STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824350	A. BUILDING _____ B. WING _____	**2/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS NURSING CENTER OF WESTLAND	**8365 NEWBURGH RD WESTLAND, MI 48185**

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F0000 SS=	INITIAL COMMENTS Four Seasons Nursing Center of Westland was surveyed for a Recertification survey on 2/12/25. Intakes: MI00149130, MI00149414, MI10049638, MI00149900, MI00149902, and MI00150143. Census: 161 (Facility Name) was surveyed for a Recertification survey on (Exit Date). Intakes: Census:	F0000		
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide timely repositioning for four dependent residents (R34, R44, R97, R118) of five reviewed for positioning. Findings include: **Resident #34**	F0684	Element #1 Residents #34, #44, #97, and #118 continue to reside at the facility. IDT has reviewed the plan of care for residents #34, #44, #97, and #118 to ensure they have not experienced skin breakdown. Element #2 Residents currently residing in the facility who require assistance with repositioning have the potential to be affected by the deficient practice. Residents currently residing in the facility who require assistance for repositioning have been identified and skin assessments completed to ensure they experienced no skin breakdown. Element #3 The facility policy on “Repositioning” has been reviewed and deemed appropriate. Licensed Nursing staff and CNAs have been re-educated on the “Repositioning” policy and procedure. Element #4 The Nurse Managers or designee will conduct	3/7/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/23/2025

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

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	On 02/10/25 at 9:38 AM, 12:29 PM, 1:54 PM, and 2:35 PM, R34 was observed to be on their backside in a specialty bed with the head of the bed elevated around 30-45 degrees and a foam wedge was on the mattress at the foot of bed. On 02/11/25 at 8:10 AM, 8:35 AM, 9:30 AM, and 11:41 AM, R34 was observed to be on their backside in bed and a foam wedge was on the mattress at the foot of bed. The head of the bed was up around twenty or thirty degrees. On 02/11/25 at 12:09 AM, 12:39 PM, and 12:43 PM, R34 was observed to be in bed dressed in a hospital style gown, turned toward the door. A foam wedge was visible behind the torso on the left side. At 12:51 PM, 2:02 PM, and 2:59 PM, the head of the bed was around 45 degrees and the wedge was behind the torso at the left side. R34 leaned over to the right edge of the bed. At 2:01 PM staff entered the room. At 2:02 PM, R34 was observed to be in bed as before with the wedge to the left side. On 02/12/25 at 8:04 AM, R34 was observed to be in bed with the head of the bed up around 45 degrees and the foam wedge was behind the torso at the left side. R34 leaned over to right edge of the bed. A review of the record for R34 revealed R34 was admitted into the facility on 03/12/15. Diagnoses included Dementia, Diabetes,		random audits of 10 residents who require assistance with positioning to ensure timely repositioning per their plan of care weekly x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected and findings will be reported to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Director of Nursing is responsible for continued monitoring and regulatory compliance. Date of compliance 3/7/25	

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	Heart Disease and Stroke. A review of the care plan initiated 05/23/19 documented, "...has alteration in mobility... reposition in bed or gerichair at least q (every) two hours and prn (as needed)..." The Minimum Data Set (MDS) assessment dated 12/22/24 documented severely impaired cognition, impaired range of motion to the upper and lower extremities on one side, and required substantial or maximal assistance to roll left and right. R34 required substantial or maximal assistance or was dependent for all activities of daily living except eating. **Resident #44** On 02/10/25 at 9:53 AM and 12:31 PM, R44 was observed to be on their backside in a specialty bed. On 02/11/25 at 8:20 AM, 9:27 AM, and 11:51 AM, R44 was observed to be on their backside in bed dressed in a hospital style gown. At 12:13 PM, hospice staff entered the room and elevated the head of the bed R44 remained on their backside in bed. At 12:42 PM and 1:45 PM, R44 appeared on their backside in bed with the head of the bed elevated around 45 degrees. A review of the record for R44 revealed R44 was admitted into the facility on 12/16/22. Diagnoses included Parkinson's, Pulmonary Disease and Stroke. A review of the care plan initiated 12/18/22 documented a self care deficit and bed mobility was a two person			

