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	734110	A. BUILDING _____ B. WING _____	**11/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADIRA NURSING AND REHAB	**3200 STATE ST SAGINAW, MI 48602**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Adira was surveyed for a Recertification survey on 11/30/23 Intakes: MI00138918, MI00139664, MI00139969, MI00139971 Census= 81	F0000		
F0558 SS= D	Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a call light within reach for 1 resident (#60) and positioned per resident preference for 1 resident (#6) of 19 residents reviewed for accommodation of needs, resulting in impaired resident access to request and receive assist. Findings include: Resident #60 Review of the medical record revealed that Resident #60 (R60) was admitted to facility 11/16/2022 with diagnoses including mild dementia, type 2 diabetes mellitus,	F0558	Element 1 Resident #6 and #60 had their call lights placed within reach during survey. Resident #6 declined to have her room rearranged or to have her TV moved to enhance line of vision and requested that the breath call light be removed and instead agreed to trial an audio monitor to alert staff if she needs assistance. The trial was successful, care plan and Kardex were updated as appropriate by 12/14/2023. Element 2 Residents of the facility were observed by nurse management on 12/8/2023 to ensure their call light was within reach. Any issues identified were corrected. Element 3 The Use of Call Light Policy was reviewed by the QAPI committee on 12/4/2023 and deemed to be appropriate. The staff development coordinator/designee has re-educated staff on the Use of Call Light policy, including the need to ensure the call light is within reach. Verification of call light placement has been added to the caring rounds forms completed by member of the IDT and forms are submitted to the administrator for review. Element 4 The DON/designee will conduct 5 random weekly audits of residents to ensure the call	12/28/2023

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

Electronically Signed | 12/22/2023

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	generalized osteoarthritis, chronic systolic heart failure, and pressure-induced deep tissue damage of sacral region. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/18/23 revealed that R60 was understood by others and able to understand others with a Brief Interview for Mental Status (BIMS-a cognitive screening tool) score of 6 (severely impaired cognition). Review of the MDS dated 7/21/23 reflected that R60 required one-person extensive assist with bed mobility and dressing and two-person extensive assist with transfers and toilet use. In an observation and interview on 11/27/23 at 10:21 AM, R60 was observed lying in bed, on back, with the head of the bed at an approximate 30-degree angle. R60's call light was observed to be attached to the upper left corner of the metal bed frame out of both R60's vision and reach. When questioned how she obtained assistance, R60 stated, "I call my son" motioning to the cell phone she held in her right hand. In an observation on 11/27/23 at 12:28 PM, R60 was observed lying in bed, on back, with eyes closed. R60's call light was observed to remain attached to the upper left corner of the metal bed frame. In an observation and interview on 11/28/23 at 8:33 AM, R60 was observed lying in bed, on back, with the head of the bed at an approximate 90-degree angle with breakfast		light is within reach x 4 weeks and then monthly thereafter. Results of the audits will be forwarded to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI committee. The Administrator is responsible for maintaining sustained compliance.	

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	tray positioned on the over the bed table in front of her. R60's call light was observed on the floor, to the left of the bed, out of both her vision and reach. When questioned regarding a call light, R60 responded "I guess I do have one. I'm not sure where it is" and proceeded to briefly look on her bed and blankets prior to resuming breakfast. In an observation on 11/28/23 at 3:21 PM, R60 was observed lying in bed, on right side, facing the wall with bed now noted to be positioned with right side against wall. R60's call light was observed to be attached to the sheet covering her and within both her vision and reach. In an interview on 11/28/23 at 4:21 PM, Registered Nurse/Unit Manager (RN/UM) "C" confirmed familiarity with R60 as stated that she was the manager on the unit where R60 resided, that R60 received hospice services, required one person assist for bathing, dressing, and transfers but was able to feed self, and that although she had a diagnosis of dementia, she was alert and oriented to self and setting and was able to make most needs known. RN/UM "C" confirmed that R60 was able to and did use call light, that it should be within reach either attached to her clothing or close by attached to her bed linens and stated that although she sometimes just waited for staff to enter her room, she had personally seen R60 activate her call light to request assist.			

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	Review of R60's Care Plan Focus "[R60] is risk for falls r/t [related to] ..." was noted to have an associated intervention which indicated, "Clip call light to resident clothing when in bed and up in wheelchair, check presence, function and activation q [every] shift and prn [as needed]" with a revision date of 5/2/2023. Review of R60's Kardex (tool used by the Certified Nurse Aide to guide them as to the care needs of a specific resident) indicated within "Safety" section to, "Clip call light to resident clothing when in bed and up in wheelchair, check presence, function and activation q shift and prn". Review of the facility policy titled "Call Light, Use of" with a 3/2023 revised date stated, "Procedure Purpose: To respond promptly to resident's call for assistance ...To assure call system is in proper working order ...Procedure Details: 1. Facility personnel must be aware of call light ...4. When providing care to residents be sure to position the call light conveniently for the resident to use ...7. Place call light on the bed or preferred location stated by the resident prior to leaving the room ..." Resident #6 (R6) Review of the medical record revealed Resident #6 (R6) was admitted to the facility on 04/04/22 with diagnoses that included Multiple Sclerosis, Quadriplegia, Neurogenic Bladder, feeding tube, Cardiovascular			

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	Accident and Depression. According to Resident #6 (R6)'s Minimum Data Set (MDS) dated 09/28/23, revealed R6 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS- a cognitive screening tool) and had no behaviors. R30 is dependent of all activities of daily living, is bedbound and requires all hydration and medication administration to be through her feeding tube. During an observation and interview on 11/28/23 at 08:06 AM, R6 stated that her call light did not work, so she had to yell, and she did not have a very strong or loud voice. R6 also stated she didn't know how often the CNA comes in to check on her, so she had no way to call for help. R6 stated that she had been without it for at least 2 days. During an interview on 11/28/23 at 08:18 AM, Licensed Practical Nurse (LPN) "HH" stated that R6 blows into the straw device and the call light panel lights up on the wall and the pagers go off. During an interview and observation on 11/28/23 at 08:23 AM, DON "B" stated she did not know how her call light worked, DON "B" walked went up and down the floor asking the Unit Manager (UM) "C" and LPN "HH" for assistance. During an interview and observation on 11/28/23 at 0828 AM, Certified Nursing			

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	Assistant (CNA) "II" and CNA "JJ" walked into the room of R6 and started looking for the white adapter called a breath call that that was not attached to the controller tubing. CNA "II" found it laying on the nightstand. Nobody knew how long she has been without it. UM "C" came into R6's room, gowned up in PPE, and placed a new breath call device on the tubing, call light was tested with CNA's, LPN "HH", and it worked now. UM "C" went out to the nurse's station to see who was on R6's schedule the last 2 days and why this was not observed. During an interview on 11/29/23 at 10:09 AM, UM "C" stated that on 11/27/23 RN-I/C/ Staff Development "H" had to work on the floor and the breath call was in place. UM "C" stated she didn't know which CNA were working with R6 on 11/27/23 Monday. UN "C" than stated on 11/28/23, CNA "KK" worked with R6 and LPN "HH". On 11/29/23 CNA "LL" worked with R6 with LPN "HH". UM "C" stated they did not put any interventions in place to prevent this from happening again yet, she had been too busy. Writer asked UM "C" if she had investigated this occurrence to find out how and when it happened. UM 'C' looked at writer with irritation and stated, no, not yet. During an observation on 11/29/23 at 10:38 AM, UM "C" stood in the hallway with a clipboard having staff sign a form/document. During an interview on 11/29/23 at 10:59 AM,			

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	DON "B" stated that nobody knows when the breath call came out on R6. DON "B" stated that the new intervention was put in place yesterday, 11/28/23. CNAs would check the placement of the breath call at the beginning and end of the shift, nurses check it during each shift. DON "B" also stated that staff should be able to see the Breath Call from the door and when they were providing care every 2 hours. Writer asked to see documentation that R6 was getting checked on every 2 hours. Observation of DON "B" looking for proof that this resident was checked, changed, and repositioned every 2 hours. DON "B" stated that the care plan kardex stated the CNAs were checking on her, changing her brief and repositioning her every 2 hours, but there was no document supporting that R6 was checked on, brief changed and repositioned every 2 hours. DON "B" stated that the CNAs check off every shift stating they performed those tasks, but no proof that it was completed. During an interview and observation on 11/29/23 at 1:08 PM, R6 stated she had asked them to move the breath call device down because it blocked her view of the TV. Writer asked R6 if staff had offered to move her call light on the other side of her head so she could watch TV better, R6 stated no. Writer asked R6 if the staff had ever offered to move the bed or TV to accommodate her needs, R6 stated no. R6 also stated that she was not involved with activities because it was too hard to get up in her chair and she cannot			

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	really participate. R6 stated she enjoys watching her TV. Writer could smell a strong urine odor and asked R6 when she was checked and changed last, R6 stated she had not been checked on in a while. During an interview on 11/29/23 at 1:20 PM, CNA "LL" stated she changed R6 between 10:00-10:15 AM. CNA "LL" also stated R6 was a heavy wetter, so it takes 2 CNAs to change her (care planned for 2 persons assist). CNA "LL" stated she was getting ready to check and change R6 and asked another CNA to assist her. During an observation on 11/29/23 at 1:30 PM, two CNAs were observed going into R6's room, and then walked out of R6's room with soiled brief and supplies. It had been over 3 hours that R6 had been checked and changed, not following the care plan Kardex stating this was to be done every 2 hours. Record review did not reflect any new interventions to better meet R6's needs. No interventions on checking the breath call as R6's only means of communicating and calling for help. No changes in the set up of her room, to allow her to see her TV better.			
F0585 SS= D	Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such	F0585	Element 1 The Activities Director met with members of the resident council on 12/5/2023 to identify any unresolved issues. Identified issues were placed on a grievance form and followed up on by the appropriate department with	12/28/2023

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	grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any		documented resolution by 12/11/2023. The Administrator met with members of the council on 12/21/2023 to ensure that issues were resolved to their satisfaction or that they were satisfied with the corrective actions that were put in place for unresolved issues. Element 2 Current residents and/or their responsible parties were queried by the IDT to identify any unresolved issues by 12/28/2023. Identified issues were placed on grievance forms and followed up on by the appropriate department with documented resolution of the issues or documented corrective action for the issue by 12/28/2023. Element 3 The Grievance/Concern Procedural Guideline policy was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Staff Development coordinator/designee has re-educated staff on the Grievance/Concern Procedural Guideline policy, including the need to address and follow up on identified concerns and utilize the grievance form when appropriate by 12/28/2023 or their next scheduled shift. A process has been instituted to ensure the tracking and timely follow-up of grievance forms. Element 4 The Administrator/designee will conduct 5 random weekly audits of resident grievance forms, including those generated from resident council, to ensure appropriate and timely follow through has been completed for 4 weeks and then monthly thereafter. Results of these audits will be forwarded to the QAPI committee. The audits will only be discontinued with substantial compliance and with the approval of the facility□s QAPI committee. The Administrator is responsible for sustained compliance.	

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	necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the		The Grievance/Concern Procedural Guideline policy was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Staff Development coordinator/designee has re-educated staff on the Grievance/Concern Procedural Guideline policy, including the need to address and follow up on identified concerns and utilize the grievance form when appropriate. A process has been instituted to ensure the tracking and timely follow-up of grievance forms. Element 4 The Administrator/designee will conduct 5 random weekly audits of resident grievance forms, including those generated from resident council, to ensure appropriate and timely follow through has been completed for 4 weeks and then monthly thereafter. Results of these audits will be forwarded to the QAPI committee. The audits will only be discontinued with substantial compliance and with the approval of the facility□s QAPI committee. The Administrator is responsible for sustained compliance.	

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	issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to utilize and maintain complete grievance documentation resulting in grievances not being documented, tracked, and the results of conclusions and/or resolutions not being recorded. This deficient practice has the potential to affect all 81 residents that reside in the facility. Findings include. During an interview on 11/30/23 at 10:05 AM, a resident council group wanted to remain anonymous. 1) Food- up to 45 minutes late, on a daily base's meals are served late and it is cold. Several complains have been filed, but no resolved. 2) Food- no flavor, requested Mrs. Dash for meals, told it was too expensive. 3) Snack- No night snacks available. Diabetics are not offered a night snack. Some items in the refrigerator, 1/2 P & J sandwich, cookies, and crackers if they don't run out. 4) Requested to have lemonade or juices available during all hours of the day.			

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	5) Want to include the Ombudsman, and Owner to attend future meetings. 6) Laundry- Still missing clothes, getting laundry delivered to their room that belongs to another resident. Spilling bleach on colored clothes, needs replaced. Have complained several times, still happening. 7) Would like small snacks served during activities. 8) Showers/baths- not getting them as scheduled, Thursday is a common day to get missed. Not offered to take one on the following day. 9) Check and changed every 2 hours is not happening, they are short staffed, all shifts and on all days. Not getting briefs checked or changed like they should be or need to be. 11) Some residents are afraid to say anything because some staff will make them pay for it. They just go without their needs being met. 12) Resident was not getting help with their portable O2 tank changed, they went down, and therapy department helped them. Staff not watching levels of O2 left in portable tanks and they are running out of O2. During an interview on 11/29/23 at 2:00 PM, Administrator "A" provided the resident council meeting minutes for the year of 2022 and 2023. Also provided a word document			

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	with the date, name of resident and the nature of the concern. No other information documented. Writer asked Administrator "A" for the grievances that go along with the concern log. Record review of past resident council minutes and complaint forms for the year of 2022 and 2023. There was no complete grievance documentation ensuring that all written grievance decisions included the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident concern or any correction action taken etc. According to the Grievance/Concern Procedural Guidelines Policies and Procedures. Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g., the State Ombudsman). The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. 1. The facility will post in a public place in an area accessible to residents, employees, and visitors the following information related to			

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	734110	A. BUILDING _____ B. WING _____	11/30/2023

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	complaints: a. Name, title, location and telephone number of the facility grievance officer in the home who is responsible for receiving complaints and conducting complaint investigations. b. The procedure for communicating with that individual and an expected timeframe for completing the review of a grievance. c. The right to receive a written decision regarding his or her grievance. d. Contact Information for independent entities that hear grievances. e. Complaint Grievance Form 2. Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and complete a written report of such findings within ten (10) working days of receiving the grievance and/or complaint ...			
F0641 SS= D	Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to accurately complete the Minimum Data Set (MDS)	F0641	Element 1 Resident #23□s assessment was corrected to reflect the use of oxygen on 11/28/2023 and submitted by the MDS coordinator on 11/29/3023. Element 2 Residents residing in the facility have the potential to be affected. MDS assessments that have been submitted and accepted in the last 30 days have had Section O (Special	12/28/2023

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	assessment for 1 (Resident #23) of 19 reviewed, resulting in an inaccurate MDS assessment and the potential for unmet care needs. Findings include: Review of the medical record revealed that Resident #23 (R23) was readmitted to facility on 10/19/2022 with diagnoses including cerebral infarction, metabolic encephalopathy, dysphagia, and chronic respiratory failure with hypoxia. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/30/23 revealed that R23 had a Brief Interview for Mental Status (BIMS-a cognitive screening tool) score of 12 (moderate cognitive impairment). Section O of the same MDS revealed that R23 had not used oxygen while a resident during the 14-day assessment period (9/17/23-9/30/23). In an observation and interview on 11/17/23 at 11:52 AM, R23 was observed lying in bed, on back, with the head of the bed positioned at an approximate 60-degree angle. R23 was observed to have oxygen in place at 4 liters per minute via nasal cannula. R23 stated that he wore oxygen "all day and all night for a long time now". Review of R23's medical record completed with the following findings noted: Physician order dated 4/27/23 stated,		treatments, procedures, and programs) reviewed for Oxygen coding accuracy by the Regional MDS nurse or designee by 12/21/2023. No additional findings. Element 3 The MDS Coordinator and MDS nurse have been re-educated on the Certifying Accuracy of the Resident Assessment policy by the Administrator on 11/30/2023. Element 4 The MDS coordinator or designee will review 5 MDS assessments per week for accuracy in section O, oxygen coding. Audits will be submitted to the QAPI committee for review. The QAPI committee will determine the ongoing frequency of audits. The Administrator is responsible for sustained compliance.	

