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	414290	A. BUILDING _____ B. WING _____	**10/24/2024**

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SKLD BELTLINE	**2320 E BELTLINE SE GRAND RAPIDS, MI 49546**

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F0000 SS=	INITIAL COMMENTS SKLD Beltline was surveyed for an Abbreviated survey on 10/23/24-10/24/24. Intake:MI00147492 Census= 121	F0000		
F0625 SS= D	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 therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide written notification of the facility bed hold policy upon discharge to an acute care hospital for 2 (Resident #102 and	F0625		

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

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

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	#103) of 3 residents reviewed for emergency hospital transfer resulting in the potential for unanticipated expense or the loss of desired room placement in the facility. Findings include: Resident #102 Review of an "Admission Record" revealed Resident #102 was originally admitted to the facility on 8/23/23 with pertinent diagnoses which included muscle weakness. Review of Resident #102's "Acute Care Transfer" note dated 10/18/24 revealed, " (Resident #102) transferred to hospital...Statement that Bed Hold Policy & Facility Initiated Transfer for Nursing Home forms Provided? Medication list and facesheet sent with (Resident #102)..." It was noted that there was no documentation noted to indicate written notification of the facility bed hold policy was provided upon discharge. Resident #103 Review of an "Admission Record" revealed Resident #103 was originally admitted to the facility on 1/23/23 with pertinent diagnoses which included insomnia. Review of Resident #103's " Progress Notes" dated 9/26/24 revealed, " (Resident #103) went to (medical specialty appointment). (Medical specialty provider) sent (Resident #103) to (local hospital)...." It was noted that there was no documentation noted to indicate written notification of the facility bed hold policy was provided upon discharge.			

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	On 10/24/24 at 8:53 AM, surveyor requested Resident #102's bed hold policy from Resident #102's hospitalization on 10/18/24 and Resident #103 's bed hold policy form from Resident #103's hospitalization on 9/26/24. During an interview on 10/24/24 at 10:07 AM, Nursing Home Administrator (NHA) "A" reported that the facility was not able to provide the bed hold policy forms for Resident #102 and Resident #103. During an interview on 10/24/24 at 2:11 PM, Director of Nursing (DON) "B" reported that the facility nurses were expected to provide the bed hold policy form to residents when they transferred to the hospital . DON "B" reported that the facility had missed providing the bed hold policies to Resident #102 and Resident #103.			
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: MI00147492 Based on interview and record review, the facility failed to address an acute change of condition and notify the physician of symptoms of increased lethargy (abnormal drowsiness), right upper extremity weakness, asymmetry (unequal) on the	F0684		

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	right side of face, decreased grip strength, increased pain, warmth, and swelling in the right knee in 1 (Resident #101) of 3 residents reviewed for quality of care, resulting in the delay of treatment and interventions in the diagnosis of subacute cerebral vascular accident (CVA) (Stroke) and acute RLE (right lower extremity) DVT (deep vein thrombosis). Findings include: According to the Mayo Foundation for Medical Education and Research, "It should be noted when signs and symptoms of a stroke begin, because the length of time they have been present may guide treatment decisions. Seek immediate medical attention if you notice any signs or symptoms of a stroke, even if they seem to fluctuate or disappear. Call 911 or your local emergency number right away. Every minute counts. Don't wait to see if symptoms go away. The longer a stroke goes untreated, the greater the potential for brain damage and disability. To maximize the effectiveness of evaluation and treatment, it's best that you get to the emergency room within 60 minutes of your first symptoms." Resident #101 Review of an "Admission Record" revealed Resident #101 was originally admitted to the facility on 12/18/23 with pertinent diagnoses which included Aphasia language disorder that affects a person's ability to communicate) following cerebral infarction (stroke). Review of Resident #101's "Incident Report" dated 9/29/24 revealed, "...Incident Description: (Resident #101) observed on the floor face down, in front of wheelchair...Immediate action taken: Assessed for injuries, neuro (neurological) evaluation started...No injuries observed at time			

