STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504014	A. BUILDING _____ B. WING _____	3/5/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBY HEALTH AND REHABILITATION CENTER	46100 SCHOENHERR RD SHELBY TOWNSHIP, MI 48315

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F0000 SS=	INITIAL COMMENTS Shelby Health and Rehabilitation Center was surveyed for a Recertification survey on 3/5/25. Intakes: MI00150801, MI00150907, MI00150437, MI00150481, MI00150560, MI00150136, and MI00150927. Census:199	F0000		
F0578 SS= D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the	F0578	F578 (D) (Request/Refuse/Discontinue treatment, formulate, advance directives) Element 1: Cited Residents R106 continues to reside in the facility and has had no change in health status due to the identified practice. The facility failed to obtain a physician□s order for an advance directive upon admission for 1 of 2 residents reviewed. A physician order was obtained for the identified resident upon identification of deficiency. A one-to-one education was completed to the identified staff member. Element 2: Like Residents All current residents in the facility have the potential to be impacted by the identified practice. Advance Directives policy was reviewed and deemed appropriate. An audit was completed for all residents to ensure an order was obtained for advance directive; no concerns were identified. Element 3: Education Licensed nurses and Social Workers will be re-educated on obtaining a physician order for Advance directive upon admission and when the Advance directive wishes change. Element 4: Audits	4/1/2025

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

Electronically Signed | 03/23/2025

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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	facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain a physician's order for an advance directive (form designed to communicate health care treatments in advance) upon admission for one resident (R106) out of two reviewed for advance directives. Findings include: A review of the medical record revealed R106 admitted into the facility on 2/7/2025 with the following medical diagnoses, Cerebral Infarction and End Stage Renal Disease. A review of the most recent Minimum Data Assessment set revealed a Brief Interview for Mental Status score of 8/15 indicating an impaired cognition. R106 also required staff assistance with bed mobility and transfers. Further review of the physician orders revealed there was no advance directive order in place. On 3/5/2025 at 9:15 AM, an interview was conducted with Social Worker (SW) "J". SW "J" stated the admitting nurse puts the code		DON or designee will complete random audits on all new admissions for the week for 4 weeks then monthly x2 months to ensure all residents have a physician order for Advance directive. DON will identify trends in areas for process improvement during regularly scheduled QA meetings for review and recommendations. Information identified will be used to drive additional training for the Licensed Nurses. Element 5: Compliance Date of Compliance: 4/1/25	

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	status order in on admission and that social work reviews it at the care conference. SW "J" stated that the nursing staff is responsible for putting the advance directive orders in and confirming them. On 3/5/2025 at 12:03 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the advance directive order should be entered upon admission. The DON stated they were unaware of why it was not completed with R106. A review of a facility policy titled, "Advance Directives-Code Status" revealed the following, " ...If the resident and/or their legal representative has chosen for the resident's code status to be a Full Code: o The physician's order for Full Code status will be entered into Point Click Care (PCC) using the template in the order's tab. From the physician order the resident's Full Code status will auto-populate and be prominently displayed on the resident's chart header in PCC and will also populate to the resident's face sheet."			
F0644 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	F0644	F644 (D) (Coordination of PASARR and Assessments) Element 1: Cited Residents R121 continues to reside in the facility and has had no change in health status due to the identified practice. The facility failed to complete an annual PASARR for 1 resident of 2 residents reviewed for PASARR screening. PASARR was completed for the identified resident upon identification of deficiency. The	4/1/2025

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	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete an annual PASARR (Preadmission Screen and Resident Review) for one resident (R121) of two residents reviewed for PASARR screening. Findings include: On 03/03/25 at 09:45 AM, R121 was observed lying in bed finishing his breakfast meal. A review of R121's medical record revealed they were admitted into the facility on 3/08/23 with the following diagnoses of vascular dementia, major depressive disorder, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and dysphagia. A Minimum Data Set (MDS) assessment dated 01/22/25 and a Brief Interview for Mental Status (BIMS) score of 12, indicating an mild impairment with cognition. R121 also scored 9 on The Patient Health Questionnaire which indicates severe depression. Further review of R121 medical record		identified staff member is no longer employed at facility. Element 2: Like Residents All newly admitted residents, residents with significant change in physical/mental condition and residents with annual due assessments have the potential to be affected by the identified practice. PASARR policy was reviewed and deemed appropriate. An initial audit for residents requiring an admission, annual and change of condition PASARR assessment. No concerns were identified. Element 3: Education Social workers were re-educated on completing PASARR assessment upon admission, with a change in physical/mental condition and annually. Element 4: Audits Social Work Director or designee will complete audits on 5 residents a week x 4 weeks then monthly x2 months requiring an annual PASARR assessment to ensure documentation is completed in a timely manner. The Social Work Director will identify trends in areas for process improvement during regularly scheduled QA meetings for review and recommendations. Information identified will be used to drive additional training for the Social Work department. Element 5: Compliance Date of Compliance: 4/1/25	

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	revealed a PASARR dated 10/8/23. On 03/05/25 at 12:15 PM an interview occurred with Social Worker "C" regarding an updated PASARR for R121. Social Worker "C" confirmed there was not an updated PASARR completed and confirmed PASARR should be updated annually. A request for a facility policy related to PASARRs was requested and not received by the end of survey.			
F0656 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) 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	F0656	F656 (D) (Develop/Implement Comprehensive Care Plan) Element 1: Cited Residents R51 continues to reside in the facility and has had no change in health status due to the identified practice. The facility failed to ensure comprehensive care plans were developed and updated for 2 of 6 residents reviewed care plans. R51 care plan was not reviewed / updated with increased behaviors and refusal of care. The care plan was reviewed/updated for the identified resident upon identification of deficiency. The identified staff member who failed to update care plan is no longer employed at facility. R89 continues to reside in the facility and has had no change in health status due to the identified practice. Care plan was not updated to include 1) appropriate interventions corresponding with the ordered NPO diet, 2) improved ADL problem and status, 3) discontinuation of neck brace as ordered by physician and 4) updated (B) hand splint wearing schedule change. The care plans were reviewed and updated for the cited residents upon identification of deficiency. A	4/1/2025