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	"Oxygen at 4 L/min [liters per minute] via nasal cannula to maintain SPO2 [oxygen saturation-measurement of how much oxygen your blood is carrying] above 94% [percent]". Treatment Administration Record dated 9/1/2023-9/30/2023 reflected 42 entries where oxygen was signed out as administered during the 9/17/23-9/30/23 assessment period. Review of oxygen levels within the vital signs tab during the 9/17/23-9/30/23 assessment period reflected 30 entries in which R23 was indicated to have "Oxygen via Nasal Cannula" in place. In an interview on 11/28/23 at 3:48 PM, Registered Nurse/Unit Manager (RN/UM) "C" confirmed familiarity with R23 as was the manager on the unit where he resided. RN/UM "C" stated that R23 had chronic respiratory issues as well as a history of a tracheostomy, had an order for oxygen, and that he had worn oxygen almost continuously for the prior two-year period that she had oversaw his care. RN/UM "C" stated that although she did not complete the MDS assessments, that she would expect that his most recent 9/2023 quarterly assessment reflect oxygen usage as confirmed that R23 utilized continuous oxygen therapy at that time. In an interview on 11/28/23 at 4:02 PM,			

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	Registered Nurse/Minimum Data Set Coordinator (RN/MDS Coordinator) "E" confirmed familiarity with R23, referenced R23's medical record and confirmed an active order for continuous oxygen therapy since 4/2023, as well as routine oxygen usage as indicated within the vital sign tab. RN/MDS Coordinator "E" confirmed that the ARD date for R23's September quarterly assessment was 9/30/23 with the 14 day look back period ranging from 9/17/23-9/30/23. Per RN/MDS Coordinator "E", an "as needed" MDS Nurse had completed R23's September 2023 quarterly assessment, had coded oxygen usage incorrectly as R23 had obviously been on oxygen during the 14 day look back period of that assessment, and that a modification would have to be done to reflect R23's actual oxygen usage during the assessment period.			
F0645 SS= D	PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the	F0645	Element 1 The PASRR for resident #9 was completed by the Administrator on 12/1/2023. Element 2 Current residents have been reviewed by the Administrator that is a licensed RN, to ensure PASRR compliance and any identified issues were corrected by 12/28/2023. Element 3 The Pre-Admission Screening and Annual Resident Review was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Administrator has re-educated the Director of Social Services on the Pre-Admission Screening and Annual Resident	12/28/2023

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	individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with		Review policy including the need to ensure PASRR compliance. This was completed by 12/22/2023. A tracking tool has been created to monitor timely PASRR completion. Element 4 The Director of Social Services/designee will conduct 5 random weekly audits of PASRR□s to ensure they are completed as scheduled X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance.	

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	a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to complete the 3878 portion of the Preadmission Screening (PAS)/Annual Resident Review (ARR) and/or failed to notify the State Agency Health Authority for 1 (Resident #9) of 2 residents reviewed for PAS/ARR from a total sample of 19, resulting in the potential for unmet mental health treatment and services. Findings include: Review of the medical record revealed that Resident #9 (R9) was initially admitted to the facility on 2/25/22 with diagnoses including anoxic brain damage, suicide attempt, major depressive disorder, mild unspecified dementia, bipolar disorder, generalized anxiety disorder, and history of traumatic brain injury. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/24/23 revealed that R9 had clear speech, was understood by others, and was able to understand others with a Brief Interview for Mental Status (BIMS-a cognitive screening tool) score of 10 (moderately impaired cognition). Section N of the same MDS reflected that R9 received antipsychotic and antidepressant medications. In an observation and interview on 11/27/23			

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	at 10:57 AM, R9 was observed lying on the floor, to the right of the bed, positioned on her right side with her head toward the foot of the bed. R9 was noted to be dressed in a facility gown with a white brief visible beneath, denied concerns when questioned as stated, "I'm fine. I'm just a little cold" but provided no response to follow-up questions regarding status. Review of the PAS/ARR dated 5/8/23 indicated an ARR which reflected R9 had diagnoses of adjustment disorder with mixed anxiety and depression, bipolar disorder, and generalized anxiety and received Zyprexa and Zoloft. Further review of the PAS/ARR was not noted to include the 3878. In an interview on 11/30/23 at 11:41 AM, Nursing Home Administrator (NHA) "A" stated that the Level 1 pre-screening was pulled from the portal by admissions and then the Social Worker tracked and completed the 30 day and annual assessments. NHA "A" stated that completion of the PAS/ARR had been a process as the facility had Social Work turnover, that she had helped complete the assessments, and confirmed completing R9's ARR dated 5/8/23. NHA "A" stated that upon completion of the 3877, the physician or the nurse practitioner would be alerted by OBRA of the need to complete the 3878 but as the facility changed ownership in May 2023, the prior physician assigned to the resident was still being notified for completion of the 3878 versus			

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	the current provider. NHA "A" stated that upon review of R9's 5/2023 ARR through the portal, that the 3878 dated 2022 pulled up versus the 2023 3878 for the associated 5/2023 3877. NHA "A" was unable to provide the Level II screening and stated that after coordinating with OBRA that no Level II for May 2023 was able to be located. Additionally, NHA "A" stated although R9 had a dementia diagnosis, her mental health history superseded that diagnosis and felt that if R9 was able to get additional mental health services through OBRA that she would benefit from them. Upon coordinating with OBRA, NHA "A" stated that the facility may have to redo R9's ARR to trigger OBRA to complete their assessment as OBRA denied having received the 5/2023 referral.			
F0656 SS= E	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	F0656	Element 1 Resident #4□s care plan was reviewed by a nurse manager and updated as appropriate to include prophylactic antibiotic use on 12/11/2023. Resident #23 had his splint placed during survey and the care plan was reviewed and updated as appropriate by a nurse manager on 12/11/23. Resident #38□s care plans were reviewed and updated as appropriate including the hospice service plan to flow to CENA Kardex on 12/22/2023. Resident #60□s low-air loss mattress was turned back on during survey and the care plan was reviewed and updated as appropriate by a nurse manager on 12/11/23. Resident # 76 no longer resides in the facility. Element 2 Care plans for residents residing in the facility	12/28/2023

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	under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: This Citation Pertains To Intake MI00139969 Based on observation, interview and record review, the facility failed to develop and implement care plans for 5 residents (R# 4, #23, #38, #60 and #76) of 19 reviewed, resulting in the potential for unmet care needs. Findings include: **Resident #4**		were reviewed and updated as appropriate by the IDT to ensure residents requiring use of low-air loss mattresses were in place and functioning. Residents requiring prophylactic antibiotics were reviewed to ensure a care plan was in place. Residents requiring the use of splints were audited to ensure that splints were in place as care planned. Residents requiring the use of oxygen were audited to ensure that oxygen care plans were in place. These reviews were completed by 12/28/2023. Element 3 The Care Plan Comprehensive policy was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Administrator has re-educated the IDT on the Care Plan Comprehensive policy including the need to ensure care planned interventions are in place and resident care plans are comprehensive and accurate by 12/28/2023 or during their next scheduled shift. The Staff Development coordinator/Designee has re-educated the nursing staff on the Care Plan Comprehensive policy including the need to ensure care planned interventions are in place and resident care plans are comprehensive and accurate by 12/28/2023 or during their next scheduled shift. The caring partner form has been updated to include that low-air loss mattresses are functioning and residents requiring splints have them in place. Element 4 The Director of Nursing/designee will conduct 5 random weekly audits of resident care plans to ensure the care planned interventions are in place and they are comprehensive and accurate X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and	

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	Review of the clinical record, including the Minimum Data Set dated and 9/30/23, R4 was admitted to the facility with diagnosis that included multiple sclerosis, R4 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). **During the initial screening process on 11/27/23 at approximately 1:00 pm, R4 was observed resting in bed and was interviewed at bedside, when queried about her antibiotic use, R4 reported she did not know why she was prescribed the antibiotic.** **Further review of the R4's clinical record reflected a physician order was written on 11/09/23 for Bactrim Oral Tablet 400-80 milligram one time daily for prophylactic due to recurrent urinary tract infections until 12/20/23. Further review of the clinical record reflected there was no care plan in place that addressed the need for an antibiotic.** **On 11/30/23 09:45 AM, during an interview with Registered Nurse /Unit Manager (RN/UM) "D", R4's record was reviewed, RN/UM "D" reported R4 had not had a urinary tract infection since August 2023 and was not certain of the rational for an antibiotic and offered no explanation as to why there was no care plan in place to address the use of the medication. When queried who was responsible for implementing care plans for antibiotics, RN/UM "D" reported Nursing staff.** **Resident #38 (R38)** **Review of the medical record revealed R38 was admitted to the facility 03/02/2023 with diagnoses that included chronic obstructive**		with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance.	

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	pulmonary disease (COPD), type 2 diabetes, diabetic neuropathy (nerve damage caused by diabetes), right above the knee amputation, nicotine dependance, alcohol abuse, benign prostatic hyperplasia (enlarged prostate), hypothermia (low body temperature), absence of left toes, protein calorie malnutrition, muscle wasting and atrophy, dysphagia (difficulty swallowing), hypertension, atrial fibrillation, hypothyroidism (low thyroid hormone), cerebral infarction (stroke), peripheral vascular disease (PVD), obstructive sleep apnea, depression, hyperlipidemia (high fat content in flood), chronic respiratory failure, and heart failure. The most recent Minimum Date Set (MDS), with an Assessment Reference Date (ARD) of 09/20/2023, demonstrated R38 had a Brief Interview for Mental Status (BIMS) of 14 (cognitively intact) out of 15. Section O (special treatments, procedures, and programs), with the same ARD of 09/30/2023, demonstrated that R38 had received hospice services while at the facility. During observation and interview on 11/30/2023 at 11:36 a.m. R38 was observed lying down in bed. R38 explained that he had been receiving hospice services while he was a resident at the facility. R 38 could not identify the name of the hospice agency that was providing care. R38 explained that two persons came twice a week to assist him with his bathing. He explained that they would come on Mondays and Thursdays. When asked what disciplines, from hospice, provided him services he could not list specifically and responded, "I get them all". R38 denied that he had been provided a hospice calendar that would have demonstrated what services were provided			

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	and when those services are provided. Review of R38's medical record demonstrated a care plan with the problem statement "Terminal Prognosis: ... has a terminal prognosis r/t (related to) heart failure. Resident admitted to ... Hospice" which was written 03/17/2023. No interventions were present listing the services that were to be provided, the disciplines that were to be provide services, or the frequency and time of those provided services. Review of R38's Visual Kardex (documentation provided in computerized charting demonstrating to Certified Nursing Aides the care to be provided) did not demonstrate that R38 was receiving hospice services. R38's medical record did not demonstrate a physician order for hospice services. In an interview on 11/30/2023 at 11:19 a.m. Certified Nursing Aide (CNA) "U" explained that she was aware that R38 was receiving hospice services because when hospice arrived at the building to provide care, she was notified by the hospice staff. CNA "U" could not explain what services where provided or what dates and times those services where to be provided. CNA "U" explained that if residents where to receive hospice services it would be listed on that resident Kardex. CNA "U" could not demonstrate that R38 was receiving any hospice services after reviewing R38's Kardex. In an interview on 11/30/2023 at 12;33 p.m. Unit Manger (UM) "D" explained that she knew R38 was receiving hospice services. She explained that it was the expectation that R38 would have a plan of care that informed			

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	the staff that he was receiving those services. She explained that an order should be in his medical record. UM "D" confirmed that no order for hospice services was present in R38's medical record. UM "D" explained that the Certified Nursing Aides (CNA's) would know what services had been provided and when by listing that would be on the plan of care and then transferred to the Kardex, which was used by the CNA's. UM "D" could not demonstrate a specific plan of care for R38's hospice services and confirmed that no information for hospice services was provided on R38's Kardex. Resident #76 (R76) Review of the medical record revelated R76 was admitted to the facility 09/13/2023 with diagnoses that included acute and chronic respiratory failure with hypoxia (low oxygen level), chronic obstructive pulmonary disease (COPD), pulmonary fibrosis (scaring of lungs) , muscle wasting and atrophy, interstitial pulmonary disease (cause scaring of lungs), ischemic cardiomyopathy (heart attack), chronic kidney disease, dependence on supplemental oxygen, malaise (general feeling of discomfort, illness, or lack of wellbeing), nicotine dependence, peripheral vascular disease (PVD), hypotension, atherosclerotic heart disease (plaque build-up in the wall of arteries), pulmonary hypertension, atherosclerosis of renal artery, congestive heart disease (CHF), insomnia, depression, hyperlipidemia (high fat content in blood), and mitral valve insufficiency. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/11/2023 revealed R76's Brief Interview of Mental Status (BIMS) was unable to be assessed. Section O (special treatments,			

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	progress, and programs), with the same ARD of 10/11/2023 demonstrated that R76 had received supplemental oxygen prior to and during her stay at the facility. R76 was discharged from the facility 10/11/2023. **In a telephone interview on 11/21/2023 at 04:15 p.m. R76 Family Member "AA" explained that R76 had been receiving oxygen therapy while she was at home and had continued to receive oxygen therapy while she was a resident at the facility. R76 Family Member "AA" explained that R76 had a fall while she was at the facility because the staff assisted her to the bathroom without keeping her oxygen on.** **Review of the medical record demonstrated that R76 had a physician order for 6 liters of oxygen administered by nasal canula. R76 plan of care did not demonstrate that R76 was to always receive oxygen by nasal canula. No information was present on R76's Kardex (documentation provided in computerized charting demonstrating to Certified Nursing Aides the care to be provided) did not list that she was to receive continues oxygen therapy. Review of the medical record demonstrated that R76 did have an fall that occurred on 09/15/2023 but did not demonstrate if oxygen was present during the fall.** Resident #23 Review of the medical record revealed that Resident #23 (R23) was readmitted to facility on 10/19/2022 with diagnoses including cerebral infarction, metabolic encephalopathy, and dysphagia. Review of			

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	the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/30/23 revealed that R23 had a Brief Interview for Mental Status (BIMS-a cognitive screening tool) score of 12 (moderate cognitive impairment). Section G of the same MDS revealed that R23 required two-person extensive assist with bed mobility, transfers, dressing, and toilet use and had an upper extremity functional limitation in range of motion on both sides. In an observation and interview on 11/27/23 at 11:52 AM, R23 was observed lying in bed, on back, with left upper arm positioned at side, elbow bent, forearm and hand resting on chest, thumb extended with remainder of fingers of left-hand flexed inward with fingertips touching palm of hand. R23 stated that he had history of a stroke, could not use, or extend left arm or fingers, and had a splint for the left hand which straightened his fingers but that he "didn't use too often" as could not place himself. A blue padded hand/wrist splint was noted on top of the dresser in the upper left-hand corner against the wall with a brown stuffed bear positioned on top of it. In an observation and interview on 11/28/23 at 3:28 PM, R23 was observed lying in bed, on back with left upper extremity positioned at side, elbow bent, with forearm and hand positioned on chest. Left thumb remained extended with remainder of fingers flexed inward with fingertips touching palm of hand.			