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	assist and R44 required "frequent turning and repositioning." The Minimum Data Set (MDS) assessment dated 11/29/24 documented impaired cognition, impaired range of motion to one or both the upper and lower extremities, and required substantial or maximal assistance to roll left and right. R34 required substantial or maximal assistance or was dependent for all activities of daily living. **Resident #97** On 02/10/25 at 4:01 PM, R97 was observed to be on their backside in bed, dressed in a hospital style gown, their head was on the left corner of the pillow and the body down in the bed. The head of the bed was elevated. R97's legs were flexed in a frog legged position. No positioning devices were visible at the sides. On 02/11/25 at 8:21 AM, 8:55 AM, 11:39 AM, 12:46 PM, and 12:52 PM, R97 was observed to be on their backside in bed with the head of the bed elevated around 45 degrees. R97's legs were flexed in a frog legged position. No positioning devices were visible at the sides. On 02/12/25 at 9:34 AM and 1:52 PM, R97 was observed to be on their backside in bed with the head of the bed elevated around 45 degrees. R97's legs were flexed in a frog legged position. No positioning devices were visible at the sides. A review of the record for R97 revealed R97			

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	was admitted into the facility on 05/23/20. Diagnoses included Dementia, Paralysis of the left side, Stroke and Contracture of the Left Knee. The care plan initiated 05/23/20 documented a self care deficit and bed mobility required a two person assist. The "risk for pressure ulcer formation" care plan documented the need for "surface support, pressure redistribution, position changes and offloading." The Minimum Data Set (MDS) assessment dated 11/22/24 documented severely impaired cognition, impaired range of motion to both the upper and lower extremities, and required substantial or maximal assistance to roll left and right. R97 required substantial or maximal assistance or was dependent for all activities of daily living. **Resident #118** On 02/10/25 at 12:00 PM, 12:54 PM, 2:06 PM and 4:06 PM, R118 was observed to be on their backside in bed on a specialty mattress, specialty boots on the feet, and the head of the bed around 20-30 degrees. No devices were observed to position R118. Per a physician note dated 2/6/25, R118 had a pressure wound to the coccyx (tailbone). On 02/11/25 at 11:55 AM, 12:55 PM, 2:06 PM, and 2:33 PM. R118 was observed to be on their backside in bed with the head of the bed around 20-30 degrees. No devices were observed at the sides of the torso to position R118 off the coccyx wound area. The resident did not make any attempts to move.			

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	On 02/11/25 at 2:33 PM, Certified Nursing Assistant (CNA) "C" entered the room of R118. At 2:39 PM, along with CNA "C" , R118 was observed with no positioning devices seen at the sides of the torso. On 02/11/25 at 2:59 PM, R118 appeared in the same position as before. On 02/12/25 at 10:05 AM, R188 was returned from dialysis to the hallway outside their door. R188 was on their backside in the recliner. On 02/12/25 at 11:27 AM, a wound observation of the coccyx wound was completed with the wound care nurse. R118 was observed to be on their backside in bed. A flat pillow was observed under the left shoulder area of R118. The pillow did not provide any visible turn or position change. A review of the record for R118 revealed R118 was admitted into the facility on 03/21/24. Diagnoses included Dementia, Diabetes and Pressure Ulcer of the Sacral (lower back, coccyx) Region. The care plan initiated 03/22/24 documented a self care deficit and bed mobility required a two person assist. The "actual pressure injury" care plan also documented the need for "...frequent turning and repositioning..." The Minimum Data Set (MDS) assessment dated 12/28/24 documented severely impaired cognition, impaired range of motion to both			