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	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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility failed to ensure comprehensive care plans were developed and updated for two (R51 and R89) of six resident reviewed care plans. Findings include: R51 A review of R51's medical record revealed they were admitted to the facility on 7/01/24 with diagnoses including mild dementia, generalized anxiety disorder, adjustment disorder and hypertensive heart disease. A review of R51's Minimum Data Set assessment dated 1/07/25 revealed the Brief Interview for Mental Status score of 15 indicating an intact cognition.		one-to-one education was completed to the identified staff members. Element 2: Like Residents Current residents of the facility with increased behaviors and physician orders changing an orthotic device wearing schedule have the potential to be impacted from the identified practice. Care Plan Comprehensive and Revision policy was reviewed and deemed appropriate. INITIAL AUDIT: The facility reviewed care plans of residents with: 1. Increased behaviors to ensure care plan is updated, 2. NPO residents to ensure care plan is accurate and up to date, 3. change in ADL status to ensure care plan is updated, 4. Orthotic devices to ensure care plan is updated and proper orthotic wearing schedules are accurate based on physician orders Any concerns identified were corrected. Element 3: Education Therapy staff, Social Workers, Dietician and the IDT members were re-educated on reviewing/updating the residents plan of care with any changes. Element 4: Audits The Social Work Director or designee will complete audits on 10 residents with identified increase in behavior weekly x 4 weeks then monthly x2 months to ensure resident plan of care is reviewed/updated and deemed appropriate. The Therapy Director or designee will complete audits on 10 residents with improved ADL status weekly x 4 weeks then monthly x2 months to ensure all care plans are accurate and updated in a timely manner. The Therapy Director or designee with completed audits on 10 residents with Orthotic devices to ensure care plan is	

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	Further review of R51's medical record revealed increased behaviors of refusal of care and assistance. Per a nursing progress note dated 2/07/25, R51 had a behavior of speaking loudly to the roommate and being upset about a window being open. The medical record indicated R51 refused bathing and assistance at least weekly during the month of February 2025. Review of the behavioral care plan initated 7/9/24 with interventions revealed there was no review or updated interventions for increased behaviors noted on February, 2025. On 03/05/25 at 12:15 PM, Social Worker "C" was interviewed regarding R51's care plan and interventions for the increased behaviors and refusal of care. Social Worker "C" said resident care plans are updated by the interdisciplinary team and confirmed there were no updates added to the care plan to address recent behaviors. R89 On 3/03/25 at 10:45 AM R89 was observed lying in bed. R89 explained they get nutrition by tube feeding and they cannot have any food or water by mouth. R89 explained they only get out of bed into a chair when therapy is present and they are supposed to have hand splints but, no one applies them. A review of R89s record revealed they were admitted to the facility on 8/14/25 for Unspecified injury at unspecified level of cervical		updated based on physician orders. The Registered Dietitian or designee with complete audits on all NPO residents weekly x 4 weeks then monthly x 2 months to ensure care plan interventions are appropriate and correspond with the NPO status. The Therapy Director, Social Work Director and Registered Dietitian will identify trends in areas for process improvement during regularly scheduled QA meetings for review and recommendations. Information identified will be used to drive additional training for the Therapy and Social Work staff. Element 5: Compliance Date of Compliance: 4/1/25	

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	spinal cord. Further review revealed a Brief Interview for Mental Status Score of 15, indicating intact cognition. A review of R89's care plan revealed the following: "Resident is NPO (nothing by mouth) with all nutrition and hydration provided via feeding tube dysphagia, bolus of Novasource renal." Dated 12/23/24 "Encourage low fat, low salt intake." Dated 12/31/24 "Monitor fluid intake to determine if natural diuretics such as coffee, tea, or cola is contributing to increased urination and incontinence." Dated 12/31/24 "Resident is not able to use B/L UE/LE (bilateral upper extremeties/lower extremeties) due to paralysis."Dated 12/27/24 "locomotion: gerichair (assistive device) with 1 person physical assist, with gait belt." Dated 12/21/24 "Transfer: hoyer x2, cervical collar on at all times, cervical precautions." Dated 12/21/24 "Bed mobility:x2, cervical collar on at all times cervical precautions." Dated 12/21/24 "Assist resident with ADLs (activities of daily living) and ambulation as needed." Dated 12/31/24 "Orthotics: (B) resting hand splints to be worn during the day. Remove & assess skin integrity and skin hygiene." 1/9/25			

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	" Restorative splint/brace1-B resting hand splints, to be worn at night as tolerated, remove for hygiene/skin checks. Dated 1/15/25" "orthosis: neck brace to be worn at all times." Dated 1/15/25 A review of R89's physician orders revealed the following active orders: "Enteral feed five times a day Enteral Nutrition Formula Name: TWOCAL HN 1 can (237ml) five times a day. Flush with 50ml water pre and post." dated 1/28/25. "Orthosis/Splint to be applied to:B resting hand splints to be worn at night, as tolerated. Every shift on in the evening." Dated 1/15/25 On 3/04/25 at 3:12 PM, the Therapy Director (Staff "K") reviewed R89's careplan when asked if R89 should be wearing a neck brace or hand splints. Staff "K" explained R89 was admitted on paraplegic cervical precautions and the neck brace was discontinued after R89's three month post operative doctor appointment around the 1st week of February. Staff "K" confirmed that the neck brace was still on the care plan and that it should have been removed. Staff "K" explained that R89 should be wearing hand splints during the day but explained they would have to get clarification due to conflicting information on the care plan. On 3/05/25 at 10:31 AM, the Director of Nursing (DON) explained careplans are a collaborative effort among the interdisciplinary team and they are created on admission and then they are updated in the morning meeting if there is a change. R89's care plan was reviewed with the DON and the DON confirmed R89's care plan was not updated nor did it reflect R89's current			

