STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	694020	A. BUILDING _____ B. WING _____	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF GAYLORD	508 RANDOM LANE GAYLORD, MI 49735

(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 Medilodge of Gaylord was surveyed for a Recertification survey on 12/17/24. Census = 82	F0000		
F0583 SS= D	Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by:	F0583	ELEMENT #1 1:1 education was provided to the nurse working D Hall on the Day Shift on 12/17/24. ELEMENT #2 All residents have the potential to be effected by this. All nurses are expected to lock their computer screen and secure any documentation with resident information prior to leaving their cart. Education will be given to staff on how to lock the EMR, reminders to close/secure written information, and when it is necessary to do so. ELEMENT #3 The DON/Designee will provide education to all staff on the Federal Rights of Nursing Center Residents Requirements for Nursing Facilities to ensure personal privacy and confidentiality of personal/medical records. DON and NHA reviewed the Federal Rights of Nursing Center Residents and deemed it appropriate. All staff are expected to monitor and notify others if there is confidential information not	2/5/2025

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

Electronically Signed | 01/10/2025

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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	Based on observation, interview and record review, the facility failed to maintain personal privacy of medical information for one hallway of four hallways reviewed. This deficient practice resulted in Residents privacy being breached. Findings include: On 12/17/24 at 9:38 a.m., an observation was made of the D-hall medical cart computer. The D-hall medical cart computer was left with an open display for Resident 179 (R179), and visible on the computer screen were Physician Orders from the Electronic Medical Record program. The D-hall medical cart also had a clearly visible 'Controlled Substance Log' for R179 used to keep accurate count of controlled substances. Review of the facility's "Federal Rights of Nursing Center Residents Requirements for Nursing Facilities" given to each resident in the "Hospitality Guide" upon admission, read, in part, " ...(3) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records ..." An interview was conducted with the Director of Nursing (DON) on 12/17/24 at 12:45 p.m. The DON confirmed that the D-Hall medical cart computer display and other documentation should have been securely locked and closed.		secured. ELEMENT #4 All management staff will complete random weekly audits to ensure computer screens are locked and documentation is secured on nursing carts for 4 weeks or until substantial compliance is achieved. DON/Designee will report the audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The DON is responsible for compliance.	
F0623 SS= E	Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i)	F0623	ELEMENT #1 Written notification of the Transfer and Discharge paperwork has been provided to	2/5/2025

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	Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and		residents/legal representatives for Resident #5, Resident #16, and Resident #33. Residents were assessed and experienced no negative effects. The October Ombudsman Log was updated to indicate if a return was expected and why the transfer occurred. It was re-sent to the Ombudsman. Resident #43 no longer resides at the facility. ELEMENT #2 Any residents who are transferred to the hospital have the potential to be effected by this. Any transferred residents who still reside in the building or their legal representative will receive a written notification of their transfer with the reason, date, and location of transfer. An audit of all of the Ombudsman Logs was completed and any months that had missing information was updated and sent to the Ombudsman. The Resident Advocate will ensure the Ombudsman Log is completely filled out prior to sending to the Ombudsman. ELEMENT #3 The DON/Designee will provide education to nurses on the Transfer and Discharge Policy for any residents who transfer to an acute care setting. DON and NHA reviewed the Transfer and	

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	email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as		Discharge Policy and deemed it appropriate. The Business Office Manager/Designee will review daily Monday through Friday in Morning Meeting to ensure all Transfer Notifications have been completed and Ombudsman Log has been updated appropriately. ELEMENT #4 The IDT will complete weekly audits to ensure written notification of transfer to resident/legal representative and Ombudsman Log accuracy for 4 weeks or until substantial compliance is achieved. The Business Office Manager will report audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The NHA is responsible for compliance.	

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	evidenced by: . Based on interview and record review, the facility failed to provide written transfer notifications to the resident/resident's representative and the Office of the State Long-Term care Ombudsman including reason, effective dates, and the location to which the resident was being transferred for four Residents (#5, #16, #33, #43) of seven residents reviewed for transfers out of the facility. Findings include: Resident #5 (R5) The medical record for R5 revealed a transfer to the hospital on 10/10/24 with readmission on 10/15/24. The medical record did not indicate a written notification of transfer in October was given to R5 or sent to the resident's representative. The Resident was on the Office of the State Long-Term care Ombudsman log as transferred but there was no indication on the log if the return was expected and no primary reason for the transfer. (This data was missing for all 16 residents on the October ombudsman log.) On 12/17/24 at 10:41 AM, Administrative Staff "F" stated the written transfer notice for R5 was not in the transfer binder and had not			

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	been sent. Staff "F" stated no written transfer notices were sent for the 9 residents on the ombudsman log for November and none were sent in December as she had not received an information from nursing. Resident #16 (R16) The medical record for R16 revealed a transfer to the hospital on 3/7/24 with readmission on 3/10/24. The medical record did not indicate a written notification of transfer was given to R16. The Resident was on the ombudsman log as transferred but there was no indication on the log if the return was expected or the primary reason for the transfer. Resident #33 (R33) The medical record for R33 revealed a transfer to the hospital on 6/22/24 with readmission on 7/2/24. The medical record did not indicate a written notification of transfer was given to R33 or the Resident's representative. The Resident was on the ombudsman log as transferred but there was no indication on the log if the return was expected or the primary reason for the transfer. Resident #43 (R43) The medical record for R43 revealed a transfer to the hospital on 12/10/24. The medical record did not document issuance of written notification for the reason for the			

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	transfer to R43 or R43's resident representative. On 12/17/24 at 2:45 p.m., Staff "F" confirmed she maintained the written notifications of bed holds and transfers in a binder. The binder contained dividers labeled by month with the written notifications filed by the month in which each resident was transferred to the hospital. The months of November 2024 and December 2024 were empty. Staff "F" said, "It's a hit or miss if I receive them from nurses. I didn't receive any for November and December." Staff "F" said the expectations is for nurses to complete the written notifications and provide them to her the next business day to file in the binder. Staff "F" confirmed the notifications would be in the binder if they had been issued. The "Transfer Discharge Policy" dated as revised 10/30/23, read in part: "...Provide transfer notice as soon as practicable to resident and representative... Social Services Director, or designee, shall provide notice of transfer to a representative of the Office of the State Long-Term care Ombudsman via monthly list..."			
F0625 SS= E	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	F0625	ELEMENT #1 Written notification of the Bed Hold paperwork has been provided to residents/legal representatives for #5, #16, and #33. Residents were assessed and experienced no negative effects. Resident #43 no longer resides at the facility. ELEMENT #2	2/5/2025

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	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 ensure four Residents (#5, #16, #33, and #43) of eight residents reviewed for hospitalization were provided written notice of bed hold when the residents were transferred to the hospital. Findings include: Resident #43 (R43) The medical record for R43 revealed a transfer to the hospital on 12/10/24. The medical record did not document issuance of the bed hold policy to R43 or R43's resident representative. Resident #16 (R16) The medical record for R16 revealed a transfer to the hospital on 3/7/24 with readmission on 3/10/24. The medical record did not indicate a notice of the resident's bed hold policy had been given to R16 or the		Any residents who are transferred to the hospital have the potential to be effected by this. Any transferred residents or their legal representatives will receive a written notification of the Bed Hold paperwork. ELEMENT #3 The DON/Designee will provide education to nurses on the Bed Hold Policy process for any residents who transfer to an acute care setting. The DON and NHA reviewed the Bed Hold Policy and deemed it appropriate. The Business Office Manager/Designee will review daily Monday through Friday in Morning Meeting to ensure all Bed Hold paperwork has been completed. ELEMENT #4 The IDT will complete weekly audits to ensure written notification of bed holds to residents/legal representatives for 4 weeks or until substantial compliance is achieved. The Business Office Manager will report the audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The NHA is responsible for compliance.	

