GRAND TRAVERSE COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES BOARD

REGULAR MEETING
October 12, 2023

Open to the public
1:00 PM Garfield Township Hall – Upstairs Main Hall
3848 Veterans Dr, Traverse City, MI 49684

Persons with disabilities which the foregoing opportunities for participation will not address should contact Darcey Gratton at (231) 932-3010 or dgratton@gtpavilions.org with questions or concerns.

AGENDA

1. **CALL TO ORDER** – 1:00 p.m. Garfield Township Hall – Cecil McNally, Chair, Grand Traverse County Department of Health and Human Services Board

2. **ROLL CALL** the member must announce his or her physical location by stating the county, city, township, or village and state from which he or she is attending the meeting remotely.

3. **FIRST PUBLIC COMMENT**
   Any person shall be permitted to address a meeting of the Grand Traverse County Department of Health and Human Services Board which is required to be open to the public under the provisions of the Michigan Open Meetings Act, as amended. (MCLA 15.261, et.seq.) Public comment shall be carried out in accordance with the following Board Rules and Procedures:
   1. Any person wishing to address the Board shall state his or her name and address.
   2. Persons may address the Board on matters which are relevant to Grand Traverse Pavilions issues.
   3. No person shall be allowed to speak more than once on the same matter, excluding time needed to answer Board Members questions. The Chairperson shall control the amount of time each person shall be allowed to speak, which shall not exceed three (3) minutes.
      a) Chairperson may, at his or her discretion, extend the amount of time any person is allowed to speak.
      b) Whenever a group wishes to address the Board, the Chairperson may require that the group designate a spokesperson; the Chairperson shall control the amount of time the spokesperson shall be allowed to speak, which shall not exceed fifteen (15) minutes.

   The Board shall not comment or respond to a person who is addressing the Board. Silence or non-response from the Board should not be interpreted as disinterest or disagreement by the Board.

   Please be respectful and refrain from personal or political attacks.

4. **COUNTY LIAISON REPORT**

5. **APPROVAL OF AGENDA**

6. **INTRODUCTION – Interim CEO/Administrator – David Hautamaki** Verbal

7. **CHAIRMAN REPORT – Cecil McNally** Verbal

8. GRAND TRAVERSE MEDICAL CARE

A. General Information

(1)	Department of Licensing and Regulatory Affairs - Annual Survey	1
	Life Safety Code Survey	2
(2)	Census Update	Verbal
(3)	Staffing Update	Verbal
(4)	Cottage Update	Verbal
(5)	Budget Development Process 2024	Verbal
(6)	Draft Operational Score Card	Handout

B. General Discussion

(1)

G.T.P. Announcements

(1) Next Board Meeting October 26, 2023

9. SECOND PUBLIC COMMENT

Refer to Rules under First Public Comment above.

10. ADJOURNMENT

Michigan Department of Licensing and Regulatory Affairs

Bureau of Community and Health Systems

NURSING HOME SURVEY DEFICIENCY SCOPE AND SEVERITY GRID

		SCOPE OF THE DEFICIENCY		
		ISOLATED (One or a very limited number of residents affected and/or one or a very limited number of staff involved, and/or the situation occurred only occasionally or in a very limited number of locations.)	**PATTERN** (More than a limited number of residents affected, and/or more than a limited number of staff involved, and/or the situation occurred in several locations and/or the same resident(s) have been affected by repeated occurrences of the same practice.)	**WIDESPREAD** (Situation was pervasive throughout the facility or represented a systemic failure that affected or had the potential to affect a large portion or all the facility's residents.)
SEVERITY OF THE DEFICIENCY	**LEVEL 4****** (Immediate jeopardy to resident health or safety)	**J**	**K**	**L**
	LEVEL 3*** (Actual harm that is not immediate jeopardy)	**G**	**H**	**I**
	LEVEL 2** (No actual harm with potential for more than minimal harm that is not immediate jeopardy)	**D**	**E**	**F**
	LEVEL 1* (No actual harm with potential for no more than minimal harm)	**SUBSTANTIAL COMPLIANCE** **A**	**SUBSTANTIAL COMPLIANCE** **B**	**SUBSTANTIAL COMPLIANCE** **C**

SHADED AREAS=SUBSTANDARD QUALITY OF CARE for any deficiency in s. 483.13 Resident Behavior and Facility Practices (F221-F226), s. 483.15 Quality of Life (F240-F258), and s. 483.25 Quality of Care (F309-F334).

Choose the HIGHEST harm level and the scope associated with that particular level of harm if the examples under one tag are at different levels of harm.

******LEVEL 4** Deficient practice caused or is likely to cause serious injury, serious harm, serious impairment or death. Immediate corrective action is needed.

*****LEVEL 3** Deficient practice led to a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and/or psychosocial well being…

****LEVEL 2** Deficient practice has led to minimal physical, mental, and/or psychosocial discomfort to the resident and/or a yet unrealized potential for compromising the resident's ability to maintain and/or reach his/her highest practicable level of physical, mental, and/or psychosocial well being…

LEVEL 1* Deficient practice has the potential for causing no more than minor negative impact on residents.

BCHS-109 (Rev. 11/15)
Authority: 42 CFR 483.13, 15, 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235088	A. BUILDING _____ B. WING _____	C 09/14/2023

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F000	INITIAL COMMENTS Grand Traverse Pavilions was surveyed for a Recertification survey from 9/11/2023 to 9/14/2023. Intakes: MI00138150 Census=138	F000		
F550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) 483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. 483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. 483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. 483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F550	1. The Birch and Dogwood units are no longer using the sunrooms. They have transitioned to using the main dining room for communal dining where the trays are delivered and passed together. While participating in communal dining, meals are served on dishes where their temperature and palatability can be maintained. The Cherry pavilion does use the sunroom. Should any residents be in the sunroom, at least one staff member will be present. Residents are fed promptly after being served. Resident #16 is not able to communicate his needs. He yells often and sometimes without reason. Staff are to anticipate his needs and provide care at routine intervals. This is care planned for him. Resident #20 has been provided with a wrist band call light as there have been times where she didnt use the light or thought she had, but didnt. The wrist call light has allowed her quick, easy access to the call light. Resident #97 was provided with reassurance that his call light is functioning appropriately. This was tested. Resident #72 pushes her call light incessantly regardless of whether she has needs that need to be met or not. Additionally, she will ring to ask for things she just had. It has	10/6/23

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F550	Continued From page 1 or resident of the United States. 483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. 483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide an environment that promoted and enhanced resident dignity in 12 (Resident #80, #431, #44, #12, #36, #125, #84, #98, #16, #20, #97, and #72) of 13 residents reviewed for dignity related to dining experience, call light wait times, and staff assistance of resident needs, resulting in the likelihood of feelings of humiliation, embarrassment, and loss of self-worth, and a negative psychosocial outcome for the residents impacting their quality of life. Findings include: Resident #80: Review of an "Admission Record" revealed Resident #80 was a female with pertinent diagnoses which included dementia, muscle weakness, anxiety, unsteadiness on feet, kidney disease, cognitive communication deficit, and abnormal weight loss. Review of a "Minimum Data Set" (MDS)	F550	been care planned that has this behavior. Staff to anticipate needs and provide care at routine intervals. This will apply to resident #80, #431, #44, #36, #12, #36, #125, #84, #98, #16, #20, #97. 2. All residents have the potential to be affected. 3. Nursing staff have been educated on ways to provide a dignified dining experience such as not placing residents in the dining room too early, providing monitoring when in the sunroom, feeding once served, serving trays together and on a clean surface, and maintaining food temperatures. Education has been provided about how best to provide care and oversight to a resident when they cannot make their needs known. This is at routine intervals. How routine intervals are defined was provided in education. The Meal Service policy was reviewed and updated to include meal service in the sunroom. This includes not putting residents in the sunroom until meal times where staff are preparing to serve the meal and assist with feeding, and providing adaptive equipment as ordered. Education completed 10/6/23. 4. The Culinary Director and Registered Dietitian will conduct two audits per week to monitor the timing of meal service on the units x 8 weeks or until compliance is achieved. Results of adults will be shared with the Director of Nursing and the unit ADONs. A weekly QA auditing the length of time it takes to serve all trays in the dining room, length of time from serving to feeding of 10-20 residents, ensuring a clean surface, and reheating appropriately and as directed. A weekly QA audit will be completed on call light response times for	

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F550	Continued From page 2 assessment for Resident #80, with a reference date of 10/27/22 revealed a Staff Assessment for Mental Status indicated Resident #80 was severely cognitively impaired. Review of current "Care Card" dated as of for Resident #80, revealed "...I eat with assist in the dining room ...I am approved to be assisted by a Paid Dining Assistant...Given my difficulties with communicating and making my needs known, If I am unable to verbalize my meal wishes, staff may make my menu selections for me..." Review of "Diet Change Form" dated 6/29/23 at 4:20 PM, revealed, "...Discontinue all assistive equipment. Needs total assist with eating..." During an observation on 09/11/23 at 01:27 PM, Resident #80 was observed seated in the Dogwood Sunroom. Resident #80 had not received her lunch meal at this time. In an interview on 09/11/23 at 01:27 PM, Certified Nursing Assistant (CNA) "AAA" reported Resident #80 was assisted to eat her meals by staff, and she does not answer you when you talk to her. During an observation on 09/12/23 at 09:18 AM, Resident #80 was observed seated in the Sunroom on the unit and she did not have a meal in front of her. No staff were present in the room. During an observation on 09/12/23 at 9:42, Resident #80 was observed seated in the Sunroom on the unit with no breakfast meal, no staff present or other residents. During an observation on 09/12/23 at 09:51 AM, CNA "HHH" placed Resident #431's and #80's	F550	10-20 residents. The QA will consist of running the call light report to ensure response times are appropriate and following-up with the resident to see if their needs are being met in a timely manner. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. 5. The Director of Nursing is responsible for ensuring compliance.	