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	condition. A facility policy addressing careplans was requested and was not returned by the completion of the survey.			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide sufficient feeding assistance for one resident (R142) out of one reviewed for Activities of Daily Living (ADL). Findings include: On 3/3/2025 at 12:07 PM, R142's lunch tray was observed sitting on the bedside table. R142 stated they were hungry but waiting for someone to help them eat. R142 stated they were visually impaired and needed feeding assistance. On 3/3/2025 at 12:14, 12:21 and 12:28 PM, R142's tray was still observed sitting on the bedside table, untouched. On 3/3/2025 at 12:31 PM, Physical Therapy was observed entering R142's room and mentioning R142 had not eaten lunch yet. R142 was heard stating they were still waiting	F0677	F677 (D) (ADL Care Provided for Dependent Residents) Element 1: Cited Residents Resident R142 continues to reside in the facility and has had no change in health status due to the identified practice. The facility failed to ensure 1 out of 1 resident reviewed received assistance with one meal in a timely manner resulting in resident frustration. A one-to-one education was completed to the identified staff member. Element 2: Like Residents All current residents in the facility requiring 1:1 feeding assistance have the potential to be impacted by the identified practice. ADL policy was reviewed and deemed appropriate. An audit was completed for all residents requiring assistance with meals, no concerns were identified. Element 3: Education Licensed nurses and CNA□s will be re-educated on the importance of meetings the resident□s needs such as leaving the resident□s meal tray in the meal cart until they are prepared to assist the resident with their meal. Element 4: Audits DON or designee will complete random audits on 10 residents (2/per nursing unit) requiring 1:1 assistance with meals 2x a week for 4 weeks then monthly x2 months to ensure	4/1/2025

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	for feeding assistance. On 3/3/2025 at 2:30 PM, R142 stated someone did come and help them eat, but the food was cold so they did not eat much. A review of the medial record revealed R142 admitted into the facility on 1/9/2025 with the following diagnoses, Cerebral Infarction and Dysphagia. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 10/15 indicating an impaired cognition. R142 also required staff assistance with bed mobility and transfers. Further review of the physician orders revealed R142 was supposed to be a 1:1 feeding assist and were in a trial period. On 3/5/2025 at 8:45 AM, R142's breakfast tray was observed sitting beside their bed. R142 stated they were waiting for somebody to come back because they wanted more French toast. R142 stated they did not know how long they had been waiting for someone to come back, but it had been a while, and they were hungry. On 3/5/2025 at 9:00 AM, R142's breakfast tray was still observed in the room. R142 stated they were still waiting on assistance to finish their breakfast, and they were still hungry. On 3/5/2025 at 9:01 AM, Registered Nurse		residents will be assisted by nursing staff with their meal upon serving their meal tray. DON will identify trends in areas for process improvement during regularly scheduled QA meetings for review and recommendations. Information identified will be used to drive additional training for the Licensed Nurses and CNA□s. Element 5: Compliance Date of Compliance: 4/1/25	

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	(RN) "E" was informed R142 was waiting for someone to help them finish breakfast. RN "E" stated someone was in there helping and they would go and see if R142 was still hungry. R142 was heard informing RN "E" that they were still hungry and needed further assistance. On 3/5/2025 at 9:20 AM, Registered Dietitian (RD) "R". RD "R" stated R142 is a 1:1 feed because they are visually impaired. RD "R" stated R142 should continue to be a 1:1 feed because they just discontinued their tube feeding and should be encouraged to eat on a consistent basis. On 3/5/2025 at 12:06 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the staff should leave the tray on the cart until staff is ready to go in the room and provide feeding assistance. The DON stated they expect for staff to stay with the resident until they are done assisting the resident. A review of a facility policy titled, "Assistance with meals" noted the following, " ...It is the Center's Policy that all patient/residents shall receive assistance with meals in a manner that meets their individual needs and per Plan of Care."			
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	F0684	F684 (D) (Quality of Care) Element 1: Cited Residents Resident R121 continues to reside in the	4/1/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504014	A. BUILDING _____ B. WING _____	3/5/2025

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	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: Related to MI00150481 Based on interview and record review, the facility failed to ensure one resident (R131) of one reviewed for outside of facility consultations recieved the recommendations from an consultant appointment. Findings Include: Review of the medical record for R131 revealed an admission into the facility on 5/28/2023 with pertinent diagnoses of: Dementia, Psychotic Disturbance, Mood Disturbance, Anxiety. R131 was evaluated by a consulting hearing service. The consulting physician was unable to remove impacted ear wax for R131 and recommended a medication to soften the wax with a return visit in 1-3 months. That order was not noted or carried out. An interview with the responsible Social Worker "C" revealed the process for communication occurs when the Social Work receives the completed consult/report, reviews the documentation and requests appropriate orders from physician and/or sets up follow up appointment. SW "C" revealed the consult and the recommendation was missed.		facility and has had no change in health status due to the identified practice. The social worker failed to ensure 1 resident of 1 reviewed for consultations received the recommendations from a consultant appointment. The recommended treatment as reflected on the hearing consult was ordered by the N.P. on 3/5/25 for the identified resident upon identification of deficiency. The identified staff member is no longer employed at facility. Element 2: Like Residents All current residents in the facility, seen by an in-house hearing consultant have the potential to be impacted by the identified practice. Consultations policy was reviewed and deemed appropriate. An audit was completed for all residents who have been seen by a hearing consultant and have documented recommendations, no concerns were identified. Element 3: Education Social Workers and Licensed Nurses will be re-educated on the importance of reviewing and proceeding with recommendations as documented on consultant form. Element 4: Audits Social Work Director or designee will complete random audits on 10 residents who have been seen by a hearing consultant weekly for 5 weeks then monthly x2 months to ensure recommendations have been followed as documented on the consultant form. The Social Work Director will identify trends in areas for process improvement during regularly scheduled QA meetings for review and recommendations. Information identified will be used to drive additional training for the Social Work department and Licensed	