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	the upper and lower extremities, and R118 was dependent on staff to roll left and right. R118 was dependent for all activities of daily living. On 02/12/25 at 8:11 AM, the Director of Nursing (DON) reported residents unable or who don't reposition themselves should be turned frequently and did not provide specific time frames. It was noted that the standard was to reposition every two hours at least. At 11:14 AM the DON reported repositioning was required even with a specialty mattress in place. A review of the facility policy titled, "Repositioning" issued 08/09/23 revealed, "The purpose of this procedure is to provide guidelines to promote comfort, assist in preventing skin breakdown, promote circulation and provide pressure relief for bed bound and chairbound residents... Resident who are immobile and/or dependent on staff for repositioning should be repositioned at least every two hours..."			
F0693 SS= D	Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical	F0693	Element #1 Resident #119 continues to reside at the facility. Resident #119's tube feeding formula has been reviewed and physician order has been verified. Element #2 Newly admitted residents requiring tube feeding the potential to be affected by the deficient practice. Current residents residing in the facility who receive tube feeding have	3/7/2025

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	condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer the correct tube feeding formula for one resident (R119) of four reviewed for tube feeding. Findings include: On 2/10/25 at 9:46 AM, R119 was observed lying in bed. A bottle of Jevity 1.5 tube feeding dated 2/9/25 was observed to be hanging on a pole in their room. On 2/11/25 at 9:19 AM, two bottles of Jevity 1.5 tube feeding, one of which was dated 2/10/25 and the other dated 2/9/25 was observed in the trash can next to R119's bed. A review of R119's record revealed they were admitted to the facility on 10/16/24 with the following diagnosis: Benign Neoplasm of Meninges (brain tumor) and Dysphagia, oropharyngeal (inability to swallow). Further record review revealed a Brief Interview for Mental Status score of 11 indicating moderate cognitive impairment. A review of R119's physician orders revealed the following: active order dated 1/29/25 "Enteral feed two times a day Nutren 2.0 @88ml/hr		been reviewed to ensure the correct formula is administered per physician order and the physician order is entered under "enteral" category. Element #3 The policy titled “Tube Feeding- Overview” has been reviewed and deemed appropriate. Facility dietitian has been re-educated on the policy with a focus on reviewing physician orders during the admission review of tube feeding orders. Licensed nurses have been educated on ensuring enteral feeding orders are entered under “enteral” category. Element #4 The Dietitian or designee will conduct random audits of 3 newly admitted residents who require tube feeding to ensure the correct tube feeding formula is ordered by the provider. The audit will occur weekly x4 weeks then monthly x2 months. The Nurse Managers or designee will conduct random audits of 5 residents who require tube feeding to ensure the correct tube feeding formula is being administered. The audit will occur weekly x4 weeks then monthly x2 months. Deficiencies will be immediately corrected and findings will be reported to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. The Director of Nursing is responsible for continued monitoring and regulatory compliance. Date of compliance 3/7/25	

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	(milliliters per hour) x 12 hours providing 1056ml (hang 5 pm to 5 am) with autoflush of 80ml/hr x 12 hrs providing 960ml fluids." A second active order dated 1/25/25 "Jevity 1.5 55ml/hr provides 1320ml, Flush 30ml to provide 1873ml one time a day for nutrition." A review of R119's Febuary 2025 Medication Administration Record (MAR) revealed both Nutren and Jevity were listed and both marked as given on 2/1/25-2/10/25 A review of R119's progress note revealed the following dietician notes: 1/27/25 "Resident readmitted to facility, TF (tube feeding) orders adjusted with plans plans to get resident back to TF orders that (they) were on prior to going out to facility. WIll continue to monitor resident's tolerance of titrating up to goal of 88ml/hr (mililiters per hour) x 12 hrs (hours) with autoflush of 80ml/hr x 12 hrs. Current orders are Nutren 2.0 @65ml/hr x16 hrs with autoflush of 60ml/hr (hang 4pm to 8 am). Resident is noted to have significant weight gain upon returning to facility. Resident did recieve IV (intravenous) fluids in hospital which could have contributed to weight gain. Full nutritional assessment in progress." 1/28/25 "Increase feedings to 75ml/hr X 14 hrs providing 1050ml, 2100Kcal, 88gm protein, 726ml free water with autoflush of 70ml/hr x14 hr providing 960ml additional fluids plus 20-30ml with medications, and 150ml q (every) shift-100% needs met via PEG (percutaneous endoscopic gastrostomy). WIll continue to monitor tolerance of new orders." 1/29/25 " ...Resident is NPO (nothing by mouth) diet order and enteral feedings. ENN (enteral			

