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| F0000 SS= | INITIAL COMMENTS<br><br>SKLD Beltline was surveyed for a Recertification survey from 1/27/25-1/29/25.<br><br>Intakes: MI00147770 and MI00149017<br><br>Census=126 | F0000 | | |
| F0550 SS= E | Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or | F0550 | | |

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

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

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| | her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br><br>This citation pertains to Intake MI00147770<br><br>Based on observation, interview and record review, the facility failed to maintain the dignity of 4 (Resident #26, Resident #55, Resident #57 and Resident #112) of 25 residents reviewed for dignity, and 3 of 6 residents who attended a confidential meeting, resulting in feelings of decreased self-worth, frustration, and residents receiving assistance with eating in a disrespectful manner.<br><br>Findings include:<br><br>Review of a "Dignity and Respect" facility policy, with a reference date of 7/11/18, revealed: "The staff shall display respect for Resident's when speaking with, caring or (sic), or talking about them".<br><br>Resident #26<br><br>Review of an "Admission Record" revealed Resident #26, was originally admitted to the facility on 8/1/22 with pertinent diagnoses which included: major depressive disorder (persistent depressed mood causing significant impairment in daily life) and generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities).<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #26, with a reference date of 12/13/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which | | | |

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| | indicated Resident #26 was cognitively intact.<br><br>Review of a "Care Plan" for Resident #26, with a reference date of 8/2/22, revealed a focus/goal/interventions of: "Resident at risk for changes in mood r/t (related to) dx (diagnosis) of borderline personality disorder ...Goal: Resident will exhibit indicators of depression ...sad mood less than daily. Interventions: ...allow resident to verbalize feelings, perceptions, and fears ...monitor mood and determine if problems seem to be related to external causes ...when conflict arises, remove resident to a calm safe environment ...".<br><br>In an interview on 1/27/25, at 12:02pm, Resident #26 reported she often heard staff members talking about residents in a negative manner. Resident #26 reported she overheard staff saying certain residents were "on their call light too much", complaining about having certain residents on their assignments, or complaining about not liking a resident. Resident #26 reported as a result of the staff comments she overheard, she often wondered about how staff felt about her and felt reluctant to ask for help because she didn't want to frustrate the staff. Resident #26 described the staff's behavior as "exasperated due to burn out".<br><br>In an interview on 1/29/25 at 11:19am, Registered Nurse (RN) "EE" reported she regularly overheard staff talking about residents in a disrespectful manner. RN "EE" reported the facility was aware of the incidents and had adjusted some assignments in effort to resolve the problem but it persisted.<br><br>In a confidential meeting on 1/28/25 at 1:30pm, 3 of 6 residents reported staff were slow to respond to their call lights, resulting in a wait time of 45minutes or more. The residents reported at | | | |

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| | times, they overheard staff members talking about residents and socializing with each other before they responded to call lights. The residents reported they experienced feelings of frustration and a sense of decreased self-worth when the staff acted as though responding to their call light was not a priority.<br><br>Resident #55<br><br>Review of "Admission Record" revealed Resident # 55 was originally admitted to the facility on 10/3/23 with pertinent diagnosis which included huntington's disease (a condition which causes nerve cells in the brain to break down over time).<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #55, with a reference date of 11/27/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 99/15 which indicated Resident #55 was severely cognitively impaired.<br><br>Review of Resident #55's "Care Plan" revealed, " (Resident #55) has an ADL self-care performance deficit r/t (related to) Aggressive Behavior, Confusion, Dementia, Fatigue, Impaired balance, Huntington's disease. Date Initiated: 03/02/2022. Interventions: Eating- 1 to 1 feeding assistance<br><br>Date Initiated: 03/02/2022..."<br><br>During an observation on 1/28/25 at 8:50 AM, Resident #55 was sitting near the nurses station in his geri chair (chair designed for people with limited mobility). Certified Nursing Assistant (CNA) "O" approached Resident #55 from behind his geri chair and out of his view and turned his chair around to face away from the nurse's station. CNA "O" did not speak to Resident #55 to let him know she was going to move him and did not interact with Resident #55 after she | | | |

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| | moved him. Resident #55 appeared startled and began to attempt to move his chair back to the position he was in prior to when CNA "O" moved him.<br><br>Resident #57<br><br>Review of "Admission Record" revealed Resident # 57 was originally admitted to the facility on 10/24/23 with pertinent diagnosis which included dementia.<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #57, with a reference date of 11/4/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 99/15 which indicated Resident #57 was severely cognitively impaired.<br><br>Review of Resident #57's "Care Plan" revealed, " (Resident #57) has an ADL self-care performance deficit r/t hemiplegia/hemiparesis (paralysis and weakness) of right dominant side r/t hx of CVA, (cerebrovascular accident) and dementia...Date Initiated: 10/24/2023. Interventions: EATING: 1 to 1 feed. Date Initiated: 10/25/2023..."<br><br>During an observation on 1/28/25 at 12:44 PM Resident #55 was being assisted to eat by CNA "Q" at one table in the dining room, and Resident #57 was being assisted to eat by CNA "O" at another table. It was noted that CNA "Q" and CNA "O" were having a loud personal conversation with each other and not interacting with Resident #55 or Resident #57.<br><br>Using the reasonable person concept, though Resident #55 and Resident #57 had decreased ability to verbally express their own thoughts due to medical diagnoses, any reasonable person would likely feel a decreased sense of self-worth and frustration in the situations observed. | | | |

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| | Resident #112<br><br>Review of "Admission Record" revealed Resident #112 was originally admitted to the facility on 4/17/24 with pertinent diagnoses which included muscle weakness.<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #112, with a reference date of 1/9/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #112 was cognitively intact.<br><br>Review of Resident #112 "Care Plan" revealed, "(Resident #112) has an ADL (activities of daily living) self-care performance deficit r/t physical deconditioning, left foot drop, gout, acute hypoxemic respiratory failure, heart failure and bilateral lower extremity edema. Date Initiated: 04/18/2024. Interventions: TOILET USE: 2p (2 person staff assistance) Sara lift (device used to assist with transfers).Date Initiated: 07/01/2024..."<br><br>During an interview on 1/27/25 at 2:17 PM, Resident #112 reported that in October she had turned on her call light to request staff assistance to go to the restroom. Resident #112 reported that Certified Nursing Assistant (CNA) "R" had answered her call light and told her that she had to wait 30 minutes for assistance because the staff were in the middle of passing lunch trays. Resident #112 reported that about 20 minutes later she saw CNA "R" on her cell phone in the hallway so she assumed she was free and she turned her call light back on. Resident #112 reported that CNA "R" entered Resident #112's room and told her "You have 5 more minutes" and turned off her call light. Resident #112 reported that she had talked to Former Social Worker (FSW) "AAA" about this interaction and had wanted to file a grievance form. Resident | | | |

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| | #112 reported that she did not hear anything else about the situation, and she was not sure if the facility followed up or not.<br><br>During an interview on 1/29/25 at 9:25 AM, FSW "AAA" reported that she worked with Resident #112 frequently and she had reported concerns that Resident #112 had regarding the way that CNA'S spoke to her. FSW "AAA" reported that she had reported those concerns to Registered Nurse Unit Manager (RN-UM) "QQ" and Nursing Home Administrator (NHA) "A" to address. FSW "AAA" reported that she had recalled the day that Resident #112 and CNA "R" had the interaction that Resident #112 was upset about. FSW "AAA" reported that she was walking by Resident #112's room and overheard what seemed like an emotional interaction between Resident #112 and CNA "R". FSW "AAA" reported that CNA "R" was leaving the room as she entered, and she could see that Resident #112 was visibly upset. FSW "AAA" reported that Resident #112 told her what CNA "R" had told her about needing to wait longer before she would help her, and that she had reported this concern to NHA "A". FSW "AAA" reported that she had heard other CNA's make snarky comments about Resident #112, and that she had also observed CNA "R" ignore Resident #112's call light while sitting at the nursing station once and stated "I can't with Resident #112 today".<br><br>During an interview on 1/29/25 at 10:08 AM, RN-UM "QQ" reported that she was only aware of two incidents where Resident #112 had concerns with staff, and neither of those situations involved CNA "R". RN-UM "OO" reported that she could not recall if FSW "AAA" had reported other concerns about the way that staff were speaking to Resident #112.<br><br>During an interview on 1/29/25 at 9:41 AM, | | | |

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| | Nursing Home Administrator (NHA) "A" reported that she had not been made aware of any reports of Resident #112 having concerns with how staff had treated and spoke to her.<br><br>On 1/29/25 at 10:06 AM, This writer attempted to contact CNA "R". CNA "R" was not able to be reached prior to survey exit.<br><br>Review of "Disciplinary Action Record" dated 11/28/23 for CNA "R" indicated that CNA "R" received a written warning for "Not showing acceptable standards of respect and/or cooperation to residents, employees, and supervisors..."<br><br>Review of "Disciplinary Action Record" dated 9/22/24 for CNA "R" indicated that CNA "R" received a written warning for failing to perform job duties satisfactorily in accordance with the established job description.<br><br>Review of the Facility's "Dignity" policy dated 7/11/18, revealed, " POLICY: It is the policy of this facility that all residents be treated with kindness, dignity and respect. PROCEDURE: 1. The staff shall display respect for Resident ' s when speaking with, caring or, or talking about them, as constant affirmation of their individuality and dignity as human beings..." | | | |
| F0558<br>SS= D | Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by: | F0558 | | |

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| | Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for 1 (Resident #27) of 5 residents reviewed for accommodation of needs, resulting in the inability to call for staff assistance, and potential unmet care needs.<br><br>Findings include:<br><br>Resident #27<br><br>Review of "Admission Record" revealed Resident #27 was originally admitted to the facility on 11/5/24 with pertinent diagnosis which included unsteadiness of feet.<br><br>Review of Resident #27's "Care Plan" revealed, " (Resident #27) has communication and/or comprehension concern r/t ( related to) Hearing deficit, deconditioning, diagnosis of Dementia. Date Initiated: 11/12/2024...Interventions: Ensure/provide a safe environment: call light in reach... Date initiated: 11/12/2024..."<br><br>During an observation on 1/27/25 at 9:52 AM, Resident #27 was lying in his bed. It was noted that Resident #27's touch pad call light was lying on the floor behind Resident #27's bed and out of his reach. Resident #27 reported that he would use his call light when staff remembered to place it in his reach.<br><br>During an interview on 1/29/25 at 10:38 AM, Registered Nurse (RN) "OO" reported that Resident #27 did use his call light when he needed assistance from staff.<br><br>During an interview on 1/29/25 at 12:34 PM, Certified Nursing Assistant (CNA) "M" reported that Resident #27 will use his call light when he needed assistance from staff. | | | |

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| | Review of the facility's "Call Light" policy dated 7/11/28 revealed, " POLICY: It is the policy of this facility to provide the resident a means of communication with nursing staff...7. Be sure call lights are placed within reach of residents who are able to use it at all times. There is no reason to place the call light within the reach of a resident who is physically and cognitively unable to use the call light..." | | | |
| F0609 SS= D | Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by: | F0609 | | |

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| | This citation pertains to Intake # MI00149017.<br><br>Based on interview, and record review, the facility failed to report allegations of abuse to the State Agency in a timely manner in 2 of 2 residents (Resident #115 & #127) reviewed for abuse and reporting, resulting in the potential for additional allegations of abuse and to go unreported and delayed investigation.<br><br>Findings include:<br><br>Review of the policy/procedure "Abuse and Neglect", dated 3/24/23, revealed "...Abuse (is) defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish...All allegations of abuse will be reported to the appropriate State Agencies immediately after the initial allegation is received..."<br><br>Resident #115<br><br>Review of an "Admission Record" revealed Resident #115 was a female, with pertinent diagnoses which included adjustment disorder with mixed anxiety and depressed mood.<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #115, with a reference date of 11/4/24, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.<br><br>In an interview on 1/27/25 at 12:06 PM, Resident #115 stated "...I was recently assaulted by a nurse..." Resident #115 reported she was counting her pills during medication administration when the nurse grabbed her blankets/shirt and | | | |