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	R23 denied that staff had placed or attempted to place left hand/wrist splint that date. The blue padded hand/wrist splint was noted to remain on top of the dresser in the upper left-hand corner against the wall with the brown stuffed bear remaining positioned on top of it and a white brief now partially covering the bear. Review of R23's Care Plan Focus "Alteration in musculoskeletal status r/t [related to] contracture of L [left] hand" revealed an associated intervention with a 5/2/23 date of revision which stated, "Implement left hand/wrist contoured orthosis to be donned in the am and remove at bed time [sic] as tolerated with q2 [every 2] hour/PRN [as needed] skin checks/range of motion/and repositioning for contracture management. Apply carrot device to left hand and left elbow posey splint at bedtime ..." In an interview on 11/28/23 at 3:33 PM, Licensed Practical Nurse (LPN) "F" confirmed familiarity with R23 and that she was his assigned nurse that date. Per LPN "F", R23 required total assist with all care as had history of a stroke that limited his upper extremity arm and hand function, wore boots for positioning of lower extremities, and had a splint for either his right or left hand. R23's room reentered in LPN "F's" presence with LPN "F" pointing to R23's left hand and confirming that although a splint was not currently in place, was worn on left hand. LPN "F" proceeded to obtain blue carrot splint (a			

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	soft splint shaped like a carrot which positions the fingers away from the palm to protect the skin from moisture, pressure, and nail puncture) from a pink basin in R23's closet, confirmed that was the splint that she normally placed in R23's left hand, and proceeded to place the carrot splint to R23's left hand with his permission. LPN "F" denied knowledge of any other hand/wrist orthotic that R23 used or had used since her hire date in May of 2023. In an interview on 11/28/23 at 3:48 PM, Registered Nurse/Unit Manager (RN/UM) "C" confirmed familiarity with R23 as he resided on the unit that she managed. RN/UM "C" stated that R23 had history of a stroke with left upper extremity contractures and that a left hand/wrist contoured splint was used during the day and a soft carrot splint was used at night. RN/UM "C" confirmed that R23 had two different splints as the contoured hand/wrist splint used during the day was to extend his fingers to decrease risk of further contracture and the soft carrot splint used at night was for protection. RN/UM "C" stated that R23 tolerated the left hand/wrist splint used during the day without difficulty, that she routinely placed when she worked as the assigned nurse on the unit, and that she had worked the unit and last placed R23's hand/wrist splint on 11/19/23. In an observation on 11/29/23 at 8:44 AM in the presence of LPN "F", R23 was observed lying in bed, on back with the head of the			

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	bed at an approximate 45-degree angle. R23 was observed to have the contoured blue hand/wrist splint in place to left upper extremity with LPN "F" stating that RN/UM "C" had assisted her to place R23's hand/wrist splint that morning as she had only ever placed the soft carrot splint prior. Resident #60 Review of the medical record revealed that Resident #60 (R60) was admitted to facility 11/16/2022 with diagnoses including mild dementia, type 2 diabetes mellitus, generalized osteoarthritis, chronic systolic heart failure, and pressure-induced deep tissue damage of sacral region. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/18/23 revealed that R60 was understood by others and able to understand others with a Brief Interview for Mental Status (BIMS-a cognitive screening tool) score of 6 (severely impaired cognition). Section M of the same MDS reflected that R60 was at risk of developing pressure injuries, had an unhealed deep tissue pressure injury, and had a pressure reducing device for her bed. Further review of the medical record reflected that R60's deep tissue pressure injury at coccyx was resolved on 11/7/23. In an observation and interview on 11/27/23 at 10:21 AM, R60 was observed lying in bed, on back, with the head of the bed at an approximate 30-degree angle. R60 was			

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	observed to have left leg extended straight out, right leg bent at knee and positioned under left, and bare feet with left heel and right lateral foot in direct contact with mattress. Soft blue cushioned heel protectors noted at foot of bed with R60 stating that she kicked them off as "they make my legs hurt". Low air loss mattress observed on bed with mattress pump attached to foot board of bed noted in the off position. In an observation on 11/27/23 at 12:28 PM, R60 was observed lying in bed, on back, with eyes closed, bilateral legs extended straight out with left lower leg crossed over right, and bare feet with bilateral heels in direct contact with mattress. Low air loss mattress pump observed to remain in off position. In an observation and interview on 11/28/23 at 8:33 AM, R60 was observed lying in bed, on back, with the head of the bed at an approximate 90-degree angle with breakfast tray positioned on the over the bed table in front of her. R60's legs were noted to be extended straight out with heels resting directly on mattress. Low air loss mattress pump observed to remain in off position. In an observation on 11/28/23 at 3:21 PM, R60 was observed lying in bed, on right side, facing wall with bed now noted to be positioned with right side against wall. Low air loss mattress was observed to remain on bed with mattress pump attached to foot board of bed noted to remain in the off			

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	position. Review of R60's Care Plan Focus "[R60] has potential for pressure ulcer development r/t [related to] HX [history] of pressure injury, immobility, incontinence, fragile skin ..." revealed an associated intervention with a 10/27/23 revision date which stated, "Provide LAL [low air loss] mattress check function q [every] shift and prn [as needed]". Review of R60's Kardex (tool used by the Certified Nurse Aide to guide them as to the care needs of a specific resident) indicated within "Resident Care" section to, "Provide LAL mattress and check function q shift and prn". In an interview on 11/28/23 at 4:21 PM, RN/UM "C" confirmed familiarity with R60 as she resided on the unit that she managed. RN/UM "C" stated that R60 required one-person assist with bathing, dressing, bed mobility, transfer, incontinency care, and toilet use. Per RN "C", R60's skin was fragile, had history of a pressure ulcer at her coccyx that had resolved on 11/7/23 but was at high risk for reopening as had scar tissue present to site with ongoing precautionary skin measures which included routine lotion application to dry skin, barrier cream to perineal area after incontinency episodes, offloading boots as allowed, and assist with repositioning. RN/UM "C" also confirmed that R60 had a low air loss mattress on her bed and that both the nurses and the aides			

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	should verify that that mattress was on and functioning whenever care was provided. Upon conclusion of interview, R60's room reentered in presence of RN/UM "C". RN/UM "C" confirmed R60 had a low air loss mattress on bed, that the mattress pump was plugged in, but that the pump was not turned on. RN/UM "C" was observed to flip the pump switch to the on position at which time the pump switch lit up. RN/UM "C" confirmed that per R60's care plan, the mattress function should be monitored by both the nurses and the aides at least every shift, the pump should not be turned off, and maintenance should be notified for any malfunctioning mattress. Review of R60's physician order dated 11/29/23 at 9:18 AM (obtained/written after completion of interview with RN/UM "C" on 11/28/23) stated, "Verify functionality of APM [alternating pressure mattress] mattress three times a day".			
F0657 SS= D	Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the	F0657	Element 1 Resident #6 have had their care plan reviewed and updated as appropriate by the IDT to ensure the care plans are accurate including the need to check functionality of her audio monitor. This was completed by 12/11/2023. Resident # 76 no longer resides in the facility. Element 2 Care plans for residents residing in the facility were reviewed and updated as appropriate by the IDT to ensure their care plans are	12/28/2023

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	participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: This Citation Pertain To Intake MI000139969 Based on observation, interview and record review the facility failed to revise care plans for 2 residents (#6, and #76) of 19 residents reviewed for care plan revisions, resulting in the potential for unmet needs. Findings include : Resident #76 (R76) Review of the medical record revealed R76 was admitted to the facility 09/13/2023 with diagnoses that included acute and chronic respiratory failure with hypoxia (low oxygen level), chronic obstructive pulmonary disease (COPD), pulmonary fibrosis (scaring of lungs) , muscle wasting and atrophy, interstitial pulmonary disease (cause scaring of lungs), ischemic cardiomyopathy (heart attack), chronic kidney disease, dependence on supplemental oxygen, malaise (general		accurate and comprehensive. This was completed by 12/28/2023. Element 3 The Care Plan Comprehensive policy was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Administrator has re-educated the IDT on the Care Plan Comprehensive policy including the need to ensure resident care plans are comprehensive and accurate on 12/4/2023. The Staff Development coordinator/Designee has re-educated the nursing staff on the Care Plan Comprehensive policy including the need to ensure resident care plans are accurate and reflect resident current status by 12/28/2023 or during their next scheduled shift. Element 4 The Director of Nursing/designee will conduct 5 random weekly audits of resident care plans to ensure they are accurate and reflect resident status X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance.	

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	feeling of discomfort, illness, or lack of wellbeing), nicotine dependence, peripheral vascular disease (PVD), hypotension, atherosclerotic heart disease (plaque build-up in the wall of arteries), pulmonary hypertension, atherosclerosis of renal artery, congestive heart disease (CHF), insomnia, depression, hyperlipidemia (high fat content in blood), and mitral valve insufficiency. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/11/2023 revealed R76's Brief Interview of Mental Status (BIMS) was unable to be assessed. Section O (special treatments, progress, and programs), with the same ARD of 10/11/2023 demonstrated that R76 had received supplemental oxygen prior to and during her stay at the facility. R76 was discharged from the facility 10/11/2023. In a telephone interview on 11/21/2023 at 04:15 p.m. R76 Family Member "AA" explained that R76 had been receiving oxygen therapy while she was at home and had continued to receive oxygen therapy while she was a resident at the facility. R76 Family Member "AA" explained that R76 had a fall while she was at the facility because the staff assisted her to the bathroom without keeping her oxygen on. Review of the medical record demonstrated that R76 had a physician order for 6 liters of oxygen administered by nasal canula. R76 plan of care did not demonstrate that R76 was to always receive oxygen by nasal canula. No information was present on R76's Kardex (documentation provided in computerized charting demonstrating to Certified Nursing Aides the care to be provided) did not list that she was to receive continues oxygen therapy. Review of the			

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	medical record demonstrated that R38 did have a fall that occurred on 09/15/2023 but did not demonstrate if oxygen was present during the fall. Review of R76's incident report, date of 09/15/2023 at 05:30 p.m., did not list any new interventions to prevent the fall that occurred. Review of R76's medical record demonstrated a care plan which stated "I am at risk for falls related to:" The plan of care did not demonstrate that R76 had an actual fall and list no new interventions related to the fall of 9/15/2023. In an interview on 11/28/2023 at 09:10 a.m. Director of Nursing (DON) "B" confirmed that R76's care plan was not updated after the fall that occurred 9/15/2023 to reflect that she had an actual fall. She could not explain why the plan of care had not been updated to include the fall or any interventions that were put into place. Resident #6 (R6) Review of the medical record revealed Resident #6 (R6) was admitted to the facility on 04/04/22 with diagnoses that included Multiple Sclerosis, Quadriplegia, Neurogenic Bladder, feeding tube, Cardiovascular Accident and Depression. According to Resident #6 (R6)'s Minimum Data Set (MDS) dated 09/28/23, revealed R6 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS- a cognitive screening tool) and had no behaviors. R30 is dependent of all activities of			

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	daily living, is bedbound and requires all hydration and medication administration to be through her feeding tube. During an observation and interview on 11/28/23 at 08:06 AM, R6 stated that her call light did not work, so she had to yell, and she did not have a very strong or loud voice. R6 also stated she didn't know how often the CNA comes in to check on her, so she had no way to call for help. R6 stated that she had been without it for at least 2 days. During an interview on 11/28/23 at 08:18 AM, Licensed Practical Nurse (LPN) "HH" stated that R6 blows into the straw device and the call light panel lights up on the wall and the pagers go off. During an interview and observation on 11/28/23 at 08:23 AM, DON "B" stated she did not know how her call light worked, DON "B" walked went up and down the floor asking the Unit Manager (UM) "C" and LPN "HH" for assistance. During an interview and observation on 11/28/23 at 0828 AM, Certified Nursing Assistant (CNA) "II" and CNA "JJ" walked into the room of R6 and started looking for the white adapter called a breath call that that was not attached to the controller tubing. CNA "II" found it laying on the nightstand. Nobody knew how long she has been without it. UM "C" came into R6's room, gowned up in PPE, and placed a new breath			

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	call device on the tubing, call light was tested with CNA's, LPN "HH", and it worked now. UM "C" went out to the nurse's station to see who was on R6's schedule the last 2 days and why this was not observed. During an interview on 11/29/23 at 10:40 AM, UM "C" stated they did not put any interventions in place to prevent this from happening again yet, she had been too busy. Writer asked UM "C" if she had investigated this occurrence to find out how and when it happened. UM 'C' looked at writer with irritation and stated, no, not yet. During an interview on 11/29/23 at 10:59 AM, DON "B" stated that nobody knows when the breath call came out on R6. DON "B" stated that the new intervention was put in place yesterday, 11/28/23. CNAs would check the placement of the breath call at the beginning and end of the shift, nurses check it during each shift. DON "B" also stated that staff should be able to see the Breath Call from the door and when they were providing care every 2 hours. Writer asked to see documentation that R6 was getting checked on every 2 hours. Observation of DON "B" looking for proof that this resident was checked, changed, and repositioned every 2 hours. DON "B" stated that the care plan kardex stated the CNAs were checking on her, changing her brief and repositioning her every 2 hours, but there was no document supporting that R6 was checked on, brief changed and repositioned every 2 hours.			