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	of incident...Notes: ... (Resident #101) had a change in LOC (level of consciousness) a day post fall. Sent to ED (Emergency Department) for further evaluation. CT and X-rays were negative..." Review of Resident #101's " Progress Note" dated 9/30/24 documented by Physician Assistant (PA) "I" revealed, "...(Resident #101) is seen today after a fall that occurred on 9/29/24 at approximately 2:00 PM. (Resident #101) was observed face down on the floor in front of her wheelchair. No head trauma, pain with ROM (range of motion), or injuries, VSS (vital signs stable), afebrile (no fever), neuro checks at baseline. Today nurse reports that (Resident #101's) mentation has declined from baseline, she has a blank stare, and isn't providing verbal answers to questions. She is also guarding her right hip and is declining to get out of bed. Sent to (local hospital) for further evaluation and management..." Review of Resident #101's "Hospital Visit" notes dated 9/30/24 revealed, " ...Diagnosis: Contusion (bruising) of right hip... hip x-rays were negative... CT of the pelvis and hip did not show any acute fracture. (Resident #101) discharged in stable condition... CT of head without IV contrast: 1. No acute intracranial abnormality..." Review of Resident #101's "Progress Note" dated 10/1/24 and documented by PA "I" revealed, " ... (Resident #101) seen today after ER visit on 9/30 s/p (status post) fall. AVS (After visit summary) reviewed... CT head showed no intracranial abnormality...She remains more lethargic than baseline but answers simple questions appropriately and follows commands. ...Physical exam:...Notes: Decreased responsiveness from baseline...Eyes: PERRLA (Pupils equal, round, and reactive to light and accommodation), EOMI			

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	(extraoccular movements intact)... Bilateral upper extremity strength equal... Assessment and plan:...Continues to be more lethargic than baseline. ER work up grossly negative. Repeat labs ordered for tomorrow...Pain in right knee: Order placed for x-ray of the right knee, femur and tib/fib (tibia and fibula)...closely monitor and work up as needed..." Review of Resident #101's "Progress Note" dated 10/1/24 and documented by Nurse Practitioner (NP) "J" revealed, "...She (Resident #101) is found sleeping in her room and rousable to questioning. She states she has severe right hip pain and moans when I attempt to remove the right foot sock. She declined to extend the right leg due to the right hip pain. Minimally responsive to commands, attributed to drowsiness... Signs and symptoms: ... Head/Eyes: No findings reported. Muscoskeletal: right hip pain...pertinent findings: guarding and decreased ROM (range of motion) of right hip, increased pain, warmth, and swelling of right knee. Generally decreased muscle tone... Neurology: No physical findings pertinent to this encounter... Assessment: acute unresolved pain...Plan: PCP placed x-ray...scheduled Tylenol 1g (gram) TID (three times a day) for 10 days and lidocaine patch. If pain is not adequately controlled, add low dose oxycodone (opioid pain medication) 2.5 mg and titrate dose up slowly as tolerated...Closely monitor and work up as indicated..." Review of Resident #101's "Progress note dated 10/2/24 and documented by PA "I" revealed, " ... (Resident #101) is seen today after x-ray review of right knee, femur, and tib/fib. Results show mild degenerative changes with no evidence of significant evidence of joint space narrowing or fracture or dislocation or significant joint space in the right knee. She continues to have significant swelling and tenderness to the right knee and			

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	declines to extend it due to pain... Exam findings: ... Positive: Awake, appears comfortable, Alert...Eyes: Positive: (PERRLA), (EOMI)...Muscle: ROM per baseline...bilateral upper extremity strength equal...notes: positive for guarding and decreased ROM of right hip. Increased pain, warmth, and swelling of right knee...Plan: scheduled Tylenol 1g (gram) TID (three times a day) for 10 days and lidocaine patch..Closely monitor and work up as indicated..." Review of Resident #101's "Progress Note " dated 10/7/24 and documented by PA "I" revealed, "... (Resident #101... She continues to hold her right hip and knee in a flexed and internally rotated position and declines to straighten them due to pain. Her right knee is observed to be edematous (abnormally swollen) and tender to palpitation. She declines to give verbal responses and is only nodding yes or no...Exam Findings: Positive: Awake, appears comfortable, Alert...Eyes: Positive: (PERRLA), (EOMI)...Muscle: ROM per baseline, decreased muscle tone, bilateral upper extremity strength equal...notes: positive for guarding and decreased ROM of right hip. Increased pain, warmth, and swelling of right knee...Plan:..Increased Oxycodone from 2.5 mg QID to 5 mg TID x 14 days. Adjust as indicated...continue Tylenol 1 gram x10 days... continue to work with PT/OT (Physical and Occupational therapy)..." Review of Resident #101's "Progress Note" dated 10/8/24 and documented by NP "J" revealed, "... (Resident #101) presents for follow up fall and acute right and hip pain... pain was not completely controlled with Tylenol and diclofenac gel (topical gel used to treat pain), and lidocaine patch. On 10/4, Oxycodone (opioid pain medication) 2.5 mg q6 (every six hours) was scheduled... This dose was tolerated and pain appears to be incompletely controlled. She			