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F550	Continued From page 3 meal in front of them. At 10:01 AM, CNA "HHH" opened the Styrofoam container and walked over to Resident #84 to check on her as she started to cough. CNA "HHH" went over to Resident #431 to assist her with set up for her meal. During an observation on 09/12/23 at 10:04 AM, CNA "ZZ" started to assist Resident #80 with eating her breakfast. Note: It was 54 minutes until Resident #80 began to eat her breakfast after being seated in the Sunroom since at least 09:10 AM when this writer entered the unit. Note: It was 13 minutes after Resident #80 received her breakfast when she was provided assistance to eat. During an observation on 09/13/23 10:39 AM, Resident #80 was observed seated in her wheelchair in the Sunroom on Dogwood with the Styrofoam container containing her breakfast in front of her. Observed on 09/13/23 at 10:44 AM, Recreation Therapist (RT) "GGG" entered the room and Resident #80 was observed looking at the RT when she entered the room and watched her as she exited the room. During an observation on 09/13/23 at 10:47 AM, Resident #80 was observed seated in the Sunroom after breakfast with her tray still in front of her and no other resident or staff member in the room with her. No TV or radio was on in the room. In an interview on 09/13/23 at 10:47 AM, CNA "QQ" reported Resident #80 received her breakfast at 09:45 AM this morning. CNA "QQ" reported the nursing staff were preparing to take her to her room and to the restroom. CNA "QQ" reported the unit ran behind "more than we normally do" and the kitchen missed 9 breakfast	F550		

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F550	Continued From page 4 trays for their residents they had to ask for. During an observation on 09/13/23 at 10:50 AM, Recreation Therapist (RT) "GGG" assisted Resident #80 to her room for her to be toileted and "placed in her recliner" per CNA "QQ". Note: Resident #80 was finished with breakfast at least one hour prior per CNA "QQ" to her being brought to her room by nursing staff. Resident #431: Review of an "Admission Record" revealed Resident #431 was a female with pertinent diagnoses which included stroke, hemiplegia (paralysis) left dominant side, falls, intellectual disabilities, gastric ulcer, depression, anemia, and lesion of the radial nerve (nerve damage due to fracture of the humerus). During an observation on 09/12/23 at 09:20 AM, Resident #431 was observed seated in a recliner at the center hub area of the unit. Resident #431 was observed with no breakfast in front of her. Resident #62, R#94, and R#86 had their breakfasts prior to this observation. During an observation on 09/12/23 at 09:50 AM, Resident #36 and R#431 did not have their breakfast. During an observation on 09/12/23 at 09:52 AM, CNA "HHH" asked Resident #431 would she like to sit in the small dining room so she would be able to assist her with breakfast meal. During an observation on 09/12/23 at 09:53 AM, Resident #84 and R#36' breakfast trays were in the Sunroom dining room area. During an observation on 09/12/23 at 09:54 AM,	F550		

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F550	Continued From page 5 Resident #36 was brough to the dining room as well as Resident #431. Resident #36's breakfast Styrofoam tray was placed in front of her. During an observation on 09/12/23 at 09:51 AM, CNA "HHH" placed Resident #431's and #80's meal in front of them. At 10:01 AM, CNA "HHH" went over to Resident #431 to assist her with set up for her meal. Note: For 10 minutes the breakfast meal sat in front of Resident #431. Resident #44: Review of an "Admission Record" revealed Resident #44 was a female with pertinent diagnoses which included dementia, anxiety, osteoarthritis, and hypertension. During an observation on 09/12/23 at 09:17 AM, this writer observed the breakfast meal cart in the hallway. Residents #36, #62, #94, #44, #86, #431, #125, and #12 were seated in the center of the unit. Residents #94, #86 and #62 were observed to have their breakfasts in front of them. Resident #12 received his breakfast at 09:37 AM. Residents #36, #44, #431, and #125 had not received their breakfasts yet. Resident #44 was seated next to R#94. During an observation on 09/12/23 at 09:38 AM, Resident #44 received her breakfast meal while located in the hub center on the unit. Note: Resident #44 did not receive her breakfast for 21 minutes following other residents observed with their breakfast trays. Resident #12: Review of an "Admission Record" revealed Resident #12 was a male with pertinent diagnoses which included hemiplegia (paralysis)	F550		

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F550	Continued From page 6 left side, weakness, reduced mobility, diabetes, dementia, epilepsy, low potassium, and Wegener's granulomatosis (condition that causes inflammation of the blood vessels, blood flow to organs and tissues may be reduced, causing damage). Review of "Care Card" dated 9/14/23, revealed, "...To encourage me to have optimal independence with my ADLs: Self feeding recommendations: Bring (Resident #12) as close to table as possible, cut up food, use of scoop plate at all meals, keep items at reach of RUE (right upper extremity)..." Note: All residents were served meals in Styrofoam containers. During an observation on 09/12/23 at 09:17 AM, this writer observed the breakfast meal cart in the hallway. Residents #36, #62, #94, #44, #86, #431, #125, and #12 were seated in the center of the unit. Residents #94 and #62 were observed to have their breakfasts in front of them. During an observation on 09/12/23 at 09:37 AM, Resident #12 received his breakfast in a Styrofoam container while he was seated in the hallway in front of the television. Note: It had been at least 20 minutes since this writer observed residents with meals and when Resident #12 received his meal. Resident #36: Review of an "Admission Record" revealed Resident #36 was a female with pertinent diagnoses which included dementia, falls, hip fracture, GERD, irregular heartbeat, and renal insufficiency.	F550		

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F550	Continued From page 7 During an observation on 09/12/23 at 09:53 AM, Resident #84 and R#36' breakfast trays were in the Sunroom dining room area. During an observation on 09/12/23 at 09:54 AM, Resident #36 was brought to the dining room as well as Resident #431. Resident #36's breakfast Styrofoam tray was placed in front of her. In an interview on 09/12/23 at 10:05 AM, Resident #36 was sitting with her breakfast container lid open and had not been assisted with her breakfast meal. In an interview on 09/12/23 at 10:06 AM, CNA "FFF" reported she was going to talk to Resident #36 to determine if she was able to feed herself. CNA "FFF" reported if she couldn't answer she would check her care card in the computer. CNA "FFF" reported she doesn't work over here very often. CNA "FFF" was observed to put on gloves and had begun to assist Resident #36 with her breakfast meal. Note: 13 minutes had passed since Resident #36's breakfast tray was observed in the Sunroom dining room area. Resident #125: Review of an "Admission Record" revealed Resident #125 was a male with pertinent diagnoses which included dementia, schizophrenia, diabetes, epilepsy, age related debility, and cognitive communication deficit (progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language). Review of "Nutritional Quarterly Assessment" dated 8/14/23, revealed, "...Level of assistance: Setup assist and supervision; easts in Dogwood DR ...Intake Adequacy: Appears adequate at	F550		

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F550	Continued From page 8 this time; historically it was likely inadequate ...Medications: levetiracetam, Iron, Metformin, Januvia, Insulin Glargine, Tamsulosin, Lisinopril, Cetirizine, Omeprazole, Simvastatin, Carvedilol, Insulin Lispro, Amlodipine, Vraylar...Assessment: 72 yo male admitted for LTC from hospital with dx including hypertensive Encephalopathy, schizophrenia, DM2, Dementia, and hyperlipidemia. Per hospital notes dx of PEM as well. AKI on hospital admission but it resolved with IV fluids. Dx normocytic anemia - likely d/t (due to) chronic disease...Attempted interview with resident, but resident very confused. Unable to report UBW or if he experienced recent weight loss. Weights improved at facility from hospital...NFPE: min/mod fat loss of orbitals AEB hollowing, scapula AEB indentation; Min/mod muscle loss: interosseous of dorsal hand, biceps, and temporalis AEB indentation. Skin appears fragile, nails brittle, hair wnl for age ...MNA: 8/14 - indicates at risk for malnutrition ...Review of nutrition notes from hospital re: malnutrition prior to admit. Resident was receiving glucerna or magic cups TID to supplement intake...Eating in Main Dogwood dining room for setup assistance and supervision at meals...Resident with PPI - risk for malabsorption (Mg level to be draw this week). Risk for weight/appetite changes d/t (due to) Vraylar (antipsychotic)...Nutrition dx: Suboptimal intake (PTA) r/t (related to) impaired cognition and comorbid conditions AEB NFPE findings of non-severe PEM with altered labs values at hospital...Nutritional goals: To consume >75% intake at meals and >50% acceptance of supplements per day to maintain body weight in range of 130-140# without significant changes through the next quarter. (New)...To maintain blood glucose in range of 70-180 mg/dL through the next quarter (New)..."	F550		

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F550	Continued From page 9 During an observation on 09/12/23 at 09:17 AM, this writer observed the breakfast meal cart in the hallway. Residents #36, #62, #94, #44, #86, #431, #125, and #12 were seated in the center of the unit. In an interview on 09/12/23 at 09:40 AM, RN "Z" reported Resident #125 did not have his breakfast. During an observation on 09/12/23 at 09:42 AM, Resident #125 received his breakfast while he was seated in a recliner in the center hub area of the unit. Note: Resident #125 had not received his breakfast Styrofoam container for at least 25 minutes after other residents had received their meals. Resident #84: Review of an "Admission Record" revealed Resident #84 was a female with pertinent diagnoses which included dementia, stroke, muscle weakness, dysphonia (functional voice difficulty), glaucoma (nerve connecting the eye to the brain is damaged), and dysphagia (damage to the brain responsible for production and comprehension of speech). During an observation on 09/12/23 at 09:55 AM, Resident #84 was brought to the Sunroom and set up was performed by CNA "HHH." Note: The breakfast Styrofoam container had been sitting on the table since at least 09:42 AM when it was observed by this writer. In an interview on 09/12/23 at 09:50 AM, RN "Z" reported the breakfast does usually get brought to the unit at about 9:00 AM. During an observation on 09/12/23 at 09:46 AM,	F550		

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F550	Continued From page 10 Licensed Practical Nurse (LPN) "BBB" was observed exiting from the locked nurse's office as the Fire Marshalls were sounding a door alarm. LPN "BBB" reported she was in the nurse's office as she had charting to complete. When queried about breakfast mealtimes she reported breakfast was delivered approximately 09:00 - 09:15 each morning. Review of the "Residents who can be assisted by a Paid Dining Assistant" document received during survey, revealed, five residents in the facility were assessed to be assisted by a paid feeing assistant with one (Resident #80) on the Dogwood unit. Review of the "Staff Who Have Completed the Paid Dining Assistant Course" document received during survey, revealed there were 36 staff members who completed the paid dining assistant course. In an interview on 09/14/23 at 09:41 AM, Director of Nursing (DON) "B" reported the COVID outbreak was something new to the facility and they had never served food on the floor front. DON "B" reported the facility tried to keep up and were dedicated but was not a well-oiled machine. When queried if the paid feeding assistants were utilized, DON "B" reported there were 4 residents on the Dogwood unit where had been evaluated to be assisted with meal by a paid feeding assistant with no response as to why the paid feeding assistants were not utilized. DON "B" reported the facility was rolling out a new electronic medical record system this week and her list of things to do were endless, addressing other issues which come up, donning/doffing, office work and other infections. DON "B" stated "what to prioritize looks different for everybody. Two weeks ago, COVID came	F550		

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F550	Continued From page 11 and it threw everything off as we had focused so much on the dining room dining experience so much this last year...for many of the staff this was their first experience with a COVID outbreak..." When quivered about whether the nurses and Assistant Director of Nursing (ADON) administrative nurses were assisting with meal delivery, set up and assistance with eating meals, DON "B" replied the ADON "LL" reported she had been on the unit busy answering call lights and addressing other concerns. Note: This writer did not observe ADON "LL" on the unit at the times this writer completed observations on the unit, especially during breakfast mealtime on 09/13/23 and lunch time on 09/14/23. DON "B" reported the other ADONs for long term care were not as engaged as the ADON for the rehabilitation unit. R98 According to the Minimum Data Set (MDS) dated 8/16/2023, R98 scored 3/15 (severely cognitively impaired) on her BIMS (Brief Interview Mental Status), required one-person limited assistance of guided maneuvering while eating. multiple sclerosis (MS), and anxiety. R98 had lost weight and was not on a physician prescribed weight loss program, was 56 inches (5'6") tall and weighed 133#. Further review of the resident's MDS revealed her weight loss 8/4/23 144#, 7/18/23 146#, and on 6/22/23 148#. During an interview on 9/13/23 at 9:09 AM, CNA "DD" stated, "I think there is a staffing issue in the kitchen. Breakfast usually comes at 8:15 AM. It was brought to the unit today at 9:27 AM." During an observation and interview on 9/13/2023 at 9:43 AM, CNA "DD" stated,	F550		