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	DON "B" stated that the CNAs check off every shift stating they performed those tasks, but no proof that it was completed. During an interview and observation on 11/29/23 at 1:08 PM, R6 stated she had asked them to move the breath call device down because it blocked her view of the TV. Writer asked R6 if staff had offered to move her call light on the other side of her head so she could watch TV better, R6 stated no. Writer asked R6 if the staff had ever offered to move the bed or TV to accommodate her needs, R6 stated no. R6 also stated that she was not involved with activities because it was too hard to get up in her chair and she cannot really participate. R6 stated she enjoys watching her TV. Record review did not reflect any new interventions on the care plan to better meet R6's needs. No interventions on checking the breath call as R6's only means of communicating and calling for help. No changes in the setup of her room, to allow her to see her TV better.			
F0676 SS= D	Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes	F0676	Element 1 Resident #45 received oral care and grooming by facility staff during the survey. Element 2 Residents residing in the facility were reviewed by the IDT to ensure appropriate oral care and grooming has been completed. Any identified issues were corrected. This was completed by 12/8/2023. Element 3	12/28/2023

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	the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide oral care to one resident reviewed for maintaining activities of daily living (Resident #45), resulting in poor oral hygiene and the potential to decline in other activities of daily living abilities. Findings include: Resident #45 (R45) Review of the medical record revealed Resident #45 (R45) was admitted to the facility initially on 08/25/21, then readmitted on 10/18/23 with diagnoses that included Pneumonia, Septicemia, Urinary Tract Infection, Dementia and Malnutrition. R45		The Bath-Shower policy was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Staff Development coordinator/Designee has re-educated nursing staff on the Bath-Shower policy including the need to ensure residents are receiving appropriate bathing, oral care, and grooming by 12/28/2023 or during their next scheduled shift. The IDT□s Caring Partner form has been updated to include observation for oral care and grooming. The forms are submitted to the Administrator for review and follow up. Element 4 The Director of Nursing/designee will conduct 10 random weekly resident observations to ensure appropriate oral care and grooming has been completed X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance.	

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	uses a wheelchair to move through the facility. According to Resident #45 (R45)'s Minimum Data Set (MDS) dated 09/28/23, revealed R45 scored 11 out of 15 (cognitively impaired) on the Brief Interview for Mental Status (BIMS- a cognitive screening tool) and had no behaviors. According to Section GG; Functional Abilities and Goals, GG0130. Self-Care scored R45 03=Partial/moderate assistance, helper does less than half the effort. During an interview and observation on 11/27/23 at 12:07 PM, R45 in the dining room waiting for his lunch to be served. Observation of R45's teeth covered with buildup, as they had not been brushed in some time. Also observed R45 trying to remove this build up with his tongue. During an interview on 11/29/23 at 11:13 AM, DON "B" stated she had to look under the care plan task to see if his teeth had been brushed or not. DON "B" stated she was looking at the care plan task and on 11/27/23, CNA did not attempt to brush his teeth. Writer asked why several days were marked as not attempted. DON "B" stated there was another section named oral care and it was documented that the staff were asking the residents at 3:00-4:00 AM to get their teeth brushed. Writer asked DON "B" why staff would be asking residents if they wanted their teeth brushed in the middle of			

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	the night. DON "B" stated it had to do with the program and the shifts that staff work. Writer reported to DON "B" that there was a concern with this resident not getting his teeth brushed for days.			
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: This citation pertains to Intake: MI00139969 Based on observation, interviews, and record review the facility failed to provide Activities of Daily Living (ADL), including bathing/showering and oral care, for two dependent residents (#6, #76) out of four resident reviewed for ADL completion resulting in missed bathing/showers, inadequate oral care and potential feelings of embarrassment. Findings Included: Resident #76 (R76) Review of the medical record revealed R76 was admitted to the facility 09/13/2023 with diagnoses that included acute and chronic respiratory failure with hypoxia (low oxygen level), chronic obstructive pulmonary disease	F0677	Element 1 Resident #6 received bathing per preference including oral care and grooming by facility staff on 11/29/2023. Resident #76 no longer resides in the facility. Element 2 Residents residing in the facility were reviewed by the IDT to ensure bathing, grooming, and oral care has been completed. Any identified issues were corrected. This was completed by 12/10/2023. Element 3 The Bath-Shower policy was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Staff Development coordinator/Designee has re-educated nursing staff on the Bath-Shower policy including the need to ensure residents are receiving appropriate bathing, oral care, and grooming by 12/28/2023 or during their next scheduled shift. The IDT□s Caring Partner form has been updated to include observation for oral care, showering and grooming. The forms are submitted to the Administrator for review and follow up. Element 4 The Director of Nursing/designee will conduct 10 random weekly resident observations to ensure appropriate bathing, oral care, and grooming has been completed X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI Committee.	12/28/2023

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	(COPD), pulmonary fibrosis (scaring of lungs), muscle wasting and atrophy, interstitial pulmonary disease (cause scaring of lungs), ischemic cardiomyopathy (heart attack), chronic kidney disease, dependence on supplemental oxygen, malaise (general feeling of discomfort, illness, or lack of wellbeing), nicotine dependence, peripheral vascular disease (PVD), hypotension, atherosclerotic heart disease (plaque build-up in the wall of arteries), pulmonary hypertension, atherosclerosis of renal artery, congestive heart disease (CHF), insomnia, depression, hyperlipidemia (high fat content in blood), and mitral valve insufficiency. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/11/2023 revealed R76's Brief Interview of Mental Status (BIMS) was unable to be assessed. Section G (Functional Abilities and Goals), with the same ARD, demonstrated that R76 required "partial/moderate assistance" with bathing/showers. R76 was discharged from the facility 10/11/2023. In a telephone interview on 11/21/2023 at 04:15 p.m. R76 Family Member "AA" explained that R76 had only received one bath/shower while she was a resident at the facility. R76 Family Member "AA" explained that R76 was not capable of bathing or showering herself. Review of R76 medical record demonstrated that R76's plan of care stated, "Bathing/Showering: I require extensive		The Administrator is responsible for sustained compliance.	

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	assistance by (1) staff with bathing/showering." Review of R76's Bathing task documentation revealed that R76 was to have a shower/bed bath on Tuesday and Friday during the second shift. Review of the documentation for Bathing/Showering task it was demonstrated that R76 was only given a shower 9/26/2023 (Tuesday). The same documentation demonstrated that the documentation for shower/bath was blank for 9/15/2023(Friday) and blank for 9/29/2023 (Friday). In an interview on 11/29/2023 at 09:18 a.m. Unit Manager (UM) "D" that necessary bath/shower are relayed to the Certified Nursing Aides (CNA'S) by a schedule that is kept at the nursing stations. She also explained that all residents receive a bath/shower twice per week. UM "D" explained that CNA staff document completion of the showers in Point of Care (computerized documentation system). UM "D" could not explain why R76 had only documentation that demonstrated one completed shower during her stay at the facility. In an interview on 11/29/2023 at 09:33 a.m. Director of Nursing (DON) "B" explained that it was her expectation that each resident was to be offered a bath/shower at least twice per week. DON "B" explained that CNA staff documentation completion of bath/shower was to be documented in Point of Care. DON "B" could not explain why R76 had only			

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	documentation that demonstrated one competed shower during her stay at the facility. Resident #6 (R6) Review of the medical record revealed Resident #6 (R6) was admitted to the facility on 04/04/22 with diagnoses that included Multiple Sclerosis, Quadriplegia, Neurogenic Bladder, feeding tube, Cardiovascular Accident and Depression. According to Resident #6 (R6)'s Minimum Data Set (MDS) dated 09/28/23, revealed R6 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS- a cognitive screening tool) and had no behaviors. R30 is dependent of all activities of daily living, is bedbound and requires all hydration and medication administration to be through her feeding tube. During an interview and observation on 11/28/23 at 09:02 AM, R6 stated she does not get her teeth/gums brushed regularly. R6's does not have her own teeth but still required oral care for good hygiene. R6 stated that if certain CNAs were working, then she knows she will get the care she needed. Writer informed R6 that I could smell urine and asked when the last time she was checked and changed. R6 stated she did not know exactly, but it had been a while.			

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	During an interview on 11/29/23 at 1:20 PM, CNA "LL" stated she changed R6 between 10:00-10:15 AM. CNA "LL" also stated R6 was a heavy wetter, so it takes 2 CNAs to change her (care planned for 2). CAN "LL" stated she was getting ready to check and change R6 and asked another CNA to assist her. During an observation on 11/29/23 at 1:30 PM, 2 CNAs were observed going into R6's room, and then walked out of R6's room with soiled brief and supplies. It had been over 3 hours that R6 had been checked and changed. Staff were not following the care plan Kardex stating this would to be done every 2 hours. Record review revealed R6 care plan revealed that R6 was to be checked and changed every 2 hours, but by observation, R6 was not checked and changed every 2 hours. Record review of the care plan task sheet revealed that R6 is getting repositioned 2 to 4 times in a 24-hour period. Care plan interventions were to reposition R6 every 2 hours. R6 is unable to reposition herself and is dependent on caregivers to provide this care every 2 hours.			
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident	F0689	Element 1 Residents #75 and #76 no longer reside in the facility. Element 2 Residents who have experienced a fall in the last 30 days have been reviewed by the IDT	12/28/2023

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	receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00138918 and MI00139969 Based on interview and record review the facility failed to adequately assess the root cause analysis of resident falls and place appropriate fall prevention interventions, after falls, for two residents (#75, #76) of four residents reviewed for accidents and hazards resulting in continued falls and the potential for resident injury. Findings Included: Resident #75 (R75) Review of the medical record revealed R75 was admitted to the facility 04/07/23 with diagnoses that included pressure ulcer of the sacral region, cognitive communication deficit, lack of coordination, dysphagia (difficulty swallowing), acute respiratory failure, congestive heart failure (CHF), cardiomyopathy (enlarged heart), nontraumatic intracerebral hemorrhage (brain bleed), paraplegia (paralysis of the legs and lower body), osteoarthritis (degeneration of cartilage in joints), depression, anemia (low red blood cells), hyperlipidemia (high fat amount in blood), and degenerative disease of the basil ganglia (parkinsonism). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/12/2013, revealed R75 had a Brief Interview of Mental Status (BIMS) of 9 (moderate cognitive		to ensure a thorough investigation and root cause analysis has been completed. Any identified issues were corrected. This was completed by 12/21/2023. Element 3 The Managing Falls-Clinical Protocol was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Clinical Support Specialist has re-educated the IDT on the Managing Falls-Clinical Protocol including the need to ensure a complete investigation and root cause analysis has been completed on 12/4/2023. The Staff Development coordinator/Designee has re-educated nursing staff on the Managing Falls-Clinical Protocol including the need to complete a thorough investigation report by 12/28/2023 or during their next scheduled shift. Morning meeting template has been updated to include determination of root cause analysis with appropriate fall prevention interventions. Element 4 The Director of Nursing/designee will conduct 5 random weekly audits of residents who have experienced a fall to ensure a thorough investigation report was completed X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance.	

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	impairment) out of 15. R75 was discharged from the facility 09/17/2023. In a telephone interview on 11/27/2023 at 10:18 a.m. R75 Family Member "Y" explained that R75 had fallen more than 9 times while he was at the facility. R75 Family Member "Y" explained that she did not feel that the facility had interventions in place to prevent him to have that many falls. Review of the R75's medical record revealed that he was found on the floor, in his room, and was trying to place himself in bed on 04/08/2023 at 07:49 a.m. Review of the incident report from this time and date demonstrated that an immediate intervention was put in place to educate R75's on the use of his call light. A note located on the incident for 04/08/2023 at 07:49, which was dated 04/10/2023 stated "IDT [Interdisciplinary team] review of risk management: resident to be moved for higher visibility, OT [Occupational Therapy] to assess for w/c [wheelchair] positioning". R75's medical record demonstrated that he did not have a room move until 04/10/2023. No route cause analysis was demonstrated on the incident report or in the medical record. Review of R75's medical record revealed that on 04/09/2023 at 02:40 a.m. that he had placed himself on the floor. The incident report demonstrated that documentation which stated, " ...resident seemed for confused at night". The immediate intervention was documented as "nurse re-educated resident how to use the call light". Documentation on R75's incident report which was dated 04/10/2023 stated "IDT [Interdisciplinary team] review of risk management: resident to be moved for			

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	higher visibility, OT [Occupational Therapy] to assess for w/c [wheelchair] positioning". No root cause analysis was demonstrated on the incident report or in the medical record. Review of R75's medical record revealed that on 04/11/23 at 12:30 a.m. he was had slide out of bed. Documentation on R75's incident report, dated 04/11/2023, demonstrated ""IDT [Interdisciplinary team] review of risk management: POC [Plan of Care] reviewed and updated to include assisting to common areas if restless at night. R75's medical record did not demonstrate the cause for restlessness or interventions to prevent restlessness. Review of R75's medical record revealed that on 04/26/2023 at 06:45 a.m. was found on the floor next to his bed. The incident report demonstrated that he was reaching for a box of candy. The incident report demonstrated that a root cause analysis was completed, and new interventions placed. Review of R75's medical record revealed that on 05/10/2023 at 09:45 p.m. was found on the floor next to his bed and R75 was observed with repeated attempts to get out of bed. The incident report demonstrated that R75 was given a bariatric bed and a parameter mattress. The incident report did not address the root cause of R75's repeated attempt to get out of bed. Review of R75's medical record revealed that on 05/19/2023 at 04:30 p.m. he was observed falling out of his bed. No immediate interventions were listed on the incident report or in R75's medical record. The incident report revealed a note dated 5/22/2023 which state, ""IDT [Interdisciplinary			

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	734110	A. BUILDING _____ B. WING _____	**11/30/2023**

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	team] review of risk management: low bed and remove wheels from bariatric bed". No root cause was completed as to why R75 was trying to get out of his bed. Review of R75's medical record revealed that on 6/19/2023 at 07:53 p.m. he was found on the floor next to his bed. Documentation on the incident report stated that he was trying to get up and walk. The immediate intervention was to place R75 in a chair at the nurse's station for observation. No root cause was completed related to that fall. Review of R75's medical record revealed that on 06/22/2023 at 02:26 a.m. he was found on the floor next to his bed. Documentation on the incident report stated that he "turned to much". No immediate intervention to prevent fall was found in the medical record. The incident report demonstrate documentation dated 06/22/2023 which stated, "IDT [Interdisciplinary team] review of risk management: POC [Plan of Care] reviewed and updated to include staff to assist into Borda chair when restless". No root cause or interventions was present in the incident report or medical record that addressed R75's "restlessness". Review of R75's medical record revealed that on 07/09/2023 at 07:00 a.m. he was found on his knees next to his bed with his head on his bed. The incident report demonstrated that he was trying to reach his TV remote. No immediate intervention was listed in the incident report or the medical record. The incident report demonstrated documentation dated 07/10/2023 which stated, ""IDT [Interdisciplinary team] review of risk management: POC [Point of Care] reviewed to include assist back to bed after breakfast			

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	as tolerated. Nothing in the incident report or medical record demonstrated a root cause analysis or an appropriate intervention for this incident. Review of R75's medical record revelated that on 07/19/2023 at 04:24 a.m. that he was found on the floor. The incident report demonstrated that he had informed staff that he had rolled out of bed. The incident report did not demonstrate immediate action taken but did demonstrate a root cause and appropriate interventions of changing the type of bed that he was to use. Review of R75's medical record revelated that on 09/05/2023 at 03:45 p.m. he was found on the floor next to his bed. No immediate intervention was demonstrated in the incident report or the medical record. R75's medical record and/or incident report did not provide a root cause analysis of the fall or new interventions that had been put into place. In an interview on 11/28/2023 at 09:25 a.m. Director of Nursing (DON) "B" explained the facility policy to prevent falls with residents. She explained that if a fall has occurred the staff must place an intervention in place, update the plan of care, and then the interdisciplinary team would conduct a root cause analysis and determine the cause of the fall and place any further intervention in the resident's plan of care that would minimize the resident's risk. DON "B" reviewed falls of R75 but could not answer to why root cause was not completed at the time of the falls and responded that she could only answer for falls that occurred while she was the DON, which was since August of 2023.			