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| | "...slammed..." her into bed, resulting in scratches to her chest. Resident #115 stated "...She (referring to the nurse) went out the door and said I did this to myself..." Resident #115 reported Administrator "A" spoke with her after the incident and felt like the entire situation was "...swept under the rug..." Resident #115 identified the alleged perpetrator as "Licensed Practical Nurse" (LPN) "L".<br><br>Review of a "Grievance and Satisfaction Form" for Resident #115, dated 1/4/25 at 11:00 AM, revealed "...(LPN "L") until (two) weekends ago would leave all my meds (medications) on my tray table for me to take whenever. Now she brings them in, flips on bright light, loudly tells me it (is) time for me to take my meds and when I wasn't fast enough for her she tried to physically...take my meds away from me telling me she is counting it as a refusal. When she grabbed me she badly scratched up my chest...Telling me this is her hallway and she would make sure I was gone from it..."<br><br>In an interview on 1/28/25 at 11:50 AM, "Certified Nursing Assistant" (CNA) "AA" reported Resident #115 had made an allegation that a nurse scratched her on the chest during medication administration. CNA "AA" reported Resident #115 was upset and crying when discussing the alleged incident, saying nobody listens to her side. CNA "AA" reported "Director of Nursing" (DON) "B" completed an investigation in regard to the allegation.<br><br>In an interview on 1/28/25 at 12:39 PM, with Social Services Director "N" and Social Services Coordinator "G", Social Services Director "N" reported they were aware of Resident #115's allegations involving LPN "L". Social Services Director "N" reported Administrator "A" was notified and an investigation was completed. | | | |

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| | Social Services Director "N" reported LPN "L" is no longer assigned to Resident #115. Social Services Coordinator "G" reported all residents on the unit were interviewed to ensure they felt safe at the facility.<br><br>In an interview on 1/28/25 at 1:48 PM, LPN "LL" reported during their shift on 1/4/25, Resident #115 made an allegation that the previous nurse (LPN "L") had scratched her on the chest during medication administration. LPN "LL" reported management was notified of the allegation.<br><br>In an interview on 1/28/25 at 4:18 PM, with Administrator "A" and DON "B", Administrator "A" reported they were notified by LPN "L" on 1/4/25 that Resident #115 had a self-inflicted wound (scratch) on her chest. Administrator "A" reported later that day, management received the "Grievance and Satisfaction Form" from Resident #115 with the allegation involving LPN "L". Administrator "A" reported Resident #115 alleged LPN "L" scratched her on the chest during medication administration. Administrator "A" reported an investigation was completed and other residents were interviewed with no concerns identified. Administrator "A" reported the allegation was not reported to the State Agency.<br><br>Resident #127<br><br>Review of an "Admission Record" revealed Resident #127 was a male, with pertinent diagnoses which included heart failure, obstructive lung disease, schizophrenia, and depression.<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #127, with a reference date of 11/15/24, revealed a "Brief Interview for Mental Status" (BIMS) score of 5, out of a total possible score of 15, which indicated severe | | | |

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| | cognitive impairment.<br><br>Review of an "Event Note" for Resident #127, dated 12/16/24 at 3:20 PM, revealed "...Resident observed by his hospice nurse to spill his cup of water on himself and the floor...she reports resident then got out of bed to clean up the water and was crawling on the floor. Facility staff put resident back to bed. No new injuries. Resident remains combative with cares and medication administration at this time..."<br><br>Review of a "Grievance and Satisfaction Form" for Resident #127, dated 12/16/24, revealed "...Received from...(Hospice Name)...Describe Grievance...Care Concerns..."<br><br>Review of an email sent from (Hospice Name) to "Director of Nursing" (DON) "B" on 12/16/24 at 7:04 PM, regarding Resident #127, revealed the statement "...(Resident #127) could be heard yelling from his room. I went to the room. His nurse ("Licensed Practical Nurse" (LPN) "MM") was attempting to give (Resident #127) his haldol. (Resident #127) was thrashing around in the bed fighting her as she was trying to get the medication into his mouth. She had one arm on him and was trying to give him the medicine. She saw me and asked her to help hold him down. I refused to assist. (LPN "MM") then had her CNA (Certified Nursing Assistant) that walked into the room right after assist. They then held him down and gave him the medication...Water was offered by (LPN "MM") and he refused..."<br><br>In an interview on 1/27/25 at 3:50 PM, LPN "MM" reported Resident #127 was extremely restless and agitated, and would often become combative during care, attempting to hit and spit on staff members. LPN "MM" reported Resident #127 was often combative during medication administration and sometimes would spit | | | |

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| | medications back out after they were given. LPN "MM" reported in regard to the incident on 12/16/24, a hospice nurse reported to the facility that they felt she (LPN "MM") did not act appropriately during medication administration for Resident #127. LPN "MM" reported she was suspended after the allegation pending investigation, and allowed to return to work the following day.<br><br>Review of a "Disciplinary Action Record" for LPN "MM", dated 12/16/24, revealed "...Suspended pending investigation of abuse...brought back by next shift - claim unsubstantiated..."<br><br>In an interview on 1/28/25 at 12:56 PM, with Social Services Director "N" and Social Services Coordinator "G", Social Services Director "N" reported Resident #127 experienced terminal restlessness near the end of his life, frequently crawling out of bed and becoming combative with staff during care.<br><br>In an interview on 1/29/25 at 1:06 PM, Administrator "A" reported after the allegation regarding Resident #127 on 12/16/24, statements were obtained from the staff involved and interviews were completed with other residents on the unit to identify if there were any care concerns involving LPN "MM". Administrator "A" reported the allegation made by hospice staff involving Resident #127 was not reported to the State Agency.<br><br>In an interview on 1/29/25 at 2:18 PM, "Director of Nursing" (DON) "B" reported they received an email from the Vice President of Compliance from (Hospice Name) on 12/16/24 that the hospice nurse had care concerns involving Resident #127. DON "B" reported they immediately suspended the nurse involved and | | | |

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| | took a statement. DON "B" reported they questioned whether or not the care concerns were an allegation of abuse, which was why LPN "MM" was suspended during the investigation. | | | |
| F0641<br>SS= D | Accuracy of Assessments §483.20(g)<br>Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:<br><br>Based on interview, observation and record review, the facility failed to complete "Minimum Data Set" (MDS) assessments that accurately reflect resident status in 1 of 25 residents (Resident #121), resulting in an inaccurate reflection of resident status and the potential for physical complications due to unidentified needs.<br><br>Findings include:<br><br>Resident #121<br><br>Review of an "Admission Record" revealed Resident #121 was originally admitted to the facility on 12/12/24, with pertinent diagnoses which included: heart attack and tracheostomy (a surgical procedure that creates an opening in the front of the neck to provide airway and allow breathing) care.<br><br>Review of a MDS assessment for Resident #121, with a reference date of 12/18/24 revealed the resident did not receive tracheostomy services while a resident.<br><br>Review of Resident #121's "Physician Orders" revealed, "Change all trach related supplies: nebulizer tubing, corrugated tubing, trach mask, overflow container, suction parts, etc. On Sunday | F0641 | | |

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| | night shift every week as needed for wet or soiled ties.<br><br>During an observation on 01/27/25 at 10:40 AM in Resident #121's room, the resident was lying in bed and a tracheostomy tube was observed in place on Resident #121's neck. There were an abundance of tracheostomy care supplies at the bedside.<br><br>In an interview on 01/28/25 at 02:39 PM, MDS Registered Nurse (MDS-RN) "H" reported that Resident #121 had a tracheostomy upon admission on 12/12/24. MDS-RN "H" reported that Resident #121's MDS record was inaccurate and would need to be modified to reflect the resident's status.<br><br>Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual", Version 1.19.1, October 2024, Chapter 3 Section O: Special Treatments, Procedures and Programs, revealed "...The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods...The treatments, procedures, and programs listed in Item O0110, Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity, and quality of life...Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs... O0110E1, Tracheostomy care...Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the resident performs their own tracheostomy care. This item includes laryngectomy tube care..." | | | |

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| F0644<br>SS= D | Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure a Level II Preadmission Screening and Resident Review (PASARR) evaluation was completed for 1 (Resident #55) of 4 residents reviewed for PASARR Screening, resulting in the potential for unmet mental health and psychiatric care needs.<br><br>Findings include:<br><br>Resident #55<br><br>Review of "Admission Record" revealed Resident # 55 was originally admitted to the facility on 10/3/23 with pertinent diagnoses which included psychotic disorder with delusions.<br><br>Review of Resident #55"s "Preadmission Screening (PAS) Annual Resident Review (ARR) Level I Screening" dated 2/5/24 indicated the | F0644 | | |

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| | following: Questions 1-4 in section II were marked "Yes": 1. Resident #55 had a current diagnosis of mental illness and dementia. 2. Resident #55 had received treatment for mental illness. 3. Resident #55 had routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days. 4. There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others. The instructions at the bottom of the page indicated that if any answers to items 1-6 in Section II were marked "YES" to send one copy to the local Community Mental Health Services program (CMHSP), with a copy of form DCH-3878 if an exemption is requested..."<br><br>During an interview on 1/28/25 at 12:13 PM, Social Serviced Director (SSD) "N" reported that she was responsible for coordinating the facility's PASSARR's screenings. SSD "N" was not able to find Resident #55's level II screening.<br><br>In a follow up interview on 1/28/25 at 2:04 PM, SSD "N" reported that she was unable to locate Resident #55's level II PASSARR screening, so she spoke to the facility's physician, who found it in his online portal to be completed. SSD "N" confirmed that the PASSAR level II screening was not completed timely, and they had missed this. | | | |
| F0656<br>SS= D | Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) | F0656 | | |

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| | and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by: | | | |

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| | Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans in 3 of 25 residents (Resident #73, #97, & #27) reviewed for comprehensive care plans, resulting in the potential for unmet medical, physical, mental, and psychosocial needs.<br><br>Findings include:<br><br>Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.19.1, Chapter 4: Care Area Assessment (CAA) Process and Care Planning", dated October 2024, revealed "...the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care..."<br><br>According to Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing, Tenth Edition - E-Book (Kindle Location 15861 of 76897). Elsevier Health Sciences. "...A nursing care plan includes nursing diagnoses, goals and/or expected outcomes, individualized nursing interventions, and a section for evaluation findings...The plan promotes continuity of care and better communication because it informs all health care providers about a patient's needs and interventions and reduces the risk for incomplete, incorrect, or inappropriate care measures. Nurses revise a plan when a patient's status changes...The plan of care communicates nursing care priorities to nurses and other health care providers. It also identifies and coordinates resources for delivering | | | |

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| | nursing care..."<br><br>Resident #73<br><br>Review of an "Admission Record" revealed Resident #73 was a female, with pertinent diagnoses which included stroke, dementia, pressure ulcers, and reduced mobility.<br><br>Review of an "Order Summary Report" for Resident #73 revealed the active physician order "...Apply offloading boots every shift..." with a start date of 10/16/24.<br><br>Review of a current "Care Plan" for Resident #73 revealed the focus "...(Resident #73) has DTI (Deep Tissue Injury) pressure ulcer to her right heel r/t (related to) Immobility, dysphagia (difficulty swallowing), protein calorie malnutrition and adult failure to thrive..." revised 1/6/25, with interventions which included "...HEEL PROTECTORS: bilateral on while in bed..." revised 11/12/24.<br><br>In an observation on 1/27/25 at 4:12 PM, Resident #73 was noted in bed in her room, positioned onto her left side. Observed a padded boot (heel protector) on her left foot. No padded boot/heel protector noted on right foot. Noted Resident #73's right foot/heel was resting directly on the surface of the mattress.<br><br>In an observation on 1/28/25 at 2:35 PM, Resident #73 was noted in bed in her room, positioned onto her left side. Observed a padded boot (heel protector) on her left foot. No padded boot/heel protector noted on right foot. Noted Resident #73's right foot/heel was resting directly on the surface of the mattress.<br><br>In an interview on 1/28/25 at 2:35 PM, "Certified Nursing Assistant" (CNA) "R" reported Resident | | | |