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F550	Continued From page 12 "Because of the outbreak of Covid here, residents eat in the hall, in their rooms, or in the "circle area". R98 requires encouragement to eat her meals." Observed CNA "DD" take R98 to the Birch unit "circle area" where the 4 halls met. The CNA gave the resident a bedside table without cleaning it, placed on it a cup of coffee, set up her breakfast 9:47 AM, and left the resident to eat on her own. One other resident was attempting to eat their breakfast in the same area. No staff were present. During an observation on 9/13/2023 at 9:46 AM two residents eating breakfast from Styrofoam containers in front of rooms 232/233 and 204/205, both were transmission-based isolation precautions rooms (Covid-19 positive resident rooms). Both room doors were open. During an observation and interview on 9/13/23 at 9:49 AM, CNA "DD" put on her jacket and had her purse stating, "I'm going on break." It was noted R98 was alone in the "circle area" with her breakfast tray with her food in a Styrofoam container in front of her. During an observation and interview on 9/13/23 at 9:49 AM, R98 stated, "My breakfast is cold. I would like to eat warm food." During an observation and interview on 9/13/23 at 9:49 AM, Licensed Practical Nurse (LPN) "P" stated, "The meal cart came to the floor about 9:00 this morning. I will warm up (R98's) food. At 9:49 AM the LPN left to warm up resident's food. At 9:53 AM, LPN "P" brought R98 her food in a Styrofoam container. The LPN stated, "I tested her food in different spots and it was 90-100 degrees." During an observation on 9/13/23 at 9:55 AM,	F550		

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F550	Continued From page 13 Birch Hall's unit kitchen had 3 resident breakfast trays all in Styrofoam containers that had not been delivered yet that morning. During observation and interview on 9/13/23 at 9:52 AM RN "JJ" stated "There are 36 residents, 2 nurses, and 5 CNAs on Birch Hall right now. I'm not sure what the aides are doing right now or why the rest of the resident trays have not been delivered." During an interview on 9/13/23 at 10:03 AM, CNA "CC" and CNA "N" stated, "We are getting one of the resident's toileted and ready for the day right now that has their breakfast still in the pantry. We will bring him his breakfast." During an observation on 9/13/23 at 10:04 AM of the "circle area", no staff was assisting R98 and neither LPN "P" or RN "JJ" were seen in the area. During an interview on 9/13/23 at 10:07 AM, LPN "P" stated, "I asked (Associate Director of Nursing (ADON) "UU") how long food could be left out before feeding it. I was told she really did not know, so I reheated the food for 20 seconds, used a gloved hand and held it over the food to feel if it was warm enough. If the food was dairy, I would have not fed it since it has been sitting for a few hours." During an interview on 9/14/23 at 9:22 AM, ADON "UU" stated, "For food time frames there are target times but because of the quarantine of Covid-19, food being put in Styrofoam containers plays a factor in getting food out late and it being cold. I do not know how long the food should sit out or if it should be put in the refrigerator until it can be served. I'd have to refer to the policy. To reheat foods, they should	F550		

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F550	Continued From page 14 be put on a plate to reheat and put back in the Styrofoam container. I do not know what temperature it should be reheated to. All unit pantries should have thermometers. This is all different because of Covid." Resident #16 Review of an "Admission Record" revealed Resident #16, was originally admitted to the facility on 5/10/2018 with pertinent diagnoses which included unspecified dementia with behavioral disturbance. Review of a "Minimum Data Set" (MDS) assessment for Resident #16, with a reference date of 6/8/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 00/15 which indicated Resident #16 was severely cognitively impaired. Review of Resident #16's "Care Plan" revealed, "Problems: ... (Resident #16) have the potential for change in my psycho-social status and mood. I am aphasic (language disorder that affects the ability to communicate) and unable at times to communicate my needs. Due to this, I have the potential to use physical means of communication. At times I (Resident #16) will yell or call out, become physically and verbally aggressive. I have the potential to get overwhelmed by my surroundings and stimuli. This may cause me to lash out at others...Interventions:... If I (Resident #16) am calling out or appear uncomfortable/angry offer to assist me with using the restroom, offering me a snack,or I (Resident #16) may be tired and wish to lay down..." Review of Resident #16's "Care Card" revealed,"... Behavioral/Mood interventions that	F550		

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F550	Continued From page 15 work for me (Resident #16): If I (Resident #16) am yelling out please offer me snack, change of position, toileting. I (Resident #16) like to listen to classic rock music please turn it on while I am in my room..." During an interview and observation on 9/13/23 at 9:53 AM, Certified Nursing Assistant (CNA) "KK" was speaking with surveyor in the hallway outside of Resident #16's room when Resident #16 began to scream out for help repeatedly. CNA "KK" reported to the surveyor that Resident #16 called out frequently as a behavior, and that she did not need to go check on him. On 9/13/23 at 9:58 AM, Resident #16 was observed sitting in his wheelchair in his room continuing to yell out for help. Resident #16 did not have any items in reach such as a tray table, television remote, call light, or water. CNA "KK" did not check on Resident #16, and left to assist another resident. During an interview on 9/13/23 at 10:00 AM, Licensed Practical Nurse (LPN) "R" reported that Resident #16 did not know how to use a call light, so he would yell out for help when he needed assistance. LPN "R" reported that when Resident #16 called out for help, staff should check on him and address his needs. During an interview on 9/13/23 at 10:09 AM, Assistant Director of Nursing (ADON) "HH" reported that Resident #16 did not know how to use a call light, so he would call out for help when he needed staff assistance. ADON "HH" reported that the facility expectation was for staff to check on any resident that called out for help. Resident #20 Review of an "Face Sheet" dated 6/13/23	F550		

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F550	Continued From page 16 revealed Resident #20 was admitted to the facility with the following pertinent diagnoses: Hemiplegia following Cerebral Infarction (paralysis on one side of the body after a stroke), Unspecified Dementia, Weakness, and Anxiety Disorder. Review of a "Minimum Data Set" (MDS) assessment dated 7/23/23 revealed Resident #20 was usually able to make herself understood and was able to understand others clearly. Review of a Brief Interview for Mental Status (BIMS) assessment revealed Resident #20 scored 9/15 which indicated the resident had a moderate cognitive impairment. Section "G" of the MDS assessment revealed Resident #20 was unsteady and required one person assistance to move from one surface to another. Section "GG" revealed Resident #20 required a helper to complete all the effort for toileting hygiene (perineal hygiene and clothing management). Section "H" of the MDS revealed Resident #20 had frequent episodes of urinary incontinence and was occasionally incontinent of bowel. Review of a "Care Plan Report" for Resident #20 dated 9/13/23 revealed "problem/goal/interventions" that stated: "Problem: I have an alteration in my ADL (activities of daily living including toileting) function ...Goal: I would like to attain the highest level of independence ...Interventions: Transfer me ...1 (staff) assist, Assist me to the bathroom per protocol". In an interview on 9/11/23 at 3:36pm, Resident #20 reported feeling frustrated and angry about ongoing lengthy delays in responding to her call light. Resident #20 reported she regularly transferred herself to a bedside commode	F550		

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F550	Continued From page 17 although she knew it was a safety risk and did so to avoid having an episode of incontinence. Resident #20 was tearful during the interview and reported the long delay in response to her call light made her feel helpless. Review of a call light audit labeled "Past Calls" revealed 15 episodes between 8/14/23-9/10/23 in which the activation and deactivation of Resident #20's call light was greater than 20 minutes. The same document revealed 4 episodes in which the elapsed time between Resident #20's call light activation and deactivation was more than 1 hour. All call light response times greater than 20 minutes occurred from 4pm-11pm. The call light response times greater than an hour occurred between 5pm-9:30pm. Resident #97 Review of a "Face Sheet" for Resident #97 dated 5/10/23, revealed the resident was admitted to the facility with the following pertinent diagnoses: hemiplegia following a Cerebral Infarction (paralysis on one side after a stroke), Polymyalgia Rheumatica (inflammation causing muscle stiffness, decreased range of motion, and pain), and Weakness. Review of a "Minimum Data Set" (MDS) assessment dated 8/8/23 revealed Resident #97 scored 15/15 on a Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Section "G" of the MDS revealed Resident #97 was dependent (full staff performance needed) to move from one surface to another and required extensive assistance for toilet use. Section "GG" revealed Resident #97 was dependent (helper does all the effort) for toileting hygiene (perineal hygiene,	F550		

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F550	Continued From page 18 adjusting clothing). Review of a "Care Plan Report" for Resident #97 dated 5/10/23 revealed "problem/goal/interventions" that stated: "Problem: I have an alteration in my ability to perform my ADLs independently and be independent with my mobility r/t (related to) being non-ambulatory and unable to bear weight ...Goal: I would like to be clean, odor free, well groomed, and comfortably dressed ...Interventions ...Assist me to the bathroom per protocol ...Transfer me per my Resident Care Card ...(name of device) mechanical lift". In an interview on 9/11/23 at 3:44pm, Resident #97 voiced frustration about lengthy call light response times. Resident #97 reported at times he wondered if the call light was working, and he felt anxious waiting for someone to respond. Review of a call light audit titled "Past Calls" dated 8/14/23-9/11/23, revealed 20 incidences in which the elapsed time between Resident #97's activation and deactivation was than 20 minutes for a response to his call light. All incidences occurred between 3pm-9pm. The longest elapsed time between activation of Resident #97's call light and deactivation was 1hour, 29minutes. Resident #72 Review of a "Face Sheet" for Resident #72 dated 1/22/19, revealed the resident was admitted to the facility with the following pertinent diagnoses: Hemiplegia following a Cerebral Infarct (paralysis on one side following a stroke), Muscle Weakness, Difficulty Walking, Generalized Anxiety Disorder, and Major Depressive Disorder.	F550		

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F550	Continued From page 19 Review of a "Minimum Data Set" (MDS) assessment dated 6/13/23 revealed Resident #72 scored 14/15 on a "Brief Interview for Mental Status" (BIMS) assessment, which indicated the resident was cognitively intact. Section "G" of the MDS revealed Resident #72 was dependent (full staff performance needed) to move from one surface to another and required extensive assistance for toilet use. Section "GG" revealed Resident #72 was dependent (helper does all the effort) for toileting hygiene (perineal hygiene, adjusting clothing). Review of a "Care Plan Report" for Resident #97 dated 6/14/19 revealed "problem/goal/interventions" that stated: "Problem: I have an alteration in my ability to perform my ADLs independently ...Goal: I would like to be clean, odor free, well groomed, and comfortably dressed ...Interventions ...Assist me to the bathroom per protocol, Keep my call light within my reach ... Anticipate and meet my needs and provide me with frequent safety checks. ...Transfer me per my Resident Care Card ...(name of device) mechanical lift". In an interview on 9/11/23 at 4:15pm, Resident #72 reported long wait times following activation of her call light and feeling embarrassed about sitting in a soiled brief while waiting for help. Resident #72 stated "it's disgusting" to have to sit in your own waste and that she worries about the condition of her skin due to the long wait times. Review of a call light audit titled "Past Calls" dated 8/14/23-9/12/23, revealed 70 incidences in which the elapsed time between Resident #72's call light activation and deactivation was greater than 20 minutes. All incidences occurred	F550		