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	Resident #76 (R76) Review of the medical record revelated R76 was admitted to the facility 09/13/2023 with diagnoses that included acute and chronic respiratory failure with hypoxia (low oxygen level), chronic obstructive pulmonary disease (COPD), pulmonary fibrosis (scaring of lungs) , muscle wasting and atrophy, interstitial pulmonary disease (cause scaring of lungs), ischemic cardiomyopathy (heart attack), chronic kidney disease, dependence on supplemental oxygen, malaise (general feeling of discomfort, illness, or lack of wellbeing), nicotine dependence, peripheral vascular disease (PVD), hypotension, atherosclerotic heart disease (plaque build-up in the wall of arteries), pulmonary hypertension, atherosclerosis of renal artery, congestive heart disease (CHF), insomnia, depression, hyperlipidemia (high fat content in blood), and mitral valve insufficiency. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/11/2023, revealed R76's Brief Interview of Mental Status (BIMS) was unable to be assessed. Section O (special treatments, progress, and programs), with the same ARD of 10/11/2023 demonstrated that R76 had received supplemental oxygen prior to and during her stay at the facility. R76 was discharged from the facility 10/11/2023. In a telephone interview on 11/21/2023 at 04:15 p.m. R76 Family Member "AA" explained that R76 had been receiving oxygen therapy while she was at home and had continued to receive oxygen therapy while she was a resident at the facility. R76 Family Member "AA" explained that R76 had a fall while she was at the facility because			

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	the staff assisted her to the bathroom without keeping her oxygen on. Review of R76 medical record revealed that a fall had occurred on 09/15/2023 at 05:30 p.m. The incident report revealed that a Certified Nursing Aide (CNA) was assisting R76 back to bed from using the bathroom and R76 lost her balance and went to the floor next to her bed. The incident report did not document the use of oxygen at that time. No immediate intervention was revealed in the medical record for this fall and no root cause analysis was present in the medical record. Review of R76 medical record revealed that on 10/11/2023 at 02:35 a.m. that R76 was found on the floor. Documentation in the medical record stated, "Notified by CNA [Certified Nursing Aide] that [resident] was on the floor. Went to res. [resident] room and she denied any pain .... When attempting to get res [resident] sat up for moving her into bed, she passed out. Res. [Resident] was laid back on the floor." Resident R76 was transferred to the hospital. The incident report demonstrated that on 10/11/23 a note which stated, "IDT [Interdisciplinary Team] review of fall 02:36 a.m. This is considered an acute medial episode; she was sent to ER [Emergency Room] where she was admitted". The incident report did not demonstrate any root cause the fall or any corrective action that may have been necessary. In an interview on 11/28/2023 at 09:10 a.m. Director of Nursing (DON) "B" was asked to review the falls for R76 that had occurred during the residents stay, and asked to demonstrate documentation the a root cause			

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	analysis had been completed interventions that would have been put into place. DON "B" could not provide documentation showing any interventions that were put into place for the fall that occurred on 09/15/2023 and no root cause analysis. DON "B" explained that it was her expectation that a root cause and an intervention would not have been completed for the fall that occurred 10/11/2023 because R76 was discharged to the hospital. When DON "B" was asked to explain why it would not at least be important to conduct a root cause analysis to determine opportunities to keep other residents safe from a system failure that may have resulted in a fall and she responded, "off course it would". DON "B" did not provide further explanation why a root cause analysis was not conducted following R76's fall on 10/11/2023. In an interview on 11/29/2023 at 10:28 a.m. Certified Nursing Aide (CNA) "R" explained that she had been the CNA that was assisting R76 back from the bathroom on 09/15/2023 at the time of the fall. CNA "R" explained that R76 had taken herself to the bathroom and did not have her oxygen on while she was in the bathroom. CNA "R" explained that she did not place oxygen back on R76 because the oxygen tubing would not reach to the bathroom. She explained that she did not obtain longer oxygen tubing because she was not aware of where longer oxygen tubing was kept. She explained that she had let someone know but could not let remember who that person would have been. Review of facility policy entitled "Falls and Risk, Managing", with an implementation date of 2001 and a last revision date of 2018 demonstrated the following:			

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	"Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the IDT, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). 3. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc. 4. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling, or indicate why those medications could not be tapered or stopped, even for a trial period. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable.			

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	7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. Monitoring Subsequent Falls and Fall Risk 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. 4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls."			
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan,	F0695	Element 1 Resident #76 no longer resides in the facility. Element 2 Current residents requiring oxygen administration have been reviewed by nurse managers to ensure a current order, and the appropriate tubing length is being utilized. Any identified issues were corrected. This was completed by 12/28/2023.	12/28/2023

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	the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00139969 Based on interview and record review the facility failed to follow physician orders for constant oxygen therapy and provide appropriate oxygen tubing for one resident (#76) of three residents reviewed for respiratory care resulting in the potential for respiratory complications. Findings Included: Resident #76 (R76) Review of the medical record revealed R76 was admitted to the facility 09/13/2023 with diagnoses that included acute and chronic respiratory failure with hypoxia (low oxygen level), chronic obstructive pulmonary disease (COPD), pulmonary fibrosis (scaring of lungs) , muscle wasting and atrophy, interstitial pulmonary disease (cause scaring of lungs), ischemic cardiomyopathy (heart attack), chronic kidney disease, dependence on supplemental oxygen, malaise (general feeling of discomfort, illness, or lack of wellbeing), nicotine dependence, peripheral vascular disease (PVD), hypotension, atherosclerotic heart disease (plaque build-up in the wall of arteries), pulmonary hypertension, atherosclerosis of renal artery,		Element 3 The Oxygen Administration policy was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Staff Development coordinator/Designee has re-educated licensed nurses on the Oxygen Administration policy including the need to enter the physicians order on the electronic record and utilizing the appropriate length of oxygen tubing by 12/28/2023 or during their next scheduled shift. Verification of appropriate oxygen tubing length has been added to the IDT Caring Partner□s form. Forms are to be submitted to the Administrator for review. Element 4 The Director of Nursing/designee will conduct 5 random weekly audits of residents requiring oxygen administration to ensure an order has been entered in the electronic record and the appropriate oxygen tubing length is being utilized X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance.	

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	congestive heart disease (CHF), insomnia, depression, hyperlipidemia (high fat content in blood), and mitral valve insufficiency. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/11/2023, revealed R76's Brief Interview of Mental Status (BIMS) was unable to be assessed. Section O (special treatments, progress, and programs), with the same ARD of 10/11/2023 demonstrated that R76 had received supplemental oxygen prior to and during her stay at the facility. R76 was discharged from the facility 10/11/2023. In a telephone interview on 11/21/2023 at 04:15 p.m. R76 Family Member "AA" explained that R76 had been receiving oxygen therapy while she was at home and had continued to receive oxygen therapy while she was a resident at the facility. R76 Family Member "AA" explained that R76 had a fall while she was at the facility because the staff assisted her to the bathroom without keeping her oxygen on. R76 Family Member "AA" also explained that the facility did not provide R76 with longer oxygen tubing that could be used while R76 used the bathroom. Review of the medical record demonstrated that R76 had a physician order for 6 liters of oxygen administered by nasal canula, which was written 09/26/23. R76's medical record revealed a previous oxygen order, Oxygen therapy at 4 liters nasal canula. Maintain SPO2 (blood oxygenation) written 9/14/23. R76 plan of care did not demonstrate that			

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	R76 was to always receive oxygen by nasal canula. No information was present on R76's Kardex (documentation provided in computerized charting demonstrating to Certified Nursing Aides the care to be provided) did not list that she was to receive continues oxygen therapy. Review of the medical record demonstrated that R76 did have a fall that occurred on 09/15/2023 but did not demonstrate if oxygen was present during the fall. In an interview on 11/29/2023 at 10:28 a.m. Certified Nursing Aide (CNA) "R" explained that she had been the CNA that was assisting R76 back from the bathroom on 09/15/2023 at the time of R76's fall. CNA "R" explained that R76 had taken herself to the bathroom and did not have her oxygen on while she was in the bathroom. CNA "R" explained that she did not place oxygen back on R76 because the oxygen tubing would not reach to the bathroom. She explained that she did not obtain longer oxygen tubing because she was not aware of where longer oxygen tubing was kept. She explained that she had let someone know but could not let remember who that person would have been. CNA "R" explained that she was not aware that R76's oxygen was to be always used. In an interview on 11/29/2023 at 10:41 a.m. Unit Manager (UM) "D" explained that if a resident is on oxygen therapy an order would be written in that persons medical record. She explained that direct care staff would be			

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	aware of the oxygenation order by reviewing the plan of care and/or it would be listed on the resident Kardex (Computerized document used by Certified Nursing Aides to provide care to residents). UM "D" confirmed that oxygen therapy was not list on R76's plan of care or on her Kardex. UM "D" explained that the facility did provide oxygen tubing that was "long enough" to reach the bathrooms. UM "D" could not explain why longer oxygen tubing was not obtained for R76 and could not explain why staff did not know where oxygen tubing was kept at the facility. In an interview on 11/29/2023 at 10:53 a.m. Director of Nursing (DON) "B" explained that it was her expectation that staff would follow physician orders regarding the use of oxygen therapy. She explained that Certified Nurse Aide's would be aware of the need for oxygen use by reviewing the residents Kardex. DON "B" confirmed that R76 plan of care did not demonstrate documentation of R76s' need for constant oxygen and confirmed that R76s's Kardex did not demonstrate documentation of R76's need for constant oxygen. DON "B" could not explain why the information that R76 required constant oxygen was not on the plan of care or the Kardex. DON "B" explained that it would not be acceptable for staff to room oxygen so that someone could go to the bathroom. DON "B" explained that the staff would be expected to provide longer oxygen tubing to reach the bathroom.			

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F0730 SS= D	Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that one Certified Nursing Aides ("J") completed 12 hours of in-service education per year and failed to ensure that two Certified Nursing Aide ("J" and "K") had competency evaluations completed on hire/annually of four Certified Nursing Aides competency and in-service records reviewed resulting in the potential for staff to lack the necessary in-service education to adequately meet the needs of the 81 Residents that currently reside at the facility. Findings Included: Record review of facility staff personnel records demonstrated Certified Nursing Aide (CNA) "J" was hired 10/21/2021. CNA "J" "CNA Competency Check List" was completed 11/06/2022. Review of CNA "J" in-service record demonstrated that she only had nine educations in the last year of employment. The record did not demonstrate	F0730	Element 1 CNA J completed the CNA competency on 12/8/2023 and the 12-hour training by 12/28/2023. CNA K completed the CNA competency on 12/8/2023 and the 12-hour training by 12/28/2023. Element 2 The Staff Development coordinator conducted an audit of CNA□s to ensure their annual competency and their 12-hour training has been completed. Any issues identified were corrected. This was completed by 12/28/2023. Element 3 The Inservice/Training Nurse Aide policy was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Staff Development coordinator/designee has re-educated CNA□s on the Inservice/Training Nurse Aide policy including the need to complete annual competencies and the 12-hour training by 12/28/2023 or during their next scheduled shift. Tracking of the annual competencies and CNA 12 hour education has been implemented by HR. Element 4 The Staff Development Coordinator/designee will conduct 5 random weekly audits of nurse aides to ensure their annual competency and the CNA 12-hour training is completed X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance.	12/28/2023

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	how many hours those educations were completed in. Record review of facility staff personnel records demonstrated Certified Nursing Aide (CNA) "K" was hired 03/07/2023. Review of her personnel file did not demonstrate that CNA "K" every had a "CNA Competency Check List" completed since date of hire. In an interview on 11/30/2023 at 08:29 a.m. Director of Human Resources " S" explained that she the educations documents did not record the numbers of hours provided for in-service education for CNA "J" and that she could not locate the "CNA Competency Check" for CNA "K" that should have been completed after her orientation was completed. In an interview on 11/30/2023 at 09:31 a.m. Nursing Educator "H" explained that she was responsible for the Certified Nursing Aide (CNA) program at the facility. She explained that it was her responsibility to ensure that "CNA Competency Check List" would be completed on completion of orientation and completed annually. She explained that it was her responsibility to ensure that CNA staff had completed, at least, the 12 hours of continuing education. Nursing Educator "H" explained that she had just started at the facility November 6, 2023, and could not explain why the 12 hours of CNA education was not completed for CNA "J" nor why her annual competency for 2023 was not			

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	completed. She could not explain why CNA "K" did not have a "CNA Competency Check List" completed after new hire orientation. Review of the facility policy "In-Service Training Program, Nurse Aide", effective date 2001 and last reviewed 04/2023, demonstrated: "All nurse aide personnel participate in regularly scheduled in-service training classes. Policy Interpretation and Implementation 1. All personnel are required to attend regularly scheduled in-service training classes. 2. The facility completes a performance review of nurse aides at least every 12 months. 3. In-service training is based on the outcome of the annual performance reviews, addressing weaknesses identified in the reviews. 4. Annual in-services: a. Ensure the continuing competence of nurse aides; b. Are no less than 12 hours per employment year; c. Address areas of weakness as determined by nurse aide performance reviews;			

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	d. Address the special needs of the residents, as determined by the facility assessment; e. Include training that addresses the care of residents with cognitive impairment; and f. Include training in dementia management and abuse prevention."			
F0732 SS= B	Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as	F0732	Element 1 The nursing hours posted was amended by the staffing coordinator to reflect actual hours worked during survey. Element 2 The Administrator reviewed the Nursing Hours posted within the last 7 days on 12/20/2023 . Element 3 The Posting Direct Care Daily Staffing policy was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Administrator has re-educated the Staffing coordinator on Posting Direct Care Daily Staffing to amend the Nursing Hours posting during her scheduled shifts to reflect actual hours worked on 11/30/2023. The Staff Development coordinator/designee has re-educated Licensed nursing staff on the Posting Direct Care Daily Staffing including the need amend the Nursing Hours posting on off hours to ensure it reflects actual hours worked by 12/28/2023 or during their next scheduled shift. Element 4 The Director of Nursing/designee will conduct 3 random weekly audits of the Nursing Hours posting to ensure it reflects actual hours worked X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and	12/28/2023

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	evidenced by: Based on observation, interview, and record review the facility failed to post the actual daily Nursing Staffing Data resulting in the potential for all 81 Residents and/or family and/or visitors to be well informed of the facility's staffing information. Findings Included: During observation on 11/29/2023 at 02:45 p.m. the "Daily Nursing Staff Hour" was posted on a desk in front of the Nursing Station (first entering the units). Review of the "Daily Nursing Staff Hour" listed the scheduled hours for all nursing staff but did not list any actual hours worked for the date of 11/29/2023. In an interview on 11/29/2023 at 02:46 Nursing Scheduler "Q" explained that she was responsible for the daily posting of the "Daily Nursing Staff Hours". She explained that scheduled hours worked are provided on the posting. She explained that the next business day she would remove the posting and fill in the actual hours worked and place it in a file in her office. When asked if the actual worked hours were ever posted on the "Daily Nursing Staff Hours" sheet while it was posted for residents and visitors, she responded that it was not. She could not explain why the hours were not completed at the completion of the shifts or why the "Daily		with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance.	