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	resident's representative. Resident #33 (R33) The medical record for R33 revealed a transfer to the hospital on 6/22/24 with readmission on 7/2/24. The medical record did not indicate a notice of the resident's bed hold policy had been given to R33 or the resident's representative. Resident #5 (R5) The medical record for R5 revealed a transfer to the hospital on 10/10/24 with readmission on 10/15/24. The medical record did not indicate a notice of the resident's bed hold policy had been given to R5 or the resident's representative. On 12/17/24 at 10:41 AM, Administrative Staff "F" stated the bed hold notice for R5 was not in the transfer binder and had not been given. On 12/17/24 at 2:45 p.m., Staff "F" confirmed she maintained the written notifications of bed holds and transfers in a binder. The binder contained dividers labeled by month with the written notifications filed by the month in which each resident was transferred to the hospital. The months of November 2024 and December 2024 were empty. Staff "F" said, "It's a hit or miss if I receive them from nurses. I didn't receive any for November and December." Staff "F" said the			

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	expectations is for nurses to complete the written notifications and provide them to her the next business day to file in the binder. Staff "F" confirmed the notifications would be in the binder if they had been issued. The "Transfer Discharge Policy" dated as revised 10/30/23, read in part: "... Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer..." .			
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure appropriate care was provided for Moisture Associated Skin Damage (MASD) according to professional standards of practice for one Resident (#47) of one resident reviewed for MASD. This deficient practice resulted in the potential for delayed wound healing, worsening of condition and pain. Findings include:	F0684	ELEMENT #1 To ensure effective prevention and management of Moisture Associated Skin Damage for Resident #47, a focused intervention regarding documentation of Incontinence Care Plan was implemented to ensure CNAs are documenting as appropriate. ELEMENT #2 Any residents who are incontinent have the potential to be affected. An audit of all incontinent residents will be completed. Individualized toileting plans have been reviewed, revised, and deemed appropriate. New admissions/readmissions will be reviewed to ensure appropriate Incontinence	2/5/2025

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	Resident #47 (R47) R47 was admitted to the facility on 1/31/22 with diagnoses including cerebral infarction (stroke), neurogenic (nerve originating problem) bladder, and type 2 diabetes. A review of R47's most recent Minimum Data Set (MDS) assessment, dated 10/2/24, revealed R47 scored 2 out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. R47 was rated as always incontinent of bowel and bladder. An observation on 12/16/24 at 11:45 a.m., revealed R47 lying in bed, with her lower body covered with a blanket visiting with her Durable Power of Attorney (DPOA). R47's DPOA stated R47 was recently diagnosed with MASD in her peri [area surrounding genitals]-area and believed there was an issue with checking and changing her brief during the night shift. R47's DPOA stated he has found R47 lying in bed soaked in urine with the same brief that she had on from the previous day, and also stated when he came in this morning, he found blood on her right hand and under her fingernails from scratching herself around her urine soaked brief. R47's DPOA stated it was discussed at the last care conference and R47 was to be checked and changed every two hours. Review of R47's Wound Evaluation dated 12/10/24 revealed the following entries: "MASD - IAD Incontinence Associated Dermatitis; Right Gluteal Fold; In-House Acquired; Area 1.46 cm2 (centimeters squared); Length .75 cm; Width 5.54 cm" "MASD - IAD Incontinence Associated		Care Plan is in place. CNAs are expected to document all check and changes in the EMR. ELEMENT #3 The DON/Designee will provide education to nurses and CNAs on the Incontinence Policy and the requirement for documentation to be in the EMR. The DON/NHA reviewed the Incontinence Policy and deemed it appropriate. The Clinical Managers will ensure new admissions or readmissions have the appropriate Check and Change task for CNAs to document in the EMR based on the resident's Incontinence Care Plan. ELEMENT #4 The IDT will complete weekly audits to ensure toileting task is documented in EMR for 4 weeks or until substantial compliance is achieved. DON will report the audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The DON is responsible for compliance.	

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	Dermatitis; Left Gluteus - Medial and Inferior; In-House Acquired; Area 11.8 cm2; Length 2.46 cm; Width 6.73 cm" Review of R47's Physician Orders read, in part, "Wound Care - bilateral buttocks/bilateral posterior upper thighs; cleanse with soap and water, rinse and pat dry. Apply Collagen powder to open areas (wound beds). Mix collagen powder w (with)/ Manuka Honey Ointment (nickel size) apply thin layer to excoriated area(s) Q (every)-shift and as needed, every shift for MASD/excoriation. Start Date: 12/6/24." An interview was conducted with Certified Nurse Aide (CNA) "M" on 12/17/24 at 12:35 p.m. CNA "M" stated staff document on a record sheet located in the hallway each time they do a check and change on R47. CNA "M" also stated they document in the electronic medical record (eMAR) sometimes, but not always. When asked to review R47's current record sheet for 12/17/24, CNA "M" verified with this Surveyor that R47 had been changed at 7 a.m. and 12:00 p.m. When asked where the old record sheets are kept, CNA "M" stated staff shred them at the end of the day. Review of R47's Care Plan read, in part, "Resident has an ADL (Activities of Daily Living) self-care performance deficit ...Toileting: Check and change q (every) 2 hours and prn (as needed) with 2 staff members at all times ..." An interview was conducted with the Director of Nursing (DON) on 12/17/24 at 12:45 p.m. The DON stated staff should be documenting in the eMAR for every check and changed performed on R47 and staff should not be			

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	destroying the record sheet at the end of each day. Review of the facility's "Incontinence" policy revised 10/26/23 read, in part, " ...all residents that are incontinent will receive appropriate treatment and services ...Residents that are incontinent of bladder ...will receive appropriate treatment to prevent infections ..."			
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer supplemental oxygen according to physician orders, change and date respiratory equipment, appropriately store respiratory equipment, and clarify parameters for administration of supplemental oxygen for three Residents (#330, #331, and #43) of seven residents reviewed for respiratory care services. Findings include: Resident #331 (R331)	F0695	ELEMENT #1 Staff will administer supplemental oxygen per orders, change & date respiratory equipment, appropriately store respiratory equipment, clarify parameters for adminstration of supplemental oxygen. Residents #331, #330, and #43 no longer reside at the facility. ELEMENT #2 Any residents who use supplemental oxygen or respiratory equipment have the potential to be effected by this practice. An audit of all resident who have supplemental oxygen or have respiratory equipment will be completed to ensure orders are correct, equipment has been changed and dated within the past 7 days, and there are containers available for equipment to be stored appropriately. ELEMENT #3 The DON/Designee will provide education to	2/5/2025

