	F686 Element 1 It is the practice of the facility to ensure wound care orders are in place for new admissions with pressure ulcers. R337 chart has been reviewed and order updated to include wound care orders for pressure ulcers.	9/17/2024

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	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: Based on observation interview and record review the facility failed to ensure there were wound care orders placed for one resident (R337) of two residents reviewed for pressure ulcers. Findings include: On 8/5/24 at 9:15 AM, R337 was observed lying in bed rest. R337 was asked how their stay at the facility had been. R337 stated that they were in pain and that someone needed to change their wound dressings but they had not done so yet. R337 stated, "There is an area on my butt that they have not changed yet." R337 explained that the abdominal wound had started to stink. R337 proceeded to show the abdominal wound area to this surveyor. There was blood and drainage on the bancage with a mild odor that came from the site. On 8/5/24 at 9:20 AM, the certified nurse aid performed incontinence care for R337. At that time R337's coccyx area was observed. The wound presented with a reddened border and a greenish yellow slough base.		Element 2 Residents that are admitted to the facility with pressure ulcers have the potential to be affected by this cited practice. Those residents□ charts have been reviewed to ensure wound care orders are in place. New admissions skin assessments have been completed to ensure any pressure ulcers have wound care orders in place. Any deficiencies have been corrected immediately. Element 3 The Interdisciplinary Team reviewed the Skin and Wound Guidelines and deemed it appropriate. Nursing staff have been educated on the Skin and Wound Guidelines with emphasis on ensuring wound care orders are in place for newly admitted patients with pressure ulcers. Element 4 The DON/designee will complete random audits three times a week for 4 weeks on five residents, then every week for 4 weeks on five residents to ensure wound care orders are in place for newly admitted patients with pressure ulcers. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance.	

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	There were two dime sized stage two pressure sores on the left gluteal cheek. A record review revealed that R337 was admitted to the facility on 8/3/24 with the diagnosis of hyperlipidemia, type two diabetes and mild protein deficit. R337 had a brief interview for mental status score of 15, indicating an intact cognition. A review of the medical record revealed further that there were no admission wound care orders placed for R337 on the day of admission on 8/3/24. On 8/6/24 at 12:00 PM, the wound care (WC) nurse was interviewed and asked who is responsible for putting in orders upon admission and shoud there be treatment orders in place until wound care rounds on patients? The WC explained that there are supposed to be orders in place on admission that is completed by the nurses if the WC nurse was not able to assess the resident. The WC nurse also explained that the admitting nurses are responsible for calling the doctors and getting a treatment order put in place until wound care can round on the residents. WC nurse was then asked was R337 supposed to have wound care orders, WC confirmed that there was not orders put in place but should there have been orders put in place. There was no additional information provided by the exit of survey			

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F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the facility failed assess promptly after a fall for one (R29) resident of reviewed for accidents. Findings include: On 8/5/24 at 9:40 AM, R29 was observed in the bathroom unassisted. R29's spouse was in the room waiting for them to return from the bathroom. R29 stated that they would like this surveyor to return once they were finished getting ready for the day. At 10:00 AM, this surveyor returned to the room, R29 was sitting in the wheel chair with their left leg elevated on the bed and the spouse sitting in a chair across the room. R29 was asked about their stay at the facility and explained that they had fallen that morning (8/5/24). R29 stated that they hurt their leg and they hit their head a little bit because when they fell, they landed on their left side. A record review revealed that R29 was admitted to the facility on 7/18/24 with diagnoses of type two diabetes, repeated	F0689	F689 Element 1 It is the practice of the facility to assess residents promptly after a fall. R29 no longer resides in the facility. Assessment was completed prior to R29 discharge. Element 2 Residents that currently reside in the facility and have a fall have the potential to be affected by this cited practice. Those residents charts have been reviewed to ensure the residents have been assessed promptly and interventions completed promptly with notification to resident and family. Any deficiencies have been corrected immediately. Element 3 The Interdisciplinary Team reviewed the Fall Management Guidelines and deemed it appropriate. Nursing staff have been educated on the Fall Management Guidelines with emphasis on ensuring the resident is assessed promptly with interventions completed promptly with notification to resident and family. Element 4 The DON/designee will complete random audits three times a week for 4 weeks on five residents, then every week for 4 weeks on five residents to ensure residents are assessed promptly after a fall with interventions completed promptly with notification to residents and family. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance.	9/17/2024