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F550	Continued From page 20 between 3pm-11pm. 9 incidences resulted in Resident #72 waiting more than an hour for a response to her call light. The longest elapsed time between Resident #72's call light activation and deactivation was 2 hours and 3 minutes In an interview on 9/13/23 at 8:49am, Director of Nursing (DON) "B" reported the facility's expectation was that a Resident's call light would be responded to within 10-15minutes. DON "B" reported call light audits had not been performed recently, and that the call light audits the facility provided did show some consistent long wait times for the residents in question.	F550		
F554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) 483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by 483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review the facility failed to perform a resident assessment and obtain a physician order for the self administration of medication for 1 of 1 resident (Resident #81), reviewed for self administration of medication, resulting in the potential for the mismanagement of medication and adverse side effects. Findings include: Review of an "Admission Record" revealed Resident #81, was originally admitted to the facility on 8/7/23 with pertinent diagnoses which included disorientation and repeated falls.	F554	1. Family had brought the eye drops in for the resident and the resident was not aware we needed an order and to complete a self-administer assessment. Nursing was not aware this medication was at the bedside. The process of needing an order for medication and self-administration assessment and consent was explained to the resident. Nursing requested an order for the Systane eye drops from the provider. Resident #81 was agreeable to having them kept in the cart and administered by nursing as she is not able to self-administer. 2. Residents with families bringing in items have the potential to be affected. 3. Nursing staff have received education about needing an order for medication brought from home, the right to self-administer, and medication storage. The right to self-administer will be reviewed with residents and families upon admission. Self-Administration policy was reviewed and updated to include education residents and families on admission about the self-administration of medication	10/6/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F554	Continued From page 21 Review of a "Minimum Data Set" (MDS) assessment for Resident #81, with a reference date of 8/14/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #81 was cognitively intact. During an interview and observation on 9/11/23 at 3:29 PM, Resident #81 reported that she suffered from chronic dry eyes, and would frequently use eye drops. Resident #81 had a bottle of Systane eye drops on her tray table. Resident #81 reported that she was not keeping track of how often she was using the eye drops, or how long she would wait between each use. During an observation on 9/12/23 at 3:57 PM, Resident #81 was observed sitting in her room in her recliner watching television. Resident #81 had Systane eye drops sitting at her tray table. During an interview on 9/12/23 at 2:30 PM, Licensed Practical Nurse (LPN) "TT" reported that she was not aware of any orders for Resident #81 to self-administer medications. During an interview on 9/13/23 at 11:21 AM, Assistant Director of Nursing (ADON) "UU" reported that Resident #81 did not have a physician order for self-administration of medications, and had not been assessed to determine if she could safely self-administer medications. ADON "UU" reported that Resident #81 did not have any orders for eye drops, and that she was not aware that Resident #81 was using eye drops. ADON "UU" reported that the facility should have completed an assessment to ensure that Resident #81 could safely self-administer the eye drops. Review of facility's "Self- Administration of	F554	process. Nursing education was completed October 6, 2023. 4. The rooms of the 10-20 residents will be audited weekly for medication that may have been brought from home. For those residents that do have medication at the bedside, nursing will ensure they have a care plan, order, and assessment with consent completed. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. 5. The Director of Nursing is responsible for compliance.	

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F554	Continued From page 22 Medication" revealed, " It is the responsibility of the interdisciplinary team to determine that it is safe for a resident to self-administer medication before the resident may exercise that right... Procedure: 1. Initial assessment upon admission by the interdisciplinary team, and then quarterly and/or as needed thereafter 2. If the interdisciplinary team determines that the resident meets cognitive and/or physical requirement(s) to safely administer the medication, the resident will be provided the Self-Administration of Medication form for signature 3. A physician order will be written stating that the resident may self-administer their own medications 4. Initiate Self-Administration of Medication Care Plan and insert a "Self-Administration" alert sheet in the resident's Treatment Administration Record (TAR)...."	F554		
F558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) 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 ensure resident's accommodation of needs were met for 5 (Resident #81, # 68, #381,#34 and #96) out of 6 residents reviewed for accommodation of needs resulting in resident's inability to call for staff assistance with the potential for unmet care needs and a resident not receiving incontinence	F558	1. Resident #81 was provided with incontinence products. Resident #68 and Resident #381, Resident #34, and Resident #96 has had their call light placed within reach. Resident #34 has been provided with a soft touch call light as this is easier for him to use. Resident #96 has been provided with a wrist call light. Resident #381 was provided with a clip on his call light so that it may be clipped to prevent falling to the floor. 2. All residents have the potential to be affected. 3. Nursing staff have received education regarding how and when to pass incontinent products. This is to be completed by the midnight shift, but all staff have access to incontinence products. Education has been provided about leaving the call light within reach when exiting the room. Education also includes clipping call lights if need be, placing call lights within	10/6/23

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F558	Continued From page 23 care products. Findings include: Resident #81 Review of an "Admission Record" revealed Resident #81, was originally admitted to the facility on 8/7/23 with pertinent diagnoses which included disorientation and repeated falls. Review of a "Minimum Data Set" (MDS) assessment for Resident #81, with a reference date of 8/14/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #81 was cognitively intact. Review of Resident #81's "Care Card" revealed, "...Toileting: Please check to ensure I am maintaining my hygiene. Provide Assist prn (as needed)..." During an interview and observation on 9/11/23 at 3:29 PM, Resident #81 reported that she used incontinence (lack of voluntary control of urination) briefs and pads daily and would often run out for days at a time before staff would bring her more. Resident #81 opened the bottom drawer of her dresser and showed surveyor an empty bag of incontinence pads and an empty bag of incontinence briefs. Resident #81 reported that she felt frustrated that the facility was not providing her with incontinence items. Resident #81 also reported that there had been a few occasions where she had soiled her clothing and recliner chair when she did not have incontinence items. During an interview on 9/12/23 at 2:30 PM, Licensed Practical Nurse (LPN) "TT" reported that Resident #81 was independent with toileting, but that Certified Nursing Assistants	F558	sight, and near strong sides. The Call Light/Systems policy was updated 10/6/23 to include ensuring the call light is within reach, requesting an alternate call light if necessary, such as a wrist call or soft touch pad, and clipping the call light in place to prevent dislocation if needed. The Incontinence Products policy was updated on 10/6/23 to include the distribution of products and where to place them in the resident room. Education completed 10/6/23. 4. A weekly QA will be completed ensuring 10-20 residents have their incontinence products for the day stocked in their room and call lights are within reach. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. 5. The Director of Nursing is responsible for ensuring compliance.	

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F558	Continued From page 24 (CNA's) were expected to check in on Resident #81 to ensure that she did not need any assistance. LPN "TT" was not aware if Resident #81 used incontinence care products. During an interview and observation on 9/12/23 at 3:57 PM, Resident #81 reported that she had not received any incontinence care products. Resident #81 showed surveyor her drawer which had one empty bag of incontinence briefs and one empty bag of incontinence pads. Resident #81 reported that she felt embarrassed when she would have accidents. Resident #81 reported that she had asked several staff staff members to bring her more incontinence products, but had "given up on asking" since she never received them. During an interview and observation on 9/13/23 at 9:12 AM, Resident #81 was sitting in her room in her recliner eating breakfast. Resident #81 reported that staff had not brought her any incontinence products, and that her drawer was empty. Resident #81's drawer had one empty bag of incontinence briefs, and one empty bag of incontinence pads in her drawer. During an interview on 9/13/23 at 11:07 AM, CNA "N" reported that Resident #81 was independent with toileting. CNA "N" reported that Resident #81 would usually let the CNA's know when she was low on products, but that she would still check in case Resident #81 forgot to ask. CNA "N" reported that she was unsure if other CNA's were checking to see if Resident #81 needed more incontinence care products. CNA "N" reported that she had not checked during the current shift if Resident #81 needed incontinence products, and she did know the last time Resident #81's drawer was stocked with incontinence care products.	F558		

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F558	Continued From page 25 During an interview on 9/13/23 at 11:21 AM, Assistant Director of Nursing (ADON) "UU" reported that she was unaware that Resident #81 was using incontinence care products, and that Resident #81's care plan did not address incontinence care product needs. Resident #68 Review of an "Admission Record" revealed Resident #68,was originally admitted to the facility on 1/24/23 with pertinent diagnoses which included dementia and difficulty in walking. Review of a "Minimum Data Set" (MDS) assessment for Resident #68, with a reference date of 7/21/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #68 was cognitively intact. Review of the "Functional Status" revealed that Resident #68 required assistance of one person for bed mobility, transfers, and toileting. Review of Resident #68's "Care Plan" revealed, "...Problem: I (Resident #68) have an alteration in my ability to perform my ADLS's (activities of daily living) independently and be independent with my mobility r/t (related to): deconditioning, recent MI (Myocardial infarction) and forgetfulness. I (Resident #68) am at risk for injury from falls d/t (due to): DM (Diabetes Mellitus) and fall risk medications. I (Resident #68) was having episodes of dizziness during my hospitalization. Resident had fall on 9/6 no injuries sustained. Interventions: ... Keep my call light within reach when I (Resident #68) am in my room. Anticipate and meet my needs...."	F558		

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F558	Continued From page 26 Review of Resident #68's "Care Card" revealed, "...Additional SAFETY instructions: ... Keep my call light within my reach when I (Resident #68) am in my room. Anticipate and meet my needs..." During an observation on 9/12/23 at 8:11 AM, Resident #68 was in her room lying in her bed. Resident #68's call light was hanging from the wall across Resident #68's tray table, which was on the other side of the room and out of Resident #68's reach. During an interview on 9/13/23 at 11:07 AM, CNA "N" reported that Resident #68 used her call light for staff assistance and was unable to get up and out of bed on her own. During an interview on 9/13/23 at 11:21 AM, ADON "UU" reported that Resident #68 used her call light for staff assistance. ADON "UU" reported that Resident #68 had become weaker recently, and required one staff member for assistance with care. Resident #381 Review of an "Admission Record" revealed Resident #381, was originally admitted to the facility on 8/29/23 with pertinent diagnoses which included weakness and diabetes. Review of a "Minimum Data Set" (MDS) assessment for Resident #381, with a reference date of 8/29/23 revealed "Staff Assessment for Mental Status" noted that Resident #381 had a memory problem, and had moderately impaired cognitive skills for daily decision making." Review of the "Functional Status" revealed that Resident #381 required extensive assistance of	F558		