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	nutrition) is 1900-2100 for wt (weight) gain. Residents goal for enteral feeding is Nutren 2.0 88ml/hr x 12 hrs providing 1056ml, 2112kcal (kilocalories), 88gm (gram) protein, and 739ml fluids with autoflush of 80ml/hr x 12 hrs with 150ml flush q (every) shift and additional fluids of 20-30ml with medications ..." On 2/12/25 at 9:52 AM, Licensed Practical Nurse (LPN "B") confirmed R119 has been getting Jevity 1.5 tube feeding from 5 pm to 5 am daily. After reviewing R119's orders, LPN "B" confirmed R119 should have been receiving Nutren instead of Jevity and explained both tube feeding orders were active but the order for Nutren was placed by the dietician and was more recent than the order for Jevity. On 2/12/25 at 10:23 AM, The Registered Dietician (RD) explained they write the orders for tube feeding and the formula and rate is calculated based on the individual resident's nutritional needs and R119 was receiving Nutren 2.0 at 88ml/hr for 12 hours to provide their nutritional needs. After reviewing R119's record the RD confirmed there was also an order for Jevity 1.5 that had been entered by a nurse. The RD explained nurses do not typically enter tube feeding orders. After reviewing R119's February 2025 MAR the RD confirmed both Nutren and Jevity were marked as given on 2/1/25-2/10/25. On 2/12/25 at 10:42 AM the Director of Nursing (DON) explained there should only be one order for tube feeding entered by the dietician and that order should be followed. A review of the facility's policy titled "Tube Feeding-Formula Administration, Flushing, and Unclogging" revealed: "Verify physicians order." Prior to administration.			

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F0759 SS= D	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent resulting in two medications errors in 32 opportunities for a 6.25% medication error rate. Findings include: On 02/11/25 at 9:03 AM, a medication pass observation was conducted with Registered Nurse (RN) "F" for R108. The Lanthanum Carbonate, 1000 mg (milligram) supplement was not available to be given. RN "F" attempted to pull two calcium carbonate 500 mg tablets and was then asked to review the order. The Lanthanum carbonate was not given. A review of the January 2025 and February 2025 Medication administration record and electronic medical record medication progress notes documented the medication was not given and or not available. The February 2025 MAR documented the medication had been given 19 times. A pharmacy receipt request for the Lanthanum Carbonate was requested and a response via email dated 03/12/25 at 2:14 PM by the Director of Nursing revealed, "Discussed again with dialysis regarding this medication - Order was active, but labs	F0759	Element 1 Residents #108, #60, and #40 continue to reside in the facility. Resident #108 labs were reviewed with dialysis and the medication order was discontinued. Residents #60 and #40 bowel movements were evaluated and no ill effects were noted. Element 2 Residents residing in the facility who receive oral medications have the potential to be affected by the deficient practice. Medication carts were audited to ensure all medications ordered were available. Element 3 The policy titled "Medication Administration" was reviewed and deemed appropriate for education. Licensed nurses have been re-educated on the policy with a focus on adhering to the rights of medication administration. Element 4 The Nurse Managers or designee will complete audits of medication administration by a licensed nurse to ensure the accurate medication is being administered. Five licensed nurses will be audited for accuracy of medication administration. The audit will occur weekly x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected and findings will be reported to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. The Director of Nursing is responsible for continued monitoring and regulatory compliance. Date of Compliance 3/7/25	3/7/2025

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	drawn on 1/31 at facility indicated normal phosphorus levels and 2/4 labs drawn in dialysis indicated level was low so they continued to monitor and nephrology requested no phosphorous binders so it was not delivered by them. They rounded at facility and indicated medication order should be discontinued and that (R108) should not have received the medication since (their) return from the hospital." On 02/12/25 at 8:22 AM, RN "H" was observed to prepare medications for R60. RN "H" dispensed a Sennasides 8.6 mg pill from the over the counter stock instead of the ordered Sennasides with Docusate Sodium 8.6 mg/50 mg pill. On 02/12/25 at 9:52 AM, Licensed Practical Nurse (LPN) "I" was observed to prepare medications for R40. LPN "I" dispensed two Sennasides 8.6 mg pills from the over the counter stock instead of the ordered Sennasides with Docusate Sodium 8.6 mg/50 mg pills. On 02/12/25 at 11:14 AM, the medication concerns were reviewed with the Director of Nursing who reported they would check into the concerns. A review of the facility policy titled, "Medication Administration" issued 08/07/23 revealed, "...Medications are administered in accordance with the following rights of medication administration: Right resident,			