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	Nursing Staff Hours" sheet, with the actual hours worked, was never posted for the residents and/or visitors to view.			
F0757 SS= D	Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-§483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure appropriate clinical justification for the use of antibiotic medication and the continuance of an unnecessary antibiotics for one (#4) of 5 reviewed for unnecessary medication use, resulting in the potential continued use of unjustified antibiotic usage. Findings include: Review of the clinical record, including the Minimum Data Set dated and 9/30/23, R4 was admitted to the facility with diagnosis that included multiple sclerosis, R4 scored 15 out of 15 (cognitively intact) on the Brief	F0757	Element 1 The primary physician for Resident #4 entered a risk versus benefits note with rationale on 12/4/2023 in the resident□s chart stating the benefits of the prophylactic antibiotic administration outweighs the risk. Element 2 Current residents receiving antibiotic medication prophylactically have been reviewed by the Infection Control Preventionist to ensure appropriate use with documentation and a care plan is present. Any identified issues were corrected. This was completed by 12/21/2023. Element 3 The Antibiotic Stewardship policy was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Clinical Support Specialist has re-educated the Infection Preventionist on the Antibiotic Stewardship policy including the need to ensure prophylactic antibiotic use is appropriate, has risk versus benefits documentation, and an active care plan on 12/4/2023. Morning Meeting template has been updated to include review initiation of antibiotics to ensure appropriate use. Element 4 The Infection Preventionist/designee will conduct 5 random weekly audits of residents receiving prophylactic antibiotic medication administration to ensure appropriate use, risk versus benefits, and an active care plan X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be	12/28/2023

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	Interview for Mental Status (BIMS). During the initial screening process on 11/27/23 at approximately 1:00 pm, R4 was observed resting in bed and was interviewed at bedside, when queried about her antibiotic use, R4 reported she did not know why she was prescribed the antibiotic. Further review of the R4's clinical record reflected a physician order was written on 11/09/23 for Bactrim Oral Tablet 400-80 milligram one time daily for prophylactic due to recurrent urinary tract infections until 12/20/23. Further review of the clinical record reflected there was no risk vs benefit for the antibiotic, no care plan in place or physician progress notes related to the use and justification for antibiotic use. On 11/30/23 09:45 AM, during an interview with Registered Nurse /Unit Manager (RN/UM) "D", R4's record was reviewed, RN/UM "D" reported R4 had not had a urinary tract infection since August 2023 and was not certain of the rational for an antibiotic. When queried if R4 sees a urologist, RN/UM "D" stated she could not recall and did not see any documentation / consult paperwork from a urologist. On 11/30/23 09:57 AM, during an interview with the facility's Infection Control Nurse (RN/IC) "H", she reported being a new employee and was aware that R4's antibiotic lacked justification of use along with a risk		discontinued with substantial compliance and with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance	

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	versus benefit from the physician, RN/IC "H" stated she voiced her concern with R4's physician but her concerns were dismissed. RN/IC "H" further reported that she too could not find any documentation from a urologist. On 11/30/23 11:37 AM during an interview with Nursing Home Administrator (NHA) "A" she stated Resident # 4 does go out of the facility to see urologist who may have recommended or ordered the antibiotic, NHA "A" further stated that R4's spouse does the transportation and fails to bring back any paperwork. When queried if she expected the Nursing staff to follow up with urology to ensure R4's needs were being met NHA "A" stated yes.			
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 a medication error rate of less than five percent when seven medication errors were observed from a total of twenty-eight opportunities for one (Resident #23) of four residents reviewed for medication administration when 7 medications were crushed, dissolved, and administered together via PEG (percutaneous endoscopic gastrostomy-a feeding tube)	F0759	Element 1 Resident #23 was assessed by a nurse manager on 12/7/2023 and remains at baseline. LPN F was re-educated on the Enteral Medication Administration on 11/30/23. Element 2 Residents requiring enteral tube medication administration have been assessed by a nurse manager and all remain at baseline by 12/21/2023. Element 3 The Enteral Tube Medication Administration was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Staff Development coordinator/designee has re-educated Licensed nurses on the Medication Administration and Enteral Tube Medication Administration policies including the need to administer each medication enterally separate by 12/28/2023 or during	12/28/2023

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	tube resulting in a medication error rate of 25 percent and the potential for reduced efficacy of medications and increased risk of adverse reactions/side effects. Findings include: Review of the medical record revealed that Resident #23 (R23) was readmitted to facility on 10/19/2022 with diagnoses including cerebral infarction, metabolic encephalopathy, dysphagia, and chronic respiratory failure with hypoxia. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/30/23 revealed that R23 had a Brief Interview for Mental Status (BIMS-a cognitive screening tool) score of 12 (moderate cognitive impairment). Section K of the same MDS revealed that R23 had a feeding tube with 51% or more of total calories provided via tube feeding. On 11/29/23 at 8:27 AM, Licensed Practical Nurse (LPN) "F" was observed to prepare multiple medications for administration to Resident #23 (R23). LPN "F" was observed to dispense Amlodipine 10 MG (milligrams) 1 tablet, Doxazosin 8 MG 1 tablet, Eliquis 2.5 MG 1 tablet, Metoprolol 25 MG 0.5 tablet, Zyrtec 10 MG 1 tablet, Lisinopril 10 MG 1 tablet, and Famotidine 10 MG 1 tablet into a single 30 ml (milliliter) plastic medication cup as well as 3 liquid medications into separate medication cups. LPN "F" was then observed to place all 7 tablets from the medication cup		their next scheduled shift. Element 4 The Staff Development Coordinator/designee will conduct 5 random weekly observations of licensed nurses to ensure appropriate medication administration X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance.	

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	into a single plastic packet and then crush all medications together using the pill crusher located on the medication cart. LPN "F" then proceeded to empty the crushed medications into a disposable plastic drinking cup and add approximately 60 ml of water to dissolve all medications. During the crushing and dissolving of the medications, LPN "F" commented that at a prior facility she had worked at that all the medications had to be crushed and administered separately via PEG tube but that at the current facility, all medications could be crushed, dissolved, and administered together. LPN "F" proceeded to R23's room with all medications on Styrofoam tray, placed personal protective equipment, verified PEG tube placement while R23 was observed to be lying in bed with the head of the bed at an approximate 45-degree angle, administered the 3 liquid medications separately via PEG tube followed by an approximate 10 ml PEG tube water flush between each medication and then proceeded to administer the 7 dissolved medications in the plastic cup via PEG tube followed by the remainder of the 175 ml water flush. Upon completion of R23's medication administration, LPN "F" removed personal protective equipment, washed hands, exited room, and signed out all R23's medications as administered in the electronic medical record.			

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	Review of R23's active orders included Zyrtec Allergy Tablet 10 MG (Milligrams), Famotidine Tablet 10 MG, Doxazosin Mesylate Tablet 8 MG, Metoprolol Tartrate Tablet 25 MG 0.5 tablet, Lisinopril Tablet 20 MG, Apixaban Tablet 2.5 MG, and Amlodipine Besylate Tablet 10 MG with instruction indicated within each order to give medication via PEG-Tube. Additional order stated, "Medication Administration by peg tube: Crushed medication, Open capsules, as well as liquid medication must be diluted with at least 5 ml (milliliters) of water. Flush peg tube with 10-15 ml of water between each medication administration". In an interview on 11/29/23 at 1:33 PM, Director of Nursing (DON) "B" stated that when preparing medications to be administered by PEG tube that all medications should be dispensed into separate medication cups, crushed separately, placed back into a separate medication cup, dissolved with approximately 5-10 ml of water, and then administered separately via PEG tube followed by an approximate 10-15 ml water flush between each medication. DON "B" stated that under special circumstances and with a specific physician order, some medications could be dissolved and administered together via PEG tube but upon referencing R23's physician orders, confirmed that all R23's medications should be dispensed, crushed, and administered via PEG tube separately followed by a water flush between each			

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	medication. Review of the facility policy titled "Enteral Tube Medication Administration" with a 4/23 reviewed date stated, "Policy ...The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes ...Procedures ...The physician's order must specify the route of any medication via feeding tube ...B. Prepare medications for administration ...ii. Crush each immediate-release tablet, one at a time, into a fine powder, and dissolve in at least 15mL (or prescribed amount) of water ...K. Administer each medication separately and flush the tubing between each medication ...i. Place 30mL (or prescribed amount) of water in syringe and flush tubing using gravity flow. ii. Pour dissolved/dilute medication in syringe and unclamp tubing ...iii. Flush tube with 5-10mL (or prescribed amount) of water between each medication ..."			
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	F0761	Element 1 Resident #70□s eye drops were discarded and re-ordered from pharmacy during survey. Resident #70 no longer resides at the facility. Resident #24□s inhaler and nasal spray were discarded and re-ordered from pharmacy during survey. Resident #24 was assessed by a licensed nurse and remains at baseline on 12/21/2023. Resident #27□s inhaler was discarded and re-ordered from pharmacy during survey. Resident #27 was assessed by a licensed nurse and remains at baseline on 12/21/2023. Element 2	12/28/2023

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	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 1. Dispose of expired medications in 3 of 4 medication carts; and 2. Label a Tuberculin vial with an open date in 1 of 2 medication rooms reviewed for medication labeling and storage, resulting in the potential for decreased medication efficacy and side effects. Findings include: On 11/29/23 at 8:14 AM, Bay 2 Medication Cart was reviewed in the presence of Licensed Practical Nurse (LPN) "MM". During the review, both an opened box of Latanoprost 0.005% Eye Drops and an open bottle within the box was noted to contain a pharmacy label reflecting Resident #70's (R70's) name. A handwritten open date of 9/28/23 was noted on the box as well as a printed pharmacy label which stated, "Refrigerate unopened. Store opened at room temp. [temperature]. Discard after 6 weeks". LPN "MM" confirmed the 9/28/23		Medication rooms and medication carts have been audited by nurse managers to ensure medications are dated when opened and not expired by 12/28/2023. Any identified issued were corrected. Element 3 The Storage of Medications policy was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Staff Development coordinator/designee has re-educated Licensed nurses on the Storage of Medication policy including the need to date medications when opening and monitoring expiration dates by 12/28/2023 or during their next scheduled shift. A form has been implemented for nurses to ensure that med carts and med rooms are checked for expired medications. Element 4 The Staff Development Coordinator/designee will conduct 2 random weekly observations of medication carts/medication rooms to ensure appropriate dating and no items are expired X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance.	

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	open date on the eye drops, stated that she believed that the eye drops were good for 4 to 6 weeks after opening and therefore were expired, would be discarded, and a new one ordered from pharmacy. Review of R70's medical record revealed an active order dated 9/27/23 for "Latanoprost Ophthalmic Solution" with once daily administration. Review of the corresponding Medication Administration Record (MAR) dated 11/1/2023-11/30/2023 reflected R70's daily receipt of the medication. On 11/29/23 at 12:30 PM, Coast Hall Medication Cart (Rooms 200-211) was reviewed in the presence of LPN "HH". During the review, an opened Advair Diskus 500-50 box was noted with a printed pharmacy label reflecting Resident #24's (R24's) name as well as printed instructions that stated, "Discard 1 month after opening foil protection ...". An opened inhaler within the same box contained a handwritten open date of "10/24/23". LPN "HH" confirmed the 10/24/23 open date on the inhaler, stated that the inhaler was expired, would be discarded, and that the new inhaler in the medication cart labeled with R24's name would be opened. Review of R24's medical record revealed an active order dated 6/2/23 for "Fluticasone-Salmeterol Aerosol [Advair]" with twice daily administration. Review of the corresponding MAR dated 11/1/2023-11/30/2023 reflected			

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	R24's twice daily receipt of the medication. On 11/29/23 at 12:48 PM, Coast Hall Medication Cart (Rooms 212-225) was reviewed in the presence of LPN "HH". During the review, an opened Flovent Diskus box was noted with a printed pharmacy label that reflected Resident #27's (R27's) name, a dispense date of 6/23/23, as well indication to "...Discard 2 months after opening..." . Neither the open box nor the open inhaler within the box was noted to be labeled with an open date. LPN "HH" confirmed the absence of an open date on both the box and inhaler, denied knowledge of when the inhaler was opened, and stated that would be disposing of and opening the new inhaler in the medication cart labeled with R27's name. Review of R27's medical record revealed an active order for Flovent with twice daily administration. Review of the corresponding MAR dated 11/1/2023-11/30/2023 reflected R27's twice daily receipt of the medication. On 11/29/23 at 1:05 PM, Bay 2 Medication Room was reviewed in the presence of Registered Nurse/Unit Manager (RN/UM) "D". During the review, the medication refrigerator within the medication room was noted to contain an opened Tuberculin Purified Protein Derivative box. Neither the open box nor the open vial within the box was noted to be labeled with an open date. Printed instruction on the vial stated, "Once entered, vial should be discarded after 30			

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	days". LPN "D" stated that the opened vial appeared to be ¾ empty, that the vial should have been dated as was only good for 30 days after opening and would be disposed of. In an interview on 11/29/23 at 1:21 PM, Director of Nursing (DON) "B" stated that her expectation would be that all eye drops, inhalers, and Tuberculin be labeled with an opened date and that all medications be disposed of within the expiration dates based on the indicated opened date. DON "B" further stated that although it was all nurse's responsibility to verify that a medication was labeled when opened and within the expiration date at the time of administration, that she had instituted a new audit approximately 1 week ago for the nurse managers to review all medication carts and rooms to ensure all medications were labeled when opened and within expiration dates.			
F0804 SS= F	Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake #MI00139971 Based on observation, interview, and record	F0804	Element 1 Resident #25 and Resident # 38 were interviewed by the Registered Dietitian regarding their food preferences, including preferred temperatures for palatability. Preferences were updated as requested on 12/19/2023. Element 2 Residents of the facility had their preferences reviewed and updated with the RD and/or CDM to ensure that they were current and up to date by 12/21/2023. Element 3 The Resident Food Preferences policy was reviewed by the QAPI on 12/4/2023 and deemed to be appropriate. Dietary staff were	12/28/2023

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	review the facility failed to ensure that food was served and held at a palpable temperature. Resulting in the potential to affect all residents (total facility census of 81) that consume food from the kitchen. Findings Included: Resident #25 (R25) Review of the medical record demonstrated that R25 was admitted to the facility 10/04/2022 with diagnoses that included type 2 diabetes, malignant neoplasm (cancer) of the endometrium (lining of the uterus) , atrioventricular block (heart block), anxiety, muscle wasting and atrophy, depression, cerebral infarction (stroke), hemiplegia (paralysis) of the left side, anemia (low red blood cell count), gout (build up of uric acid in joints), hyperlipidemia (high fat amount in blood), and hypertension. During observation and interview on 11/27/2023 at 09:27 a.m. R25 was observed siting at the side of her bed in a wheelchair. When R25 was questioned regarding the food at the facility, she explained that the food is "terrible". She explained that the food was always cold. On 11/28/2023 at 12:27 p.m. a resident's tray was removed from the tray cart of the 200-hall. Regional Dietary Manager "T" was asked to please take temperature of food present on the tray. It was observed that the beef and potato casserole was registering at 126.8 F		re-educated by the CDM and/or RD on the Resident Food Preferences policy by 12/28/2023. Resident food committee meetings have been increased to bi-weekly to ensure that the residents are satisfied with the palatability of food temperatures being served. Element 4 The CDM/designee will conduct 5 random interviews with residents weekly to ensure that their meals are being served at temperatures that they find palatable and that their preferences are being honored. The CDM/designee will conduct 5 random tray observations to ensure resident tray card preferences are being honored. Any concerns will be immediately addressed. Results of the audits will be forwarded to the QAPI committee for further recommendations. The Administrator is responsible for sustained compliance.	