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F558	Continued From page 27 for bed mobility, dressing, personal hygiene and toileting, and that Resident # 381 was dependent and required full staff performance for transfers. Review of Resident #381's "Care Plan" revealed, " I (Resident #381) have an alteration in my ability to perform ADL's independently and be independent with my mobility r/t: CVA (cerebral vascular accident), left sided hemiplegia (paralysis to one side of the body), left sided blindness, weakness, HTN (hypertension), hyperlipidemia (high cholesterol), left sided AKA (Above the knee amputation), depression. Interventions:... Keep my call light within my reach when I (Resident #381) am in my room. Anticipate and meet my needs and provide me with frequent safety checks..." Review of Resident #381's "Care Card" revealed, " ...Call light: Ensure my call light if left within reach of my strong right side..." During an observation on 9/12/23 at 11:41 AM, Resident #381 was lying in bed on his back watching television. Resident's call light was on the floor under Resident #381's bed and out of reach. During an interview on 9/13/23 at 11:07 AM, CNA "N" reported that Resident #381 used his call light for staff assistance and was unable to get up and out of bed on his own. During an interview on 9/13/23 at 11:17 AM, ADON "UU" reported that staff were expected to ensure that residents call lights were within reach every time they checked on a resident and left their room.	F558		

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F558	Continued From page 28 R34 According to the Minimum Data Set (MDS) dated 7/11/2023, R34 scored 14/15 (cognitively intact) on his BIMS (Brief Interview Mental Status), required extensive assistance from two-persons for dressing and personal hygiene, extensive assistance of one-person for eating, with impairment of his left arm and both legs. His diagnoses included stroke leaving him partially paralyzed. During an observation and interview on 9/12/23 at 10:43 AM, R34 was awake sitting sideways in a broda chair (positioning wheelchair) in his room. His left hand was contracted into a fist. His soft touch call light was hanging from the right side of his bed almost touching the floor. R34 stated, "I am uncomfortable sitting like this. I cannot reach the call light. I "messed" (bowel movement) in my pants too. I cannot call for help like this." During an observation on 9/12/23 at 10:50 AM Certified Nursing Assistant (CNA) "PP" entered R34's room, telling him she needed another staff to assist her to transfer him to bed to clean him up and left his room. Observed on 9/14/2023 at 9:22 AM R34's soft touch call light hanging off the right side of the bed touching the floor out of sight and reach of the resident. R96 According to the MDS dated 8/1/2023, R96 scored 7/15 (cognitively impaired) on her BIMS, required limited assistance for transfers, walking in her room, and toileting. Her diagnoses included a recently fractured back from a fall.	F558		

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F558	Continued From page 29 Review of R96's Care Plan (treatment plan to direct staff's care of resident) reported she had an alteration in her ability to perform her ADLs (activities-of-daily living) independently and be independent with mobility r/t (related to): age-related physical debility and vertigo. She was at risk for injury from falls due to age-related physical debility, history of falls, osteoporosis, vertigo, impaired balance, and times of incontinence. (STATUS: Active (Current) EFFECTIVE: 2/15/2022 - Present. Her goal was to be clean, odor free, well groomed, and comfortably dressed with encouragement to participate as able. Interventions to meet this goal included "assist me to the bathroom per protocol." "Keep my call light within my reach when I am in my room." During an observation and interview on 9/12/2023 at 9:30 AM, R96 was sitting in a wheelchair with a bedside table in front of her. No call light or call bell was visible in her bed area. R96's room was the farthest room from the central hall and at the end of the hall. During an observation and interview on 9/12/23 at 9:35 AM of R96's room with Registered Nurse (RN) "RR". RN stated, "(R96) does not remember to push her call light. Staff tries to check on her frequently. I do not know the specific time, at least every hour, she transfers herself, she has a sign to tell to use the call light." After about 10 minutes, RN "RR" came back to Surveyor stating, "I just double-checked (R96's) care plan and it said to keep her walker within reach, shoes or socks with traction are to be worn, and keep her frequently used stuff within reach. In the bathroom she is to keep her walker with her. She sometimes uses the bathroom by herself. I do not think she is	F558		

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F558	Continued From page 30 ambulating as much after her last fall." At this time CNA "V", walked by stating, "(R96) quite often uses the bathroom by herself." RN "RR" walked back into R96's room and found R96 had gone into her bathroom and had transferred herself from her wheelchair onto the toilet. R96 stated, "I had to go pee pee and poop." RN stated, "Oh dear." and assisted resident with toileting. RN did not educate resident to use the call light. During an observation and interview on 9/12/23 at 10:27 AM R96 was in her wheelchair next to her bed stating "I want to go sleepy. I want to go to bed so I sleep and get better." R96 stated, "I do not know where call light is. You go get someone to help me." Call light was found under blankets on the bed not visible to resident. Resident was shown call light and she said, "I push the button." Resident used call light at 10:27 AM. At 10:30 AM, CNA "S" answered call light, straightened up resident's bed, placed a call light across her torso, and assisted her with a transfer using walker and pivot into bed. During an observation on 9/14/2023 at 9:20 AM R96 was sitting in a wheelchair eating breakfast with a bedside table in front of her. A call light was under her blankets on her bed out of sight of resident. During an interview on 9/14/2023 at 9:22 AM, Unit Manager/Registered Nurse (UM-RN) "UU" stated, "Every resident's call light should be within reach. When staff do room checks they should make sure the call light is within the resident's reach and it should be on the resident's stronger side. The call light should be clipped to the resident within reach." Review of signage in Birch Hall reported, "CALL	F558		

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F558	Continued From page 31 LIGHTS - All call lights are to be clipped within easy reach of the Resident. When the Resident is in a chair, be sure the call bell is attached to the chair and within reach. Before you leave the room, always check for placement. Remember that Resident safety is your responsibility."	F558		
F609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) 483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: 483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. 483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F609	. The note documented in resident #95s chart could not be addended as we no longer have access to that EMR. A note has been placed in the progress notes of PointClickCare referencing that note and that it was in the wrong patients chart. The patient whose chart this belonged in has expired. 2. All residents have the potential to be affected. 3. Nursing staff have received education on the abuse reporting requirements including reporting all allegations regardless of whether or not the resident says they were joking. Nursing staff have received education about maintaining accurate medical records and how to proceed should a note or assessment be documented in the wrong chart. The Abuse policy was reviewed on 10/4/23 and is up to date. Nursing education was completed on October 6, 2023. 4. An weekly audit will be completed assessing the employees understanding of the abuse reporting requirements. We will review the reporting requirements with a minimum of 10-20 nurses weekly. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. 5. The Director of Nursing is responsible for compliance	10/6/23

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F609	Continued From page 32 by: Based on interview and record review, the facility failed to follow their policy and immediately report to the State Agency an allegation of staff to resident abuse for 1 residents (Resident #95) of 6 residents residents reviewed for abuse, resulting in the potential for allegations of abuse to go unreported, undetected and the potential for further abuse to continue and go unrecognized. Findings include: Review of an "Admission Record" revealed Resident #95, was originally admitted to the facility on 8/30/22 with pertinent diagnoses which included: chronic kidney disease. Review of a "Minimum Data Set" (MDS) assessment for Resident #95, with a reference date of 8/24/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 11/15 which indicated Resident #95 was mildly cognitively impaired. Review of Resident #95 "Electronic Medical Record" (EMR) revealed: "On 6/25/2023 at 18:29 (EDT) CNA came up to med cart and informed this nurse that resident (Resident #95) had accused CNA of punching him (Resident #95). CNA stated that resident (Resident #95) said "you punched me." This nurse gave resident (Resident #95) his medications and asked him what happened. The resident (Resident #95) stated "I got punched in the eye by the CNA today." When I asked which CNA the resident (Resident #95) responded with "go look whose on the floor today geez." This nurse called and reported the incident to the CM (CM-weekend on-call manager). The CM questioned	F609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235088	A. BUILDING _____ B. WING _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F609	Continued From page 33 the resident (Resident #95) as well. Resident (Resident #95) had no observable injuries. Resident (Resident #95) later calmed down during lunch and told the CM that he (Resident #95) "does not think the punch was malicious." The CM reported the incident to their higher up and was informed this was not a reportable even, in which, CM informed this nurse that the event was not reportable. This nurse filled out a witness statement..." During an interview on 9/13/23 at 2:10 PM., "Social Worker" (SW) "GG" reported ("Director of Nursing" (DON) "B") was the abuse coordinator. SW "GG" reported if an allegation of abuse for any resident was made about a staff member, the staff member should immediately be removed from the unit and or facility pending investigation. SW "GG" reported all allegations of abuse must be reported to (DON B") and then reported to the "State". SW. "GG" reported she was unsure if the "nursing progress note" dated 6/25/23 for (Resident #95) was reported or investigated, and she (SW ""GG") does not recall being asked any questions or write a statement and/or speak with (Resident #95) after the note was documented in the medical record for (Resident #25). SW "GG" reported this was the first time she (SW "GG") was made aware that of that "nursing progress note" in (Resident #95's) medical record. During an interview on 9/13/23 at 2:22 PM., "Assistant Director of Nursing" (ADON) "LL" reported (DON 'B") was the abuse coordinator. ADON "LL" reported she was the ADON for the unit in which Resident #95 resided on. ADON "LL" and this surveyor reviewed Resident #95's progress note dated 6/25/23 in which Resident #95 reported to a staff member that a "CNA had punched him in the eye." ADON "LL" reported	F609		

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F609	Continued From page 34 that the note was written on a weekend according to her schedule. ADON "LL" reported the staff would have called the on call manager, and then (DON "B") so that the allegation of abuse could be reported to the "State" and an investigation could be started. ADON "LL" reported any time an allegation of abuse is reported, if it is an accusation towards a staff member, that staff member must immediately be removed from any direct care/contact with residents. ADON "LL" reported she was unsure if the allegation was reported to the "State Agency" or if there was an investigation. During an interview on 9/14/23 at 10:53 AM., Director of Nursing (DON) "B" reported no abuse reporting or investigation of an allegation of "staff to resident abuse" was completed for Resident #95. DON "B" reported the progress note in (Resident #95's) EMR dated 6/25/23 was for a different resident who no longer resides in the facility. DON "B" reported she did not report the allegation for the "other resident" either. DON "B" reported when it was brought to her attention, she was told that the "other resident" was "joking." DON "B" reported she did not report or investigate the allegations of abuse to the "State Agency" because she did not think it met the level of abuse. During an interview on 9/14/23 at 11:04 AM., Nursing Home Administrator (NHA) "A" reported she was unaware of the "allegation of abuse" in Resident #95's medical chart, nor did she (NHA "A") know the documentation was in the wrong chart. NHA "A" indicated no allegations of abuse were reported or investigated for Resident #95 or any other resident on 6/25/23. Review of a facility "Policy" titled "Abuse Prohibition and Prevention Program". Dated	F609		

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F609	Continued From page 35 "7/12/23" revealed ... "PURPOSE-Our Organization will not condone any form of resident abuse and will continually monitor our policies, procedures, training programs, systems, etc., to assist in preventing resident abuse .... PROCEDURE...1. Our organization is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. REPORTING ABUSE ...1. Our Organization will not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff or other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals ....2. All personnel, residents, family members, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the organization or its staff ....3. Employees, consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Director of Nursing (DON "B") or designee ....4. If there is a resident incident that may involve abuse or neglect at the (Facility name omitted) ...you are to notify (DON "B") immediately .... a. If unable to reach (DON "B"), follow the list below until you contact someone: Administrative Nurse On-Call ... (phone number omitted) ...b. If you are unsure if the incident is a case of abuse or neglect, still proceed with contacting the (DON "B") or designee above. 5. The Administrator must be immediately notified of suspected/allege abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator (NHA "A) must be	F609		