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| | #73 wears a padded boot on her left foot due to a wound. CNA "R" stated Resident #73's right heel is "...fine..." and does not require a padded boot (heel protector).<br><br>In an interview on 1/28/25 at 2:45 PM, Unit Manager "QQ" reported Resident #73 has a pressure wound on her right heel. Unit Manager "QQ" reported Resident #73 has padded boots to wear on her feet to relieve pressure on her heels.<br><br>Resident #97<br><br>Review of an "Admission Record" revealed Resident #97 was originally admitted to the facility on 11/9/22, with pertinent diagnoses which included: right side paralysis following a stroke.<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #97, with a reference date of 11/6/24 revealed that Resident #97 had functional limitations in range of motion (ROM) on one side of upper and lower extremities.<br><br>During an observation on 01/27/25 at 11:19 AM Resident #97 was in his room and his right arm/hand was observed resting on a padded tray attached to his wheelchair. Resident #97 lifted his right hand/arm using his left hand/arm, but was not able to actively open his right hand. Resident #97 was not wearing a splint device on his right hand.<br><br>During an observation on 01/28/25 at 02:18 PM Resident #97 was in his room, and there was no splint device observed on his right hand.<br><br>In an interview on 01/28/25 at 03:04 PM, Certified Nursing Assistant (CNA) "FFF" reported that Resident #97 had a blue split that he is supposed to wear on his right hand, and | | | |

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| | proceeded to show this surveyor that it was sitting on his nightstand, and that he had worn it for about 45 minutes that morning. CNA "FFF" reported that she worked regularly with the resident, but not every day, and that the splint should be noted on Resident #97's care plan. CNA "FFF" reviewed Resident #97's care plan and reported that she did not see any mention of the hand splint.<br><br>Review of Resident #97's "Care Plan" revealed, "...limited physical mobility r/t (related to) hemiplegia and hemiparesis following cerebral infarction affecting right and left side...Interventions: ...Skilled rehabilitation therapy evaluation and treatment as ordered..." There was no record of limited range of motion, prevention of contractures (joint stiffness and inability to move), and/or hand splint orders in place.<br><br>Review of Resident #97's "Kardex" revealed, no record of limited range of motion, contractures, and/or hand splint orders in place.<br><br>In an interview on 01/28/25 at 04:13 PM, Therapy Director (TD) "WW" reported that Resident #97 was prescribed a right hand splint in May 2023 to prevent contractures. TD "WW" reported that the resident should have orders to wear the splint throughout the day and off at night. TD "WW" reported that she was not able to enter orders and did not see any record of the orders in Resident #97's medical record. TD "WW" reported that Resident #97 was recently on case load for general strengthening of upper and lower body, but that his right hand was not evaluated or treated due to the history of impaired mobility status.<br><br>Review of Resident #97's "Therapy Records" provided by TD "WW" indicated on 5/22/23, | | | |

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| | "...right sift (sic) hand split (sic) applied with patient able to tolerate for 30 minutes w/o (without) any signs of redness, discomfort, to prevent contractures..." There was no other record of the hand splint, and or contracture of the right hand in the therapy notes that were provided, from 5/22/23-1/14/25.<br><br>Resident #27<br><br>Review of "Admission Record" revealed Resident #27 was originally admitted to the facility on 11/5/24 with pertinent diagnoses which included dementia.<br><br>Review of Resident #27's "Care Plan" did not reveal a care plan focus for Resident #27's dementia diagnosis.<br><br>During an interview on 1/29/25 at 11:02 AM, Social Services Director (SSD) "N" reported that she was responsible for creating care plans for residents in collaboration with the nursing manager, and that all residents with a diagnosis of dementia should have a dementia care plan. SSD "N" reviewed Resident #27's care plan with this writer and confirmed that Resident #27 did not have a care plan focus related to his dementia diagnosis.<br><br>During an interview on 1/29/25 at 11:45 AM, Registered Nurse Unit Manager (RN-UM) "QQ" reported that social services were responsible for creating dementia care plans. RN-UM "QQ" confirmed that all residents in the facility with a diagnosis of dementia should have a dementia care plan in place. | | | |
| F0658<br>SS= D | Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the | F0658 | | |

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| | comprehensive care plan, must- (i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to follow professional standards of practice for wound care and documentation of meal intake in 3 of 25 residents (Resident #230, #27, & #89) reviewed for professional standards, resulting in missed wound treatments and inaccurate documentation.<br><br>Findings include:<br><br>The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe that the orders are in error, violate agency policy, or are harmful to the patient." Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 20717-20719). Elsevier Health Sciences. Kindle Edition.<br><br>A health care provider's order for changing a dressing indicates the dressing type, the frequency of changing, and any solutions or ointments to be applied to the wound." Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 72648-72650). Elsevier Health Sciences. Kindle Edition.<br><br>Resident #230<br><br>Review of an "Admission Record" revealed Resident #230 was a female, with pertinent diagnoses which included left lower limb cellulitis, peripheral vascular disease, kidney | | | |

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| | disease, and diabetes.<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #230, with a reference date of 1/21/25, revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.<br><br>In an observation and interview on 1/28/25 at 8:36 AM, Resident #230 was noted in bed in her room. Observed dressings in place to her bilateral feet and left lower leg, dated 1/25/25. Resident #230 reported her wound dressings haven't been changed in two days. Observed visible wound drainage on the outside of the bandages.<br><br>Review of a current "Care Plan" for Resident #230 revealed the focus "...(Resident #230) has potential/actual impairment to skin integrity r/t (related to)...cellulitis of the lower left leg, bilateral diabetic/vascular foot ulcers..." initiated 1/21/25.<br><br>Review of an "Order Summary Report" for Resident #230 revealed the active physician order "...Left lower (lateral)/posterior leg-Cleanse with wound cleanser or NS (Normal Saline) and pat dry. Apply Xerofoam (sic) in double layer to wound bed and cover with foam (dressing). Change daily and PRN (as needed) if (dressing) is soiled or falling off...every night shift for Wound healing..." with interventions which included "...Follow physician orders for treatment of skin impairments..." both initiated 1/21/25.<br><br>Review of an "Order Summary Report" for Resident #230 revealed the active physician order "...Right/Left feet- Cleanse with NS or wound cleanser and pat dry. Next using a 4x4 gauze moisten with Dakin's solution...and fill toe amputation site (left foot great toe) with the | | | |

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| | gauze. Next apply Xerofoam (sic) in double layers to the top of both feet. Next cover with abd (a large gauze pad used to absorb discharge from heavily draining wounds) and wrap with gauze and secure with tape. Change daily and PRN if (dressing) is soiled or falling off...every night shift for Wound healing..." with a start date of 1/21/25.<br><br>Review of the January 2025 "Treatment Administration Record" (TAR) for Resident #230 revealed the physician order "...Left lower (lateral)/posterior leg-Cleanse with wound cleanser or NS and pat dry. Apply Xerofoam (sic) in double layer to wound bed and cover with foam (dressing). Change daily and PRN if (dressing) is soiled or falling off...every night shift for Wound healing..." was documented as completed on 1/26/25 (Note the dressing observed was dated 1/25/25). Noted no documentation (missed treatment) on 1/27/25.<br><br>Review of the January 2025 "Treatment Administration Record" (TAR) for Resident #230 revealed the physician order "...Right/Left feet-Cleanse with NS or wound cleanser and pat dry. Next using a 4x4 gauze moisten with Dakin's solution...and fill toe amputation site (left foot great toe) with the gauze. Next apply Xerofoam (sic) in double layers to the top of both feet. Next cover with abd and wrap with gauze and secure with tape. Change daily and PRN if (dressing) is soiled or falling off...every night shift for Wound healing..." was documented as completed on 1/26/25 (Note the dressing observed was dated 1/25/25). Noted no documentation (missed treatment) on 1/27/25.<br><br>In an interview on 1/28/25 at 2:45 PM, Unit Manager "QQ" reported Resident #230 admitted to the facility with the wounds to her bilateral lower extremities. Unit Manager "QQ" reported | | | |

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| | the treatments to Resident #230's bilateral feet and left lower leg should be completed once a day.<br><br>In an interview on 1/29/25 12:04 PM, "Licensed Practical Nurse" (LPN) "V" reported Resident #230's bilateral feet and left lower leg wound treatments should be completed once a day and as needed per physician order and documented in the TAR. LPN "V" reported if a nurse was unable to complete ordered wound care, the physician should be notified and a "Progress Note" should be written regarding the situation. LPN "V" reported the oncoming shift may be asked to complete the treatment depending on the situation.<br><br>Review of the "Progress Notes" for Resident #230 revealed no documentation to indicate why Resident #230's left lower leg/bilateral feet wound treatments were not completed on 1/27/25.<br><br>Resident #27<br><br>Review of "Admission Record" revealed Resident #27 was originally admitted to the facility on 11/5/24 with pertinent diagnosis which included unsteadiness of feet.<br><br>Review of Resident #27's " January 2025 Treatment Administration Record" revealed, " Order: Left Buttock: Cleanse wound with wound cleanser or NS (normal saline) and pat dry. Apply MANUKAhd Super Lite honey coated absorbent drsg (dressing) to wound and cover with silicone bordered superabsorbent (sic) drsg. Change Q hs (every night) and PRN (as needed) if drsg is soiled or falling off. every night shift for Wound healing." It was noted that there was missing documentation for this order on 1/4/25, 1/10/25, 1/16/25 and 1/27/25. | | | |

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| | Review of Resident #27's " January 2025 Treatment Administration Record" revealed, " Right 1st and 2nd Toe Wound Paint wounds with Betadine to necrotic tissue (dead skin) let air dry, place 2x2 gauze pad between toes to keep them from rubbing together. Cover with gauze roll but leave toes OTA (open to air), secure with tape. Changes dressing daily on night shift. every night shift for Wound management." It was noted that there was missing documentation for this order on 1/4/25, 1/10/25, 1/16/25, 1/24/25, and 1/27/25.<br><br>Review of Resident #27's " January 2025 Treatment Administration Record" revealed, " Old Supra pubic catheter site- Cleanse with wound cleanser or NS and pat dry. Apply silicone bordered superabsorbent (sic) drsg q shift and PRN if drsg is soiled or falling off. every shift for Wound healing." It was noted that there was missing documentation for this order on 1/4/25, 1/10/25, 1/16/25, and 1/27/25.<br><br>Resident #89<br><br>Review of "Admission Record" revealed Resident #89 was originally admitted to the facility on 6/6/24 with pertinent diagnosis which included unspecified protein calorie malnutrition.<br><br>Review of Resident #89's " Meal Intake Documentation" revealed that Resident #89 was missing meal intake documentation for the following dates; 1/2/25, 1/5/25, 1/10/25, 1/16/25, 1/22/25, 1/24/25, and 1/28/25.<br><br>During an interview on 1/29/25 at 12:34 PM, Certified Nursing Assistant (CNA) "M" reported that CNA's were expected to document resident's meal intake for each meal when they removed the resident's trays from their room. CNA "M" reported that it was important for CNA's to document meal intake so the facility could | | | |

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| | monitor resident's nutrition status.<br><br>During an interview on 1/29/25 at 12:47 PM, Director of Nursing (DON) "B" reported that the expectation for nursing staff to document when a treatment was administered or why the treatment was not administered. DON "B" reported that staff were also expected to document meal intake for each meal that resident consumed. DON "B" reviewed Resident #27's and Resident #89's electronic health record (EHR) and confirmed that staff had missed documenting Resident #27's wound care treatments and Resident #89's meal intake. DON "B" was unable to locate any further documentation from staff on why there was missing treatments for Resident #27.<br><br>Review of the facility's " Charting and Documentation" policy dated 7/11/2018 revealed, "POLICY: All services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional or psychosocial condition, shall be documented in the resident ' s medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident ' s condition and response to care... " | | | |
| F0679<br>SS= E | Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. | F0679 | | |

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| | This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to provide individualized activities for 4 of 6 Residents (Resident #26, Resident #39, Resident #42 and Resident #55) reviewed for activities, resulting in feelings of boredom, and a potential for a decline in physical, mental and psychosocial well-being.<br><br>Findings include:<br><br>Review of "Revolutionizing the Experience of Home by Bringing Well-Being to Life: The Eden Alternative Domains of Well-Being", Copyright 2012, Rev. 2020, revealed The Eden Alternative defined one domain of wellness as "Connectedness- the state of being connected; alive ...engaged, involved ..." Without meaningful interactions the individual can become disconnected ...develop loneliness, helplessness, and boredom.<br><br>Review of "Participating in Activities You Enjoy as You Age", published by the National Institute on Aging, 3/28/22, revealed: "Research has shown that older adults with an active lifestyle: ...may lower risk for developing some health problems, including dementia, heart disease, stroke, and some types of cancer ... Studies looking at people's outlooks and how long they live show that happiness, life satisfaction, and a sense of purpose are all linked to living longer. ...Studies suggest that older adults who participate in activities they find meaningful, ...say they feel happier and healthier ...research suggests that participating in certain activities, such as those that are mentally stimulating or involve physical activity, may have a positive effect on memory - and the more variety the better ...". | | | |