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FOUR SEASONS NURSING CENTER OF WESTLAND	8365 NEWBURGH RD WESTLAND, MI 48185

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	Right medication, Right dose, Right route, Right time and frequency ...Read transcribed physician order on the MAR: resident name, medical?on name, dosage, route, and interval ordered..." A review of the facility policy titled, "Medication Error" issued 08/23/23 revealed, "...A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. Examples of medications errors include: Omission - a drug is ordered but not administered. Unauthorized drug - a drug is administered without a physician ' s order. Wrong dose (e.g., Dilantin 12 mL ordered, Dilantin 2 mL given). Wrong route of administration (e.g., ear drops given in eye). Wrong dosage form (e.g., liquid ordered, capsule given). Wrong drug (e.g., vibramycin ordered, vancomycin given)..."			
F0761 SS= D	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with	F0761	Element #1 No specific resident was identified in the citied deficient practice. Upon notification, the unlabeled/undated inhalers and vials were removed from the medication carts and medication storage rooms. Element #2 All currents residents residing in the facility receiving inhalers, insulin, and tuberculin	3/7/2025

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	State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications were dated when opened in two of five medications carts and two of two medication rooms reviewed. Findings include: On 02/12/25 at 8:43 AM, the Spring unit front cart was reviewed with Regeistered Nurse (RN) "H" revealed an Arnuity inhaler was not labeled with a resident identifier and not dated when opened on the inhaler nor the box. On 02/12/25 at 9:01 AM, the Spring unit back cart was reviewed with Licensed Practical Nurse (LPN) "J" a lispro insulin was not dated when opened and was without a resident identifier. On 02/12/25 at 11:12 AM, the Winter		derivative injections have the potential to be affected by the deficient practice. All 8 Medication Carts and 4 Medication Storage rooms have been inspected for properly dated/labeled medications and vials. Element #3 The facility policy “Storage of Medication/Biologicals” has been reviewed and deemed appropriate. Licensed Nurses have been re-educated on the policy “Storage of Medication/Biologicals” with the focus on the importance of labeling and dating medications per policy and manufactures guidelines. Element #4 The Nurse Managers or designee will conduct random audits of the 8 Medication Carts and 4 Medication Storage Rooms to ensure proper labeling, dating, and storage. The audit will occur weekly x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected and findings will be reported to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. The Director of Nursing is responsible for continued monitoring and regulatory compliance. Date of compliance 3/7/25	

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	medication storage room was reviewed with LPN "K", one tuberculin derivative vial was not dated when opened on the vial nor the box. On 02/12/25 at 11:51 AM, the Summer medication storage room was reviewed with LPN "J", one tuberculin derivative vial was not dated when opened on the vial. On 02/12/25 at 11:14 AM, the Director of Nursing (DON) reported the tuberculin vials should be dated when opened. A review of the manufacturer's insert for the tuberculin vial revealed, "...Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..." A review of the prescribing information for the Arnuity Inhaler revealed, "Arnuity Ellipta should be stored inside the unopened moisture-protective foil tray and only removed from the tray immediately before initial use. Discard Arnuity Ellipta 6 weeks after opening the foil tray or when the counter reads "0" (after all blisters have been used), whichever comes first..."			
F0805 SS= F	Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by:	F0805	Element #1 There were no specifics residents identified in the citied practice. Upon notification the pan of puree carrots was immediately discarded. Element #2 All residents currently residing in the facility with physician orders for pureed diets have	3/7/2025