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	falls, and generalized anxiety disorder. R29 had a brief interview for mental status score of 15, indicating and intact cognition. A further review of the record revealed that R29 was supposed to get assisted when using the restroom. On 8/6/24 at 9:00 AM, R29 was observed lying in bed. R29 was asked how they were feeling. R29 stated that there were sick to their stomach, they had been vomiting, and leg was in pain. R29 stated they were "exhausted." R29 was then asked did they tell anyone about the vomiting and pain? R29 stated that they did tell the facility. R29 explained that she started having those symptoms yesterday, while visiting with her spouse. A review of the medical record revealed with a progress note dated for 8/5/24 at 2:44 PM written by the nurse who cared for R29 during the shift stated " Resident was observed lying on their left side around 9:05 AM. R29 stated that they was trying to get out the chair and fell on their bottom. Resident was quickly assessed and the team lifted to the chair then to the bed. Resident stated they had no pain at this time. Vital signs were 94/51 pulse 72, temperature 98.1 pulse oximetry 100 on room air. Spoke with the Nurse Practitioner(NP) she was in the building to assess the patient and she ordered 500cc (cubic centimeters) bolus for hypotension. And she ordered Neurochecks, waiting assess for peripheral IV (intravenous)			

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	placement ..." On 8/6/24 at 9:05 AM, the Unit Manager (UM) was interviewed and asked how does the facility follow up with residents after a fall. The UM stated they use a neuro check sheet, but R29 did not complain of anything yesterday (warranting the neuro check sheet). This surveyor explained that R29 had stated that they were in pain yesterday as well as this morning but added that they feel sick to their stomach and had started to vomit yesterday. The UM explained that R29 never complained of anything. The UM was then asked to asses R29 with the surveyor and once in the room, R29 stated that they were in pain , felt sick to stomach and explained when the pain started after the fall and the nausea and vomiting after lunch on 8/5/24. The UM asked R29 were they still sick to stomach and R29 stated, "Yes." After we left the room the UM stated that she would call the doctor to let them know that R29 was in pain to order x-rays, labs and to order Zofran for the nausea. On 8/7/24 at 10:13 AM R29 and their spouse were interviewed about the fall that resident had experienced on the morning of 8/5/24 asked how they were feeling. R29 stated that they felt better and that the facility finally took an Xray of their leg, but did not understand why they did not take one of their head. Spouse stated that no one from the facility even called them to let them know R29 had a fall and no one mentioned the fall			

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	to them. The spouse stated, "I was at the facility all day no one ever mentioned the incident." No additional information was provided at the exit of survey.			
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 maintain the ventilation hood filters in a sanitary manner, failed to ensure the dish machine was sanitizing, and failed to maintain the dish machine in a sanitary manner. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include:	F0812	F812 Element 1 It is the practice of the facility to maintain the ventilation hood filters in a sanitary manner, and to ensure the dish machine is sanitizing, and to maintain the dish machine in a sanitary manner. The ventilation hood filters have been cleaned. The dish Machine has been repaired to ensure sanitizing with the sanitizer log updated and the dish machine has been cleaned. No residents were affected by this deficient practice. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Residents that currently reside in the facility have been assessed, no residents have been affected by this deficient practice. Element 3 The Interdisciplinary Team reviewed Hood Cleaning policy and the Warewashing policy and deemed it appropriate. Kitchen Staff have been educated on the Hood Cleaning policy and the Warewashing policy with emphasis on maintaining the ventilation hood filters in a sanitary manner, ensuring the dish machine is sanitizing, and to maintain the dish machine in a sanitary manner. Element 4 The Food Service Director/designee will complete 3 random audits weekly for 4 weeks, then every week for 4 weeks to ensure that	9/17/2024