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| | Review of a "Activities-Resident's Choice" policy provided by the facility, with a reference date of 8/1/19 revealed; "POLICY: It is the policy of this facility that residents shall have the right to participate or not participate in leisure, recreation and social involvement of their choosing .... Residents will be invited to attend activities and will be provided the opportunity to participate in structured and individual programs. Preferences for residents who have Dementia will be determined through communication with the resident, family, friends and care givers. Assistance will be provided for residents who wish to participate but are not able to get to activities on their own. Residents who prefer not to participate in structured programs will be offered alternatives and necessary support/resources for meaningful individual pursuit of leisure interest."<br><br>Resident #26<br><br>Review of an "Admission Record" revealed Resident #26, was originally admitted to the facility on 8/1/22 with pertinent diagnoses which included: major depressive disorder (persistent depressed mood causing significant impairment in daily life) and generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities).<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #26, with a reference date of 12/13/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #26 was cognitively intact.<br><br>Review of a "Care Plan" for Resident #26, with a reference date of 10/25/23, revealed a focus/goal/interventions of: "Focus:(Resident #26) needs encouragement to participate in activities ...enjoys coffee time and doing puzzles | | | |

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| | independently or in a small group. Goal: The resident will express satisfaction with type of activities and level of activity involvement ...Interventions: Activity staff to make sure puzzle table is stocked with puzzles, explain to the resident the importance of social interaction, leisure activity time. Encourage the resident's participation ...visit 1:1 (one on one) with resident as she allows ...".<br><br>Review of an "Infection Control Closure" list provided by Nursing Home Administrator (NHA) "A" revealed the facility had not provided group activities from 10/2/24-12/27/24 and from 1/17/25-1/28/25.<br><br>Review of an "Activity Interview for Daily and Activity Preferences" for Resident #26, with a reference date of 6/25/24 revealed Resident #26 felt it was very important for her to have books, newspapers, and magazines to read, to be around animals such as pets, and to participate in religious activities.<br><br>Review of "Activity Participation" records for Resident #26 revealed no involvement in religious activities or activities involving pets between 12/1/24-1/27/25.<br><br>During an observation on 1/27/25 at 2:29pm, Resident #26 sat in her wheelchair in her darkened room.<br><br>In an interview on 1/27/25, at 2:32pm, Resident #26 reported she often felt bored and lonely because the facility had not offered group activities for several weeks. When further queried, Resident #26 reported the facility offered 1:1 visits to residents who were room bound but had not provided any support for her to pursue independent leisure interests. Resident #26 reported she understood the facility was trying to | | | |

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| | reduce the risk of illness by limiting gathering of residents, but she felt her mental well-being was at risk due to her lack of leisure involvements.<br><br>During an observation on 1/27/25 at 4:14pm, Resident #26 self propelled her wheelchair through the hallway.<br><br>During an observation on 1/28/25 at 9:32am, Resident #26 self propelled her wheelchair through the hallway.<br><br>In an interview on 1/28/25 at 9:33am, Resident #26 reported she was propelling her wheelchair in the hallway because she was bored.<br><br>In an interview on 1/29/25 at 11:31am, Activity Assistant (AA) "KK" reported the facility had not offered group activities for several weeks during recent months, due to infection control concerns. AA "KK" reported during that time, the activities staff was "doing the best we could, but we couldn't meet their (residents) needs ...". When further queried, AA "KK" reported residents who were seen for 1:1 visits should be seen at least twice a week to support leisure needs, but that had not been possible.<br><br>Resident #39<br><br>Review of an "Admission Record" revealed Resident #39, was originally admitted to the facility on 10/13/22 with pertinent diagnoses which included: major depressive disorder, anxiety disorder, dementia (general term for loss of memory, language, problem solving or other abilities that are severe enough to interfere with daily life), hemiplegia (loss of function on one side of the body).<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #39, with a reference | | | |

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| (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 |
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| | date of 1/20/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 11/15 which indicated Resident #39 was moderately cognitively impaired.<br><br>Review of a "Care Plan" for Resident #39, with a reference date of 1/22/16, revealed a focus/goal/interventions of: "Focus: Enjoys activities such as the Bible and religious activities, R&B music, pets, word search puzzles ...group activities ...socializing, games ...Goal: Will participate in independent leisure activities of choice ...Interventions: offer and encourage participation in activity program directed toward specific interests such as religious activities, cards/games, socials, patient has radio at bedside, assist with use, provide social visits and one on one visits as needed ..."<br><br>Review of the most recent "Activity Interview for Daily and Activity Preferences" for Resident #39, with a reference date of 2/12/24 revealed the resident indicated it was very important to her to listen to music she liked, and somewhat important for her to do her favorite activities, including doing things with groups of people.<br><br>During an observation and interview on 1/27/25, at 10:07am, Resident #39 was sitting in her bed, in a darkened room. Her television was playing but she was not watching it. Resident #39 reported she felt bored much of the time.<br><br>In an interview on 1/27/25 at 2:41pm, Family Member (FM) "BBB" reported Resident #39 received little support with pursuing the leisure activities of interest to her. FM "BBB" reported she visited regularly and provided CD's, a CD player and headphones for Resident #39 but the staff did not assist her with listening to her music. FM "BBB" described Resident#39 as a "people person" and that she enjoyed watching basketball | | | |

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| | and reading in the past. FM "BBB" reported no one from the Activities Department had asked her about Resident #39's interests. FM "BBB" reported she worried Resident #39's mental health and physical strength was at risk for decline because she spent most of her time in bed with little activity.<br><br>During an observation on 1/27/25 at 1:54pm, Resident #39 was in her bed, in a darkened room, with her television on. Resident #39 appeared to be asleep.<br><br>During an observation on 1/28/25 at 2:56 pm, Resident #39 was dressed, lying awake in bed, no music was playing in her room. Resident #39 did not direct her attention toward the television that was playing.<br><br>During an observation on 1/29/25 09:39am, Resident #39 was lying in bed, in a darkened room, her eyes were closed, no music was playing.<br><br>During an observation on 1/29/25 at 10:59 am, Resident#39 was awake, remained in bed, her room was dark. No music was playing.<br><br>Review of "Activity Participation" records for Resident #39 revealed the resident had no activity involvement for extended periods including: 10/22/24-11/4/24, 11/17/24-11/22/24, 11/28/24-12/13/24, and 12/24/24-1/20/25. Of the activities recorded, none reflected the resident listened to music. Group activities were not provided by the facility for 14 of the 16 weeks reviewed.<br><br>Resident #42<br><br>Review of an "Admission Record" revealed Resident #42, was originally admitted to the facility on 3/8/21 with pertinent diagnoses which | | | |

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| | included: adjustment disorder (excessive reaction to stress that involves negative thoughts, strong emotions, and behavioral changes).<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #42, with a reference date of 12/17/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 5/15 which indicated Resident #42 was severely cognitively impaired. Section "F" of the MDS revealed Resident #42 reported it was "very important" to him to do his favorite activities.<br><br>Review of a "Care Plan" for Resident #42, with a reference date of 12/21/22, revealed a focus/goal/interventions of: "Focus: "(Resident #42) is independent for meeting emotional, intellectual, physical, and social needs r/t (related to) ...prefers independent (sic). Res (resident) enjoys time with dogs ...has ipad in room, t.v. Goal: (Resident #42) will maintain involvement in cognitive stimulation, social activities as desired. Interventions: Ensure that adaptive equipment the resident needs is provided and is present and functional to be active with leisure interests, ...offer social visits, encourage participation in room activities and provide leisure supplies as needed".<br><br>Review of the most recent "Activity Interview for Daily and Activity Preferences" assessment for Resident #26, with a reference date of 11/20/23, revealed the resident indicated it was very important for him to listen to music he liked, somewhat important to be around pets, and somewhat important to do his favorite activities.<br><br>During an observation and interview on 1/27/25, at 10:29am, Resident #42 was lying in his bed with the curtain pulled around him. His television was playing but he did not attend to it. When approached, Resident #39 began talking rapidly | | | |

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| | and reported he'd been waiting for someone to come into his room. The resident spoke for several minutes and indicated he wanted someone to stay with him. Resident #42 stated "glad you're here".<br><br>In an interview on 1/27/25, at 11:01am, Licensed Practical Nurse (LPN) "DDD" reported Resident #42 spent all his time in bed.<br><br>During an observation on 1/28/25 at 2:59pm, Resident #42 was lying in bed, awake. His television was playing but he did not attend to it. When approached, Resident #42 quickly solicited social interaction and continued to talk for several minutes.<br><br>During an observation on 1/29/25 at 9:40am, Resident #42 was lying in bed, awake. His television was playing but he did not attend to it. When approached, Resident #42 quickly solicited social interaction and stated "I need to get ahold of my son. It's important".<br><br>In an interview on 1/29/25 at 11:19am, Registered Nurse (RN) "EE" reported Resident #42 spent all of his time in bed and preferred in-room activities. RN "EE" reported Resident #42 previously had a computer tablet that he used frequently but his son had taken it several weeks ago and that was why the resident wanted to contact his son. RN "EE" reported Resident #42 asked staff about his tablet many times in recent months.<br><br>In an interview on 1/29/25 at 11:31am, Activity Assistant (AA) "KK" reported the facility had tablets that residents could borrow to use in their rooms. AA "KK" motioned to 2 tablets and stated, "we have these 2 available right now". When queried about Resident #42, AA "KK" reported she was unaware the resident's personal | | | |

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| | tablet was no longer available to him or that he had expressed a desire to use a tablet. AA "KK" reported Resident #42 was one of the resident's she was assigned to for 1:1 visits, that visits should be conducted a few times a week, but she had not been able to consistently provide those visits. AA "KK" reported she was not sure if Resident #42 could speak, but she would follow up with him about his needs.<br><br>Review of "Activity Participation" records for Resident #42 reflected the resident had no activity involvement for extended periods, including the following dates: 10/1-10/16/24, 10/17-11/5/24, 12/4-12/18/24, and 12/18-1/14/24. The record reflected Resident #42 was last noted using his computer tablet on 11/5/24. None of the activity involvement documented for Resident #42 involved listening to music or being around pets, the interests he identified as important.<br><br>Resident #55<br><br>Review of "Admission Record" revealed Resident # 55 was originally admitted to the facility on 10/3/23 with pertinent diagnosis which included huntington's disease (a condition which causes nerve cells in the brain to break down over time).<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #55, with a reference date of 11/27/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 99/15 which indicated Resident #55 was severely cognitively impaired.<br><br>Review of Resident #55's "Care Plan" revealed, " While in the facility, it is important to have opportunity to engage in daily routines that are meaningful relative to their preferences. Preferences Resident #55 enjoys/enjoyed reading on the computer, sports almanac, watching | | | |

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| | baseball/ foot ball (tigers, lions, mainstream/ Detroit metromusic ie John Fogerty and Kid Rock, loves dogs. Try to engage him with helping with bird care in the aviary. Date Initiated: 05/18/2022. Interventions: Encourage and facilitate patients activity preferences. Date Initiated: 08/17/2021. enjoy listening to music and prefer John Forgery and Kid Rock. Date Initiated: 08/17/2021. I enjoy watching/listening to TV. Date Initiated: 08/17/2021..."<br><br>Review of Resident #55's " Activity Participation Log" revealed that Resident #55 participated in 7 activities in October 2024, 3 activities in November 2024, and 6 activities in December 2024.<br><br>During an observation on 1/27/25 at 11:01 AM, Resident #55 was sitting in his geri chair (chair designed for people with limited mobility) near the nurses station. Resident #55 appeared restless, and frequently looking around the area at staff and residents walking by.<br><br>During an observation on 1/27/25 at 12:04 PM, Resident #55 was resting in his bed. Resident #55's eyes were open. It was noted that Resident #55 did not have any music playing, and no other sensory activities were noted.<br><br>During an observation on 1/28/25 at 7:56 AM, Resident #55 was sitting in his geri chair near the nurse's station. Resident #55 was frequently repositioning himself and appeared restless.<br><br>During an observation on 1/28/25 at 8:50 AM, Resident #55 was sitting near the nurse's station in his geri chair. He appeared restless and frequently looking around the area at staff and residents walking by.<br><br>During an observation on 1/28/25 at 11:13 AM, | | | |