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	(Fahrenheit) , carrots registered at 127.3F, strawberry desert registered at 38.9F, and coffee registered at 148.0F. During this time Regional Dietary Manager "T" explained that the beef potato casserole and the carrots were not in palpable levels. She stated both items should be at least 135.0F. She also explained that the strawberries should have been over 32.0F so that they were not frozen. Regional Dietary Manager "T" could not explain why the food items where not withing palpable levels. Resident 38 (R38) According to the clinical record, including the Minimum data Set dated with an Assessment Reference date (ARD) of 9/30/23 R38 was admitted to the facility on 11/03/22 with diagnoses that include heart failure, chronic obstructive pulmonary disease and diabetes. Resident # 38 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). During the initial screen on 11/27/23 at 2:07 pm, R38 was observed resting in bed he was observed to be extremely thin. When queried about his appetite he reported it could be better, but the real issue was the food. When asked to elaborate R38 reported the food was usually served cold, had very little variety and was of poor quality. R38 further elaborated that the "alternative" and all other choices consisted of peanut butter and jelly or a grilled cheese.			

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F0849 SS= D	Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the	F0849	Element 1 Resident #38 has received his hospice encounter calendar for 12/2023, a hospice order has been entered in his chart, the care plan has been updated to include the current hospice company name and the calendar has been included and the CNA visits are on the Kardex, the hospice binder has been labeled appropriately and includes blank pages for handwritten hospice communications post visit. This was completed by nurse management by 12/22/2023, Element 2 Residents requiring hospice services have been reviewed by nurse managers to ensure the receipt of the hospice encounter calendar for 12/2023, a hospice order has been entered in the chart, the care plan is current and includes the calendar of visits and the hospice aide visit days are on the Kardex, the hospice binder has been labeled appropriately and includes blank pages for handwritten hospice communications post visit. This was completed by 12/28/2023. Element 3 The Hospice Program was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Staff Development coordinator/designee has re-educated licensed nursing staff on the Hospice program including the need to provide the hospice encounter calendar, a hospice order has been entered in the chart, the care plan is current and includes the calendar of visits and the hospice aide visit days are on the Kardex, the hospice binder has been labeled appropriately and includes blank pages for handwritten hospice communications post visit. This was completed by 12/28/2023 or during their next scheduled shift.	12/28/2023

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	following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and		Hospice has been added to morning meeting template to ensure that collaboration of care has been initiated. Element 4 The Director of Nursing/designee will conduct 5 random weekly audits of residents requiring hospice services to ensure receipt of the hospice encounter calendar, a hospice order has been entered in the chart, the care plan is current and includes the calendar of visits and the hospice aide visit days are on the Kardex, the hospice binder has been labeled appropriately and includes blank pages for handwritten hospice communications post visit X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance.	

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	physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most			

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	recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to coordinate hospice services for one resident (#38) out of one resident reviewed for coordination of hospice services resulting in the potential for care note being provided to resident receiving hospice services and the potential for residents not be fully informed of hospice services provided.			

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	Findings Included: Resident #38 (R38) Review of the medical record revealed R38 was admitted to the facility 03/02/2023 with diagnoses that included chronic obstructive pulmonary disease (COPD), type 2 diabetes, diabetic neuropathy (nerve damage caused by diabetes), right above the knee amputation, nicotine dependence, alcohol abuse, benign prostatic hyperplasia (enlarged prostate), hypothermia (low body temperature), absence of left toes, protein calorie malnutrition, muscle wasting and atrophy, dysphagia (difficulty swallowing), hypertension, atrial fibrillation, hypothyroidism (low thyroid hormone), cerebral infarction (stroke), peripheral vascular disease (PVD), obstructive sleep apnea, depression, hyperlipidemia (high fat content in flood), chronic respiratory failure, and heart failure. The most recent Minimum Date Set (MDS), with an Assessment Reference Date (ARD) of 09/20/2023, demonstrated R38 had a Brief Interview for Mental Status (BIMS) of 14 (cognitively intact) out of 15. Section O (special treatments, procedures, and programs), with the same ARD of 09/30/2023, demonstrated that R38 had received hospice services while at the facility. During observation and interview on 11/30/2023 at 11:36 a.m. R38 was observed lying down in bed. R38 explained that he had			

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	been receiving hospice services while he was a resident at the facility. R 38 could not identify the name of the hospice agency that was providing care. R38 explained that two persons came twice a week to assist him with his bathing. He explained that they would come on Mondays and Thursdays. When asked what disciplines, from hospice, provided him services he could not list specifically and responded, "I get them all". R38 denied that he had been provided a hospice calendar that would have demonstrated what services were provided and when those services are provided. No hospice calendar was observed in R38's room. Review of R38's medical record demonstrated a care plan with the problem statement "Terminal Prognosis: ... has a terminal prognosis r/t (related to) heart failure. Resident admitted to ... Hospice" which was written 03/17/2023. No interventions were present listing the services that were to be provided, the disciplines that were to be provide services, or the frequency and time of those provided services. Review of R38's Visual Kardex (documentation provided in computerized charting demonstrating to Certified Nursing Aides the care to be provided) did not demonstrate that R38 was receiving hospice services. R38's medical record did not demonstrate a physician order for hospice services. Review of R38's care conference notes did not demonstrate involvement from any hospice			

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	representatives. Review of the hospice documentation was, into the medical record, 11/27/2023, 11/20/23, 11/13/2023 and 11/08/2023 and 11/06/2023. In an interview on 11/30/2023 at 11:19 a.m. Certified Nursing Aide (CNA) "U" explained that she was aware that R38 was receiving hospice services because when hospice arrived at the building to provide care, she was notified by the hospice staff. CNA "U" could not explain what services where provided or what dates and times those services where to be provided. CNA "U" explained that if residents where to receive hospice services it would be listed on that resident Kardex. CNA "U" could not demonstrate that R38 was receiving any hospice services after reviewing R38's Kardex. In an interview on 11/30/2023 at 11:25 a.m. Registered Nurse (RN) "V" explained that he was providing care to R38 today. RN "V" could not demonstrate any document that would show what Hospice services frequency or what services were had been provided. He explained that when the hospice provider is at the facility they give him verbal report about R38 and he signs a document but has never been given the document to review. RN "V" did not know if hospice documentation was ever provided or scanned into R38's medical record. In an interview on 11/30/2023 at 11:29 a.m. Hospice Registered Nurse (RN) "W" explained			

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	that she was the hospice nurse that provide services to R38. She could not explain if a hospice was involved in the quarterly care plan meetings with the facility. She explained that R38 had hospice aide services twice per week, nurse services once per week, and a social worker services once per month. Hospice RN "W" explained once documentation of services was provided to the facility but that it could take two weeks for the facility to receive that documentation. Hospice RN "W" denied that R38 had ever been given a calendar for when and who would provide hospice services. She could not provide when the last time a hospice representative attended R38's care conference. In an interview on 11/30/2023 Unit Manger (UM) "D" explained that she knew R38 was receiving hospice services. She explained that it was the expectation that R38 would have a plan of care that informed the staff that he was receiving those services. She explained that an order should be in his medical record. UM "D" confirmed that no order for hospice services was present in R38's medical record. UM "D" explained that the Certified Nursing Aides (CNA's) would know what services had been provided and when by listing that would be on the plan of care and then transferred to the Kardex, which was used by the CNA's. UM "D" could not demonstrate a specific plan of care for R38's hospice services and confirmed that no information for hospice services was provided on R38's			

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	Kardex. UM "D" explained that a binder was at the nurses station that included R38's calendar, hospice plane of care, hospice notes. On 11/30/23 at 11:42 p.m. Unit Manger (UM) "D" took this surveyor to the 100-hall nurse's station. She attempted to find the binder/notebook that contained R38's hospice information. She finally found a notebook (which was not labeled on the outside) in a cabinet. The binder was not observed to contain notes of last visits or a schedule of those services. UM "D" explained that the calendar that was taped to the top of the cabinet door was R38's hospice calendar. The calendar was observed to be for the month of November and contained the R38's name. Nothing on the calendar was labeled as "Hospice Calendar". The days that were identified has receiving services was labeled on the date of 11/23/23 as "HS11H and MSCOSIGN". There was no explanation of what those services were, and UM "D" could not explain what those services would have been. No documentation was observed on the calendar for the remainder of the days in November. On 11/20/23 at 12: 43 p.m. Director of Nursing (DON) "B" explained that she knew that hospice coordinated services because she had a meeting weekly with a hospice representative. DON "B" could not provide documentation of that coordination of care and none was provide by time of exit.			

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F0880 SS= E	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 §483.70(e) 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 (A) Resident #9 was assessed by a nurse manager on 12/22/2023 for signs and symptoms of infection. None were identified. CNA G was re-educated on the Enhanced Barrier Precautions policy during survey. Element 2 (A) Current residents requiring enhanced barrier precautions, meal tray service, and IV administration have been assessed by a nurse manager 12/16/2023 for signs and symptoms of infection and none were identified. The IC nurse has reviewed current antibiotics to ensure appropriate antibiotic usage as evidenced by meeting criteria. No trend was identified. This was completed by 12/21/2023. Element 3 (A) The Enhanced Barrier Precaution, Hand Hygiene, and Antibiotic Stewardship-Surveillance policies have been reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Staff Development coordinator/designee has re-educated staff on the Enhanced Barrier Precaution and Hand Hygiene policies including the need to don PPE while providing high contact care, performing hand hygiene in between serving meal trays, and appropriate changing of gloves during IV administration by 12/28/2023 or during their next scheduled shift. The Clinical Support Specialist has re-educated the IP nurse to ensure appropriate antibiotic usage as evidenced by meeting criteria and if a trend was identified education was completed. This was completed on 12/4/2023. The monthly infection control surveillance forms have been updated to include tray pass observation, hand hygiene observations and	12/28/2023

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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 follow acceptable infection control guidelines for hand washing and failed to follow adhere to Enhanced Barrier Precautions resulting in the potential spread of infection and disease to all 81 residents at the facility. Findings Included: During observation on 11/27/2023 at 12:10 pm observed Certified Nursing Aide (CNA) " I" pass a food tray to room 109 and then passed food tray to room 115. CNA "I" was not observed washing or sanitizing her hands between tray passes. Then CNA "I" was observed passing at room tray to room 116 and was observed moving his box of Kleenex, removing a lid to his drink container then exiting the room without washing or sanitizing her hands and proceeded to pass another food tray to room 119. At no time between passing food trays between rooms was CNA "I" observed to wash or sanitize her hands.		appropriate use of enhanced barrier precautions. Element 4 (A) The Infection Preventionist/designee will conduct 5 random weekly observations of high contact care being provided to residents requiring enhanced barrier precautions to ensure appropriate PPE is being utilized, meal tray pass and IV antibiotic administration to ensure appropriate hand hygiene is completed X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI Committee. The Infection Preventionist/designee will conduct 5 random weekly audits of resident infections to ensure appropriate antibiotic usage as evidenced by meeting criteria and if a trend was identified education was completed X 4 weeks, then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance.	