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	continues to hold her right hip and knee in a flexed and internally rotated position and declines to straighten them due to pain. Swelling and TTP (tender to palpitation) to her right knee and hip are present... She appears to be in pain when attempting to move her leg, grimacing. She is less conversant than before fall. AAO (Alert and oriented x1), only nodding yes or no to questions... she spends more time in bed. Before the fall she was often in her wheelchair in communal areas...Physical exam:...pertinent findings: positive for guarding, and decreased ROM of right hip. Increased pain, warmth, and swelling of the right knee... neurology: less cooperative following commands for neuro exam today..." It was noted that there were no changes to the plan of care. Review of Resident #101's " Progress Note" dated 10/10/24 and documented by PA "I" revealed, " (Resident #101) is seen today for increased weakness and lethargy. Initially on exam, She (Resident #101) presented with right upper extremity weakness and asymmetry on her right side of her face. She was awake but did not provide verbal responses to questions. She favored her left upper extremity with decreased grip strength on her right side... On repeat exam, her asymmetry on her right side of her face had improved and she was able to follow commands. Grip strength improved but she continued to favor her left upper extremity. NP "J" evaluated and felt that she was at her baseline. She has experienced a functional decline since her recent fall and she is on scheduled oxycodone for her right hip and knee pain, which may be contributing to her progressive weakness. She now requires assistant with eating and frequent cueing to chew and swallow... Assessment and plan: Noted to have a functional decline. She has remained in bed a majority of the time since her fall and now requires assistance with eating...Closely monitor for neurological changes. Low threshold to send			

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	to ER for stroke rule out..." Review of Resident #101's " General Progress Note" dated 10/10/24 and documented by Licensed Practical Nurse (LPN) "W" revealed, " Nurse (LPN "W") with (PA "I") assessed (Resident #101) this AM. (Resident #101) unable to open twitching right eye. Right side of face appeared to be dropping. (Resident #101) nonverbal (baseline (Resident #101) able to verbalize needs before and after fall). (Resident #101) hand grips baseline were equal, today (Resident #101) unable to grab with right hand. (Resident #101) appeared to be pocketing food with fluids dripping out of right side of mouth. CENA (Certified Nursing Assistant) states (Resident #101) has been drooling foods/fluids for days now. (Resident #101) expresses pain currently with facial grimace. Providers aware. (NP "J") stated this was baseline for (Resident #101)..." Review of Resident #101's "Progress Note" dated 10/11/24 and documented by PA "I" revealed, " (Resident #101) is seen today for follow up of increased weakness and lethargy. She is resting in bed and opens her eyes to verbal stimuli. No facial asymmetry observed. She slowly nods yes or no to questions but does not follow verbal commands...BP soft (blood pressure low) at 100/83...Low threshold to send to ER for decline in condition if she shows no improvement..." Review of Resident #101's "Progress Notes" dated 10/11/24 and documented by NP "J" revealed, " (Resident #101) presents with functional decline since her 9/30 fall. She has not had a BM (bowel movement) in 4 days and has notable decrease in oral intake of foods and fluids with 1 on 1 assistance feeding... she continues to grimace in pain with turns and cares...Order obstruction series as indicated if no BM by			