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	On 8/5/24 at 9:30 AM, the cookline hood ventilation filters were observed with a buildup of grease. Certified Dietary Manager (CDM) "O" stated kitchen staff were responsible for cleaning the hood vent. According to the 2017 FDA (Food and Drug Administration) Food Code Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "...(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." On 8/5/24 at 9:40 AM, a plate simulating dishwasher tester was sent through the dish machine to check the sanitizing properties of the facility's high temperature dish machine. The maximum temperature recorded on the plate simulator was noted to be 152 degrees Fahrenheit. At 9:50 AM, the plate simulator was again sent through the dish machine, and the maximum temperature noted on the plate simulator was 153 degrees Fahrenheit. At that same time, the digital temperature display unit on the dish machine noted the final rinse temperature to be 146 degrees Fahrenheit. When queried about what temperature the rinse temperature should be to ensure sanitization, CDM "O" stated "150-160". On 8/5/24 at 9:45 AM, the "Temperature Log" for the dish machine was reviewed and noted the following:		ventilation hood filters are maintained in a sanitary manner, dish machine is sanitizing, and the dish machine is maintained in a sanitary manner. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance.	

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	8/1 AM 165/147 8/2 AM 175/139 8/2 PM 173/140 8/3 AM 175/139 8/4 AM 122/139 8/4 PM 122/139 When queried about the low temperatures documented on the dish machine temperature log, CDM "O" stated he was not made aware of the low temperatures for the dish machine. CDM "O" was unable to provide an explanation as to why staff continued to use the dish machine after logging inadequate temperatures. On 8/5/24 at 10:00 AM, kitchen staff was observed using the dish machine to clean soiled dishware. The plate simulating dishwasher tester was again sent through the machine, and recorded the maximum temperature of 147 degrees Fahrenheit. The final rinse temperature on the machine's digital display unit was noted to be 155 degrees Fahrenheit. At that time, dietary staff noted the dishwasher temperature on the temperature log as 151/155. On 8/5/24 at 11:10 AM, Maintenance Supervisor "P" was observed working on the			

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	dish machine. When queried, Maintenance Supervisor "P" stated there were forks inside that were blocking the sensor and that the machine needed cleaning inside. At that time, the inside of the dish machine as well as the coils, were observed with a thick, slime buildup. According to the 2017 FDA Food Code section 4-703.11 Hot Water and Chemical, After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in: "(B) Hot water mechanical operations by being cycled through EQUIPMENT that is set up as specified under §§ 4-501.15, 4-501.112, and 4-501.113 and achieving a UTENSIL surface temperature of 71°C (160°F) as measured by an irreversible registering temperature indicator; P" According to the 2017 FDA Food Code section 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures, "(A) Except as specified in ¶ (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90°C (194°F), or less than: Pf (1) For a stationary rack, single temperature machine, 74°C (165°F); Pf or (2) For all other machines, 82°C (180°F). Pf".			
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,	F0880	F880 Element 1 It is the practice of the facility to ensure proper	9/17/2024

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	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 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.		infection control protocols and practices including hand hygiene during meals, transmission-based precautions (TBP) regarding use of personal protective equipment (PPE) and room placement. R42, R73, R288 and R289 have been assessed for any infection control signs and systems with no signs or systems noted. R289 room was changed prior to the end of the survey. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Those Residents have been assessed to ensure proper infection control protocols and practices including hand hygiene during meals, transmission-based precautions (TMP) regarding personal protective equipment (PPE) and room placements are being followed. Any deficiencies have been corrected immediately. Element 3 The Interdisciplinary Team reviewed the Hand Hygiene policy, Infection Control Standard and Transmission-Based Precautions policy, and Summary of Personal Protective Equipment (PPE) Use and Room Restriction When Caring for Residents in Nursing Home and deemed it appropriate. Nursing staff have been educated on Hand Hygiene policy, Infection Control Standard and Transmission-Based Precautions policy, and Summary of Personal Protective Equipment (PPE) Use and Room Restriction When Caring for Residents in Nursing Home with emphasis on ensuring proper infection control protocols and practices including hand hygiene during meals, transmission-based precautions (TBP) regarding use of personal protective equipment (PPE) and room placement with those on precautions. Element 4	