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	Based on observation, interview, and record review, the facility failed to ensure pureed food items were of the proper consistency. This deficient practice had the potential to affect all 9 residents receiving a pureed diet texture. Findings include: 02/10/25 at 12:15 PM, the lunch tray-line service was observed in the main kitchen. A pan of pureed carrots was observed on the steam table. The mixture was observed with visible small chunks of orange carrot bits, mixed in with a pale orange viscous substance. On 02/10/25 at 12:25 PM, a puree test tray was obtained. A taste test of the pureed carrots revealed small chunks of carrots, that required chewing before swallowing. On 02/10/25 at 12:30 PM, Dietician "M" and Chef "L" were shown the pureed carrots and asked if the texture looked acceptable for a pureed diet. Both stated the pureed vegetable was not the proper consistency, and that the vegetable would be pulled from the steam table and re-made. According to an IDDSI (International Dysphagia Diet Standardization Initiative) chart posted in the facility kitchen, for a pureed diet, the appearance should be smooth, and the texture should be like pudding with no lumps.		the potential to be affected by the deficient practice. Element #3 Dietary staff to include cooks and aides have been re-educated on the IDDSI chart posted in the facility kitchen for a purred diet to ensure the appearance is a smooth and the texture should be like pudding without lumps. Element #4 The Dietary Manager or designee will conduct audits of pureed food items to ensure appearance of purred food is smooth and texture is like pudding without lumps 3xWK x 4WKs then 1xWK x 4WKs. Deficiencies will be immediately corrected and findings will be reported to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Dietary Manager is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance. Date of compliance 3/7/25	

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F0880 SS= D	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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 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	F0880	Element #1 Residents #26 and #122 continue to reside at the facility and have had urinal holders placed on the beds. Resident #135 is currently not residing in the facility. Element #2 Current residents residing in the facility who use urinals have the potential to be affected by the citied deficient practice. Residents currently residing in the facility who use urinals have been provided with urinal holders on beds. Element #3 The facility policy “Infection Control-Standards and Transmission-Based Precautions” has been reviewed and deemed appropriate. Licensed Nursing staff, CNAs, and current residents using urinals have been re-educated on the policy “Infection Control-Standards and Transmission-Based Precautions” with the emphasis of not putting urinals on the bedside tables to ensure urinals are not placed on bedside tables and are placed in the holders when not in use. Element #4 The Infection Control Nurse or designee will conduct random audits of 5 residents with urinals to ensure urinals are removed from bedside tables. The audit will occur weekly x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected and findings will be reported to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. The Director of Nursing is responsible for continued monitoring and regulatory compliance. Date of compliance 3/7/25	3/7/2025

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	disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain infection control practices by removing used urinals from overbed tables for three residents (R26, R122, 135) out of three residents reviewed for infection control practices. Findings Include: R26 On 02/10/25 at 9:15 AM, R26 was observed laying in bed watching television and a urinal half filled with yellowish urine sitting on over bed table. The resident was preparing for breakfast. A review of R26's medical record revealed R26 was admitted on 11/07/23 with diagnoses of atherosclorotic heart disease, muscle weakness, and atrial fibrillation. A review of R26's Minimum Data Set (MDS)			

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	assessment dated 11/13/2024 revealed a Brief Interview of Mental status (BIMS) assessment of 15/15 indicating resident is cognitively intact. R22 On 02/10/25 at 9:20 AM, R122 was observed laying in bed watching television with a urinal noted quarter filled with yellowish urine sitting on the over bed table. R122 had recently had breakfast and tray was being being picked up by staff. A review of R122's medical record revealed R122 was admitted on 3/20/24 with diagnoses of cervical disc disorder and anemia. A review of R122's Minimum Data Set (MDS) assessment dated on 12/26/2024 revealed a Brief Interview of Mental Status (BIMS) assessment of 10/15 which indicated resident had moderate cognitive impairment. R135 On 02/10/25 at 9:30 AM, R135 was observed sitting up halfway in bed in their room. R135 was noted with a urinal filled with yellowish urine sitting on the over bed table. A review of R135's medical record revealed R135 was admitted on 1/01/24 with the diagnoses of fracture of lower end of right ulna, disorder of the muscle, and osteoarthritis. A review of R135's Minimum Data Set (MDS) assessment dated on 1/08/25			