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	Monday after bowel regimen initiated, or exam findings such as nausea, vomiting, or guarding abdomen. For poor oral intake of food and water: initiate NS 75 mL/hr. (local EMS provider) called for IV placement.... reviewed plan with (Director of Nursing (DON) "B" and (Unit Manager (UM) "H")..." Review of Resident #101's "Progress Noted" dated 10/11/24 revealed, " This nurse spoke with (Resident #101's)guardian regarding current status. With increased decline, guardian wants (Resident #101) sent to the ED for further eval..." Review of Resident #101's " Progress note dated 10/11/24 and documented by LPN-UM "H" revealed, " At 10:00 AM spoke with (Medical Director (MD) "K)" about sending Resident #101 to hospital for a CT scan. However, (Medical Director) "K" recommended UA (urinalysis) specimen to assess for UTI (urinary tract infection). Unable to obtain UTI due to dehydration. Notify (Medical Director "K") and (PA "I"). Recommended hypodermoclysis. Reported that Resident #101 hasn't been eating, drinking, or engaging in activities. Upon assessment of Resident #101, observed right side facial drooping, right eye twitching. (Resident #101) is nonverbal, prior to fall Resident #101 was able to verbalize needs and wants. No bowel movement report in 4 days...Spoke with (NP "J"), (NP "J") stated "this is resident's current baseline, no evaluation recommended at this time. At 2:16 PM, contacted on call provider of significant change in status, provider ordered to send resident to ED for evaluation..." Review of Resident #101's "Hospital Notes" dated 10/11/24 revealed, " ... Physical Exam: Eyes:.. Right eye: Nystagmus (rapid, uncontrollable eye movement) present...Left eye: left pupil not reactive: left			

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	beating...Musculoskeletal: Limited passive ROM RUE (right upper extremity) with some stiffness and grimacing from patient. Grimacing also with passive movement of either LE (lower extremity)... Neurological:...Motor: weakness present. Comments: Spontaneous eye opening and LUE (left upper extremity) movement. right facial weakness. RUE weak with LROM (limited range of motion) and weaker grip. Clonus bilateral feet. (an abnormal reflex response that involves involuntary and rhythmic muscle contractions)...nonverbal and no attempts to speak...Details of hospital stay: (Resident #101) is a female with prior history of CVA (cerebrovascular accident-stroke) (2011, no residual deficits)... who presented from (facility) after staff noted right sided weakness and decline in mental status and several days of decreased intake. Of note the patient presented on 9/30/25 after a fall and head CT at that time was reported to be negative...new since 9/30/24 evolving lacunar infarction in the superior cerebellar artery distribution on the right (stroke), likely subacute...USV (ultrasound) showed acute RLE DVT. (right lower extremity deep vein thrombus)..." During an interview on 10/23/24 at 1:46 PM, Guardian "BB" reported that the facility had contacted her on 10/11/24 and informed her of Resident #101's change in condition. Guardian "BB" reported that she told the facility that she wanted Resident #101 sent to the hospital. Guardian "BB" reported that she felt like the facility did not send Resident #101 to the hospital as soon as they should have because of Resident #101's history of strokes. Guardian "BB" reported that she was informed by the hospital that Resident #101 had a stroke, and that there was concern related to the delay in care. Guardian "BB" reported that when the facility had contacted her and told her about changes with			

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	Resident #101 prior to 10/11/24, they had only reported that they were only concerned with the continued pain Resident #101 was experiencing, and they did not disclose the neurological changes that she was experiencing. Guardian "BB" reported that if she had been made aware of the neurological changes, she would have asked the facility to send Resident #101 to the hospital sooner. During an interview on 10/23/24 at 12:01 PM, Licensed Practical Nurse (LPN) "W" reported that she frequently cared for Resident #101 and was familiar with Resident #101's baseline. LPN "W" reported that she had returned from a few days off of work on 10/10/24 and was concerned with her assessment of Resident #101. LPN "W" reported that when she went to administer Resident #101's morning medications she had noted that Resident #101 was not communicating at all, that her face appeared to be drooping on the right side, her hand grips were not equal, and Resident #101 was pocketing food in the side of the mouth and seemed to be unable to swallow. LPN "W" reported that she had been informed by a Certified Nursing Assistant (CNA) that Resident #101 had been struggling to swallow food and liquids for a few days. LPN "W" reported her concerns to PA "I". LPN "W" reported that PA "I" assessed Resident #101 with LPN "W" and then spoke with NP "J" about the assessment. LPN "W" reported that she had been told that Resident #101 did not need to be sent to hospital because NP "J" felt that the assessment findings that LPN "W" noted were Resident #101's baseline. LPN "W" reported that she had concerns that Resident #101 was experiencing stroke symptoms, but since she had not seen Resident #101 for a few days and NP "J" reported this was her new baseline, she did not do anything further for Resident #101 that day. During an interview on 10/23/23 at 3:55 PM,			