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	R331 was admitted 11/26/24 with diagnoses of acute respiratory failure with hypoxia (low levels of oxygen), chronic obstructive pulmonary disease, dependence on supplemental oxygen, and others. On 12/15/24 at 10:56 a.m., R331 was observed wearing a nasal cannula (tube that delivers supplemental oxygen). The nasal cannula tubing was dated 12/3/24. The supplemental oxygen was set at a delivery rate of 10 liters per minute. On 12/15/24 at 10:56 a.m., a Bipap machine (a non-invasive, mechanical breathing device) was observed on R331's nightstand. A hand-written note taped to the machine read: "Increase O2 [oxygen] to 10 L [liters] when Bipap is on at HS [bedtime]. Decrease O2 to 7 L when Bipap is off at AM [morning]." R331 said, "that [Bipap] came off three or four hours ago when I woke up earlier." An unbagged, undated nebulizer mask (a drug delivery device used to administer medications into the lungs) was observed on 12/15/24 at 10:56 a.m. on R331's bedside stand without a barrier beneath it. The nebulizer and the tubing did not contain dates to indicate when the mask or tubing was changed. A receptacle was not available to place the nebulizer mask when not in use. Physician orders for R331 included an order that read "Oxygen tubing/filter change every week ..."		all staff on the CPAP/BiPAP/NIPPV Support Policy, the Oxygen Administration Policy, and Nebulizer Therapy Policy. The DON and NHA reviewed the CPAP/BiPAP/NIPPV Support Policy, the Oxygen Administration Policy, and Nebulizer Therapy Policy and deemed them all appropriate. Clinical Managers will monitor oxygen parameters and equipment to ensure orders are followed for supplemental oxygen, equipment has been changed and dated each week, and oxygen equipment is appropriately stored during rounds. ELEMENT #4 The IDT will complete weekly audits of oxygen parameters, equipment storage, and date changes to equipment for 4 weeks or until substantial compliance is achieved. DON will report the audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The DON is responsible for compliance.	

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R331 had a physician's order that read "Oxygen: run @ (at) 7 L/min (minute) via N/C (nasal cannula) during the day. Run at 10 L at NOC (night) while on Bipap ..."

Resident #330 (R330)

On 12/15/24 at 10:54 a.m., R330 was observed wearing a nasal cannula for delivery of supplemental oxygen. The nasal cannula tubing was undated. R330 said he was on oxygen when he was at home. R330 said he was recently admitted to the facility from home but could not recall if the nasal cannula was the same cannula R330 was wearing from prior to admission or if it was changed when R330 was admitted to the facility.

Physician's orders for R330 included the order: "Oxygen: RUN @ [2-5] L/MIN VIA [X]N/C ... [X] CONTINUOUS ..." The order did not contain resident indicators or oxygen saturation parameters to direct nurses regarding the flow rate of the supplemental oxygen.

During an interview on 12/16/24 at 2:32 p.m., Licensed Practical Nurse (LPN) "B" confirmed she was the nurse manager on the "B" unit where R330 resided. LPN "B" was asked the criteria for nurses to determine the number of liters for supplemental oxygen delivery if a range for liters per minute was provided in the order. LPN "B" said, "it depends on if there is shortness of breath or difficulty

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	breathing or the oxygen saturation." LPN "B" said, "Nurses complete respiratory assessments every time they go into the room." When asked the frequency of respiratory assessments or where the assessments were documented, LPN "B" did not provide a response. LPN "B" confirmed there were no parameters for nurses to determine the flow rate of supplemental oxygen for R330. LPN "B" was asked regarding the storage of respiratory equipment when not in use, including nebulizers and cannulas. LPN "B" said nebulizers and nasal cannulas are required to be in a bag when not in use by the resident. LPN "B" was asked about changing and dating nebulizers, cannulas, and oxygen tubing. LPN "B" responded, "they should be changed weekly and dated when they are changed." LPN "B" said the nurses on the night shift are responsible for dating and changing nebulizers and tubing each week. Resident #43 (R43) On 12/15/24 at 11:25 a.m., an unbagged, undated nebulizer was observed lying atop R43's bed without a barrier beneath it. The nebulizer and tubing did not contain dates to indicate when the nebulizer or tubing was changed. A receptacle was not available to place the nebulizer when not in use. An unbagged, undated nasal cannula was observed atop R43's nightstand without a			

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	barrier beneath it. On 12/16/24 at 9:08 a.m., Certified Nurse Aide (CNA) "C" was observed making R43's bed. The undated, unbagged nebulizer was atop R43's nightstand while CNA "C" was making the bed. After the bed was made, CNA "C" picked up the nebulizer from the nightstand and placed it atop the bed. CNA "C" was asked why the nebulizer was placed atop the bed. CNA "C" replied, "I just put it back where I found it before I made the bed." The Director of Nursing (DON) was interviewed on 12/17/24 at 11:50 a.m. The DON was asked regarding the expectation for changing, dating, and storing nebulizers, cannulas, and oxygen tubing. The DON said, "I haven't been trained on any of that but it's a standard of practice to be changed and dated weekly, and they should be in bags when not being used." The DON confirmed oxygen was expected to be administered according to physician orders. The policy "Oxygen Administration" dated as last reviewed/revised on 10/26/23 read, in part: " ...Infection control measures include: ... b. Change oxygen tubing and mask/cannula weekly and as needed ...e. Keep delivery devices covered in plastic bag when not in use ..." The policy "Nebulizer Therapy" dated as reviewed/revised on 5/15/24 read, in part: " ...Once completely dry, store the nebulizer			

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	cup and the mouthpiece in a zip lock bag. H. Change nebulizer tubing weekly ..." The policy "CPAP/BiPAP/ NIPPV (Non-Invasive Positive Pressure Ventilation) Support" dated as last reviewed/revised 1/1/21 read, in part: "...Review the physician's order to determine the oxygen concentration or liter flow..."			
F0732 SS= C	Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F0732	ELEMENT #1 Nursing Staffing Information was updated on 12/15/24 around 11:00am. ELEMENT #2 All residents in the facility have the potentital to be affected by not knowing the daily Nursing Staffing Information. Daily Nursing Staffing Information will be posted prior to the start of the Day Shift by the A Hall midnight nurse. ELEMENT #3 The DON/Designee will provide education to all staff on the Daily Nursing Staffing Information Form to ensure it is up to date prior to the start of Day Shift 7 days per week. NHA educated the Scheduler on completing the Daily Nursing Staffing Information Form. Management staff will review posting daily to ensure completion.	2/5/2025

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	This REQUIREMENT is not met as evidenced by: **Based on observation, interview and record review, the facility failed to ensure daily posting of nurse staffing information, resulting in the inability of residents, resident's representatives and visitors to determine the number of staff available to provide resident care and had the potential to affect all 82 residents in the facility.** **Findings include:** **On 12/15/2024 at 9:02 a.m. the facility's, "Daily Nurse Staffing Form," was observed posted on the wall in entrance hallway of the facility. Review of the staffing form revealed the form was dated 12/12/2024, three days prior to the observation.** **During an interview on 12/17/2024 at 11:47 a.m., the facility Staffing Coordinator, Staff "A", reported she was responsible for completion and posting of the daily staffing levels using the "Daily Nurse Staffing Form." Staff "A" reported she did not work from 12/13/2024 until 12/16/2024 and nursing staff were responsible for completion and posting of the forms in her absence. The Nursing Home Administrator (NHA), who was present during the interview, stated she was aware of the requirement for daily posting of staffing information. The NHA reported she believed nursing staff did not complete the staff posting because the form was not "user-friendly", and they were confused about how to complete the form.**		ELEMENT #4 Management staff will complete random weekly audits to ensure daily posting prior to Day Shift for 4 weeks or until substantial compliance is achieved. Scheduler will report the audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The NHA is responsible for compliance.	
F0755	Pharmacy	F0755	ELEMENT #1	2/5/2025