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F0688 SS= D	Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to apply a hand splint as ordered for one resident (R89) of two residents reviewed for range of motion. Findings include: On 3/03/25 at 9:25 AM, R89 was observed lying in bed with arms folded and both hands on their chest. Two hand splints were observed on top of the dresser across the room. O3/03/25 at 10:45 AM, R89 was observed still lying in bed with their hands and arms still in the same position. Two hand splints were still	F0688	Nurses. Element 5: Compliance Date of Compliance: 4/1/25 F688 (D) (Increase/Prevent Decrease in ROM/Mobility) Resident R89 continues to reside in the facility and has had no change in health status due to the identified practice. The facility failed to apply a hand splint as ordered for 1 resident of 2 residents reviewed for range of motion. A one-to-one education was completed to the identified staff member. Element 2: Like Residents Current residents of the facility with orders for orthotic devices have the potential to be impacted from the identified practice. Care plan policy was reviewed and deemed appropriate. INITIAL AUDIT: The facility reviewed care plans to ensure the physician order and care plan match residents with orders for orthotic devices to ensure proper orthotic interventions are implemented and documented. No concerns were identified. Element 3: Education Therapy staff will receive remedial education on proper way of obtaining and entering physician order on how and when to apply orthosis. Licensed Nurses and CNAs will receive remedial education on completing the task of donning and doffing of orthosis according to physician orders . Element 4: Audits Therapy Director or designee will complete random audits on 10 residents (2 residents per nursing unit) with orthotic devices 2x a	4/1/2025

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	504014	A. BUILDING _____ B. WING _____	3/5/2025

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	observed to be on the dresser across the room. R89 explained they cannot use their arms or hands. R89 demonstrated attempting to move their right arm and was observed to lift it about 2 inches off of their chest and was unable to move their fingers. R89 explained when they were first admitted they were able to move their arms and hands more than they can now and stated, "but due to neglect, now they are like concrete." When R89 was asked if they are supposed to wear the hand splints on the dresser R89 explained that they are supposed to but that no one ever puts them on. On 3/04/25 at 3:03 PM, R89 was observed lying in bed with arms folded and their hands on their chest. Two hand splints were observed on the dresser across the room in the same place and position as previously observed. On 3/05/25 at 8:34 AM, R89 was observed lying in bed with their arms folded and their hands on their chest. Two hand splints were observed on top of the dresser across the room in the same place and position as previously observed the day prior. When asked if anyone had put the splints on R89's hands overnight R89 explained that no one had put them on and that they "never do". A review of R89s record revealed they were admitted to the facility on 8/14/25 for Unspecified injury at unspecified level of cervical spinal cord. Further review revealed a Brief Interview for Mental Status Score of 15, indicating intact cognition. A review of R89's physician orders revealed the following active order: "Orthosis/Splint to be applied to: B (both) resting hand splints to be worn at night, as tolerated. Every shift on in the evening off in the morning." Dated 1/15/25		week for 4 weeks then monthly x2 months to ensure that staff is applying the orthosis according to physician order and care plan. The Therapy Director will identify trends in areas for process improvement during regularly scheduled QA meetings for review and recommendations. Information identified will be used to drive additional training for the Therapy staff and Licensed Nurses. Element 5: Compliance Date of Compliance: 4/1/25	

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	A review of R89's care plan revealed the following: "Orthotics: (B) resting hand splints to be worn during the day. Remove & assess skin integrity and skin hygiene." 1/9/25 "Restorative splint/brace1-B resting hand splints, to be worn at night as tolerated, remove for hygiene/skin checks. Dated 1/15/25" On 3/05/25 at 8:22 AM, Licensed Practical Nurse (LPN) "J" explained R89 reported to them that R89's hands are stiffening up because therapy refuses to help and they do not know if R89 has hand splints. On 3/05/25 at 8:31 AM, Certified Nurse Assistant (CNA) "M" explained R89 is paralyzed and did not know if R89 had hand splints. On 3/04/25 at 3:12 PM, Therapy Director (Staff "K") explained R89 was admitted to the facility as a paraplegic with cervical precautions. Staff "K" explained Occupational therapy was working with R89 from 12/24-1/29 and was doing range of motion for all joints. On 3/5/25 at 9:11 AM, staff "K" confirmed R89 is supposed to have hand splints on and explained the splints should be applied at night by the nursing staff since the restorative aides are not here at night. On 3/5/25 at 11:58 AM, restorative Certified Nurse Assistant (CNA) "N" explained R89 wears hand splints at night. On 3/05/25 at 10:31 AM, the Director of Nursing (DON) explained if a resident has hand splints ordered they should be applied and it is a collaborative effort between nursing and therapy.			