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	§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: Based on observation, interview and record review the facility failed to ensure proper infection control protocols and practices including hand hygiene during meals, transmission-based precautions (TBP) regarding use of personal protective equipment (PPE) and room placement for four (R42, R73, R288, and R289) of four residents reviewed for infection control. Findings include: Dining Observation: On 8/5/24 at 1:00 PM, the family member of R42 was observed standing at the end of the table and feeding the R42 by the spoonful. This family member was then observed to state to R73, "You look like you haven't had a crumb of food in years, right?". During this time, the family member was observed to touch their clothing, hair, and table multiple times. This family member was then observed to assist R73 and R42 at the		The DON/designee will complete random audits three times a week for 4 weeks on five residents, then every week for 4 weeks on five residents to ensure residents proper infection control protocols and practices including hand hygiene during meals, transmission-based precautions (TBP) regarding use of personal protective equipment (PPE) and room placement with those on precautions. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance.	

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	same time. There was no use of hand sanitizer or washing of hands by this family member in between assisting the two residents with their lunch meal. Additionally, although nursing staff were present, no one was observed to intervene or address this family member's actions. On 8/7/24 at 8:45 AM, an interview was conducted with Nurse Manager (NM 'N'). When asked about the observations during the lunch meal on 8/5/24, NM 'N' reported they had observed the same, and had spoken to that family member as well that day. When asked why no one intervened if they observed continued actions, they were unable to offer any further explanation. R42 Review of the clinical record revealed R42 was admitted into the facility on 7/1/20, readmitted on 8/30/20, signed onto hospice on 11/21/23 with diagnoses that included: Alzheimer's disease with late onset, adult failure to thrive, unspecified severe protein-calorie malnutrition, and anorexia. According to the Minimum Data Set(MDS) assessment dated 5/31/24, R42 had severe cognitive impairment. Review of the resident's plan of care included, "...Announce self when entering room and explain all procedures...Assistance needed with feeding, may fluctuate day to			

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	day...EATING: 1 person assist as needed..." R73 Review of the clinical record revealed R73 was admitted into the facility on 2/10/21 and readmitted on 2/23/21 with diagnoses that included: cerebral palsy, bipolar disorder, metabolic encephalopathy, unspecified severe protein-calorie malnutrition, and unspecified intellectual disabilities. According to the facility's MDS assessment dated 6/21/24, R73 had severe cognitive impairment. Review of the resident's plan of care included, "...EATING: 1 person assist...Encourage resident to join small dining for meals..." According to the facility's policy titled, "Hand Hygiene" dated 4/14/2023: "...SITUATIONS IN WHICH USING SOAP AND WATER OR ALCOHOL BASED HAND RUB CAN BE USED...Between direct contact with residents...After handling contaminated objects, equipment, dressings, etc..." R288 On 8/5/24 at 10:30 AM, R288 was observed lying in bed. A sign announcing "Contact Precautions" was posted on the door and a isolation cart was observed in the hallway immediately outside R288's room which			

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	contained personal protection equipment (PPE) including isolation gowns and gloves. R288 was asked about care at the facility. R288 explained their doctor, Dr. "F", had come in the day before, but was touching their PICC (peripherally inserted central catheter) line and the dressing over the wound on their foot without gloves...when they told Dr. "F" to put on gloves, Dr. "F" "got an attitude" about wearing gloves. R288 also explained they had told Dr. "F" they did not want them as their doctor anymore because they would not put on glove before touching them. Review of the clinical record revealed R288 was admitted into the facility on 7/29/24 with diagnoses that included: diabetes, cellulitis and acute kidney failure. According to a Brief Interview for Mental Status (BIMS) exam dated 7/30/24, R288 scored 14/15 indicating intact cognition. Review of R288's progress notes revealed a Physician Team - H&P (health and physical) note written by Dr. "F" dated 8/4/24 at 4:08 PM that read, "Patient refused exam". On 8/7/24 at 9:13 AM, Dr. "F" was interviewed by phone and asked about R288. Dr. "F" explained they were not wearing gloves, they wanted to see the PICC line, but R288 would not let them touch it, then they noticed a bandage on R288's foot, so they tried to move the blanket, but R288 yelled at them for not wearing gloves. Dr. "F" was			