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SS= D	Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to timely destroy discontinued scheduled II medication and dispensed medication without a physician order for one Resident (#58) and failed to initiate a stop date on an as needed antianxiety medication for one Resident (#279) of eighteen residents reviewed for pharmacy services. Findings include:		The nurse working on A Hall on 10/25/24 was given 1:1 education about reading and verifying orders in the eMAR prior to administering medication. All staff have been educated on using both the eMAR and the Controlled Substance Log when administering controlled substances. Resident #58's discontinued Lorazepam was removed from the medication cart by the DON on 12/15/24 and it was destroyed per policy. Resident #279 no longer resides at the facility. ELEMENT #2 Any residents who are prescribed prn medications or controlled substances have the potential to be effected by this. An audit was completed for all residents prescribed prn medications and controlled substances to ensure 14 day stop dates were in place and discontinued medications were removed from the medication carts and destroyed. An audit was completed of all the Controlled Substance Logs to ensure that they match the eMARs. ELEMENT #3 The DON/Designee will provide education to all nurses on the Medication-Destruction Policy, Controlled Substance Administration and Accountability Policy, Medication Administration Policy and the Medications-PRN Policy.	

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	Resident #58 (R58) Review of R58's physician order, dated 5/5/24, revealed the following: Lorazepam tablet 0.5 mg (milligrams), give one tablet by mouth every eight hours as needed for anxiety related to adjustment disorder, with a discontinuation date of 9/16/24. R58's as needed antianxiety medication should have been reevaluated after 14 days per the regulation and no evidence of reevaluation could be seen in the Electronic Medical Record (EMAR). Review of R58's controlled substance log, with the medication date received on 4/3/24, revealed R58 received a dose of the antianxiety medication on 10/25/24 after the medication was discontinued. Review of R58's electronic medication administration record (eMAR) and controlled substance log sign out sheet, dated 4/3/24 through 12/15/24, revealed the following; a.) Dispensed on 5/21/24 at 7:15 PM and not signed out on the eMAR, b.) Dispensed on 5/23/24 at 7:00 PM, not signed out on the eMAR and prior administration was at 4:20 PM (not within the as needed every four hours physician order), c.) Dispensed on 6/8/24 at 5:40 PM and not signed out on the eMAR and,		DON and NHA reviewed the above policies and deemed them appropriate. The Clinical Management Team will review prescribed prn medications daily Monday-Friday in Morning Meeting to ensure stop dates are in place. ELEMENT #4 The IDT will complete weekly audits to ensure prn stop dadtes are entered, discontinued medications are removed from medication carts and destroyed per policy, medication administration is completed via eMAR, and the controlled substance logs match the eMAR per policy for 4 weeks or until substantial compliance is achieved. DON will report the audit results to the QAPI Committee monthly until substantial compliacne is achieved and maintained. The DON is responsible for compliance.	

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	d.) Dispensed on 7/30/24 at 2:42 PM and not signed out on the eMAR. Review of the A-hall medication cart on 12/15/24, revealed R58's discontinued antianxiety medication remained in the narcotic controlled lock box approximately three months after the medication was discontinued. Resident #279 (R279) Review of R279's physician order, dated 12/13/24, revealed the following: Alprazolam tablet 0.25 mg, give one tablet by mouth every four hours as needed for anxiety related to generalized anxiety, with no discontinuation date. R279's as needed antianxiety medication should have had a discontinued date after 14 days per the regulation and no evidence of reevaluation could be seen in the EMR. On 12/15/24 at 2:15 PM, an interview was conducted with the Director of Nursing (DON) who was asked how long discontinued medications should be left in the controlled substance lock box, if medications are given without a physician order, and if the medication administration should reflect the controlled substance log. The DON stated, "If controlled substances are discontinued, they should be removed as soon as possible. Medications are not to be dispensed without			

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	a physician order. The residents electronic medical record should reflect what is given on the narcotic log sheets." Review of policy titled, "Medication-Destruction of Unused Drugs", dated 1/18/24, read in part, "Policy: All unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations ...Policy Explanation and Compliance Guidelines ...6. Scheduled II, III, and IV controlled drugs must be destroyed by the Director of Nursing Services and another licensed nurse ..." Review of policy titled, "Controlled Substance Administration and Accountability", dated 10/26/23, read in part, "Policy: It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. Policy Explanation and Compliance Guidelines ... Review of policy titled, "Medication Administration", dated 1/17/23, Read in part, "Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines ...10. Review MAR to identify			

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	medication to be administered. 11. Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time of administration ...17. Sign MAR after administration ..." Review of policy titled, "Medications - PRN", dated 1/30/24, read in part, "Policy: PRN medications by staff who are legally authorized to do so through certification or licensure, in accordance with a physician's order ...Policy Explanation and Compliance Guidelines ...3. When administering a PRN medication: a. Verify physician's order for the medication ...5. PRN orders for psychotropic drugs are limited to 14 days ..."			
F0758 SS= D	Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs	F0758	ELEMENT #1 Residents #68 and #20 prescribed psychotropic medications were evaluated to ensure an appropriate diagnosis. A GDR or Risk vs. Benefit was initiated. Staff on the Dementia Unit were educated and reminded to document non-pharmacological interventions and their effectiveness prior to the nurse administering prn psychotropic medications. Residents were assessed and experienced no negative outcomes. Resident #179 no longer resides at the facility. ELEMENT #2 Any residents who are prescribed prn or scheduled psychotropic medications have the	2/5/2025

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	pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to: 1) ensure non-pharmacological interventions attempted and failed prior to the administration of as needed (prn) anxiolytic medication were documented; 2) ensure appropriate indication for use for an antipsychotic medication; and, 3) ensure consideration of a gradual dose reduction (GDR) of an anti-depressant medication, affecting three Residents (#68, #179, & #20) of five residents reviewed for unnecessary medications. Findings include:		potential to be effected. A full house audit of residents who are prescribed prn psychotropic medications was completed to ensure target behavior charting is on and non-pharmacological interventions are documented with results of intervention prior to nurse administering prn medication. A full house audit of residents who are prescribed psychotropic medications has been completed to evaluate GDR schedule or Risk vs. Benefit and appropriate diagnoses. ELEMENT #3 The DON/Designee will provide education to clinical IDT team and providers regarding appropriate diagnosis for psychotropic medications. The DON/Designee will provide education to CNAs on documenting behaviors and attempting multiple non-pharmacological interventions prior to requesting prn psychotropic medications. Nurses will be re-educated on documenting effectiveness of non-pharmacological interventions prior to administering prn psychotropic medications. NHA/DON reviewed the Use of Psychotropic Drugs and Gradual Dose Reductions Policy and deemed it appropriate. New psychotropic medications will be reviewed Monday-Friday in Morning Clinical Meeting to ensure appropriate diagnoses, GDR or Risk/Benefits, and/or rationales are completed and reviewed.	