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	LPN Unit Manager (LPN-UM) " H" reported that she had contacted the Medical Director (MD) "K" on 10/11/24 regarding Resident #101's decline in the morning on 10/11/24. LPN-UM "H" reported at that time "MD "K" thought it was appropriate to continue to keep Resident #101 in the facility, and he ordered a urinalysis (UA) to check to see if Resident #101 had a urinary tract infection. LPN-UM "H" reported that they were not able to obtain a UA on Resident #101, so she notified PA "I", who recommended the facility start hypodermoclysis on Resident #101. LPN-UM "H" reported that around 1:30 pm in the afternoon she went to assess Resident #101 and noted that Resident #101's face was drooping, her right eye was twitching, and she was not able to communicate. LPN-UM "H" reported that she was concerned that Resident #101 was having a stroke and reported her concerns to NP "J". LPN-UM "H" reported that NP "J" assessed Resident #101 and did not want to send Resident #101 to the hospital because she felt that Resident #101 did not have a change in condition and was at her baseline. LPN- UM "H" reported that she then contacted Director of Nursing (DON) "B" and reported her concerns with Resident #101 because she was not comfortable with NP "J"'s recommendation and she did not feel that Resident #101 was at her baseline. LPN-UM "H" reported that DON "B" agreed with her concerns and they contacted the on call provider and obtained an order to send Resident #101 to the hospital. LPN-UM "H" reported that she also contacted Resident #101's guardian and informed her of Resident #101's condition. LPN-UM "H" reported that Resident #101's guardian asked for Resident #101 to be sent to the hospital. LPN-UM "H" reported that Resident #101's stroke like symptoms began on 10/10/24. LPN-UM "H" confirmed that Resident #101 did have a stroke. LPN-UM "H" reported that she felt like the facility should have acted sooner on Resident #101's change in condition.			

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	414290	A. BUILDING _____ B. WING _____	**10/24/2024**

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	During an interview on 10/24/24 at 9:06 AM, DON "B" reported that she was aware of Resident #101's decline after her fall on 9/30/24. DON "B" confirmed that she did not have any staff approach her on 10/10/24 to inform her of Resident #101's change in condition, and she had learned about the changes noted in assessments on 10/10/24 on 10/11/24 when she was reviewing charts. DON "B" confirmed that she asked NP "J" to assess Resident #101 on 10/11/24. DON "B" reported that NP "J" assessed Resident #101 and did not feel that she needed to go the hospital. DON "B" reported that shortly after that, LPN-UM "H' approached DON "B" and voiced her concern about Resident #101 needing to go to the hospital. DON "B" reported that LPN-UM "H" reported that Resident #101 had a more pronounced facial droop, and that her symptoms were advancing. DON "B" confirmed that she called the on call provider and they obtained an order to send Resident #101 to the hospital. DON "B" confirmed that the expectation for nursing and providers was that they they would send a resident out immediately if they were experiencing neurological changes. DON "B" confirmed that the facility was not equipped to manage an acute change in condition such as a stroke. DON "B" confirmed that Resident #101 was diagnosed with a stroke in the hospital. DON "B" reported that the longevity provider (NP "J") was part of a collaborative team, and the other providers in the facility were able to send residents to the hospital without NP "J" 's consent. During an interview on 10/23/24 at 12:36 PM, PA "I" reported that she had assessed Resident #101 on 10/10/24 after nursing staff reported concerns about a change in Resident #101's condition. PA "I" reported that when she assessed Resident #101 on 10/10/24 around 9:00 AM she noted that Resident #101 had increased weakness,			