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| | Resident #55 was sitting near nurse's station in his geri chair. He appeared restless. There were several staff members at the nurses station talking, but they were not interacting with Resident #55.<br><br>During an observation on 1/28/25 at 3:02 PM, Resident #55 was resting in bed. It was noted that his eyes were open. Resident #55 was not listening to music, and no other sensory activities were noted.<br><br>During an observation on 1/29/25 at 7:52 AM, Resident #55 was sitting in his geri chair across from the nurse's station.<br><br>During an observation on 1/29/25 at 11:09 AM, Resident #55 was sitting in his geri chair across from the nurse's station. Resident #55 appeared restless.<br><br>During an observation on 1/29/25 at 12:44 PM, Resident #55 was sitting in his geri chair across from the nurse's station.<br><br>During an interview on 1/29/25 at 7:52 AM, Licensed Practical Nurse (LPN) "DD" reported that Resident #55 spent most of his time sitting in his geri chair near the nurses station. LPN "DD" was not able to report what kinds of activities that Resident #55 had participated in.<br><br>During an interview on 1/29/25 at 9:09 AM, Family Member (FM) "YY" reported that Resident #55 enjoyed sports and loved watching football, baseball, and boxing. FM "YY" reported that Resident #55 loved animals, and would benefit from animal visits. M "YY" reported that Resident #55 also loved rock music. FM "YY" reported that Resident #55 was very social and he felt that Resident #55 would benefit from being involved in group activities, even if he could not | | | |

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| | participate. FM "YY' reported that the facility had never reached out to him to learn more about Resident #55's interests and hobbies.<br><br>During an interview on 1/29/25 at 11:41 AM, Activity Director (AD) "NN" reported that Resident #55 would passively participate in group activities. When this writer queried on what kind of group activities the facility included Resident #55 in, AD "NN" reported watching television and movies. AD "NN" reported that the facility utilized a lot of music playing for a sensory activity for Resident #55. AD "NN" reported that she had never reached out to Resident #55's guardian to find out what kind of activities Resident #55 enjoyed/used to enjoy.<br><br>During an interview on 1/29/25 at 12:14 PM, Activities Assistant (AA) "KK" reported that she was the activity aide that provided activities for Resident #55. AA "KK" reviewed Resident #55's activity participation log with this writer and reported that the facility had not been providing enough activities for Resident #55. AA "KK" reported that she struggled with including Resident #55 in activities because she could not transport Resident #55 in his geri chair. AA "KK" reported that she had not addressed her concerns with transporting Resident #55 to nursing or management. AA "KK" confirmed that Resident #55 spent most of his day sitting in the same spot at the nurses station in his geri chair.<br><br>During a follow up interview on 1/29/25 at 12:20 PM, AD "NN" reported that she was responsible for completing quarterly activity assessments for residents. AD "NN" was unable to show this writer any activity assessments completed for Resident #55.<br><br>During an interview on 1/29/25 at 12:47 PM, Director of Nursing (DON) "B" reviewed | | | |

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| | Resident #55's Electronic Health Record (EHR) and confirmed that Resident #55 had not had an activity assessment completed since 2023. DON "B" confirmed that AD "NN" should have been completing activity assessments for Resident #55 quarterly. | | | |
| F0680 SS= F | Qualifications of Activity Professional §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on interview and record review, the facility failed to employ an Activity Director who possessed the required qualifications resulting in the potential for unmet psychosocial needs, feelings of boredom and a lack of person-centered activities. This citation has the potential to impact all 126 residents within the facility.<br><br>Findings include:<br><br>Review of certification standards of the National Certification Council for Activity Professionals revealed "ADC (Activity Director Certified) | F0680 | | |

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| | Certification ensures an individual has the knowledge and skills to lead and direct an activities and life enrichment department. ADC Certification validates the competencies necessary to be an Activity Director including leadership, management, advocacy, care planning and documentation."<br><br>Review of a "Activities Director Job Description" provided by the facility revealed: "Education, Training, and Experience: ...eligible for certification as a therapeutic recreation specialist or activities professional..qualified Occupational Therapist...has completed a training course approved by the state...".<br><br>In an interview 1/29/25 at 11:31am, Activity Assistant (AA) "KK" reported the facility had been without an Activities Director for nearly a year until another Activity Assistant was allowed to take the role. AA "KK" reported during the time the facility did not have an Activities Director, she was responsible for completing resident assessments but found she was not successful in completing those tasks.<br><br>On 1/29/25 at 12:02pm, when queried if the current Activities Director possessed the required qualifications for the role, Nursing Home Administrator (NHA) "A" responded via an email: "She (Activities Director (AD) "NN") does not have a certificate yet ...we thought she could just take the test based on her career but they informed her she has not been a director long enough...".<br><br>In an interview on 1/29/25 at 1:30pm, NHA "A" reported the facility had been without a qualified Activities Director for a year. NHA "A" reported AD "NN" was allowed to take the role without having the qualifications and had not been supervised by a qualified individual. | | | |

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| | A facility policy regarding the overall Activities program and role of the director was requested, but was not provided at the time of the completion of the survey. | | | |
| F0684 SS= D | Quality of Care § 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on interview and record review, the facility failed to properly assess a resident after a fall in 1 (Resident #48) of 25 residents reviewed for quality of care, resulting in a potential for unidentified injuries after a fall.<br><br>Findings include:<br><br>Review of an "Admission Record" revealed Resident #48 was originally admitted to the facility on 2/18/23 with pertinent diagnoses which included: unsteadiness on feet.<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #48, with a reference date of 11/19/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 13/15 which indicated Resident #48 was cognitively intact. Section "J" revealed Resident #48 experienced almost constant pain and two or more falls during the assessment period. | F0684 | | |

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| | Review of a "Care Plan" for Resident # 48, with a reference date of 1/15/25, revealed a focus/goal/interventions of: "(Resident #48) is at risk for falls ...Goal: (Resident #48) will remain free from fall related injury ...Interventions: ...anti roll backs to wheelchair ...gripper socks on at all times ...keep personal items within reach ...".<br><br>Review of a "Physician's Assistant Progress Note" with a reference date of 1/2/25 revealed: "Chief Complaint: low back pain, radiates to bilateral (both) hips. Diagnoses: ...Malignant neoplasm metastatic to bone (cancer spread to the bone that increases the risk of fracture) ...Imaging: numerous lesions ...involving the sacrum (tailbone) and visualized pelvis (portion of the body between the hips).<br><br>During an observation on 1/28/25 at 12:18pm, a loud "thud" was audible 25' from Resident #48's room. Licensed Practical Nurse (LPN) "MM" yelled toward Resident #48's room, "Are you on the floor?!". LPN "MM" and LPN "DD" entered Resident #48's room.<br><br>During an observation on 1/28/25 at 12:19pm, LPN "MM" and LPN "DD" assisted Resident #48 from a seated position on the floor, back into his wheelchair. LPN "MM" and LPN "DD" provided physical lifting assistance to Resident #48 by hooking their forearms under Resident #48's armpits, and lifting him to the seat of his wheelchair. LPN "MM" and LPN "DD" then exited the room. No assessment for potential injuries was observed prior to moving Resident #48.<br><br>In an interview on 1/28/25 at 1:12pm, LPN "DD" reported she and LPN "MM" picked Resident #48 up off the floor after he fell from the seat of his wheelchair. LPN "DD" reported the resident denied any pain. When asked if a resident should | | | |

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| | have a full assessment before being moved after a fall, LPN 'DD" did not answer the question. It was noted that less than 1 minute elapsed from the time the Resident #48 fell until he was placed back in his chair.<br><br>In an interview on 1/29/25 at 9:55am, Unit Manager (UM) "QQ" reported a nurse should complete a proper assessment, including range of motion for the extremities and a full set of vital signs before moving a resident after a fall. UM "QQ" confirmed that a proper post fall assessment could not be completed in less than 1 minute. UM "QQ" reported moving a resident after a fall, before properly assessing their injuries, could result in further injuries and complications. UM "QQ" confirmed that Resident #48 was at a greater risk of fractures in his pelvis and sacrum due to his diagnosis of metastasis. Unit Manager "QQ" confirmed that no vital signs were documented post-fall on 1/28/25 for Resident #48. Unit Manager "QQ" also confirmed that no post fall monitoring was ordered. UM "QQ" confirmed that post fall monitoring was important to ensure any symptoms of potentially unrecognized injuries were identified quickly and acted upon.<br><br>In an interview on 1/29/25 at 11:19am, LPN "DD" confirmed there was no record of any post fall vital signs for Resident #48 on 1/28/25. When further queried, LPN "DD" confirmed she also did not initiate post fall monitoring.<br><br>Review of a "Nursing Administration Fall" facility policy with a reference date of 7/11/18 revealed: "POLICY: It is the policy of this facility to evaluate extent of injury after a fall, prevent complications and provide emergency care ...Resident will not be moved until a nurse evaluates the resident's condition. Check the resident for any abnormalities: i.e. deformed, | | | |

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| | discolored or painful body parts, bumps, bruises, cuts, abrasions, scrapes, confusion ...obtain vital signs, complete range of motion ...". | | | |
| F0692 SS= E | Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure timely and consistent weight measurements; follow-up of residents at risk for altered nutrition status; and on-going nutritional assessment for 4 (Residents #59, #89, #111, and #121) of 5 residents reviewed for nutritional care and services, resulting in missed re-weights (Resident #59), incomplete nutrition status monitoring of a tube fed resident with a stage IV pressure ulcer (Resident #111), inconsistent weight measurements for a newly admitted resident (Resident #121), missed nutritional assessments (Resident #89, #111) and the | F0692 | | |

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| | potential for unidentified weight loss, nutritional status decline, and unmet nutritional needs for all residents.<br><br>Findings include:<br><br>Review of the policy "Nutrition Monitoring & Management Program" Adopted 7/11/2018 revealed, "POLICY: It is the policy of this facility to ensure that all residents maintain acceptable parameters of nutritional status, such as body weight and protein levels; unless the resident's clinical condition demonstrates that is not possible ...PROCEDURE Weights 1. Each resident is to be weighed within twenty-four (24) hours of admission, weighed weekly for four (4) weeks and weighed monthly and as needed thereafter ...Dietary Evaluation 1. Each resident's nutritional status is assessed by the Registered Dietician or his/her designee on admission and at least quarterly thereafter, and following a change in condition ...Clinical Evaluation ...4. Any resident meeting the criteria for weight loss and any resident at risk will be weighed weekly, with the weight entered into the weekly weight change progress notes. Weekly weights will be reviewed each week during the meeting of the Nutrition Committee. A. Residents at risk include (but are not limited to) the following: ...vi. Residents being tube fed ...<br><br>Resident #59<br><br>Review of an "Admission Record" revealed Resident #59 was a male, with pertinent diagnoses which included: unspecified protein-calorie malnutrition, anemia unspecified, and dysphagia (swallowing difficulty) oral phase.<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #59, with a reference date of 1/7/25 revealed, "Section K - | | | |

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| | Swallowing/Nutritional Status ...K0300. Weight Loss of 5% or more in the last month or loss of 10% or more in last 6 months ...2. Yes, not on physician-prescribed weight loss regimen ..."<br><br>Review of Resident #59's weight history revealed the following entries:<br><br>1/2/25 ...210.5 Lbs (pounds) - a decrease of 13.7% in 1 month = significant<br><br>12/5/24 ...244.0 Lbs<br><br>11/3/24 ...246.5 Lbs<br><br>In an interview on 1/28/25 at 2:41 PM, "Registered Dietitian" (RD) "P" reviewed Resident #59's weight history with this surveyor and reported because Resident #59's weight showed a significant loss in 1 month, he should have been reweighed to confirm the loss. RD "P reported she had requested a reweight from nursing on 1/8/25 in writing and had followed up again on 1/13/25, 1/15/25, and 1/17/25 to no avail. RD "P" reported the CNAs (certified nurse aides) were responsible for getting the reweights but the unit manager and the director of nursing assisted with facilitating the reweights. RD "P" reported the timeline for obtaining reweights should be within a day or two so that she could implement new nutritional interventions if indicated. RD "P" reported she believed Resident #59 has lost weight but wasn't certain if he had lost 34 pounds since his previous weight but was unable to confirm without the reweight.<br><br>In an interview on 1/29/25 at 10:55 AM, CNA "XX" reported CNAs were responsible for obtaining resident weights and reweights. CNA "XX" reported the CNA should automatically obtain a reweight if they notice the resident weight has changed plus or minus 5 pounds since | | | |