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	revealed a Brief Interview of Mental Status (BIMS) assessment of 9/15 indicating moderare cognitive impairment. On 2/12/25 at 10:15 AM, an interview was held with the Infection Control Nurse "A". Nurse "A" asked about residents' urinals on over bed table. Nurse "A" confirmed urinals should not be stored on overbed tables. A review of the facility policy titled, "Infection Control - Standard and Transmission-Based Precautions" revealed the following: "To provide guidelines for standard and transmission-based precautions to control the spread of infection to residents, visitors, and employees...Standard precautons are designed to reduce the risk of transmittng microorganisms from both recognized and unrecognized sources of infection in healthcare settings. Standard precautions are designed to protect both employees and residents from contact with infectious agents. Standard precautions relate to: Blood, Bodily fluids, secretions, and excretions, Non-intact skin, Mucous membranes. Standard precautions include: Hand hygiene (handwashing with soap and water or use of an alcohol-based sanitizer), and Personal protective equipment (PPE) when exposure to blood, body fluids, excretions, and secretions."			
F0919 SS= D	Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff	F0919	Element #1 Residents #42 and #24 are currently residing in the facility. Residents #42 and #24's call	3/7/2025

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	assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for two (R42, R24) of two dependent residents. Findings include: R42 On 02/12/25 at 9:13 AM, R42 was observed to be in a recliner at the nurse's station outside the door to the dining room. At 10:19 AM, R42 was observed to have been returned to bed and changed into a hospital style gown. The call light was tucked under the left edge of pillow for their head. R42 was asked if they could reach the call light. R42 attempted to reach the light with their right hand but was not able to reach the call light. R42 was not able to move their left arm to reach the light. R42 reported it had been affected by a stroke. A review of the record for R42 revealed R42 was admitted into the facility on 12/11/19. Diagnoses included Stroke and Heart Disease. The care plan initiated 06/18/20 documented an "alteration in mobility" related to "limited range of motion to the left		lights were inspected upon notification to ensure proper clip on call light and proper placement of call light within resident reach. Element #2 Residents currently residing in the facility have the potential to be affected by the cited deficient practice. Residents currently residing in the facility call lights have been inspected to ensure call light has a proper clip and is within resident reach. Element #3 The facility policy on “Call light Accessibility and Timely Response” has been reviewed and deemed appropriate. Facility staff has been re-educated on the policy “Call light Accessibility and Timely Response” with the focus on the importance of proper placement of the call light within resident reach. Element #4 The Nurse Managers or designee will conduct random audits of 10 residents to ensure their call light is within reach. The audit will occur weekly x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected and findings will be reported to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. The Director of Nursing is responsible for continued monitoring and regulatory compliance. Date of compliance 3/7/25	

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	shoulder." The care plan did not provide an intervention for call light placement. The care plan initiated 12/11/19 documented a "self care deficit" and the need for feeding assistance with meals, and bed mobility required a two person assist. R24 On 2/10/25 at 9:29 AM, R24 was observed lying in bed with the call light hanging on the wall behind the bed, out of the residents reach. At 12:10 PM, 1:48 PM, and 3:16 PM, R24 was observed in bed with the call light hanging on the wall behind the bed out of reach. When asked if they could reach their call light R24 responded "no". When asked what they would do if they needed help, R24 responded "I don't know." On 2/11 at 9:27 AM, and 12:31 PM, R24 was observed in bed with the call light hanging on the wall behind the bed out of reach. A review of R24s record revealed they were admitted to the facility on 8/19/24 with a diagnosis of Unspecified Dementia. Further review of R24s record revealed a Brief Interview for Mental Status (BIMS) score of one, indicating severe cognitive impairment. On 2/12/25 at 10:01 AM, Licensed Practical Nurse (LPN) "E" confirmed every resident should have call light within reach. On 2/12/25 at 10:42 AM, the Director of Nursing (DON) explained call lights should always be in reach. A review of the facility's policy titled: "Call Light Accessibility and Timely Response" revealed the			

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	following: "...Staff will ensure the call light is plugged in, functioning, within reach of residents, and secured, as needed. The call system will be accessible to residents while in their room at bedside as well as in the bathroom and shower room."			