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	a twitch in her right eye and that her right eye was opening spontaneously which she noted to be an acute change for Resident #101. PA "I" confirmed that she had also noted facial asymmetry and increased weakness in Resident #101's right arm, as well as unequal grip strength and guarding of her right leg. PA "I" confirmed that due to Resident #101's history of strokes, she was concerned that Resident #101 may have been experiencing a stroke. PA "I" reported that she notified NP "J" of her concerns, and that NP "J" felt that Resident #101 was at her baseline and did not need to be sent to the hospital. PA "I" reported that she did not order for Resident #101 to be sent to the hospital since NP "J" did not want to send her, and that NP "J" had more authority to make that decision. PA "I" reported that she did reassess Resident #101 a few hours later and she seemed like she had improved, so she did not think it was necessary to escalate her concern to MD "K". PA "I" confirmed that Resident #101 presented with the same assessment the next day and was sent to the hospital. PA "I" confirmed that Resident #101 did have a stroke. PA "I" confirmed that Resident #101 had been reporting pain, warmth, and swelling in her right leg since her fall on 9/30/24. PA "I" confirmed that the facility did not order any testing to for DVT. PA "I" reported that she had not considered that Resident #101 may have had an DVT. PA "I" confirmed that pain, swelling, and redness are symptoms for DVT. PA "I" reported that she was unaware that Resident #101 was diagnosed with a DVT at the hospital. PA "I" confirmed that she felt that Resident #101 should have been sent to the hospital sooner, and that the facility had delayed treatment and care for her. During an interview on 10/23/24 at 4:26 PM, NP "J" reported that she had been caring for Resident #101 for the last few months. NP "J" reported that since Resident #101's right knee x-ray was			

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	negative for a fracture, she referred her to physical therapy and ordered pain medication for her. NP "J" confirmed that Resident #101 continued to report increased pain, swelling, and redness in her right leg. NP "J' confirmed that she did not order any testing to assess for a DVT. NP "J" was unaware that Resident #101 was diagnosed with a DVT. NP "J" reported that had not assessed Resident #101 on 10/10/24 because she had not been notified about a change in condition. NP "J" reported that she assessed Resident #101 on 10/11/24 and that she did not feel that Resident #101 was experiencing a change on condition and she did not think it was necessary for Resident #101 to be sent to the hospital. NP "J" reported that when she assessed Resident #101 on 10/11/24, Resident #101 would occasionally open her eyes, and that she noticed her face was asymmetrical, but that she had attributed that to Resident #101 laying on her right side. NP "J" reported that she was not able to test Resident #101's grip strength. NP "J" reported that she was supposed to have the decision in sending residents to the hospital because she was the longevity provider. (Provider specializing in longevity medicine and preventative care). NP "J" confirmed that Resident #101 had been diagnosed with having a stroke at the hospital. During an interview on 10/23/24 at 4:59 PM, MD "K" reported that he had not been made aware of Resident #101's potential stroke symptoms. MD "K" reported that if he had been made aware that Resident #101 was experiencing facial drooping, right eye twitching, and decreased grip strength, he would have ordered for Resident #101 to be sent to the hospital for stroke-like symptoms. MD "K" reported that it was his expectation that nurses and providers send any resident experiencing stroke like symptoms to the emergency room immediately. MD "K" confirmed that the facility was not equipped to			

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	handle acute neurological changes. .			
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 observation, interview, and record review, the facility failed to ensure resident safety with eating assistance for 1 (Resident #101) of 4 residents reviewed for accidents/hazards resulting in the potential for accidents and serious injury. Findings include: Resident #101 Review of an "Admission Record" revealed Resident #101 was originally admitted to the facility on 12/18/23 with pertinent diagnoses which included aphasia (language disorder that affects a person's ability to communicate) following cerebral infarction (stroke) and dysphasia (difficulty swallowing). Review of Resident #101's "Orders" revealed, " Regular Diet: Dysphagia/pureed/NDD1 (National Dysphagia 1 Diet) texture, regular fluid, thin consistency, 1:1: assist, 1 tsp at a time. Order start date: 10/21/24..." Review of Resident #101's "Kardex (care plan	F0689		