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| | their previously recorded weight. CNA "XX" reported the RD would also give the CNAs a list of residents who needed a reweight. CNA "XX" reported when a reweight was requested, the CNA should get it for the requestor right away.<br><br>In an interview on 1/29/25 at 11:00 AM, CNA "CC" reported if a resident weight was off from the previous weight between 3 - 5 pounds, a reweight should automatically be obtained. CNA "CC" reported the RD also asked for reweights and when the RD requested a reweight, it should be done right away within the day.<br><br>Resident #111<br><br>Review of an "Admission Record" revealed Resident #111 was a male, with pertinent diagnoses which included: dysphagia (swallowing problem), and pressure ulcer of sacral (tailbone) region.<br><br>Review of a current "Physician's Order" for Resident #111 revealed, "Enteral Feed Order every shift for NPO Continuous Enteral Feeding: Formula: Osmolite 1.5; Rate: 60mL/hour for 19 hours a day ...Order Date 9/10/24"<br><br>Review of Resident #111's "Skin Alteration Evaluation" dated 12/24/24 revealed, " ...AREA #1..Site ...Sacrum (tailbone) Type Pressure Length 6.0 Width 5.0 Depth 2.0 Stage IV ..."<br><br>Resident #111's electronic medical record was reviewed on 1/29/25 at approximately 10:30 AM for evidence of on-going nutritional assessment and monitoring given Resident #111's at risk nutritional status. There was one "Dietary Evaluation Type Admission" completed on 4/18/24 by RD "P". No other dietary evaluation documentation was found. The last Nutrition/Weight Progress note found was dated | | | |

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| | 10/4/24. No subsequent nutrition/weight progress note was found.<br><br>In an interview on 1/29/25 at 10:37 AM, RD "P" reported Resident #111 was considered high risk for alteration in nutritional status due to his tube feeding and that the RD should chart on his nutritional status monthly. RD "P" reviewed Resident #111's dietary evaluation history with this surveyor and reported the "Dietary Evaluation Type Admission" dated 4/18/24 was the only one done and that additional assessments should have been completed quarterly. RD "P" reported she did look at high risk residents, like Resident #111, monthly and she should be charting on them but that she couldn't keep up.<br><br>Resident #121<br><br>Review of an "Admission Record" revealed Resident #121 was originally admitted to the facility on 12/12/24, with pertinent diagnoses which included: gastrostomy (an surgical opening in the stomach for a feeding tube to be inserted, allowing for direct route to administer nutrition and medications when by mouth method is not possible).<br><br>Review of Resident #121's "Physician Orders" indicated that the resident received Enteral feeding (nutrients delivered through a tube to the stomach) via Peg Tube (the tube that is inserted through the skin into the stomach).<br><br>Review of Resident #121's "Nutritional Assessment" dated 12/17/24 indicated that the resident was at risk for malnutrition.<br><br>Review of Resident #121's "Weight Record" revealed on 12/12/24 the resident's weight was 155 pounds and then on 1/2/25 the resident's weight was 152.6 pounds, indicating a loss of | | | |

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| | 1.55%. There were no other weights recorded.<br><br>In an interview on 01/29/25 at 10:44 AM, Registered Dietician (RD) "P" reported that she typically would write a progress note monthly for residents that are receiving tube feedings, but had not gotten a chance for Resident #121. RD "P" reported that all new admissions should be weighed weekly, and that Resident #121 had missed a couple weight checks.<br><br>Resident #89<br><br>Review of "Admission Record" revealed Resident #89 was originally admitted to the facility on 6/6/24 with pertinent diagnoses which included unspecified protein calorie malnutrition.<br><br>Review of Resident #89's "Electronic Health Record (EHR)" on 1/27/25 revealed that Resident #89 had one dietary evaluation completed on 6/11/24. There were no further dietary assessments documented since 6/11/24.<br><br>Review of Resident #89's "Weights" revealed that Resident #89's weight had decreased from 190.4 pounds on 6/6/24 to 174.0 pounds on 1/1/25.<br><br>During an interview on 1/28/25 at 11:39 AM, Physician Assistant (PA) "CCC" reported that she was not aware of Resident #89's weight loss.<br><br>During an interview on 1/29/25 at 10:08 AM, Registered Nurse Unit Manager (RN-UM) "QQ" reported that she was not aware of Resident #89's weight loss.<br><br>During an interview on 1/29/25 at 10:38 AM, Registered Nurse (RN) "OO" reported that nurses in the facility were responsible for reviewing resident's weights, and reporting weight loss to the facility dietician and physician. RN "OO" | | | |

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| | reported that she was unaware of Resident #89's weight loss.<br><br>During an interview on 1/28/25 at 12:02 PM, Registered Dietician (RD) "P" reported that Resident #89 was overdue for nutrition assessments. RD "P" reported that she should have completed nutrition assessments for Resident #89 in September 2024 and December 2024, and that they were missed. RD "P" reported that the quarterly nutrition assessments would have evaluated Resident #89's weight loss. RD "P" reported that she had missed Resident #89's nutrition assessments because she was the only dietician in the facility, and she was unable to manage the case load of all residents in the facility. RD "P" reported that she had informed facility management that she was behind and unable to manage the work load, but that the facility had not made any changes to assist her with her work load.<br><br>During an interview on 1/29/25 at 12:47 PM, Director of Nursing (DON) "B" reported that she was not aware that RD "P" had not completed a nutrition assessment for Resident #89 since June 2024. DON "B" reported that she was not aware that RD "P" had reported that she was unable to manage her work load. | | | |
| F0699<br>SS= D | Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.<br>This REQUIREMENT is not met as evidenced by: | F0699 | | |

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| | Based on interview and record review, the facility failed to ensure that a resident who was a trauma survivor received care and services that addressed their psychosocial needs for 1 (Resident #39) of 25 residents reviewed for trauma-informed care, resulting in a potential for Resident #39 to experience re-traumatization.<br><br>Findings include:<br><br>Review of "Trauma-Informed Therapy Explained", 2/16/24, PositivePsychology.com, revealed: "Trauma-Informed care, a vital approach in mental health, acknowledges trauma's impact and aims to establish a safe, healing environment ...trauma informed care involves being mindful of potential triggers to prevent re-traumatization ...".<br><br>Resident #39<br><br>Review of an "Admission Record" revealed Resident #39 was originally admitted to the facility on 10/13/22 with pertinent diagnoses which included: major depressive disorder (persistent sad or depressed mood that impacts daily life) anxiety disorder, and dementia (general term for loss of memory, language, problem solving or other abilities that are severe enough to interfere with daily life).<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #39, with a reference date of 1/20/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 11/15 which indicated Resident #39 was moderately cognitively impaired.<br><br>Review of a "Care Plan" for Resident #39, with a reference date of 1/22/16, revealed a focus/goal/interventions of: "Focus: At risk for | | | |

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| | changes in mood r/t (related to) anxiety, depression. Goal: Will accept care and medication as prescribed. Interventions: Administer medication per physician orders, Assess for physical/environmental changes that may precipitate change in mood, regarding s/s (signs and symptoms) of anxiety/depression: encourage expression of feelings, provide support, elicit family support ..."<br><br>Review of a "Psychiatry Follow Up" report for Resident #39 with a reference date of 11/13/24 revealed: "Social History: Trauma History: Sexual abuse at age 10".<br><br>In an interview on 1/29/25 at 9:12am, Social Services Director (SSD) "N" reported if a resident had a history of trauma, they should have a care plan that outlined steps staff should use during cares to mitigate the risk of re-traumatization. SSD "N" reported the facility monitored contractual behavioral health services reports and hospital records to ensure it identified residents who had a history of trauma. SSD "N" reported a resident's history of trauma was also assessed during initial social work assessments, however, residents who were admitted more than a few years ago, were not assessed for trauma. When further queried regarding Resident #39, SSD "N" reported to her knowledge, the resident did not have a history of trauma. Upon reviewing Resident #39's "Psychiatry Follow Up" report, dated 11/13/24, SSD "N" reported the resident did have a history of trauma, but SSD "N" was unaware. SSD "N" confirmed Resident #39 had not been assessed for any triggers related to her trauma at this time. SSD "N" confirmed that it was important to know if a resident had a history of trauma/ triggers related to their trauma in order to avoid accidental re-traumatization during cares.<br><br>In an interview on 1/29/25 at 1:30pm, Nursing | | | |

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| | Home Administrator (NHA) "A" reported the facility did not have a policy related to trauma informed care. | | | |
| F0791<br>SS= D | Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.<br>This REQUIREMENT is not met as evidenced by: | F0791 | | |

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| | Based on interviews and record review, the facility failed to facilitate outside dental services in a timely manner for 1 of 1 residents (Resident #55) reviewed for dental care, resulting in Resident #55 having prolonged poor condition of teeth, and the potential for a life threatening infection.<br><br>Findings include:<br><br>Resident #55<br><br>Review of "Admission Record" revealed Resident # 55 was originally admitted to the facility on 10/3/23 with pertinent diagnoses which included huntington's disease (a condition which causes nerve cells in the brain to break down over time).<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #55, with a reference date of 11/27/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 99/15 which indicated Resident #55 was severely cognitively impaired.<br><br>Review of Resident #55's "Medical Practitioner Progress Note" dated 6/6/24 and documented by Nurse Practitioner (NP) "ZZ" revealed, " ... (Resident #55) recently missed appointment with (local facility dental service provider) because he would not open his mouth for visit, per visit note. (Resident #55) is noted to have extensive periodontal disease (inflammation and infection in the gums and the bone that supports the teeth)..."<br><br>Review of Resident #55's "Medical Practitioner Progress Note" dated 6/28/24 and documented by NP "ZZ" revealed, " (Resident #55's) legal guardian recently emails to give consent to pursue extraction of teeth with severe periodontal | | | |

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| | disease...Attempt BID (twice daily) toothbrushing. Monitor for decreased food intake or symptoms of dental pain... Increased risk of orofacial infections due to chronic periodontal disease. Guardian has consented to surgical extraction of teeth due to severe periodontal disease; follow up with specialist..."<br><br>Review of Resident #55's "Medical Practitioner Progress Note" dated 9/11/24 and documented by NP "ZZ" revealed, "...I continue to work with clinical scheduler to seek local options for dental x-rays and tooth extraction due to behaviors...Guardian has consented to surgical extraction of teeth due to severe periodontal disease- scheduler seeking local options due to strain of long ride on (Resident #55) to the preferred option of (name redacted) as well as difficulty contacting the clinic; follow up with specialist..."<br><br>Review of Resident #55's "Medical Practitioner Progress Note" dated 9/18/24 and documented by NP "ZZ" revealed, " ... there is a tooth on his anterior lower gumline with significant erosion, gum swelling and erythema (redness). PCP (Primary Care Provider) notes history of dental infections progressing to sepsis and requiring hospitalization... PCP ordered Augmentin (antibiotic)..."<br><br>Review of Resident #55's "Medical Practitioner Progress Note" dated 10/7/24 and documented by NP "ZZ" revealed, " (Resident #55) is seen for a follow up of dental infection. He completed the course of Augmentin without complication. His brother and guardian has (sic) consented to dental extraction of teeth, all of which have severe periodontal disease. (Resident #55) does not allow for toothbrushing during cares. He would require anesthesia for dental work to be completed, and so far have been unable to find | | | |