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F609	Continued From page 36 contacted and informed of such incident. 6. When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the Administrator will immediately (but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than twenty four (24) hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury) notify the appropriate agencies. Such agencies may include the following: a. The State licensing/certification agency responsible for surveying/licensing the facility.... b. The Local/State Ombudsman; c. The Resident's Responsible Party; d. Adult Protective Services; e. Law Enforcement Officials; f. The Resident's Attending Physician, and g. The Facility Medical Director ..."	F609		
F610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) 483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: 483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. 483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. 483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be	F610	. The note documented in resident #95s chart could not be addended as we no longer have access to that EMR. A note has been placed in the progress notes of PointClickCare referencing that note and that it was in the wrong patients chart. The patient whose chart this belonged in has expired. 2. All residents have the potential to be affected. 3. Nursing staff have received education on the abuse reporting an investigating requirement including reporting all allegations regardless of whether or not the resident says they were joking. Nursing staff have received education about maintaining accurate medical records and how to proceed should a note or assessment be documented in the wrong chart. The Abuse policy was reviewed on 10/4/23 and is up to date. Nursing	10/6/23

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F610	Continued From page 37 taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their policy and procedure and thoroughly investigate and protect residents after an allegation of staff to resident physical abuse was made by Resident #95, resulting in the alleged perpetrator not being immediately removed from direct resident care, and an allegation of physical abuse not being investigated, and the potential for future mistreatment and/or abuse to go undetected and investigated to protect a vulnerable population. Findings include: Resident #95 Review of an "Admission Record" revealed Resident #95, was originally admitted to the facility on 8/30/22 with pertinent diagnoses which included: chronic kidney disease. Review of a "Minimum Data Set" (MDS) assessment for Resident #95, with a reference date of 8/24/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 11/15 which indicated Resident #95 was mildly cognitively impaired. Review of Resident #95 "Electronic Medical Record" (EMR) revealed: "On 6/25/2023 at 18:29 (EDT) CNA came up to med cart and informed this nurse that resident (Resident #95) had accused CNA of punching him (Resident #95). CNA stated that resident (Resident #95) said "you punched me." This nurse gave resident (Resident #95) his medications and asked him what happened. The resident	F610	education was completed on October 6, 2023. 4. A weekly audit will be completed assessing the employees understanding of the abuse reporting and investigating requirements. We will review the reporting requirements with a minimum of 10-20 nurses weekly. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. 5. The Director of Nursing is responsible for compliance.	

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F610	Continued From page 38 (Resident #95) stated "I got punched in the eye by the CNA today." When I asked which CNA the resident (Resident #95) responded with "go look whose on the floor today geez." This nurse called and reported the incident to the CM (CM-weekend on-call manager). The CM questioned the resident (Resident #95) as well. Resident (Resident #95) had no observable injuries. Resident (Resident #95) later calmed down during lunch and told the CM that he (Resident #95) "does not think the punch was malicious." The CM reported the incident to their higher up and was informed this was not a reportable even, in which, CM informed this nurse that the event was not reportable. This nurse filled out a witness statement..." During an interview on 9/13/23 at 2:10 PM., "Social Worker" (SW) "GG" reported she was the SW for the unit Resident #95 resided on. SW "GG" reported ("Director of Nursing" (DON) "B") was the abuse coordinator. SW "GG" reported if an allegation of abuse for any resident was made about a staff member, the staff member should immediately be removed from the unit and or facility pending investigation. SW "GG" reported all allegations of abuse must be reported to (DON B") and then reported to the "State". SW. "GG" reported she was unsure if the "nursing progress note" dated 6/25/23 for (Resident #95) was reported or investigated, and she (SW ""GG") does not recall being asked any questions or write a statement and/or speak with (Resident #95) after the note was documented in the medical record for (Resident #25). SW "GG" reported this was the first time she (SW "GG") was made aware that of that "nursing progress note" in (Resident #95's) medical record. During an interview on 9/13/23 at 2:22 PM.,	F610		

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F610	Continued From page 39 "Assistant Director of Nursing" (ADON) "LL" reported (DON 'B") was the abuse coordinator. ADON "LL" reported she was the ADON for the unit in which Resident #95 resided on. ADON "LL" and this surveyor reviewed Resident #95's progress note dated 6/25/23 in which Resident #95 reported to a staff member that a "CNA had punched him in the eye." ADON "LL" reported that the note was written on a weekend according to her schedule. ADON "LL" reported the staff would have called the on call manager, and then (DON "B") so that the allegation of abuse could be reported to the "State" and an investigation could be started. ADON "LL" reported any time an allegation of abuse is reported, if it is an accusation towards a staff member, that staff member must immediately be removed from any direct care/contact with residents. ADON "LL" reported she was unsure if the allegation was reported to the "State Agency" or if there was an investigation. During an interview on 9/14/23 at 10:53 AM., Director of Nursing (DON) "B" reported no abuse reporting or investigation of an allegation of "staff to resident abuse" was completed for Resident #95. DON "B" reported the progress note in (Resident #95's) EMR dated 6/25/23 was for a different resident who no longer resides in the facility. DON "B" reported she did not report the allegation for the "other resident" either. DON "B" reported when it was brought to her attention, she was told that the "other resident" was "joking." DON "B" reported she did not report or investigate the allegations of abuse to the "State Agency" because she did not think it met the level of abuse. During an interview on 9/14/23 at 11:04 AM., Nursing Home Administrator (NHA) "A" reported she was unaware of the "allegation of abuse" in	F610		

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F610	Continued From page 40 Resident #95's medical chart, nor did she (NHA "A") know the documentation was in the wrong chart. NHA "A" indicated no allegations of abuse were reported or investigated for Resident #95 or any other resident on 6/25/23. Review of a facility "Policy" titled "Abuse Prohibition and Prevention Program". Dated "7/12/23" revealed ... "PURPOSE-Our Organization will not condone any form of resident abuse and will continually monitor our policies, procedures, training programs, systems, etc., to assist in preventing resident abuse .... PROCEDURE...1. Our organization is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. REPORTING ABUSE ...1. Our Organization will not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff or other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals ....2. All personnel, residents, family members, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the organization or its staff ....3. Employees, consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Director of Nursing (DON "B") or designee ....4. If there is a resident incident that may involve abuse or neglect at the (Facility name omitted) ...you are to notify (DON "B") immediately .... a. If unable to reach (DON "B"), follow the list below until you contact someone:	F610		

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F610	Continued From page 41 Administrative Nurse On-Call ... (phone number omitted) ...b. If you are unsure if the incident is a case of abuse or neglect, still proceed with contacting the (DON "B") or designee above. 5. The Administrator must be immediately notified of suspected/allege abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator (NHA "A) must be contacted and informed of such incident. 6. When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the Administrator will immediately (but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than twenty four (24) hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury) notify the appropriate agencies. Such agencies may include the following: a. The State licensing/certification agency responsible for surveying/licensing the facility.... b. The Local/State Ombudsman; c. The Resident's Responsible Party; d. Adult Protective Services; e. Law Enforcement Officials; f. The Resident's Attending Physician, and g. The Facility Medical Director ..."	F610		
F656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) 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	F656	. Resident #33 had her facial hair shaved. The intervention to hold a stuffed animal has been removed as this is no longer needed and was in place to prevent skin breakdown. Resident #86 has been provided with his adaptive equipment. Resident #12 has been served his meals promptly with others as they are served. 2. All residents have the potential to be affected. 3. Education included the importance of shaving facial hair if that is residents preference, providing adaptive equipment,	10/6/23

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F656	Continued From page 42 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.24, 483.25 or 483.40; and (ii) Any services that would otherwise be required under 483.24, 483.25 or 483.40 but are not provided due to the resident's exercise of rights under 483.10, including the right to refuse treatment under 483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. 483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F656	and serving meals within a reasonable timeframe. The Care Planning policy has been updated on 10/6/23 to include removing interventions that are no longer applicable and adding interventions as appropriate. The Removal of Facial Hair policy was updated 10/6/23 to include using a personal electric razor to remove facial hair and documenting refusals. The Meal Service policy was reviewed and updated to include meal service in the sunroom. This includes not putting residents in the sunroom until meal times where staff are preparing to serve the meal and assist with feeding, and providing adaptive equipment as ordered. Education completed 10/6/23. 4. The Registered Dietitian will continue to complete weekly test trays on going, with results reported to the Culinary Director. A weekly QA on 10-20 residents will be conducted, auditing the removal of facial hair, ensuring residents with adaptive equipment have it, and that meals are served within a reasonable timeframe of one another. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. The Registered Dietitian will continue to conduct three tray accuracy audits per week on going to ensure the appropriate adaptive equipment is provided to residents. 5. The Director of Nursing is responsible for compliance.	

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F656	Continued From page 43 review, the facility failed to implement resident comprehensive care plans for 3 of 3 residents (Resident #12, #86, and #33) reviewed for care planning, resulting in a lack of service for residents to maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #33: Review of an "Admission Record" revealed Resident #33 was a female with pertinent diagnoses which included dementia, depression, low back pain, anxiety, candidiasis (yeast infection), dysphagia (,(damage to the brain responsible for production and comprehension of speech), psychosis, pain, anemia, underweight, lumbrosacral neuritis (inflammation of the nerves along the spinal canal), and dermatitis (skin inflammation). Review of a "Minimum Data Set" (MDS) assessment for Resident #33, with a reference date of 7/11/23 revealed a Staff Assessment for Mental Status was completed indicating Resident #33 was severely cognitively impaired. Review of current "Care Plan" for Resident #33, currently active focus, "...I have an alteration in my ability to perform my ADLs independently due to dementia..." with the interventions "...Explain all care to me...If I am resistive or combative to care please leave me in a safe place and reapproach me...Approach me in a calm and gentle manner ...Explain all care to me prior to beginning a task and while we are participating in a task...Talk during care with me as I respond well to encouragement and praise..." Review of "Care Card" active as of 9/13/23,	F656		

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F656	Continued From page 44 revealed, "...Hygiene and Grooming: AM Care PM Care Dependent...To encourage me to have optimal independence with my ADLs...Please position a soft object such as a pillow or stuffed animal to relieve pressure to my chest that I apply when I keep my hands and arms tightly folded on my chest..." During an observation on 09/13/23 at 09:05 AM, Resident #33 was in the dining room being assisted with her breakfast by Certified Nursing Assistant (CNA) "CCC." Resident #33 was observed to have bristly chin hairs approximately an inch in length forming a goatee on her chin. Resident #33 was observed to have longer hairs in the moustache area of her upper lip. During an observation on 09/13/23 at 02:52 PM, Resident # 33 was observed lying in her bed, low to the ground, had her arms crossed across her chest with no soft object on her chest, eyes closed, and Resident #33 was observed with the to have bristly chin hairs approximately an inch in length forming a goatee on her chin and longer hairs in the moustache area of her upper lip. Resident #86: Review of an "Admission Record" revealed Resident #86 was a male with pertinent diagnoses which included cerebral palsy (abnormal brain development, congenital disorder of movement, muscle tone, or posture), weakness, anemia, contracture (muscles, tendons, joints, or other tissues tighten or shorten causing a deformity) left and right wrists, vitamin D deficiency, chronic pain, depression, convulsions, GERD, and type 2 diabetes.	F656		