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	Resident #68 (R68) Review of the Minimum Data Set (MDS) assessment, dated 9/16/2024, revealed R68 was admitted to the facility on 6/12/2024 and had diagnoses including dementia with behavioral disturbance, insomnia, hallucinations and depression. Further review of the MDS assessment revealed R68 had severe cognitive impairment. Review of R68's physician orders revealed the following: "Diazepam [Valium, a controlled medication used to treat anxiety and insomnia] oral tablet 5 MG [milligram] ... Give 1 tablet by mouth every 6 hours as needed for anxiety for 14 days. Start Date: 11/27/2024 1245 [12:45 p.m.]." Review of R68's December 2024 Medication Administration Record (MAR), accessed on 12/15/2024 at 12:08 p.m., revealed the medication was administered on the following dates without documentation in the electronic medical record (EMR) of attempted non-pharmacological interventions prior to the administration: 12/01/2024 at 8:58 a.m. and 2:54 p.m. 12/06/2024 at 12:25 p.m. and 7:40 p.m. 12/07/2024 at 11:15 a.m. and 5:39 p.m. 12/08/2024 at 8:12 a.m. and 6:23 p.m. 12/09/2024 at 6:19 p.m. 12/10/2024 at 2:27 p.m. and 8:30 p.m.		ELEMENT #4 The Clinical IDT will complete 5 random weekly audits to ensure appropriate diagnoses for psychotropic medications, initiation of GDR or Risk/Benefit of psychotropic medications, and documentation of behaviors and non-pharmacological interventions/effectiveness are completed for 4 weeks or until susbtantial compliance is achieved. Social Services Director will report the audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The DON is responsible for compliance.	

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	12/11/2024 at 1:25 p.m. 12/13/2024 at 2:00 p.m. and 8:36 p.m. 12/14/2024 at 6:46 a.m. and 5:23 p.m. 12/15/2024 at 8:07 a.m. During an interview on 12/27/2024 at 1:25 p.m., the Director of Nursing (DON) confirmed non-pharmacological interventions should be attempted prior to the administration of R68's prn diazepam (Valium) and the effectiveness of the interventions should be documented in the Resident's EMR. The DON stated keeping a record of interventions attempted and failed assists the physician to make determinations of needed changes to the medication regimen and to assist staff in revising the person-centered care plan. Review of the facility policy titled, "Unnecessary Drugs - Without Adequate Indication for Use," last revised 10/26/2023, revealed the following, in part: "It is the facility's policy that each resident's drug regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical and psychosocial well-being free from unnecessary drugs ... When psychopharmacological medications are used as an emergency measure, adjunctive approaches, such as individualized, non-pharmacological approaches and techniques must be implemented ..." Surveyor: Ranville, Gail			

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Resident #179 (R179)

R179 was admitted to the facility on 12/12/24 with a primary diagnosis of a cutaneous (affecting the skin) abscess (a pus filled cavity) of the left lower leg. The medical record diagnoses tab contained no record of any psychotic related issues. The medication list for R179 included, "SEROquel Oral Tablet (an antipsychotic medication) 25 MG (Quetiapine Fumarate)" with indicated use of: "Give 1 tablet by mouth at bedtime for sleep".

The discharge instructions from the hospital stay prior to R179's admission to the facility read in part: "Medications and Prescriptions:... QUEtiapine (SEROquel 25 mg oral tablet) 1 tab oral every day at bedtime." This record also included: "Discharge Diagnosis 1. Abscess of left thigh. 2. Abscess - Leg (left) 3. Phlebitis (vein trauma) of left leg. 4. Staphylococcus infection.; Hyperlipidemia; Hypertension; Macular degeneration; PVD (peripheral vascular disease)."

The "Transcribed Physician Progress Note" of 12/13/2024 at 14:25 (2:25 PM) read in part: "H&P (History and Physical) Patient is a pleasant 93 year old female recently admitted for therapy services s/p (after) hospitalization. She is participating with therapy as ordered. She continues nafcillin (antibiotic) until 12/27 for abscess of left thigh. All questions and

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	concerns addressed as posed ...Able to make wants and needs known. confusion noted ...Hx: (History) Cutaneous abscess of left lower limb, peripheral vascular angioplasty status with implants and graphs, atherosclerosis of coronary artery bypass grafts without angina pectoris, PMH (Past Medical History): old myocardial infarction, essential primary hypertension, hyperlipidemia unspecified, unspecified macular degeneration, peripheral vascular disease unspecified, presence of cardiac pacemaker. Plan: Patient is counseled and encouraged to notify staff of needs. Practitioner gives no new orders." During an interview on 12/17/24 at 12:09 PM, the DON and Regional DON "H" discussed the issue of the prescribed antipsychotic medication being given since admission without a diagnosis or reason. The DON stated, "I am not sure about the follow up we do on antipsychotic meds." The Regional DON "H" stated the facility should look at the diagnosis, why the physician ordered the medication, and monitor for signs and symptoms of effectiveness. The DON then reviewed the medical record and stated, "I don't know why she (R179) is on this med. There is no diagnosis (for it's use)." The facility policy titled "Unnecessary Drugs-Without Adequate Indication for Use" dated as last reviewed/revised on 10/26/23 read in part: "The attending physician will assume leadership in medication management by			

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	developing, monitoring, and modifying the medication regimen in collaboration with residents and/or representatives, other professionals, and the interdisciplinary team. Each resident's drug regimen will be reviewed on an ongoing basis, taking into consideration the following elements: ...c. Indications and clinical need for medication...Documentation will be provided in the resident's medical record to show adequate indications for the medication's use and the diagnosed condition for which it was prescribed." Resident #20 (R20) The medical record Minimum Data Set (MDS) assessment dated 9/25/24 listed an admission date for R20 of 12/20/23. Diagnoses for R20 included depression and cognitive communication deficit. The medication regimen for R20 included "DULoxetine HCl (hydrochloride)Oral Capsule Delayed Release Particles 30 MG (Duloxetine HCl). Give 1 capsule by mouth in the morning related to MAJOR DEPRESSIVE DISORDER". This medication was ordered and started on 12/20/2023. The care plan for R20 included a focus of: "Resident is at risk for alteration in psychosocial well-being related to diagnosis of depression, anxiety." The "Social Service Progress Review" dated 9/26/2024 contained a section listed as "Psychoactive Medication Review" with the question "List the psychoactive medication			

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	name, related diagnosis and last GDR or contraindication". No medications were listed. No GDR or contraindications were noted. The "Social Service Progress Review" dated 6/27/2024 contained a section listed as "Psychoactive Medication Review" with the question "List the psychoactive medication name, related diagnosis and last GDR or contraindication". Duloxetine was listed however no GDR or contraindications were noted. During an interview on 12/17/24 at 11:30 AM, the Nursing Home Administrator (NHA) stated she tracked the GDRs. The NHA reviewed the record for R20 and stated, "We do not have a GDR for duloxetine". The facility policy "Gradual Dose Reduction of Psychotropic Drugs" dated as last reviewed/revised on 10/26/2023 read in part: "Policy: Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs ... Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility will attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated."			