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	orders for Certified Nursing Assistants)" revealed, " Foods/Fluids: "...Ensure (Resident #101's) HOB (head of bed) is elevated at 90 degrees for all meals. Pureed diet, all thin liquids given with spoon. NO STRAWS...." Review of Resident #101's " Speech Therapy Evaluation" note dated 10/16/24 revealed, " ...Precautions: Precautions Details: liquids via tsp only, upright, 1:1 assist with feeding, cues to "swallow," and wait time between sips. .." Review of Resident #101's " Speech Therapy" note dated 10/18/24 revealed, " Precautions Details: liquids via tsp only, upright, 1:1 assist with feeding, cues to "swallow," and wait time between sips...(Resident #101) seen in room...SLP (Speech Language Pathologist) trialed puree via spoon. (Resident#101) opened mouth to receive food, and demonstrated adequate transit on 5/10 attempts, requiring cues and wait time for other reps... Spoke with unit manager (LPN-UM "H") and staff on updates and developed a visual aid with changes. Updated staff on upgrade of puree and thin liquids given by spoon only..." Review of Resident #101"s "Speech Therapy" note dated 10/21/24 revealed, " Precautions Details: liquids via tsp only, upright, 1:1 assist with feeding, cues to "swallow," and wait time between sips...(Resident #101) seen in room... Educated(Certified Nursing Assistant) CNA "R" on precautions... (Resident #101) is tolerating puree and thin liquids via tsp only... Review of Resident #101"s "Speech Therapy" note dated 10/23/24 revealed, " Precautions Details: liquids via tsp only, upright, 1:1 assist with feeding, cues to "swallow," and wait time between sips...(Resident #101) seen in room... (Resident #101) required increased wait time and			

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	cues to swallow, then after the 8th swallow, pt fell asleep and did not wake for attempts... Nursing aids aware and will attempt to continue meal later. Continue POC (plan of care)..." During an observation on 10/24/24 at 10:09 AM, Resident #101 was in her bed. It was noted that Resident had a cup of water on her tray dated 10/24/24 with a straw in the cup and two "sip" cups which were full of some type of juice. During an interview on 10/24/24 at 12:02 PM, CNA's " E" and "R" reported that Resident #101 used "sip" cups to drink, and used a sip cup or straws to drink. During an observation and interview on 10/24/24 at 12:28 PM, CNA "E" was observed exiting Resident #101's room with her meal tray. When this surveyor queried about Resident #101's meal intake, CNA "E" reported that she had provided Resident #101 apple juice with her lunch via a sip cup and that Resident "did much better" with a sip cup than a teaspoon. It was noted that Resident #101 had a new cup with a straw in it dated 10/24/24 on her tray table. During an interview on 10/24/24 at 12:34 PM, SLP "L" reported that she had been working with Resident #101 to assist her in improving her swallowing. SLP "C" confirmed that Resident #101 was only supposed to receive liquids via teaspoon because Resident #101's cognition to swallow had been impacted and she needed frequent cues to swallow. SLP "L" reported that Resident #101 would be at a great risk for choking if staff used a straw or sip cup to provide liquid to Resident #101. SLP "L" reported that Resident #101's feeding assistance orders were in her "Orders" and "Kardex" and that she communicated the orders to staff. SLP "L" confirmed that Resident #101's orders had been in			

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	place since 10/16/24. During an interview on 10/24/24 at 1:20 PM, CNA "V" reported that she had noticed a sign above Resident #101's bed that noted the orders for Resident #101 to not have straws and for liquids to be given via teaspoon on 10/21/24. CNA "V" reported the orders were also in Resident #101's "Kardex". which was where staff should look for resident care orders. CNA "V" confirmed that she was using a sip cup on 10/21/24 to give Resident #101 liquids until she saw the sign. CNA "V" reported that she had noticed that Resident #101 was not tolerating the sip cup well because she could not open her mouth up wide enough for the cup. During an interview on 10/24/24 at 1:44 PM, Kitchen Manager (KM) "CC" reported that Resident #101's "meal ticket" was noted to have "sip cup" as an adaptive equipment to send on Resident #101's meal tray. KM "CC" reported that the kitchen staff did not place straws on trays. During an interview on 10/24/24 at 1:53 PM, Licensed Practical Nurse(LPN-UM) "H" reported that Resident #101 was not supposed to have straws or sip cups in her room, and that staff had been educated on this. LPN-UM "H" reported that Resident #101 had orders in her chart that noted no straws or sip cups, and there was also a sign in her room. LPN-UM "H" went to Resident #101's room with surveyor and noted that there were two sip cups and a cup with a straw on Resident #101's tray table. During an interview on 10/24/24 at 2:11 PM, Director of Nursing (DON) "B" reported that the facility had not yet updated Resident #101's eating assistance orders because SLP "L" had just made the recommendations for Resident #101 on 10/23/24.			

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