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| | providers to do the work locally. He was last seen by (facility dental provider) in July 2024, but exam was limited as he was not cooperative due to cognitive impairment..."<br><br>Review of Resident #55's " Facility Dental Provider Summary Report" dated 12/6/24 revealed, " ...(Resident #55) does have a couple of root tips present. Unable to determine precise location...X-rays not taken (Resident #55) unable to stay open..."<br><br>Review of Resident #55's Electronic Health Record (EHR) did not reveal any referrals to outside dental providers for dental services.<br><br>During an interview on 1/29/25 at 9:09 AM, Family Member (FM) "YY" reported that he was not aware of any upcoming dental appointments or referrals for Resident #55. FM "YY" reported that he had left the decisions for Resident #27's dental care up to the facility to manage.<br><br>During an interview on 1/29/25 at 7:52 AM, Licensed Practical Nurse (LPN) " DD" reported that Resident #55 had experienced ongoing issues with his teeth. LPN "DD" reported that Resident #55 would need antibiotics when his teeth would get infected. LPN "DD" reported that she could tell when Resident #55 was dealing with an infected tooth because his behavior would change, and he would show symptoms of being in pain.<br><br>During an interview on 1/28/25 at 11:39 AM, Physician Assistant (PA) " CCC" reported that she was aware that Resident #55 had suffered from recent tooth infections, but she was not sure if he needed his teeth extracted. PA "CCC" reported that she did feel that Resident #55 would benefit from having his teeth extracted due to his severe periodontal disease. | | | |

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| | During an interview on 1/29/25 at 10:12 AM, RN Unit Manager (RN-UM) "QQ" reported that she did not believe that the facility was working on finding a dental provider for Resident #55. RN-UM "QQ" reported that she thought that the facility was waiting for Resident #55's guardian to provide consent for Resident #55 to have dental extractions completed.<br><br>During an interview on 1/29/25 at 10:53 AM, Medical Records Coordinator (MRC) "TT" reported that she was the staff member responsible for scheduling dental appointments at the facility. MRC "TT" reported that Resident #55 had seen the facility's dental provider on 12/6/24 and she did not receive a referral for Resident #55 to be scheduled for extractions. MRC "TT" confirmed that the dental care that Resident #55 was able to receive from the facility's dental provider was limited as he struggled to open his mouth, and they were not able to complete a thorough exam due to this. MRC "TT" reported that she was unaware that NP "ZZ" had requested that Resident #55 be scheduled with a dental provider for extractions.<br><br>During an interview on 1/29/25 at 11:35 AM, NP "ZZ" reported that Resident #55 did require dental extractions due to his severe periodontal disease. NP "ZZ" confirmed that the facility had to provide antibiotics for Resident #55 for tooth infections. NP "ZZ" reported that Resident #55 would require sedation for dental procedures due to his cognition and inability to keep his mouth open. NP "ZZ" reported that she had provided a referral to Unit Secretary (US) "X" and that US "X" had been actively working to try to find a dental provider to provide dental services to Resident #55. NP "ZZ" reported that Resident #55 was referred to (Name redacted) dental office, but that US "X" had been unable to reach the office to schedule. NP "ZZ" confirmed that | | | |

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| | she had received consent from Resident #55's guardian for Resident #55 to receive the dental extractions when they found a dental provider.<br><br>During an interview on 1/29/25 at 12:40 PM, US "X" reported that she was not the staff member responsible for scheduling appointments for dental appointments, and she did not know anything about Resident #55's referral for dental services. US "X" reported that MRC "TT" was the staff member at the facility that coordinated all dental appointments.<br><br>During an interview on 1/29/25 at 12:47 PM, Director of Nursing (DON) "B" reported that the facility was waiting for Resident #55's guardian to provide consent for the facility to move forward with scheduling with a dental provider. DON "B" reported that she was unaware that NP "ZZ" had obtained consent from Resident #55's guardian and had reported that the facility was trying to find a dental provider. DON "B" was unable to locate any information about Resident #55's referral for dental extractions, DON "B" confirmed that dental extractions had been recommended for Resident #55 since June 2024. DON "B" reported that she was going to investigate the situation and let this writer know what she discovered.<br><br>During a follow up interview on 1/29/25 at 2:45 PM, DON "B" reported that she had talked to NP "ZZ" and that NP "ZZ" had "confused residents, and that Resident #55 had not yet been referred to a dental provider. DON "B" was unable to report why NP "ZZ" had several notes documenting that Resident #55 had been referred to a dental provider and informed this writer that she would continue to investigate to determine why Resident#55's progress notes documented by NP "ZZ" were conflicting. | | | |

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| | No further information was provided by the facility prior to survey exit. | | | |
| F0812<br>SS= F | Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food in the kitchen.<br><br>Findings include:<br><br>An initial kitchen/food service tour was conducted on 1/27/25 beginning at 9:46 AM with "Food Service Director" (FSD) "II". The following observations/interviews were completed:<br><br>At 9:50 AM in the freezer, it was noted that cases | F0812 | | |

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| | of hamburger patties, Salisbury steaks, and egg patties were opened but were not securely closed (to prevent contamination). FSD "II" reported the food products should have been securely closed after opening. There was a frozen pickle slice on the floor of the freezer, and it was noted that there was a buildup of dirt, grime, and debris underneath the food storage racks and in the corners of the floor. There was a plastic cover over the sprinkler head in the ceiling that was broken in half, part of which was on the freezer floor in the corner underneath a storage rack. FSD "II" reported that the freezer floor was cleaned monthly but swept weekly. FSD "II" reported the freezer floor should also be swept as needed and confirmed the freezer floor needed swept/cleaned.<br><br>At 9:58 AM, in the reach-in cooler, it was noted that there was a rack with trays of prepared food product stored on it. The rack had a buildup of dried food product and debris. FSD "II" reported the rack was thoroughly cleaned monthly but should also be cleaned as needed.<br><br>At 10:07 AM in the storeroom, there was a box of chocolate cake mix that was opened but not securely closed. There was a case of flaked coconut that was opened but not securely closed. The floor of the storeroom was noticeably soiled with debris, dried food product, and a buildup of dust in the corners of floor. FSD "II" reported the floor was swept and mopped on Mondays and Thursdays and would be done that day after stock was put away.<br><br>At 10:18 AM in the 600-hall nourishment room, it was noted that there was a significant amount of lime buildup on the interior and exterior of the ice dispenser on the ice machine. There was dried spillage on the bottom of the refrigerator. There was a condiment tray with spilled sugar packets, one of which was stuck to the wall of the tray. | | | |

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| | FSD "II" reported maintenance was responsible for maintaining and cleaning the ice machine and housekeeping was responsible for cleaning the refrigerator.<br><br>At 10:23 AM in the 300-hall nourishment room, it was noted that there was a lunchbox in the refrigerator that was not labeled or dated. There was dried spillage on the door of the refrigerator and underneath the drawers. There was a container of beef broth in the refrigerator that was labeled with an opened date of 1/9/25. FSD "II" reported the beef broth should have been discarded after 7 days once opened. There were two opened beverages (an energy drink and a bottle of cola) in the refrigerator that were not labeled with opened or discard dates. There was dried, frozen spillage in the freezer. Upon exiting the nourishment room, FSD "II" asked a CNA (certified nurse aide) whose lunchbox was in the refrigerator. The CNA reported it was hers. FSD "II" instructed that staff food should not have been stored in the nourishment room refrigerator.<br><br>During a tour of the kitchen, at 10:28 AM on 1/28/25, observation found the kitchen hot and humid compared to the rest of the facility. When asked if the exhaust system was working, FSD "II", stated it has been down for a while. When asked if it stays this warm in the kitchen all the time, FSD "II" stated it was worse this summer. When asked what the issue was, FSD "II" stated that the roof top HVAC unit over the kitchen stopped working and so we have no kitchen exhaust or air conditioning.<br><br>During an interview with Maintenance Director "I", at 10:41 AM on 1/28/25, it was found that the exhaust roof top unit has been down awhile and it's been tricky getting it replaced. When asked if there was a timetable in place to get the unit replaced. MD "I" said its been discussed, but I am | | | |

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| | not sure.<br><br>During a tour of the kitchen, at 10:40 AM on 1/28/25, an interview with Food Service Director (FSD)"II" found that that the floor mixer gets used every other day. Observation of the floor mixer found dried white crusted debris on the under arm of the unit.<br><br>During a tour of the dish machine area, at 11:13 AM on 1/28/25, it was observed that a black hose was connected to a hose bib underneath the dirty side of the dish machine. At this time, the hose was flushing water into the floor drain with no atmospheric vacuum breaker protecting the potable water supply.<br><br>During a tour of the 500-hall pantry, at 11:19 AM on 1/28/25, it was observed that an unopened fruit smoothie was in the refrigeration unit with a best by date of 12/11/24. Further review of the unit found an accumulation of white crusted debris around the spout of the ice machine and slime debris inside of the spout. When asked who takes care of the ice machines, FSD "II" stated, maintenance.<br><br>During a tour of the 600-hall pantry, at 2:09 PM on 1/28/25, observation of the ice machine found increased accumulation of white crusted debris and a layer of slime debris inside of the spout of the machine.<br><br>During a tour of the 100-hall pantry, at 2:34 PM on 1/28/25, a review of the refrigeration unit found that commercially prepared salsa and hummus with open dates of 12/31/24. Both items were labeled with discard dates coinciding with their manufactures discard when not opened. Further review of the 100-hall pantry found an open container of condiments, including packets of sugar, creamer, soy sauce, ketchup, relish, and | | | |

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| | single use straws. These items were found at risk of contamination due to being in proximity of the hand sink.<br><br>During a tour of the 600-hall pantry, at 9:10 AM on 1/29/25, it was observed that the ice machine spout was in the same condition as yesterday. An interview with Maintenance Director "I" found that the facility has a vendor that comes out quarterly and would be due in February.<br><br>According to the 2022 FDA Food Code section 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor.<br><br>According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. "(A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean ..."<br><br>According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris."<br><br>According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. "(A) Except when PACKAGING FOOD using a REDUCED | | | |

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| | OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety ..."<br><br>According to the 2022 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. "(A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) ..." | | | |

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| | According to the 2022 FDA Food Code section 6-304.11 Mechanical.<br><br>"If necessary to keep rooms free of excessive heat, steam, condensation, vapors, obnoxious odors, smoke, and fumes, mechanical ventilation of sufficient capacity shall be provided."<br><br>According to the 2022 FDA Food According to the 2017 FDA Food Code section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: "(A) Repaired according to LAW; and (B) Maintained in good repair**."** | | | |
| F0880<br>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 infections before they can spread to other persons in the facility; (ii) When and to whom | F0880 | | |

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| | 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:<br><br>This citations contains two Deficient Practice Statements:<br><br>DPS A<br><br>Based on observation, interview, and record review, the facility failed to: 1.) maintain safe infection control practices in regards to hand hygiene (glove use) during direct care for 1 resident (Resident #121) and 2.) ensure that all | | | |

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| | staff consistently don proper PPE (personal protective equipment) prior to entering a room where Transmission Based Precautions are in place in 1 resident (Resident #112) of 25 residents reviewed for infection control, resulting in the potential for cross-contamination and the development and spread of bacteria.<br><br>Findings include:<br><br>Resident #121<br><br>Review of an "Admission Record" revealed Resident #121 was originally admitted to the facility on 12/12/24, with pertinent diagnoses which included: tracheostomy (a surgical procedure that creates an opening in the front of the neck to provide airway and allow breathing) and a gastrostomy (an surgical opening in the stomach for a feeding tube to be inserted, allowing for direct route to administer nutrition and medications when by mouth method is not possible).<br><br>Review of Resident #121's "Physician Orders" revealed the following relevant orders, "Enhanced Barrier Precautions (EBP) for trach (tracheostomy) and TF (tube feeding)... Change all trach related supplies: nebulizer tubing, corrugated tubing, trach mask, overflow container, suction parts, etc. On Sunday night shift every week as needed... Enteral feeding (nutrients delivered through a tube to the stomach)... Peg Tube site (the tube that is inserted through the skin into the stomach)..."<br><br>In an interview on 01/28/25 at 12:14 PM, Licensed Practical Nurse (LPN) "LL" reported that Resident #121 was found with vomit coming out of her trach early that day, therefore the resident's tube feeding was on hold to allow her stomach to rest. LPN "LL" reported that she | | | |