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F0761 SS= F	. Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly store and dispose of expired medications, and log refrigerator temperatures for immunization and insulin medications for one of one medication room and three of three medication carts reviewed for medication storage. Findings include: On 12/15/24 at 12:21 PM, Registered Nurse (RN) "L" was asked to open the medication	F0761	ELEMENT #1 An inspection of medications in the refrigerator was completed to verify expiration dates were in compliance and a Refrigerator Temperature Log was posted on the refrigerator door. Inspection of medication carts for unidentified, loose, and expired medications was completed. ELEMENT #2 Any resident who are given medications have the potential to be effected by this. ELEMENT #3 The DON/Designee will provide education to the Clinical IDT and nurses regarding writing the open and expiration date on multi-use vials, checking the refrigerator temperature and logging it on the form twice daily, and ensuring no unlabeled medications are in the cart (i.e. loose pills). The NHA and DON reviewed the policies Vaccine Storage Temperature Log, Medication Storage, and Medication-Destruction of Unused Drugs and deemed them appropriate. ELEMENT #4 The Clinical IDT will complete 5 random weekly audits to ensure any opened multi-use	2/5/2025

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	room on D-hall. RN "L" was asked about refrigerator temperature logs and replied, "I am not sure. I have never checked the temperature in the refrigerator. I was not aware we needed to do that." Inside the medication room an observation was made of one expired box of eight therapeutic nutrition powder supplement packages with a brand name, lot number 528092S00, and a use by date of 01NOV2024. No temperature log tracking sheet was placed/observed on the vaccination/medication refrigerator at the time of the observation. Review of the D-hall refrigerator temperature binder log, dated February 2024 through December 2024, revealed that temperatures for the medication refrigerator were not being completed twice daily as indicated on the tracking sheet findings include: a.) February temperature tracking sheet revealed 36 of 58 opportunities to record refrigerator temperature were not completed. b.) March temperature tracking sheet revealed 44 of 62 opportunities to record refrigerator temperature were not completed. c.) April temperature tracking sheet revealed 58 of 60 opportunities to record refrigerator temperature were not completed. (Last completed temperature check was on 4/14/24 no further temperatures recorded after this date).		vials in the refrigerator are dated with open/expiration dates, stored properly, and the refrigerator temp log is being completed. Medication carts will be audited for 5 weeks for loose pills and medication properly labeled with open/expiration dates as needed (i.e. Insulins, nasal sprays, eye drops, inhalers, etc.). The DON will report the audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The DON is responsible for compliance.	

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	d.) May temperature tracking sheet revealed 62 of 62 opportunities to record refrigerator temperature were not completed. e.) June through December lacked any start of a tracking month/daily sheet to record refrigerator temperatures. On 12/15/24 at 12:25 PM, RN "L" unlocked the medication room on D-hall's refrigerator and inside the refrigerator an observation was made of one multi-use vial of influenza vaccine with an opened date of 11/9/24. RN "L" was asked how long the multi-use vial of influenza vaccine was good to use after it had been opened and replied, "I am not sure. I would have to ask." Further inspection on the A-hall medication refrigerator revealed a second multi-use vial of tuberculosis testing solution with an opened date of 10/9/24 that was faded and worn. On the outside of the medication vial holder was a sticker for a date opened and expired that was not filled out. RN "L" again was not sure how long either vial was ok to use after it had been opened. On 12/15/24 at 12:34 PM, an observation was made of the medication cart on A-hall and revealed the following: a.) One name brand insulin pen with an opened date of 11/4/24 and an expiration date of 12/2/24. b.) One loose white oblong pill in the second drawer and identified as buspirone 15			

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	milligrams (mg). c.) One inhaler (Umeclidinium/Vilanterol) opened with a count of 11 and undated. (Per pharmacy formulary only good for 42 days after opened). d.) One inhaler (Fluticasone/Umeclidinium/Vilanterol) opened with a count of 8 and undated. e.) One inhaler (Umeclidinium/Vilanterol) opened with a count of 7 and undated. On 12/15/24 at 1:00 PM, an observation was made of the medication cart on D-hall and revealed the following: a.) Three name brand insulin pens opened without an expiration date. b.) Two loose white pills with only one being identified as metoprolol 100 mg. c.) One nasal spray (Ipratropium Bromide) opened and undated. d.) Two empty boxes of name brand inhalers. e.) Three name brand inhalers opened and undated. On 12/15/24 at 1:08 PM, an interview was conducted with Licensed Practical Nurse (LPN) "G" who was asked where the inhalers were and replied, "I am not sure. They should			

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	be in the boxes." LPN "G" was asked if medications needed an opened date and replied, "I guess. I just started a few months ago." On 12/15/24 at 1:44 PM, an observation was made of the medication cart on B-hall and revealed the following: a.) An unlocked and unattended medication cart. No staff or nurse in sight. One resident in the hallway in a wheelchair with a family member visiting them. b.) Two loose pills in the second draw, one red capsule with imprint of "mayne 330" unable to be identified, and one round yellow tablet identified as carbidopa-levodopa 25/100 mg. c.) One pill container with four compartments for morning, noon, evening, and bedtime. Pill container had six pills unidentified in the morning compartment, no pills in the noon compartment, two pills in the evening compartment, and three pills in the bedtime compartment. The pill container was not labeled with any resident name. On 12/15/24 at 1:50 PM, an interview was conducted with RN "J" who was responsible for the B-hall medication cart and was asked why the medication cart was unlocked and replied, "I just forgot to lock it. I happen to do that from time to time. I know it should have been locked. I was just on a break." RN			

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	"J" was asked about the loose pills and pill container and replied, "Yeah, the medication cart needs to be cleaned out. I am not sure who's pill container that is and it should have a name on it." On 12/15/24 at 2:05 PM, an interview was conducted with the Director of Nursing (DON), who was asked about the refrigerator in the medication room, dating medications, loose pills in the medication carts, and expired medications and replied, "When medications are opened, they should be dated. Medication carts should be cleaned regularly. The medication refrigerator temperature needs to be checked twice daily. I was not aware that it was not being completed." The DON was asked how long multi-use vials were good to use after they had been opened and replied, "I would have to check with pharmacy, but usually a month." Review of facility document titled, "Vaccine Storage Temperature Log", dated March (2024) days 16-31, read in part, " ...Instructions: Place a (check mark) in the box that corresponds with the temperature (rows), day of the month, and am or pm (columns) for your temperature check. Then enter your initials and the time you monitored the temperature in the boxes at the top of the chart ..." Review of facility document titled, "Did You Know", undated, read in part, " ...Open			

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	containers - Rule of thumb - Once drug products are opened and in use., they must be used within a specific time frame to avoid reduced stability, sterility and potentially reduced efficacy ...A drug product's Beyond Use Date (BUD) is the manufacturers supplied expiration date OR the shortened date after opening, whichever comes first ...TB (tuberculosis) solution: 30 days, refrigerated. Flu vaccine MDV (multi-dose vial): 28 days, refrigerated ..." Review of policy titled, "Medication Storage", dated 1/30/24, read in part, "Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines: 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e. medication carts ...) ...5. Refrigerated Products ...b. Temperatures are maintained within 36 - 46 degrees F. Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee ...7. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused			

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	Drug Policy." Review of policy titled, "Medication-Destruction of Unused Drugs", dated 1/18/24, read in part, "Policy: All unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations ..."			
F0842 SS= D	Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F0842	ELEMENT #1 Resident #15 no longer resides in the facility. ELEMENT #2 Any resident who has wounds has the potential to be effected. An audit of wounds will be completed to ensure appropriate diagnosis and wound classification. Any changes made will have a progress note written to explain the reason for the change. ELEMENT #3 The DON/Designee will provide education to clinical IDT and providers about classifying wounds. DON/Designee will also educate nurses on taking wound pictures upon admission after hours/on weekends to ensure accuracy of wound classification upon admission. The NHA and DON reviewed the Wound Playbook regarding Identification and Classifciation of Wounds and deemed it appropriate.	2/5/2025

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	purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an accurate record of wounds for one Resident (#15) of two residents reviewed for wound documentation, resulting in the inaccurate reflection of the resident's condition and the potential for communication of inaccurate medical information to healthcare providers. Findings include: Resident #15 (R15)		Wounds will be discussed daily Monday-Friday in Morning Clinical Meeting to ensure appropriate classification, diagnosis, and treatment. ELEMENT #4 The Clinical IDT will complete 5 random weekly audits to ensure wounds are correctly classified taking into consideration the residents' diagnoses and the etiology of the wound for 4 weeks or until substanital compliance is achieved. The Wound LPN will report the audit results to the QAPI Committee monthly until substanial compliance is achieved and maintained. The DON is responsible for compliance.	