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	A review of the facility's policy titled "Medical Device-Internal and External" revealed the following: "It is the policy of the facility to accommodate residents who have internal and external medical devices that are within the staff members scope of practice."			
F0758 SS= D	Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic	F0758	F758 (D) (Free from Unnecessary Psychotropic Meds/PRN Use) Element 1: Cited Residents Resident R146 continues to reside in the facility and has had no change in health status due to the identified practice. The facility failed to complete an initial Abnormal Involuntary Movement Scale (AIMS) assessment for 1 resident out of 1 reviewed for antipsychotic medication use. A current AIMS assessment was completed for the identified resident. A one-to-one education was completed to the identified staff member. Element 2: Like Residents Current residents of the facility with orders for Anti-Psychotic medications have the potential to be impacted from the identified practice. Like residents are identified in clinical meeting to ensure AIMS assessment is completed as required. Psychotropic Medication use policy was reviewed and deemed appropriate. INITIAL AUDIT: The facility reviewed medication orders for Anti-Psychotic medications to ensure an AIMS assessment has been completed. No concerns were identified. Element 3: Education Social Workers and Licensed Nurses will be re-educated on the importance of completing an AIMS assessment upon a new order for an anti-psychotic.	4/1/2025

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	drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete an initial Abnormal Involuntary Movement Scale (AIMS) assessment for one resident (R146) out of one reviewed for antipsychotic medication use. Findings include: A review of the medical record revealed that R146 admitted into the facility on 1/18/2025 with the following diagnoses, Alzheimer's Disease and Brief Psychotic Disorder. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental status score of 99, indicating R146 was unable to complete assessment and required staff assistance with bed mobility and transfers. Further review of the physician's orders revealed R146 was prescribed Seroquel (Antipsychotic) once daily. Further review of R146's assessments on 3/4/2025 did not reveal an AIMS assessment to detect abnormal movements across the face, lips, tongue, upper extremities, lower extremeities and trunk caused by antipsychotics.		Element 4: Audits Social Work Director or designee will complete random audits on 10 residents with new orders, for Anti-Psychotic medication weekly for 5 weeks then monthly x2 months to ensure an AIMS assessment has been completed. The Social Work Director will identify trends in areas for process improvement during regularly scheduled QA meetings for review and recommendations. Information identified will be used to drive additional training for the Social Work department and Licensed Nurses. Element 5: Compliance Date of Compliance: 4/1/25	

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	On 3/5/2025 at 12:05 PM, an interview was completed with the Director of Nursing (DON). The DON stated the nursing staff should complete an AIMS assessment quarterly whether the resident is being followed by psychiatry or not, if they see the resident is on an antipsychotic. A request for a facility policy related to antipsychotics was requested and not received by the end of survey.			
F0761 SS= E	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F0761	F761 (E) (Label/Store Drugs and Biologicals) Element 1: Cited Residents Resident R51, continues to reside in the facility. R78 no longer resides in the facility. The facility failed to ensure medications were properly stored and labeled for 2 of 2 residents reviewed, for medications at bedside without a self-administration of medication assessment being completed. The 2 bottles of vitamins were immediately removed from resident room after educating the resident on medication safety. 3 of 13 medication carts were observed. 1 medication was observed in the medication cart in a medication cup. Medication was immediately disposed of in an appropriate container. 3 insulin pens were not labeled with resident name /date first accessed. The 3 insulin pens were immediately discarded. A one-to-one education was completed for the identified staff members. Element 2: Like Residents All residents currently in the facility have potential to be impacted by the identified practice. Medication and Treatment Storage	4/1/2025

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	Based on observation, interview, and record review, the facility failed to ensure medications were properly stored and labeled for two residents (R51 and R78) of ten residents reviewed, three of thirteen medication carts. Findings include: R78 On 3/3/25 at 1:30 PM, an observation was made of a medicine cup filled with a red liquid on R78's dresser. R78 was interviewed and asked about the medicine cup on their dresser and stated, "I think it's cough medicine." R78 was asked if they self-administered their medication and said nursing administered their medications to them. On 3/3/25 at 1:35 PM, Unit Nurse Manager, Licensed Practical Nurse (LPN) "I" was requested to come to R78's room and was shown the medicine cup on R78's dresser and asked about it. LPN "I" indicated the medicine cup contained a protein supplement and removed the medicine cup from R78's dresser and discarded it. A review of R78's electronic medical record (EMR) indicated the following physician's order, Start date: 1/22/25; End date: 3/5/25. Order: House Liquid Protein Source One time a day for Protein assistance. Further review of R78's EMR revealed R78		policy was reviewed and deemed appropriate. The facility completed an initial audit to ensure no medications were at bedside, no medications stored in a medication cup in the med cart and multi-use medications are labeled with resident name and date first accessed for all residents. No concerns were identified. The facility will monitor current and future residents to ensure no medications are stored in resident rooms and all multi dose medications are dated when first accessed. Element 3: Education Facility policies on 1) Medication and Treatment Storage and 2) Medication Self-Administration were reviewed and deemed appropriate. Licensed Nurses will be Re-Educated on proper storage of medications, and proper labeling and dating of multi-dose medications. Element 4: Audits DON or designee will complete rounding on each unit 2x a week for 4 weeks then monthly x2 months to ensure that no meds are kept in the residents room unless a self-administration eval and physician order is in place. DON or designee will complete audits on each medication cart 2x a week for 4 weeks then monthly x 2 months to ensure that no medications are improperly stored in the medication cart and that all multi-use medications are labeled with resident name and date first accessed. DON will identify trends in areas for process improvement during regularly scheduled QA meetings for review and recommendations. Information identified will be used to drive additional training for the Licensed Nurses. Element 5: Compliance Date of Compliance: 4/1/25	

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	was most recently admitted to the facility on 1/9/25 with diagnoses that included, Sepsis (Infection) and Paroxysmal atrial fibrillation (Irregular Heartbeat). R78's most recent minimum data set assessment dated 1/15/25 revealed R78 had a moderately impaired cognition and was fully dependent and/or required maximum assistance for all activities of daily living (ADLs) other than toileting and eating. R51 On 03/03/25 at 9:25 AM, R51 was observed sitting up in bed finishing their breakfast tray. A bottle of Vitamin C and a bottle of Vitamin B-12 were observed sitting on the night stand. When asked about the bottles, R51 stated, "Those are my bottles, I take one of each pill every day." On 03/04/25 at 1:15 PM, R51 was observed sitting up in the bed watching television. The same bottles of Vitamin C and Vitamin B-12 was observed on the nightstand. A review of R51's medical record revealed they were admitted to the facility on 7/01/24 with diagnoses including mild dementia, generalized anxiety disorder, adjustment disorder and hypertensive heart disease. A review of R51's Minimum Data Set dated 1/07/25 revealed the Brief Interview for Mental Status score of 15 indicating intact cognition.			