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F656	Continued From page 45 Review of "Care Card" Revealed, "...Feeding ability/ adaptive devices: Ranges from independent to supervision needed after setup help. Adaptive equipment includes: Thermo-mug with lid, scoop bowl with suction and scoop plate, dycem, built up silverware..." During an observation on 09/12/23 at 09:17 AM, this writer observed Resident #86 was seated in his wheelchair in the center hub of the unit waiting for his breakfast. Resident #86 received his breakfast which was placed in a Styrofoam container. He did not have the required adaptive equipment to ensure he would be able to feed himself. Resident #86 did not have a scoop bowl with suction and scoop plate, or dycem. Resident #12: Review of an "Admission Record" revealed Resident #12 was a male with pertinent diagnoses which included hemiplegia (paralysis) left side, weakness, reduced mobility, diabetes, dementia, epilepsy, low potassium, and Wegener's granulomatosis (condition that causes inflammation of the blood vessels, blood flow to organs and tissues may be reduced, causing damage). Review of "Care Card" dated 9/14/23, revealed, "...To encourage me to have optimal independence with my ADLs: Self feeding recommendations: Bring (Resident #12) as close to table as possible, cut up food, use of scoop plate at all meals, keep items at reach of RUE (right upper extremity)..." Note: All residents were served meals in Styrofoam containers. During an observation on 09/11/23 at 01:17 PM,	F656		

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F656	Continued From page 46 Resident #12 was observed seated in the center hub of the unit with a Styrofoam container on a rolling tray table placed in front of him while he was seated in his wheelchair. During an observation on 09/12/23 at 09:37 AM, Resident #12 received his breakfast in a Styrofoam container while he was seated in the hallway in front of the television. Note: It had been at least 20 minutes since this writer observed residents with meals and when Resident #12 received his meal. In an interview on 09/12/23 at 10:09 AM, LPN "BBB" reported there was a white board in the nurse's station which has important information on residents, who the COVID patients were, and other details about the residents, and the last 24 hours for their care. LPN "BBB" reported the nurses gave 24-hour report at shift change and the CNAs do that as well indicating the prior shift shared with the oncoming shift any pertinent information about the residents. LPN "BBB" reported the nurses and CNAs do not do walking rounds with the staff who were taking over patient care. LPN "BBB" reported how to care for the residents was on the touch screen and the CNAs can access how to care for their residents on there as it tells how they transfer, continence, ADL care, and the resident's diet. Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.16, Chapter 4: Care Area Assessment (CAA) Process and Care Planning", revealed "...the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident 's highest practicable physical, mental, and	F656		

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F656	Continued From page 47 psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident 's written plan of care..."	F656		
F657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) 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 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:	F657	Therapy was able to clarify the transfer status. Resident #297s care plan and resident care card was updated to reflect the most recent therapy recommendations. Since survey, we have transitioned to PointClickCare where the care planned interventions are updated within the Kardex once entered into the care plan. 2. All residents have the potential to be affected. 3. Nursing staff have received education on how to update the care plan with therapy recommendations. They have also been educated on how to send interventions to the Kardex from the Care Plan window. Therapy has received education about this process as well and the importance of using only approved abbreviations. The Care Planning policy has been reviewed and updated to include updating the Care Plan and ensuring those that need to be are viewable on the Kardex. Education was completed on October 6, 2023. 4. An audit will be performed weekly where therapy recommendations are reviewed against the care plan. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. 5. The Director of Nursing will be responsible for compliance.	10/6/23

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F657	Continued From page 48 Based on interview and record review the facility failed to revise an individualized care plan to reflect current therapy recommendations for 1 (Resident #297) of 25 residents reviewed for care plan revision, resulting in the potential for staff to provide care that was not consistent with the needs of the resident. Findings include: Review of a current activities of daily living "Care Plan" intervention for Resident #297 on 9/12/2023 at 8:57 AM revealed staff were directed to use one person assistance with a "Sara Stedy" for all transfers. Review of Resident #297's latest "Therapy Communication" to the interdisciplinary team, dated 9/1/2023, revealed therapy recommended staff use one person assistance with a front wheeled walker to transfer Resident #297. In an interview on 9/12/2023 at 2:45 PM, Assistant Director of Nursing (ADON) "SS" reported Resident #297's care card was updated on 9/3/2023 to reflect the "Therapy Communication" from 9/1/2023 but not the care plan. ADON "SS" reported Resident #297's care plan still directed staff to use the "Sara Stedy" for transfers instead of directing staff to use the latest recommendation from the "Therapy Communication" note from 9/1/2023. ADON "SS" reported nursing staff should have updated Resident #297's care card and care plan at the same time and the two documents should agree. ADON "SS" reported nursing staff is responsible for updating care plans after "Therapy Communication" from the therapist suggest changes to the interdisciplinary team. Review of facility policy/procedure "Care	F657		

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F657	Continued From page 49 Planning", dated 7/25/2022, revealed " ...The care plan will be reviewed and updated by the interdisciplinary team as needed and quarterly ..."	F657		
F677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) 483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was consistently provided with personal hygiene related to facial hair and overall cleanliness with daily ADL care for 5 of 5 residents (Resident #7, #381, #72, #33 and #67) reviewed for activities of daily living, resulting in unmet personal hygiene needs with the potential for isolation, psychosocial harm, skin breakdown, harboring infection, and decreased self-esteem. Findings include: Resident #33: Review of an "Admission Record" revealed Resident #33 was a female with pertinent diagnoses which included dementia, depression, low back pain, anxiety, candidiasis (yeast infection), dysphagia (,(damage to the brain responsible for production and comprehension of speech), psychosis, pain, anemia, underweight, lumbrosacral neuritis (inflammation of the nerves along the spinal canal), and dermatitis (skin inflammation).	F677	Resident #33 had her facial hair shaved. The intervention to hold a stuffed animal has been removed as this is no longer needed and was in place to prevent skin breakdown. Staff attempted to shave resident #67. She would not allow staff to shave her face. Resident #67 does have her electric razor. She is care planned to shave if she allows. Resident #72 has had her hair combed, teeth brushed, and facial hair shaved. Resident #7 was provided with oral care, washed and combed hair, and facial hair shaved. Resident #7s glasses were cleaned. Resident #381 was provided with clean clothing and bedding. A CNA task in PointClickCare will be pushed to the CNA staff to alert them to shave and document the care on residents #33, #67, and #72. 2. All residents have the potential to be affected. 3. Nursing received education on daily hygienic practices such as shaving female facial hair, washing and combing hair, and dental/oral hygiene. Staff have been educated and reminded to clean the hands and face of residents following meals. Additionally, they have been educated/reminded to change their clothing after meals if soiled. The Removal of Facial Hair Policy has been updated to include honoring the residents requests, documenting refusals, and requesting family provide an electric razor if necessary. 4. A weekly QA will be completed ensuring	10/6/23

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F677	Continued From page 50 Review of a "Minimum Data Set" (MDS) assessment for Resident #33, with a reference date of 7/11/23 revealed a Staff Assessment for Mental Status was completed indicating Resident #33 was severely cognitively impaired. Review of current "Care Plan" for Resident #33, currently active focus, "...I have an alteration in my ability to perform my ADLs independently due to dementia ..." with the interventions "...Explain all care to me...If I am resistive or combative to care please leave me in a safe place and reapproach me ...Approach me in a calm and gentle manner...Explain all care to me prior to beginning a task and while we are participating in a task...Talk during care with me as I respond well to encouragement and praise..." Review of "Care Card" active as of 9/13/23, revealed, "...Hygiene and Grooming: AM Care PM Care Dependent...To encourage me to have optimal independence with my ADLs...Please position a soft object such as a pillow or stuffed animal to relieve pressure to my chest that I apply when I keep my hands and arms tightly folded on my chest..." During an observation on 09/13/23 at 09:05 AM, Resident #33 was in the dining room being assisted with her breakfast by Certified Nursing Assistant (CNA) "CCC." Resident #33 was observed to have bristly chin hairs approximately an inch in length forming a goatee on her chin. Resident #33 was observed to have longer hairs in the moustache area of her upper lip. During an observation on 09/13/23 at 02:52 PM, Resident # 33 was observed lying in her bed, low to the ground, had her arms crossed across	F677	10-20 residents are without facial hair, hair is washed and combed, and teeth are brushed. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. 5. The Director of Nursing is responsible for ensuring compliance.	

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F677	Continued From page 51 her chest with no soft object on her chest, eyes closed, and Resident #33 was observed with the to have bristly chin hairs approximately an inch in length forming a goatee on her chin and longer hairs in the moustache area of her upper lip. Resident #67: Review of an "Admission Record" revealed Resident #67 was a female with pertinent diagnoses which included Alzheimer's disease, difficulty in walking, pain in left leg, muscle weakness, repeated falls, anxiety, and dysphagia. Review of a "Minimum Data Set" (MDS) assessment for Resident #67, with a reference date of 6/16/23 revealed a Staff Assessment for Mental Status was completed indicating Resident #33 was severely cognitively impaired. Review of a "Minimum Data Set" (MDS) assessment for Resident #67, with a reference date of 6/16/23 revealed a Staff Assessment for Mental Status was completed indicating Resident #33 was severely cognitively impaired. Review of "Care Card" dated 09/13/23, revealed, "...Hygiene and Grooming...AM Care PM Care Dependent ..." Review of "Monthly Summary" dated 9/7/23 at 09:18 PM, revealed, "...Resident requires an assist x1 for all activities related to hygiene, dressing, toileting, and showers..." During an observation on 09/12/23 at 10:53 AM, Resident #67 was observed sitting in the day room in front of the television. Resident #67 was observed with long white hairs on her chin	F677		

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F677	Continued From page 52 approximately 1.5 inches in length as well as long white hairs approximately inch on her upper lip area. During an observation on 09/13/23 at 09:03 AM, Resident #67 was observed seated at a table in the dining room. She was observed to have long white hairs on her chin approximately 1.5 inches in length as well as long white hairs approximately inch on her upper lip area. During an observation on 09/13/23 at 02:47 PM, Resident #67 was observed lying in a recliner with her feet up. She was observed to have long white hairs on her chin approximately 1.5 inches in length as well as long white hairs approximately inch on her upper lip area. In an interview on 09/13/23 at 02:55 PM, CNA "CCC" reported there were a few of the female residents who required removal of facial hair. CNA "CCC" reported the facility had requested for Resident #33's family to bring in an electric razor for her as she was currently requiring the use of a razor with blades. CNA "CCC" reported Resident #67 had an electric razor somewhere but "it disappeared one day...couldn't tell for sure (when it was or where it was)..." CNA "CCC" reported midnight shift sometimes would take the razor to clean it and they "could have put it somewhere." In an interview on 09/13/23 at 04:00 PM, Assistant Director of Nursing (ADON) LL" reported the CNAs would document in the medical record when care was provided for personal hygiene and showers. ADON "LL" reported she would follow up with the CNAs to address the concern of facial hair. Review of the policy, "Quality of Care" dated	F677		