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	On 12/15/2024 at 9:14 a.m., R15 was observed lying in bed on her left side wearing an incontinence brief and shirt. Further observation revealed a large dark purple area covering R15's right hip. The center portion of the discolored area appeared boggy (soft, spongy texture indicative of a deep tissue injury). During an interview at the time of the observation, Licensed Practical Nurse (LPN) "G" reported R15 had three wounds at the present time. When asked the classification of the wounds, LPN "G" reported R15 was receiving hospice care and had "skin failure." Review of R15's "Wound Evaluation(s)", abstracted from the electronic medical record (EMR), revealed R15 had wounds on rear left trochanter (hip, bony prominence), rear right trochanter and sacrum (bony prominence just above the intergluteal cleft). Review of R15's rear left trochanter "Wound Evaluation", dated 12/10/2024, revealed the wound type was documented as "Other - Not Set." Further review of the documentation revealed the wound was assessed as "deteriorating" and "in-house acquired." Review of the photograph of the left hip wound included with the evaluation revealed a Stage 3 (full thickness tissue loss) pressure injury with slough (whitish-tan dead tissue) covering the wound bed and reddened, inflamed skin surrounding the wound. Measurement of the wound included with the evaluation were 2.27 centimeters (cm) long by 4.49 cm wide with a depth of 0.9 cm at the deepest point. Review of R15's initial rear left trochanter "Wound Evaluation", dated 11/08/2024, revealed the wound was initially evaluated as a Stage 1 (area of non-blanchable skin indicative of pending			

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	tissue death) pressure injury. Review of R15's rear right trochanter "Wound Evaluation", dated 12/10/2024 revealed the wound type was documented as "Other - Not Set." Review of the photograph of the right hip wound included with the evaluation revealed a large, dark purple area indicative of a deep tissue pressure injury (a serious form of pressure injury that may progress rapidly to a full-thickness injury). Measurements of the wound were documented as 10.16 cm long by 7.61 cm wide with a depth of 0.1 cm. Review of R15's sacral "Wound Evaluation", dated 12/10/2024, revealed the wound type was documented as "Abrasion." Review of the photograph of the sacral wound included with the evaluation revealed a Stage 2 (partial-thickness tissue loss) pressure injury approximately two inches above and slightly to the right of R15's gluteal cleft. Measurements of the wound were documented as 1.48 cm long by 0.71 cm wide with a depth of 0.4 cm and undermining of 0.2 cm from "6 to 11 o'clock [location of wound undermining using a clock figure]." Review of R15's initial sacral "Wound Evaluation", dated 10/14/2024, revealed the wound was initially evaluated as a Stage 2 pressure injury. During an interview on 12/17/2024 at approximately 10:00 a.m., the Nursing Home Administrator (NHA) reported R15's wounds were due to the Resident's terminal diagnosis and recent diagnosis of "skin failure." Review of R15's "Transcribed Physician Progress Note", dated 10/15/2024 at 12:03 p.m., revealed R15 was seen for "a newly present stage ii {2} pressure ulcer to sacrum ..." Review of R15's hospice physician order, dated			

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	12/08/2024 at 6:15 p.m. and obtained from R15's hospice communication binder, revealed R15's right hip wound was classified as "unstageable", and the left hip wound was classified as a "Stage 3 wound." During an interview on 12/17/2024 at 10:19 a.m., the facility's Certified Wound and Ostomy Nurse, LPN "B" was queried regarding the classification of R15's wounds. LPN "B" stated she was instructed by her regional management to classify R15's hip wounds as "Other" due to the Resident's diagnosis of "Skin Failure." When asked if R15's wounds were pressure injuries, LPN "B" confirmed R15's right and left hip wounds were pressure injuries. During a review of R15's initial sacral wound evaluation, LPN "B" confirmed the wound to be a pressure injury. LPN "B" reported she was instructed by regional management to change the wound classification to "abrasion." When asked why she would change her documentation, LPN "G" stated she was new in her role as wound care nurse and was following the direction of management. LPN "B" confirmed the importance of maintaining accurate wound assessments to ensure continuity of care and formulation of effective interventions to prevent worsening of the wounds and promote healing, when possible. LPN "B" acknowledged the possibility of ineffective treatment plans when incorrect information was documented and communicated to care teams and outside providers. During an interview on 12/17/2024 at approximately 10:25 a.m., anonymous Staff "N" reported clinical staff were at times directed to avoid documenting pressure injuries for Residents with a diagnosis of "Skin Failure." Staff "N" stated Regional Clinical Staff "O" advised staff to change documentation from pressure injuries to "Other", even when the etiology of the wounds was pressure.			

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	During an interview on 12/17/24 at 10:45 a.m., MDS Coordinator, Registered Nurse (RN) "P" reported information to complete R15's comprehensive assessment is gleaned from the EMR. When asked what information she uses to complete "Section M - Skin Conditions", RN "P" reported she uses the "Wound Evaluation(s)," documentation to determine what to include in the assessments. RN "P" reported if wounds are not documented as pressure injuries in the "Wound Evaluation(s)", then the wounds would not be documented as pressure injuries on the comprehensive assessments. RN "P" confirmed R15's wounds were not documented as pressure injuries on the "Wound Evaluation(s)."			
F0880 SS= F	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a 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 §483.71 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	F0880	ELEMENT #1 The facility RN Infection Preventionist received certification on 12/27/24. The Infection Control & Prevention Binder Basics Program was reviewed and deemed appropraite in addition to the Annual LTC Facility Self-Assessment Tool on 11/19/24. The 2024 IPCP Binder was updated to include December 2024 information. The January 2025 IPCP Binder has been created and is being updated in real time for infection tracking. ELEMENT #2 All residents have the potential to be effected by the Infection Prevention & Control Program. McGeer Criteria has been posted at the medication carts to help nurses evaluate the	2/5/2025

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	infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: **Based on interview and record review, the facility failed to implement an infection prevention and control program (IPCP) to prevent, recognize, and control infections, and failed to update infection control policies annually. This deficient practice resulted in the potential spread of infectious organisms and disease to all 82 residents residing in the**		likelihood of infections. ELEMENT #3 The facility Infection Preventionist and DON have been re-educated on the process for completion of the Infection Watch report and the Infection Line Listing and data analysis. Education also included the structure of an inclusive Infection Prevention Program as outlined by the corporate Infection Control & Prevention Binder Basics Manual to futher elucidate all required elements of an inclusive program. The DON/Designee will educate all nurses on McGeer Criteria for evaluation of infections. The facility Infection Prevention & Control Policy has been reviewed by the NHA and DON and deemed appropriate. ELEMENT #4 The DON/Designee will conduct an audit of the Infection Control & Prevention Program including Infection Watch, auditing, and Line Listing compliance weekly for 4 weeks and monthly until substantial compliance is achieved. The DON/Designee will report the audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The DON is responsible for compliance.	