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	On 03/04/25 at 1:18 PM, the Director of Nursing (DON) was asked to accompany surveyor to R51's room. Upon entering R51's room, the DON noted the two bottles of vitamins on the bedside table. The DON stated R51 has not been assessed for self administration of medications and should not have medications at the bedside. On 03/04/25 at 02:10 PM, during a review of the low numbered medication cart with Licensed Practical Nurse (LPN) "A", on Unit 100, a narcotic (Norco) tablet was found in a medicine cup, partially dissolved. LPN "A" revealed they had given a resident the narcotic with they're other medication and the resident spit it out. LPN "A" explained they were waiting for a second nurse to dispose of the medication appropriately. On 03/04/25 at 02:35 PM, during review of the high numbered medication cart for unit 300 with LPN "F", A KwikPen Humalog insulin pen was noted without a label or date. LPN "F" indicated the KwikPen should have a label and date. On 3/4/2025 at 03:00 PM, review of medication storage and labeling for Unit 400 medication , low number cart with LPN "B", two KwikPen Humalog insulin were found without identifying label or open date. On 03/04/2025 at 2:30 PM, an interview with the Director of Nursing (DON) revealed that "wasted" narcotics are to be "wasted" in the			

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	container that renders the medication harmless, at the time the medication is not going to be used after removing from the medication cart. The DON revealed this process requires two licensed nurses. On 3/5/25 at 11:04 AM, the Administrator (NHA) was interviewed regarding their expectations for medication storage and labeling. The NHA indicated that all medications should be stored safely. A review of a facility policy titled, "Medication and Treatment Storage Issued Date: 8/7/2023" revealed the following, "Policy Overview: It is the policy of this facility to ensure accurate labeling and dating of medications for safe administration and safe secure storage ...of all medications and treatments." "Labeling of medications and biologicals dispensed by the pharmacy will be consistent with applicable federal and State requirements and currently accepted pharmaceutical principles and practices including expiration dates ..." "Medications designed for multiple administration, the label will identify the specific resident for who it was prescribed." "Multi-use vials will be dated when the vial is first accessed." "All medications requiring refrigeration are			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504014	A. BUILDING _____ B. WING _____	3/5/2025

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	stored in refrigerators in the medication room ...logs are kept on each refrigerator and temperature levels are recorded daily..."			
F0803 SS= D	Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to honor food preferences for one resident (R142) out of one reviewed for food. Findings include: On 3/3/2025 at 12:28 PM, R142's lunch tray was noted to be sitting on their bedside table. A review of their dietary ticket had dislikes-no cucumbers with it highlighted in a pink color. An observation of the side salad revealed cucumbers on the salad. R142	F0803	F803 (D) (Menus Meet Resident Needs/Prep in Adv/Followed) Element 1: Cited Residents R142 Continues to reside in facility and has had no change in health status due to the identified practice. A one-to-one education was completed to the identified staff member. Element 2: Like Residents All current residents have the potential to be affected by this practice. Food preferences policy was reviewed and deemed appropriate. Initial audit by RD identified preferences are reflected on meal ticket highlighted in pink. Element 3: Education All staff will be educated to check meal ticket when removing meal tray from food cart to ensure all preferences are honored prior to delivering meal tray to resident. Element 4: Audits RD or designee will audit 1 tray with food preferences indicated on meal ticket per meal cart at: 1. Breakfast weekly x4 weeks, Then monthly x2 months 2. Lunch weekly x4 weeks, Then monthly x2 months 3. Dinner weekly x4 weeks, Then monthly x2 months to ensure that food preferences are honored prior to delivery of meal to residents. Registered Dietitian will identify trends in areas for process improvement during	4/1/2025

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	504014	A. BUILDING _____ B. WING _____	3/5/2025

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	stated they do not like cucumbers, and the kitchen staff often put them on even though they've said they do not want them. A review of the medical record revealed R142 admitted into the facility on 1/9/2025 with the following diagnoses, Cerebral Infarction and Dysphagia. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 10/15 indicating an impaired cognition. R142 also required staff assistance with bed mobility and transfers. On 3/5/2025 at 9:43 AM, an interview was conducted with Dietary Manager (DM) "Q". DM "Q" stated the dietary staff should read the tray ticket, and they highlight it to make sure it is seen. DM "Q" stated that floor staff should also be checking before they give the resident the tray. A review of a facility policy titled Food Preferences and Select Menus noted the following, "The facility will provide meals that accommodate resident allergies, intolerances, and food preferences."		regularly scheduled QA meetings for review and recommendations. Information identified will be used to drive additional training for the Licensed Nurses. Element 5: Compliance Date of Compliance: 4/1/25	
F0880 SS= F	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must	F0880	F880 (F) (Infection Prevention & Control) Element 1: Cited Residents Resident R141, R17, R106 All residents continue to reside in the facility. With no change in health status due to the identified practice. The facility failed to stock, demonstrate sufficient Infection Control practices, and don/doff (put on/take off)	4/1/2025