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	asked if they were aware R288 was in Contact Precautions. Dr. "F" explained they normally enters the room and does an evaluation of what supplies they would need, then exits the room to gather the supplies and then they would put on a gown and gloves to do the examination and look at the wound, otherwise they would have to put on the PPE just to take it off again to go get the supplies they would need and then put on PPE again when going back into the room. Dr "F" was asked in a Contact Precaution situation, could R288's gown over the PICC line and the blanket over their wound potentially have the infectious organism on them. Dr. "F" did not answer. On 8/7/24 at 9:28 AM, Registered Nurse (RN) "B", who served as the Infection Control Nurse, was interviewed and asked about going into a Contact Precaution room. RN "B" explained everyone who entered the room and would have contact with R288 or objects in the room must wear a gown and gloves at all times. On 8/7/24 at 9:32 AM, the Director of Nursing (DON) was interviewed and asked if physicians were required to wear PPE in a Contact Precaution room. The DON explained all staff, including physicians must wear PPE for any contact with a resident or objects in a Contact Precaution room. R289			

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	On 8/5/24 at 11:11 AM, R289 was observed lying in a bed different than the room census provided by the facility. R289 was asked about being in that particular room. R289 explained their room had been changed that morning. Review of the clinical record revealed R289 had been admitted into the facility on 8/1/24 with diagnoses that included: open wound of abdominal wall, prostate cancer and chronic kidney disease. According to a BIMS exam dated 8/2/24, R289 scored 13/15 indicating intact cognition. Review of R289's census revealed upon admission, R289 was in Room 421. On 8/3/24, R289 was moved to Room 419, then on 8/5/24 R289 was moved to Room 417, their current room. Observation of room 419 revealed a Contact Precautions sign on the door and an isolation cart with PPE in the hallway directly outside the room. Review of the census revealed the resident in Room 419 had been admitted 7/29/24 and had been on Contact Precautions from admission. On 8/6/24 at 11:14 AM, Registered Nurse (RN) "B", who served as the Infection Control Nurse, was interviewed and asked about R289 being put in Room 419, a Contact Precaution room. RN "B" explained R287 should not have been put in the Contact Precaution room.			

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	On 8/6/24 at 11:36 AM, RN "H", who served as the Midnight Manager, was interviewed by phone and asked why R287 was put into a Contact Precaution room. RN "H" explained R287 requested to change rooms and there was not a Contact Precaution sign on the door to Room 419, so they moved R287 into that room. On 8/6/24 at 11:46 AM, the DON was interviewed and asked about R287 being moved into a Contact Precaution room. The DON explained R287 should not have been moved into that room, but they had been moved out again to another room and they would monitor them closely. Review of a facility policy titled, "Infection Control - Standard and Transmission-Based Precautions" revised 3/4/24 read in part, "...Transmission based precautions are used for residents who are known or suspected to be infected with infectious agents that require additional control measures above standard precautions to effectively prevent transmission which included: Contact precautions (direct or indirect contact with infectious agent)...Employees, residents, and visitors are responsible for complying with precautions...Contact transmission is the most frequent mode of transmission of healthcare associated infections. It includes direct contact transmission (where there is a person-to-person physical transfer of microorganisms between an infected person			

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	to another person) and indirect contact transmission (where there is a transfer of microorganisms between a contaminated object and a person)...Resident placement - Provide a private room with a dedicated bathroom or cohort residents who have the same infection from the same microorganism..."			