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	facility. Findings include: On 12/15/24 at 12:43 p.m., the Director of Nursing (DON) was asked the name of the facility's Infection Preventionist (IP). The DON said the facility did not have an IP. The DON explained that someone from another building who was not employed at the facility was keeping up with infection control information at the facility. The DON said Registered Nurse (RN) "D" was the MDS nurse in the facility and had training in infection prevention and control, and any questions regarding the IPCP should be directed to RN "D." The IPCP was reviewed with RN "D" on 12/17/24 at 9:09 a.m. RN "D" presented an IPCP binder divided by each month. The divider for December 2024 was empty. RN "D" was asked where December 2024 information was maintained. RN "D" said she did not know and said she would email the person who worked in a different building to obtain the December infection control monitoring and tracking. RN "D" explained that someone at another facility maintained their infection control program because they did not have an IP in the building. RN "D" was asked how the facility tracked residents who experienced signs and symptoms of infections. RN "D" said antibiotics are monitored on the dashboard in the electronic health records each day during morning meeting, but she did not know if or how they were documented for monitoring and tracking. RN "D" said the facility utilized McGeer Criteria (a minimum set of signs and symptoms which, when met, indicate a			

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	resident likely has an infection and may require an antibiotic). RN "D" was asked if nurses who work the floor had been educated on McGeer Criteria or if they had access to the McGeer Criteria. RN "D" said the nurses who work the floor were not provided education on McGeer Criteria nor did they have access to the McGeer Criteria to evaluate the likelihood of infections. Resident #60 (R60) R60 was prescribed the antibiotic Doxycycline in December 2024 for a respiratory infection. The respiratory symptoms persisted after the antibiotic course was completed and the Doxycycline was re-implemented as a second course of antibiotic therapy. During an interview with RN "D" on 12/17/24 at 9:09 a.m., RN "D" was asked about the Doxycycline for R60. RN "D" said, "I think it's prescribed for osteomyelitis in his collar bone ...or was that the amoxicillin?" RN "D" was told the Doxycycline was documented as being for a respiratory infection. When asked why the same antibiotic was resumed if it was ineffective in resolving the infection after the first course of antibiotic therapy, RN "D" said, "I do MDS. I've never been trained on the infection control policies. I don't really know anything about the infection control program..." Resident #42 (R42)/Resident #329 (R329) RN "D" was asked about symptoms, monitoring, tracking, dates of positive testing, and mapping for two residents R42 and R329 who tested positive for COVID-19 in December 2024. RN "D" confirmed there was			

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	no information in the IPCP binder for R42 and R329. RN "D" reviewed the medical records of R42 and R329 and said nurses were documenting signs and symptoms. RN "D" was asked if testing of other residents had been completed when R42 and R329 tested positive. RN "D" said, "I don't know. There was some talk in the morning meeting about doing testing on other residents, but I don't have a list if other residents who were tested, and I didn't take part in any testing." RN "D" was asked if a prevalent organism had been identified as the cause of infection for several residents with urinary tract infections. RN "D" admitted she did not know. RN "D" said nurse managers talked about urinary catheter care, pericare, and hand washing in the morning meeting, but said she didn't know if any documented education had been provided to the Certified Nursing Aides (CNA) who were responsible for providing direct care to residents. RN "D" admitted she did not know what was to be monitored, surveilled, tracked, evaluated, investigated, or documented for the IPCP. RN "D" said she is unfamiliar with the IPCP policies. RN "D" confirmed the IPCP policies that were provided were the most updated policies. The following infection control policies were not updated annually: 1. "Pneumococcal Vaccine (Series)" policy was dated as last reviewed/revised 10/30/23 2. "Infection Preventionist" policy was dated as last reviewed/revised 10/26/23			

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	3. "Influenza Vaccination" policy was dated as last reviewed/revised 10/26/23 **4. "COVID-19 Vaccination" policy was dated as last reviewed/revised 10/20/23.** **On 12/17/24 at 11:57 a.m., the DON was interviewed regarding the IPCP and said, "we know infection control is a problem."** **The policy "Infection Prevention and Control Program" dated as reviewed/revised 12/27/23 read, in part: "...The designated Infection Preventionist is responsible for the oversight of the program and serves as a consultant to our staff...The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings...The facility shall conduct an annual review of the infection prevention and control program, including associated programs and policies and procedures..."**			
F0882 SS= F	Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as	F0882	ELEMENT #1 The facility RN Infection Preventionist received her certificate on 12/27/24. ELEMENT #2 All residents have the potential to be effected by not having an Infection Preventionist in-house. The MDS RN has an IP Certificate. The DON will complete the Infection	2/5/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	694020	A. BUILDING _____ B. WING _____	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF GAYLORD	508 RANDOM LANE GAYLORD, MI 49735

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	evidenced by: **Based on interview and record review, the facility failed to ensure a qualified Infection Preventionist was employed at least part-time in the facility and was present to properly assess, implement, and manage the Infection Prevention and Control Program (IPCP). This deficient practice resulted in the potential for the spread of infection and communicable diseases to all 82 residents in the facility. Findings include:** **On 12/15/24 at 12:43 p.m., the Director of Nursing (DON) was asked the name of the facility's Infection Preventionist (IP). The DON said the facility did not have an IP. The DON explained that someone from another building who was not employed at the facility was keeping up with infection control information at the facility. The DON said Registered Nurse (RN) "D" was the MDS nurse in the facility and had training in infection prevention and control, and any questions regarding the IPCP should be directed to RN "D."** **During an interview with RN "D" on 12/17/24 at 9:09 a.m., RN "D" was unable to answer questions regarding processes for identifying, monitoring, tracking, correlating, reporting, documenting, and controlling infections and communicable diseases for residents, staff, and other individuals in the facility. RN "D" said, "I do MDS. I've never been trained on the infection control policies. I don't really know anything about the infection control program. An IP from another facility does our infection control."** **The Policy "Infection Preventionist" dated as**		Preventionist Course by 1/31/25. Another Clinical Manager RN has been hired and will be expected to be cross-trained on Infection Prevention. With 4 IP Certified RNs in-house, the Infection Prevention Prgoram will have multiple staff to ensure completion/follow-up. ELEMENT #3 The facility Infection Preventionist and DON have been re-educated on Infection Prevention Policy regarding the process for completion of the Infection Watch report, Infection Line Listing, and data analysis. The Infection Preventionist and DON have been re-educated on regarding the structure of an inclusive Infection Prevention Program as outlined by the corporate Infection Control and Prevention Binder Basics Manual to further elucidate all required elements of an inclusive program to mitigate the risk of infection in the facility. The facility Infection Prvention & Control Policy has been reviewed by the NHA and DON and deemed appropriate. ELEMENT #4 The IP/Designee will conduct an audit of Infection Control & Prevention Program including Infection Watch auditing and Line Listing Compliance weekly for 4 weeks and monthly until susbtantial compliance is maintained.	

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	reviewed/revised on 10/26/23 read, in part: "...The facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program... The facility will designate a qualified individual as Infection Preventionist (IP) whose primary role is to coordinate and be actively accountable for the facility's infection prevention and control program to include the antibiotic stewardship program....The IP will have the knowledge to perform the role...the IP must have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees...The IP will physically work onsite in the facility..."		The IP RN will report the audit results to the QAPI Committee monthly until substanital compliance is achieved and maintained. The DON is responsible for ongoing compliance.	