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	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 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		Personal Protective Equipment for 3 residents in isolation precautions out of 3 reviewed for Infection Control. A one-to-one education was completed to the identified staff members. Element 2: Like Residents Residents currently on isolation precautions residing in the facility have the potential to be impacted by the identified practice. Infection Control Standard and Transmission-based precautions policy was reviewed and deemed appropriate. An initial audit was completed to ensure PPE is available in isolation box located on resident door. No concerns were identified. Element 3: Education Facility staff will be re-educated on proper Isolation policies and procedures including having supplies readily available and proper PPE DON/Doffing practices. Element 4: Audits Infection Control Nurse or designee will complete audits on 10 residents weekly x5 weeks then monthly x2 months for residents in isolation precautions to ensure: 1. An adequate supply of PPE is available on resident doors for residents on isolation precautions. 2. Facility staff is using proper PPE DON/Doffing practices. 3. Ensure items brought into isolation room is placed on a barrier 4. Preforming hand hygiene as appropriate 5. Any equipment brought out of isolation room must be sanitized Infection Control Nurse will identify trends in areas for process improvement during regularly scheduled QA meetings for review and recommendations. Information identified will be used to drive additional training for the	

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	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 stock, demonstrate sufficient Infection Control practices, and don/doff (put on/take off) Personal Protective Equipment (PPE- gown, gloves, and masks) for three residents (R141, R17 and R106) in isolation and precautions out of three reviewed for Infection Control (IC). Findings include: R141 On 3/3/2025 at 11:57 AM, R141's call light was activated, and their intravenous (IV) machine was heard beeping. R141 had a PPE caddy on their door, with a sign stating they were on contact isolation (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident ' s environment) and should don gloves, mask, and gloves when entering room. On 3/3/2025 at 12:01 PM, a nurse was observed entering R141's room without putting on any PPE. The nurse was then observed to silence the IV machine, come back out and grab supplies to disconnect the		facility staff. Element 5: Compliance: Date of Compliance: 4/1/25	

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	IV machine from R141. The nurse was then observed to reenter R141's room without putting on PPE and disconnected R141's IV machine from the resident only donning gloves. A review of the medical record revealed R141 admitted into the facility on 2/12/2025 with the following medical diagnoses, Osteomyelitis, Left Ankle and Foot. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 3/15 indicating an impaired cognition. R141 also required staff assistance with bed mobility and transfers. On 3/5/2025 at 11:30 AM, an interview was completed with Infection Control Preventionist (ICP) "D". ICP "D" stated their expectation of staff entering a contact isolation room is that they don all appropriate PPE and stated the signs on the door clearly list what they should be putting on prior to entering the room and performing care. ICP "D" confirmed the nurse that entered R141 should have put on all appropriate PPE needed for contact precaution, including a gown, prior to disconnecting their IV. R17 On 3/3/25 at 10:53 AM, an observation of R17's room revealed signage which indicated R17 was on EBP (Enhanced Barrier Percautions -set of infection control			

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	practices). A PPE caddy (storage unit for PPE) on R17's door was observed to contain no gloves or face masks. On 3/4/25 at 11:00 AM and 3:52 PM, R17's caddy was observed to contain no face masks. On 3/4/25 at 3:56 PM, R17 and confidential family member "S" were interviewed and asked if staff consistently wore PPE when providing care for R17. R17 and family member "S" stated, "I don't think so." On 3/5/25 at 9:38 AM, R17's caddy was observed to contain no gowns or face masks. On 3/5/25 at 11:47 AM, ICP "D" was interviewed about their expectations for PPE which should be available in the door caddy of residents on EBP. ICP "D" indicated that the caddy should be fully stocked with gloves, gowns, and face masks. ICP "D" indicated the nurses on the units should be replacing the PPE in the caddy as needed. A review of R17's EMR revealed that R17 was most recently admitted to the facility on 2/26/25 with diagnoses that included Kidney failure and Post traumatic stress disorder (PTSD) (Mental health condition). R17's Nursing Admission Evaluation completed on 2/26/25 revealed that R17 had an intact cognition and required assistance for all activities of daily living (ADL's) including catheter care.			

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	R106 On 03/20/2025 at 07:35 AM, Licensed Practical Nurse (LPN) "B" retrieved the glucometer tray from medication carts bottom drawer and entered R106's room that had a PPE Caddy on the door with a sign specifying what PPE to don (gown, gloves, and mask) for the room. LPN "B" was observed to place glucometer tray and blood pressure cuff on R106's bed without a barrier, hand hygiene was not performed, PPE was not used. LPN "B" was not satisfied with the reading obtained for R106's blood pressure and left the room to obtain a wrist blood pressure machine. No hand hygiene performed. Upon completion of these tasks LPN "B" took the equipment and left R106's room. Hand hygiene was not performed. Blood pressure equipment was returned to nursing station, the glucometer tray replaced in medication cart without cleaning. No hand hygiene was performed upon leaving R106's room. On 3/4/2025 at 2:00 PM, LPN "B" was asked what the cleaning protocol was for the glucometer and blood pressure cuffs. LPN "B" stated the glucometer tray, the glucometer, and the blood pressure cuffs were supposed to be cleaned with bleach wipes. The Equipment cleaning policy was requested but not received by end of survey.			
F0919 SS= E	Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff 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	F0919	F919 (E) (Resident Call System) Element 1: Cited Residents Resident R 53, R15, R41, 1, R110 continues to reside in the facility with no change in health status nor any concerns voiced due to the identified practice. R78 no longer resides in the facility. The facility failed to ensure call	4/1/2025