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	During observation on 11/27/2023 at 12: 18 p.m. observed Certified Nursing Aide (CNA) "J" remove a food tray from the cart and take it into room 124 and then came out of room and passed another tray to room 102. At no time between or after passing room was CNA "J" observed to have washed or sanitized her hands. During observation on 11/28/2023 at 12:01 observed Certified Nursing Aide (CNA) "L" remove a food tray from the care and take it into room 119, then she exited the room and removed another room tray from the cart and took it into room 116, then she exited the room and removed another room tray from the cart and took it into room 114. At no time between or after passing room trays was CNA "L" observed to wash or sanitizer her hands. In an interview on 11/29/2023 at 02:05 p.m. Infection Control Coordinator (IC) " H" explained that it was a standard of practice to either wash or sanitize your hands with alcohol hand sanitizer before passing food trays and also in between passing food trays between different residents. During an observation on 11/29/23 at 08:04 AM, residents were not offered or had their hands washed before they were served breakfast. During an interview on 11/29/23 at 09:18 AM, RN-I/C/ Staff Development "H " stated the expectation is to have bowls and cups covered with lids and staff are to wait and uncover in front of them, alcohol hand sanitizer is acceptable unless a staff person gets food on their hands or touched the residents personal stuff, then soap and water should be used. RN-I/C/ Staff Development "H " stated when administering one residents medications, if they are on Enhanced Barrier Precautions (EBP), staff need to wear disposable gown and gloves. Staff also need to			

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	hand sanitize between glove change or use soap and water. Observation of an IV antibiotic infusion on 11/29/23 at 08:27 AM. LPN "HH "was observed hanging IV antibiotic Rocephin 2 grams/ 100ml in an hour using an IV pump on said resident. LPN "HH" Washed her hands, gloved, combined the solution and powder together and mixed thoroughly, had 2 NS for flushes in hand. Had gloves on, had to adjust the resident up in his wheelchair, pulled his wheelchair out from the wall, removed gloves, and put on a new pair of gloves, did not wash her hands after removing her gloves and putting on the new gloves. IV antibiotic bag spiked with new IV tubing, primed the tubing. Programmed the Infusion pump per orders. Cleaned the port to the PICC line with an alcohol wipe, flushed with 10cc NS, wiped port again with alcohol wipe, attached the IV tubing, started the IV pump to start administering IV. The infusion pump started beeping, LPN "H" took off her gloves and replaced with a new pair, no hand washing between. Alarm was for air in the line, primed the tubing again to remove all air bubbles. Wiped port with alcohol wipe and reattached the IV tubing to his port. Once the IV was infusing, LPN "H" removed all personal protective equipment, put in an open small wastebasket sitting by the sink and door. During an interview on 11/29/23 at 08:57 AM, RN-I/C/ Staff Development "H" stated the Enhanced Barrier Precautions is for all residents for foley, colostomies, picc lines, surgical sites, wound care. Staff are to wear PPE when giving residents direct care. RN-I/C/ Staff Development "H" also stated CDC put this recommendation out in June23, and their corporate wanted this to be put in place. RN-I/C/ Staff Development was told the previous RN-I/C/ Staff Development nurse had educated staff on the use of PPE for Enhanced Barrier Precautions (EBP) vs			

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	Transmission Based Precautions (TBP). RN-I/C/ Staff Development "H" stated she plans to educate staff on precautions, and expectations going into the resident's room. Also stated she would provide education on enhanced Barrier Precautions to all staff in the building. RN-I/C/ Staff Development "H ", added that she would provide education on the difference between flu and Covid. RN-I/C/ Staff Development "H" stated she maintains a list of caregivers who called in, unit they worked on, symptoms they were experiencing, triaged their symptoms and would have them drive to the facility and get tested for Covid in the parking lot. Additional education on the difference of diarrhea vs clostridioides difficile (C-diff). RN-I/C/ Staff Development "H" stated she agrees that staff did not know the difference between EBP and TBP and not currently following expectation. RN-I/C/ Staff Development "H " stated moving forward she was completing audits; very evident staff did not have the training or education needed. RN-I/C/ Staff Development "H" stated the Minimum Data Set (MDS) nurse reached out to her as she marked several residents having TBP not EBP on the initial 802 and she was supposed to correct the 802. When RN-I/C/ Staff Development "H" was reviewing the infection surveillance plan, there want one in place, but not being implemented as evidence of not following the McGeer criteria (tool used for retrospectively counting true infections) and residents were taking antibiotics with no rational for use. Record review revealed a high rate of urinary tract infections and vaginal infections in June 2023,18 out of 14 residents had at least one of both infections. Record review did not reveal any education provided to caregivers regarding proper			

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	hand washing and prevention of spreading infections, no utilization of McGeer criteria, no tracking of infections or audits to monitor progress. These same findings were present in 2022. Record review on 12/2022 presented a list of residents and the name of the antibiotic they took but with no completion date, did not use McGeers criteria approval list. Record review of 05/2023 revealed 23 infections in the building and 5 were facility acquired. No identification of sources, trends, tracking, or audits were completed. According to the Surveillance for Infection Policy. ...The Infection Preventionist is responsible for gathering and interpreting surveillance data ... ...For the residents with infection that meet the criteria for definition of infection for surveillance, collecting the following data as appropriate. Identification information, diagnosis, infection site, pathogens, invasive procedures, pertinent remarks, treatment measures and precautions ... ...Calculating infection rates ... Resident #9 Review of the medical record revealed that Resident #9 (R9) was initially admitted to facility 2/25/2022 with diagnoses including personal history of traumatic brain injury, unspecified dementia, dysphagia, and gastrostomy status. Review of the Minimum Data Set (MDS) with an Assessment			

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	Reference Date (ARD) of 8/24/23 revealed that R9 had a Brief Interview for Mental Status (BIMS-a cognitive screening tool) score of 10 (moderate cognitive impairment). Section K of the same MDS revealed that R9 had a feeding tube. In an observation and interview on 11/27/23 at 10:57 AM, R9's room door was noted to be 3/4 closed with a sign on the outside of the door which indicated, "ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting ...". A yellow bag with divided compartments containing disposable blue gowns, face shields, medical procedure masks, gloves, red trash bags, and disinfectant wipes was noted to be hung on the outside of the same door. Upon knocking and entering room, R9 was observed lying on the floor, to the right of the bed, positioned on her right side with her head toward the foot of the bed. R9 was noted to be dressed in a facility gown with a white brief visible beneath, denied concerns when questioned as stated, "I'm fine. I'm just a little cold" but provided no response to follow-up questions regarding status.			

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	On 11/27/23 at 11:00 AM, Licensed Practical Nurse (LPN) "F" was alerted that R9 was on the floor in her room. LPN "F" confirmed familiarity with R9, stated that she was her assigned nurse that date, and that R9 often preferred to be on the floor as was more comfortable. Upon room reentry on 11/27/23 at approximately 11:02 AM, R9 was observed to remain on floor but positioned vertical to bed and lying on stomach. LPN "F" entered room following by Certified Nurse Aide (CNA) "G", both observed to place gloves and assist R9 to a sitting position on floor with back against bed frame. LPN "F" then stood at R9's left side with CNA "G" at R9's right side with both placing one of their arms under R9's and lifting her to a sitting position at the edge of the bed. LPN "F" then assisted in positioning R9's upper body into a lying position on the bed while CNA G" lifted R9's legs to position her lower body. CNA "G" was then observed to obtain wet washcloths to change R9's brief at which time R9 requested that only CNA "G" be in the room. In an interview on 11/27/23 at 11:14 AM, LPN "F" stated that R9 had a feeding tube and therefore was in "Enhanced Barrier Precautions". Per LPN "F", precautionary measures included placing a mask, gown, and gloves prior to providing any type of feeding tube care only and that the precautionary measures listed on the sign which included use of a gown would not routinely be			

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	followed when assisting R9 with transfers, toilet use, or incontinency care. In an interview on 11/27/23 at 11:22 AM, CNA "G" confirmed familiarity with R9 and that she was her assigned aide that date. CNA "G" stated that R9 required assist of one with all bathing, dressing, and toilet use and was also incontinent of urine. CNA "G" confirmed that R9 was in Enhanced Barrier Precautions and that she would generally place a mask, gown, and gloves prior to providing any hands-on resident care but that as she had only entered R9's room to check on her, not knowing she was going to provide care, she had not placed a gown. CNA "G" stated that in hindsight when she realized that R9 needed assist with transfer and had been incontinent and needed to have her brief changed, she should have placed a gown prior to providing the hands on care. Review of R9's electronic medical record completed with the following findings noted: Physician order dated 11/8/23 stated, "Enhanced Barrier Precautions: PEG [percutaneous endoscopic gastrostomy-a feeding tube] Verify sign is in place outside of room, isolation bag hanging on door, and appropriate PPE [personal protective equipment] is stocked" with associated order noted to be reflected on November Medication Administration Record and signed out by LPN "F" 19 times since 11/9/23			

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	order initiation. Care Plan Focus dated 11/9/23 which stated, "I am at risk for MDRO [Multidrug Resistant Organisms] infection ..." with an associated intervention, "Enhanced Barrier Precautions: Staff will wear PPE (gown and gloves) while engaged in high contact activities" also dated 11/9/23. Kardex (tool used by the Certified Nurse Aide to guide them as to the care needs of a specific resident) indicated, "Enhanced Barrier Precautions: Staff will wear PPE (gown and gloves) while engaged in high contact activities". In an interview on 11/28/23 at 4:12 PM, Registered Nurse/Unit Manager (RN/UM) "C" stated that the facility initiated Enhanced Barrier Precautions for anyone that had a wound, ostomy, feeding tube, or intravenous line and that PPE (which included a gown and gloves) should be used when providing any type of hands on care including assisting a resident with transfers, toilet use, dressing, oral care, and incontinency care. RN/UM "C" confirmed familiarity with R9 as was the manager on the unit in which she resided, stated that R9 required extensive assist with transfers, dressing, toilet use, and incontinency care, and that R9 had a feeding tube and therefore was on Enhanced Barrier Precautions. RN/UM "C" confirmed that all staff should wear a gown and gloves when assisting R9 with transfer and incontinency			

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	care. Review of the facility policy titled "Enhanced Barrier Precautions" with a 3/2023 reviewed/revised date stated, "Policy Statement ...Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents ...Policy Interpretation and Implementation ...2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply ...a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) ...3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing b. bathing/showering c. transferring d. providing hygiene e. changing linens f. changing briefs or assisting with toileting ...5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices ..."			
F0881 SS= E	Antibiotic Stewardship Program §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by:	F0881	Element 1 No specific residents were identified. Element 2 The IC nurse has reviewed current antibiotics to ensure appropriate antibiotic usage as evidenced by meeting criteria and if a trend was identified education was completed. This was completed by 12/21/2023. Element 3 The Antibiotic Stewardship-Surveillance policy has been reviewed by the QAPI committee	12/28/2023

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	734110	A. BUILDING _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADIRA NURSING AND REHAB	3200 STATE ST SAGINAW, MI 48602

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	Based on interview, observation and record review, the facility failed to maintain an effective antibiotic stewardship program, including ongoing monitoring of antibiotic use protocols and an ongoing system to monitor antibiotic use. This deficient practice resulted in the potential for the development of Multi Drug Resistant Organisms (MDRO's) within the entire vulnerable facility's population, family members of the facility population, staff, volunteers, contractual providers, and the surrounding community. Findings include: During and interview and observation on 11/29/23 at 11:45 AM, RN-I/C/ Staff Development "H" stated that she had been reviewing the previous infection surveillance plan, there want one in place, but not previously being implemented as evidence of not following the McGeer criteria and residents were taking antibiotics with no rational for use. Record review revealed a high rate of urinary tract infections and vaginal infections in June 2023,18 out of 14 residents had at least one of both infections. Record review did not reveal any education provided to caregivers regarding proper hand washing and prevention of spreading infections, no utilization of McGeer criteria, no tracking of infections or audits to monitor progress.		and deemed appropriate on 12/4/2023. The Clinical Support Specialist has re-educated the IP nurse to ensure appropriate antibiotic usage as evidenced by meeting criteria and if a trend was identified education was completed. This was completed on 12/4/2023. Element 4 The Infection Preventionist/designee will conduct 5 random weekly audits of resident infections to ensure appropriate antibiotic usage as evidenced by meeting criteria and if a trend was identified education was completed X 4 weeks, then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance.	

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	These same findings were present in 2022. Record review on 12/2022 presented a list of residents and the name of the antibiotic they took but with no completion date, did not use McGeers criteria approval list. Record review of 05/2023 revealed 23 infections in the building and 5 were facility acquired. No identification of sources, trends, tracking, or audits were completed. During the same interview and observation on 11/29/23 at 11:55 AM, RN-I/C/ Staff Development "H" presented an updated implementation plan for antibiotic stewardship program.			
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 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 the resident call system was functioning for one (R6) of 19 sampled residents, resulting in decreased emergent response time and potential resident adverse clinical outcomes.	F0919	Element 1 The filter for Resident #6 call light was replaced during survey. Element 2 Current resident call lights have been tested for functionality by the Maintenance Director. No issues were identified. This was completed by 12/8/2023. Element 3 The Use of Call Light policy was reviewed by the QAPI committee and deemed appropriate on 12/4/2023. The Staff Development coordinator/designee has re-educated staff on the Use of Call Light policy including the need to round frequently to ensure call light functionality by 12/28/2023 or during their next scheduled shift. Functionality of the call light has been added to the Caring Partner forms completed by the IDT. Forms are to be forwarded to the Administrator for review.	12/28/2023

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	Findings Include Resident #6 (R6) Review of the medical record revealed Resident #6 (R6) was admitted to the facility on 04/04/22 with diagnoses that included Multiple Sclerosis, Quadriplegia, Neurogenic Bladder, feeding tube, Cardiovascular Accident and Depression. According to Resident #6 (R6)'s Minimum Data Set (MDS) dated 09/28/23, revealed R6 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS- a cognitive screening tool) and had no behaviors. R30 is dependent of all activities of daily living, is bedbound and requires all hydration and medication administration to be through her feeding tube. During an observation and interview on 11/28/23 at 08:06 AM, R6 stated that her call light did not work, so she had to yell, and she did not have a very strong or loud voice. R6 also stated she didn't know how often the CNA comes in to check on her, so she had no way to call for help. R6 stated that she had been without it for at least 2 days. During an interview on 11/28/23 at 08:18 AM, Licensed Practical Nurse (LPN) "HH" stated that R6 blows into the straw device and the call light panel lights up on the wall and the pagers go off.		Element 4 The Director of Nursing/designee will conduct 5 random weekly audits of residents to ensure the call light is functioning X 4 weeks then monthly thereafter. Results of these audits will be brought to the QAPI committee. These audits will only be discontinued with substantial compliance and with the approval of the facility QAPI Committee. The Administrator is responsible for sustained compliance.	

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	During an interview and observation on 11/28/23 at 08:23 AM, DON "B" stated she did not know how her call light worked, DON "B" walked went up and down the floor asking the Unit Manager (UM) "C" and LPN "HH" for assistance. During an interview and observation on 11/28/23 at 0828 AM, Certified Nursing Assistant (CNA) "II" and CNA "JJ" walked into the room of R6 and started looking for the white adapter called a breath call that that was not attached to the controller tubing. CNA "II" found it laying on the nightstand. Nobody knew how long she has been without it. UM "C" came into R6's room, gowned up in PPE, and placed a new breath call device on the tubing, call light was tested with CNA's, LPN "HH", and it worked now. UM "C" went out to the nurse's station to see who was on R6's schedule the last 2 days and why this was not observed. During an interview on 11/29/23 at 10:09 AM, UM "C" stated that on 11/27/23 RN-I/C/ Staff Development "H" had to work on the floor and the breath call was in place. UM "C" stated she didn't know which CNA were working with R6 on 11/27/23 Monday. UN "C" than stated on 11/28/23, CNA "KK" worked with R6 and LPN "HH". On 11/29/23 CNA "LL" worked with R6 with LPN "HH". UM "C" stated they did not put any interventions in place to prevent this from happening again yet, she had been too busy. Writer asked UM "C" if she had investigated this occurrence to			

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	find out how and when it happened. UM 'C' looked at writer with irritation and stated, no, not yet. During an interview on 11/29/23 at 10:59 AM, DON "B" stated that nobody knows when the breath call came out on R6. DON "B" stated that the new intervention was put in place yesterday, 11/28/23. CNAs would check the placement of the breath call at the beginning and end of the shift, nurses check it during each shift. DON "B" also stated that staff should be able to see the Breath Call from the door and when they were providing care. Record review did not reflect any new interventions to better meet R6's needs. No interventions on checking the breath call as R6's only means of communicating and calling for help. No changes in the setup of her room, to allow her to see her TV better.			