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| | would be restarting Resident #121's tube feeding soon.<br><br>During an observation on 01/28/25 at 12:19 PM in Resident #121's room, LPN "LL" donned gloves and a gown prior to direct care, per the signage indicating enhanced barrier precautions. While at the bedside, LPN "LL" used the bed control to raise the level of the bed, then pulled the resident's covers back to find the Peg tube. Then using a syringe, LPN "LL" held onto the Peg tube and inserted the syringe to check for residual stomach contents. Then LPN "LL" went to the water faucet, filled the syringe and then inserted the syringe back into the resident's Peg tube to flush the tube prior to restarting the tube feeding. LPN "LL" was still wearing the gloves that she had donned when she entered the room. Then LPN "LL" reprogrammed the tube feeding machine, attached the tubing to the resident's Peg tube, and restarted the feeding. Then using the same gloves, LPN "LL" removed gauze from the resident's tracheostomy that was soiled with thick mucus, then obtained clean gauze and repeatedly wiped around the trach to remove all mucus debris. LPN "LL" obtained supplies to replace the trach gauze, and humidifying mask that was covering the trach. Then with the same gloves that were donned upon entrance to the resident's room, LPN "LL" placed a clean gauze and oxygen mask around Resident #121's trach. After all care was finished, LPN "LL" removed her gloves and gown.<br><br>In an interview on 1/28/25 at 12:26 PM, LPN "LL" reported that the resident was highly susceptible to infections due to having a trach and feeding tube. LPN "LL" reported that she did not change her gloves after touching potentially contaminated surfaces in the residents room, and/or prior to trach care. | | | |

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| | Resident #112<br><br>Review of "Admission Record" revealed Resident #112 was originally admitted to the facility on 4/17/24 with pertinent diagnoses which included muscle weakness.<br><br>Review of Resident #112's "Orders" revealed, "Droplet precautions are ordered start date 1/17/25- 1/29/25."<br><br>During an observation on 1/27/25 at 9:57 AM, Housekeeping Aide (HA) "EEE" donned (put on) a gown and gloves to enter Resident #112's room. It was noted that HA "EEE" did not put on eye protection. It was noted that the sign on Resident #112's door indicated that all staff were to don eye protection, gloves, gown, and mask before entering the room. At 10:00 AM, HA "EEE" exited Resident #112's room while wearing the gown. It was noted that HA "EEE" no longer had gloves on. HA "EEE" grabbed some items from her cleaning cart and re-entered Resident #112's room without gloves or eye protection on. At 10:06 AM, HA "EEE" exited Resident #112's room, Wearing the gown which she removed in the hallway, not in the resident's room prior to exit. It was noted that HA "EEE" did not wash her hands after she removed her gown.<br><br>Review of the facility's "Droplet Precaution" policy dated 2/22/21 revealed, " POLICY: It is the policy of this facility that Droplet Precautions shall be used in addition to standard precautions for residents with infections that can be transmitted by droplets. Droplet transmission involves contact of the conjunctiva or mucous membranes of the nose or mouth of a susceptible person with large-particle droplets containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets may be generated by the | | | |

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| | resident's coughing, sneezing, talking, or during the performance of procedures, e.g. suctioning. A negative culture is required to remove the resident from Droplet Isolation if a MDRO is present. The facility will follow the MD orders for treatment and discontinuation of Isolation... PROCEDURE: ... 3. Mask A. A mask should be worn when entering the resident ' s room. 4. Eye Protection A. Eye protection should be worn when entering a resident ' s room (e.g., goggle or face shield)..."<br><br>DPS B<br><br>Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility.<br><br>Findings include:<br><br>During an observation of the kitchen, at 10:32 AM on 1/28/25, it was observed that a water line was found coming out from behind the two-door reach in cooler where an ice machine used to be located.<br><br>An interview with Maintenance Director (MD) "I", at 10:42 AM on 1/28/25, in the kitchen, found that he was unaware of the water line. When asked about how the facility handles flushing stagnant water lines. MD "I" stated that he goes to vacant rooms to flush them once a month. When asked about minimal use or unused fixtures in the facility, MD "I" stated his focus has been on the vacant rooms. | | | |

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| | During a tour of the 700 hall, at 1:15 PM on 1/28/25, it was observed that a drinking fountain was observed with no cover or out of order sign. Upon pushing the drinking fountain to operate, no water came out of the unit.<br><br>During a tour of the 600 hall Soiled Utility room, at 1:26 PM on 1/28/25, it was observed that brown water momentarily came out of the cold and hot valves in the fixture above the hopper.<br><br>During a tour of the 600 hall spa tub room, at 2:25 PM on 1/28/25, it was found that black water and debris momentarily come out of the hot valve in the water fixture on the tub. At this time, the tub was found with equipment, briefs, and padding inside of its basin.<br><br>During a tour of the 600 low Soiled Utility room, at 2:27 PM on 1/28/25, it was observed that brown water momentarily came out of the faucet when the hot and cold water was turned on.<br><br>During a tour of the 100 hall Soiled Utility room, at 2:33 PM on 1/28/25, it was observed that the spray on the hopper did not work and was creating a stagnant water line.<br><br>During a tour of the 500 hall Soiled Utility room, at 3:18 PM on 1/28/25, brown discolored water was found momentarily coming out of the hot water valve on the fixture over the hopper.<br><br>During a tour of the 400 hall Soiled Utility room, at 3:38 PM on 1/28/25, it was observed that the water to the hopper did not turn on or flush, indicating a stagnant water line.<br><br>During a tour of the facility, at 8:52 AM on 1/29/25, an interview with MD "I" found that they currently don't use or flush the drinking fountains around the facility, and they have a | | | |

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| | long-term plan to remove them.<br><br>An interview with MD "I", at 8:55 AM on 1/29/25, found that staff are doing monthly flushing's on vacant rooms. At this time, observation of the 600 high Soiled Utility found brown water still in the hopper basin from running the water yesterday, and momentarily, more brown water that was discharged from the faucet was observed.<br><br>An interview with MD "I", at 9:26 AM on 1/29/25, in the 600 low Spa, found that staff have not been flushing the tubs, but will add them to the list.<br><br>An interview with MD "I", at 10:48 AM on 1/29/25, regarding the facilities Water Management Plan found that the facility has been taking free chlorine samples. A review of the facilities logged samples found little deviation in results provided (even as the range of the municipality source water would deviate in chlorine concentration over the course of the year). While survey was onsite, MD "I" was unable to find the chlorine test kit he had been using to document results, so no verification of accuracy could be determined.<br><br>A review of the facilities Water Management Plan found a document entitled, "Operation, Maintenance, and Control Limits", not dated, that states "Flush low-flow pipe runs, dead legs and infrequently used fixtures weekly." | | | |
| F0921<br>SS= E | Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>This REQUIREMENT is not met as | F0921 | | |

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| | evidenced by:<br><br>Based on observation, interview, and record review the facility failed to maintain a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This resulted in an increased potential for contamination and a possible decrease in the satisfaction of living, affecting residents in following areas:<br><br>Findings Include:<br><br>During a tour of the facility, at 1:18 PM on 1/28/25, a review of empty resident room 701 found an accumulation of dust, dirt, sand, and dead ants under the register on the far side of the room.<br><br>During a tour of the 600 hall spa room, by resident room 624, at 1:21 PM on 1/28/25, it was observed that the spa room was hot and humid upon entering the room. A temperature of the wall with an infra-red thermometer found it to be 82F with moisture dripping down the windowsills. Aluminum window frame was observed with black spots and accumulation of black debris. Black debris was able to be wiped away from the window frame with a paper towel. Further review of the spa room found open and exposed linens (three towels and a dozen wash cloths) laid out on a shower bed in the middle of the room. Observation of the storage cabinet found urine remover and personal hygiene products stored together on the same shelf.<br><br>During a tour of the 600 linen closet, at 2:14 PM on 1/28/25, it was observed that two holes were found in the concrete wall where water fixtures used to service the room (One hole is roughly 7"x 7" and the other is 9"x 6"). The water fixtures were observed capped off, but the wall was not | | | |

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| | patched. Air could be felt entering the room from the holes in the concrete.<br><br>During a tour of the 100 hall clean utility room, at 2:44 PM on 1/28/25, it was observed that the floor juncture on the far right side of the floor was missing its vinyl coving and left a half to one inch gap in the bottom of the floor and the wall.<br><br>During a tour of the 500 hall spa, at 3:22 pm on 1/28/25, it was observed that a cloth backed chair was in the spa room near the shower area. Further observation of the room found a used brief half hanging out of the trash receptacle next to the sink. Observation of the alarm cord, next to the commode, found a white braided string that faded to yellow and brown as it hung from the alarm and laid on the floor. A couple inches away from the commode call light was a smear of dried brown debris on the wall.<br><br>During a tour of resident room 515, at 3:27 PM on 1/28/25, it was observed that the far outside wall was found to have an accumulation of sand, dirt, debris, and dead ants.<br><br>During a tour of the 400 hall spa room, at 3:41 PM on 1/28/25, it was observed that a mostly full roll of toilet paper was on the ground next to the commode. A plastic cart with gloves and briefs was found stored next to the sink and commode. A box of Kleenex was found open on the sink.<br><br>During a tour of the 600 hall spa, with Maintenance Director (MD) "I" at 9:00 AM on 1/29/25, an interview found that the facility has some exhaust ventilation that is currently down. When asked about the timetable on getting the exhaust repaired, MD "I" stated that he's been waiting to have some help to get this fixed.<br><br>During a tour of the 600 hall Soiled Utility room, | | | |

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| | at 9:10 AM on 1/29/25, a foul odor was noticed when entering the room. A piece of paper towel was used to determine if the exhaust ventilation was working. It was not observed to be holding or pulling the paper towel into the vent.<br><br>During a tour of the 200 hall janitor closet, at 9:17 AM on 1/29/25, it was observed that the janitors closet was found with an attached chemical pre-dispense and the water was left on and under constant back pressure. The faucet fixture has an internal vacuum breaker that is not approved for constant back pressure.<br><br>During a tour of the 500 hall spa, at 9:58 AM on 1/29/25, it was observed that the stained alarm cord, dried brown debris next to the alarm, and the cloth backed chair, were all found in the same condition as the day before. An interview with MD "I" found that he can change the alarm cord out with something more cleanable.<br><br>During a tour of the 400 hall shower, at 10:08 AM on 1/29/25, it was observed that a small pile of sand was noticed on the floor juncture where the wall and floor meet inside the shower. The sand was whiped away, and three ants were found coming from the area. When asked what the facility has been doing for ants, MD "I" stated that they have regular pest control come in and staff usually tell him when they find concerns. When asked if staff ever log pest occurrences, MD "I" stated that there is no log he is aware of, just what staff tell him about.<br><br>During an observation on 01/27/25 at 01:44 PM room 114 had multiple large areas of peeling paint on the wall next to the resident's bed.<br><br>During an observation on 1/17/25 at 11:32 AM in Room 604, it was noted that there were several areas of chipped paint on the room walls. | | | |

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| | During an observation/interview on 1/27/25 at 12:48 PM in Room 610, it was noted that there were several areas of chipped paint on the room walls. The border on the bottom of the wall next to the resident's bed at the floor was partially detached from the wall and falling off. There was a black streak on the wall at the head of the resident bed. The resident present in the room at the time of the observation reported that it bothered her that the walls were in such bad condition.<br><br>During an observation/interview on 1/27/25 at 1:26 PM in Room 612 Bed 2, it was noted that the personal fan that was on and blowing toward the resident, who was wearing oxygen, was caked with a significant amount of dust and debris on the grates and blades of the fan. Balls of dust, attached to the grates of the fan, were blowing outward toward the resident during the observation. The resident in Room 612 Bed 2 reported she knew the fan was dusty because the dust blew into her eyes. The resident reported she had asked people to clean her fan, but nobody came to clean it.<br><br>During an observation on 1/27/25 at 1:29 PM in Room 612 Bed 1, it was noted that the personal fan sitting on the chair facing the resident was soiled with a moderate build-up of dust on the grates and blades of the fan.<br><br>In an interview on 1/28/25 at 11:34 AM, "Housekeeping Aide" (HA) "UU" reported resident fans should be dusted at least 2 - 3 times per week.<br><br>In an observation/interview on 1/28/25 at 11:38 AM, "Housekeeping Account Manager" (HAM) "VV" reported the housekeeping department was responsible for cleaning resident personal fans. HAM "VV" reported he usually did an audit once | | | |

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| | a month to check the fans and would take fans apart and clean them when needed. HAM "VV" reported resident personal fans should also be cleaned as needed in between that time. HAM "VV" accompanied this surveyor to Room 612 and, after obtaining permission from the residents in the room, looked at the two personal fans in the room. The resident in Room 612 Bed 2 reiterated to HAM "VV" that her fan was so dusty that the dust blew off onto her face and into her eyes. HAM "VV" confirmed the two fans should have been cleaned. | | | |