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	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 six residents (R1, R15, R41, R53, R78, and R110) of six residents reviewed for call light accessibility. Findings include: Resident R1 On 3/3/25 at 11:15 AM, R1's call light was observed on their wheelchair out of reach. An interview was conducted with R1 and confidential family member "O" and they were asked about the call light being out of reach. Family member "O" confirmed that [R1's] call light had been observed to be out of reach on multiple occasions when they had visited them. A review of R1's electronic medical record (EMR) revealed that R1 was most recently admitted to the facility on 2/7/25 with diagnoses that included Cellulitis (Bacterial skin infection) of left lower leg and Heart failure. R1's most recent minimum data set assessment (MDS) dated 2/13/25 revealed that R1 had a moderately impaired cognition and was dependent and/or required maximum assistance for all activities of daily living (ADLs) other than eating. R78		lights were in reach for 6 of 6residents reviewed for call light accessibility. A one-to-one education was completed to the identified staff members. Element 2: Like Residents All current residents residing in the facility were identified to have potential impact by identified practice. Call light Accessibility and Timely Response policy was reviewed and deemed appropriate. An initial audit was completed to ensure all residents had call light with clip in reach. No concerns were identified. Element 3: Education The facility staff will be re-educated to ensure call lights are in reach for all residents during routine rounding and after care is provided prior to leaving resident room. Call light clips are available at each nurse□s station. Element 4: Audits Administrative Assistant or designee will complete 10 random audits 3x a week for 5 weeks then monthly x2 months to ensure residents have their call light in reach and call light has clip attached to call light. Administrative Assistant will identify trends in areas for process improvement during regularly scheduled QA meetings for review and recommendations. Information identified will be used to drive additional training for the facility staff. Element 5: Compliance Date of Compliance: 4/1/25	

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	504014	A. BUILDING _____ B. WING _____	3/5/2025

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	On 3/4/25 at 4:35 PM, R78's call light was unable to be located in their room. R78 was interviewed regarding the location of their call light and did not know where their call light was located. Upon further observation, R78's call light was located in a shut dresser drawer out of reach and sight. A review of R78's EMR revealed that R78 was most recently admitted to the facility on 1/9/25 with diagnoses that included, Sepsis (Infection) and Paroxysmal atrial fibrillation (Irregular Heartbeat). R78's most recent minimum data set assessment dated 1/15/25 revealed that R78 had a moderately impaired cognition and was fully dependent and/or required maximum assistance for all activities of daily living (ADLs) other than toileting and eating. R110 On 3/5/25 at 10:22 AM, R110 was observed in bed with their call light hanging underneath their bed on the floor out of reach and sight. On 3/5/25 at 10:30 AM, Nurse/LPN (Licensed Practical Nurse) "P" was interviewed and asked what their expectations were for call light accessibility in residents' rooms. Nurse "P" stated, "The call light should be in reach of the resident." A review of R110's EMR revealed that R110 was most recently admitted to the facility on 2/27/25 with diagnoses that included			

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	Epilepsy (Brain Disorder) and Asthma (Inflamed Airways). R110's Nursing Admission Assessment (NAA) dated 2/27/25 revealed that R110 had a moderately impaired cognition and required assistance for all ADLs. R15 At 03/03/25 at 09:28 AM, R15 was noted sitting in a wheelchair, on the window side at the foot of bed, with call light located at top of the bed just below the pillow. When queried whether R15 could get to the light, R15 indicated it is real hard because the room is tight in this area (foot of bed on window side of bed). On 03/03/25 at 09:28 AM R15 was facing the window in a wheelchair, consuming thier lunch from the overbed table. There was not room for R15 to turn the wheelchair around in order to access the call light located on the opposite side of the bed up near the pillow. On 3/4/2025 a review of the Electronic Medical Record (EMR) revealed R15 was admitted on 12/23/2021 with diagnoses of Alzheimer's Disease, Anxiety, and Cardiac Disease. The EMR further revealed a Basic Inventory of Medical Status score of 13, indicating intact cognition. R41 On 03/03/25 at 09:17 AM, R41's call light was			

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	out of reach, secured on the night stand's top drawer handle. R41 was looking for it. When R41 saw it, they were unable to reach it. On 03/03/25 at 01:07 PM, R41's call light was attached to the night stand's top drawer handle out of reach. On 03/04/25 at 11:08 AM, R41's call light was noted to be woven between two pillows against the head of the bed. When R41 was queried regarding the location of their call light they began to look for it and was unable to find it becoming frustrated. A review of the EMR revealed R41 was admitted on 11/13/2024 with diagnoses of Urinary Tract Infection, Cervical Disc Disorder with Myelopathy, and Anxiety. The EMR further revealed a BIMS score of 14 indicating intact cognition. R53 On 03/03/25 at 10:23 AM, R53 was sitting in their wheelchair. Call light was noted on opposite of bed from resident. R53 was asked where the call light was and was unable to locate it. A review of the EMR revealed R53 was admitted on 3/10/2023 with a diagnoses of Diabetes, Type 2 Dementia, Mood Disorder and Anxiety. The EMR further revealed a BIMS score of 03 indicating severe impaired cognition.			

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	504014	A. BUILDING _____ B. WING _____	**3/5/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBY HEALTH AND REHABILITATION CENTER	**46100 SCHOENHERR RD SHELBY TOWNSHIP, MI 48315**

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	On 3/5/25 at 11:04 AM, the Administrator (NHA) was interviewed regarding call light accessibility for the residents. The NHA indicated the call light should be within reach of the resident. A facility policy titled "Call Light Accessibility and Timely Response, Issued Date: 8/16/2023" was reviewed and revealed the following, "Policy Overview: The purpose of this policy is to assure that the facility is adequately equipped with a call light at each residents' bedside...to allow residents to call for assistance. Staff will ensure that call lights are within reach of residents'...The call system will be accessible to residents in their room at bedside..."			