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F677	Continued From page 53 3/15/22, revealed, "...Each resident will receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psycho-social well-being in accordance with the comprehensive assessment and plan of care...A resident who is unable to carry out activities of daily living will receive the necessary services to maintain: 2. Grooming, personal and oral hygiene..." Resident #72 Review of a "Face Sheet" for Resident #72 dated 1/22/19, revealed the resident was admitted to the facility with the following pertinent diagnoses: Hemiplegia following a Cerebral Infarct (paralysis on one side of the body following a stroke), Muscle Weakness, Difficulty Walking, Generalized Anxiety Disorder, and Major Depressive Disorder. Review of a "Minimum Data Set" (MDS) assessment dated 6/13/23 revealed Resident #72 scored 14/15 on a "Brief Interview for Mental Status" (BIMS) assessment, which indicated the resident was cognitively intact. Section "G" of the MDS revealed Resident #72 required extensive assistance for personal hygiene including combing hair, brushing teeth, shaving, applying makeup, washing, and drying face and hands. Review of a "Care Plan Report" for Resident #97 dated 6/14/19 revealed "problem/goal/interventions" that stated: "Problem: I have an alteration in my ability to perform my ADLs independently ...Goal: I would like to be clean, odor free, well groomed, and comfortably dressed ...Interventions ... Keep my call light within my reach ... Anticipate and meet my needs ...Please moisture my dry skin ...".	F677		

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F677	Continued From page 54 During an observation on 9/11/23 at 4:00pm, Resident #72 was dressed in a hospital gown, hair appeared uncombed and facial hair was present near her chin. In an interview on 9/11/23 at 4:15pm, Resident #72 reported she felt embarrassed by her appearance, specifically her facial hair. Resident #72 reported sometimes the staff were too busy to assist her with brushing her teeth and managing her facial hair. In an interview on 9/12/23 at 4:09pm, Certified Nursing Assistant (CENA) "YY" reported at times the smaller care tasks such as nail care, teeth brushing, and removal of facial hair for female residents were not done due to time constraints on staff. CENA "YY" reported this was currently more of a problem because several residents were acutely ill, required more care, and as a result, staff did not have time to complete other tasks. Resident #7 Review of an "Admission Record" revealed Resident #7, was originally admitted to the facility on 11/20/17 with pertinent diagnoses which included difficulty in walking and dementia. Review of a "Minimum Data Set" (MDS) assessment for Resident #7, with a reference date of 7/3/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 2/15 which indicated Resident #7 was severely cognitively impaired. Review of the "Functional Status" revealed that Resident #7 required extensive assistance of	F677		

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GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F677	Continued From page 55 one person for bed mobility, transfers, dressing, personal hygiene and toileting. Review of Resident #7's "Care Plan" revealed, " I (Resident #7) have an alteration in my ability to perform my ADL's (activities of daily living) independently and be independent with my mobility r/t dementia, schizoaffective disorder, as well as the need for increased assistance for ADL'S. Goals: I (Resident #7) would like to be clean, odor free, well groomed, and comfortably dressed with encouragement to participate as able... Interventions:.. Assist me with oral care per protocol. Monitor me for and report changes in my oral status... I (resident #16) wear glasses for vision. Ensure they are clean and place on me when I am up. Report changes in my vision to the nurse..." Review of Resident #7's "Treatment Administration Record" (TAR) indicated that Resident #7 was scheduled to receive one shower weekly. Start date 8/4/2023. Charting on the TAR record revealed that Resident #7 had received a shower on 9/1/23 and 9/8/23. During an observation on 9/11/23 at 3:56 PM, Resident # 7 was sitting in her wheelchair in the hallway outside of her room. Resident's hair was greasy and tangled. Resident's had several pieces of food particles between her teeth. Resident's jeans were covered with several spots of food debris. Resident #7 had several long hairs noted on her chin. During an observation on 9/12/23 at 11:23 AM, Resident #7 was sitting in her wheelchair in the hallway outside of her room. Resident's hair was tangled and greasy. Resident had several long hairs noted on her chin.	F677		

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F677	Continued From page 56 During an observation on 9/12/23 at 2:43 PM, Resident #7 was observed sitting in the common area in her wheelchair. Resident #7's hair remained tangled and greasy. Resident had several long chin hairs noted on her chin. During an observation on 9/13/23 at 9:30 AM, Resident #7 was sitting in her wheelchair in the common area. Resident #7's hair was tangled and greasy. There were several particles of food noted between Resident #7's teeth. It was noted that Resident #7's eyeglass lenses were dirty with some sort of debris on them. Resident #7 had several long chin hairs noted on her chin. During an interview on 9/13/23 at 9:48 AM, CNA "KK" reported that Resident #7 did not refuse cares, and would allow staff to assist her with daily care. During an interview on 9/13/23 at 9:38 AM, Registered Nurse (RN) "NN" reported that residents were assigned showers on specific days. RN "NN" reported that Resident #7 last had a shower on 9/8/23. RN "NN" reported that daily ADL care was completed by Certified Nursing Assistants as they help residents get up in the morning. RN "NN" reported that Resident #7 had received morning ADL care that day. During an interview on 9/13/23 at 10:09 AM, Assistant Director of Nursing, ADON "HH" reported that the expectation was that staff were to assist residents that required assistance with ADL care with daily cleansing, perineal care, toileting, dressing, face washing, brushing and cleaning hair, oral care, and any other cleaning preferences each resident had. ADON "HH" reported that if a resident appeared disheveled, she would expect staff to offer to assist the resident with ADL care. ADON "HH"	F677		

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F677	Continued From page 57 reported that Resident #7 did not go to a salon to get her hair washed, and that staff should have washed her hair on her shower days. ADON "HH" reported that Resident #7 used to have her own razor that staff would use to remove her chin hairs, as that was her preference, but it was recently broken and Resident #7's husband was replacing it. ADON "HH" reported that staff could use a straight razor in the interim, and that she expected staff to be helping Resident #7 to remove her chin hairs. ADON "HH" reported that Resident #7 did not refuse care often. During an observation 9/13/23 at 10:31 AM, ADON "HH" reported that she felt that Resident #7 looked disheveled. ADON "HH" reported that Resident #7's hair appeared more greasy than usual and that her glasses were dirty. ADON "HH" reported that she did not have any notes regarding Resident #7 missing her last shower, but was going to check to see if something had happened with her last shower, because she felt that Resident #7 did not look clean. Resident #381 Review of an "Admission Record" revealed Resident #381, was originally admitted to the facility on 8/29/23 with pertinent diagnoses which included weakness and diabetes. Review of a "Minimum Data Set" (MDS) assessment for Resident #381, with a reference date of 8/29/23 revealed "Staff Assessment for Mental Status" noted that Resident #381 had a memory problem, and had moderately impaired cognitive skills for daily decision making." Review of the "Functional Status" revealed that Resident #381 required extensive assistance of	F677		

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F677	Continued From page 58 for bed mobility, dressing, personal hygiene and toileting, and that Resident # 381 was dependent and required full staff performance for transfers. Review of Resident #381's "Care Plan" revealed, " I (Resident #381) have an alteration in my ability to perform ADL's independently and be independent with my mobility r/t: CVA (cerebral vascular accident), left sided hemiplegia (paralysis to one side of the body), left sided blindness, weakness, HTN (hypertension), hyperlipidemia (high cholesterol), left sided AKA (Above the knee amputation), depression. Goals: I (Resident #381) would like to be clean, odor free, and comfortably dressed with encouragement to participate as able. Interventions:... I (Resident #16) need assistance maintaining my hygiene. Please assist me with keeping my face clean and ensuring I am clean after meals..." During an observation on 9/11/23 at 2:54 PM, Resident #381 was observed lying in bed on his back. Resident had food particles throughout his beard and shirt, and on his pillow and bed sheets. During an observation 9/12/23 at 11:41 AM, Resident #381 was lying in bed wearing a red shirt. The front of Resident #381's shirt was observed to have an substance that looked like applesauce on it. Resident #381 was also observed to have food crumbs on his shirt, pillow and bed. During an observation on 9/12/23 at 4:00 PM, Resident #381 was lying in bed and wearing the same red shirt. The substance that looked like applesauce was removed from his shirt, and there was a wet spot left on Resident #381's	F677		

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F677	Continued From page 59 shirt from where the food was. It was noted that Resident #381 still had food crumbs on his shirt, pillow, and bed. During an interview on 9/13/23 at 11:17 AM, ADON" UU" reported that Resident #381 required extensive assistance with ADL care. ADON "UU" reported that she expected staff to ensure that Resident #381 was being cleaned after meals as needed, and remove soiled clothing if there was food on the clothing.	F677		
F684 SS=D	Quality of Care CFR(s): 483.25 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly assess and monitory a resident after a fall in 1 (Resident #297) of 5 residents reviewed for accidents and injuries, resulting in the potential for unnoticed and untreated head injury. Findings include: Review of a "Face Sheet" revealed Resident #297 admitted to the facility on 8/11/2023 with pertinent diagnoses which included dementia, cognitive communication deficit (difficulty	F684	Resident #297 completed her fall monitoring. She has discharged from the facility. 2. All residents have the potential to be affected. 3. The facility has updated its fall policy to include completing neuro checks with every fall. Nursing staff have received education on this and it was completed October 6, 2023. The Fall and Injury Prevention care plan was updated 10/6/23 to reflect completing a neuro assessments with every fall through the duration of the fall follow-up. Education was completed 10/6/23. 4. A weekly audit will be completed on the residents with falls to ensure neuro assessments are being completed with every fall and at appropriate intervals. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. 5. The Director of Nursing is responsible for compliance.	10/6/23

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F684	Continued From page 60 communicating), and fall with hip fracture. Review of a "Minimum Data Set" (MDS) assessment for Resident #297, with a reference date of 9/5/2023 revealed a "Brief Interview for Mental Status" (BIMS) score of 5, out of a total possible score of 15, which indicated Resident #297 was severely cognitively impaired. Further review of same MDS assessment revealed Resident #297 had been taking anticoagulant medication. Review of Resident #297's "Physician Orders" revealed an order for the anticoagulant medication Lovenox, ordered 8/16/2023 to continue until 9/8/2023. Review of Resident #297's August Medication Administration Record (MAR) revealed she received subcutaneous enoxaparin (Lovenox) from 8/15/2023 until her fall on 8/19/2023. Review of Resident #297's "Fall/Incident Report" revealed she was observed on the floor after an unwitnessed fall on 8/19/2023 at approximately 7:27 PM. Further review revealed she fell while trying to get out of bed and was tearful and upset with herself, hitting her fist on the floor. Staff noted Resident #297's left wrist was offset and splinted her arm before emergency medical services arrived to transport her to the local hospital. Resident #297 returned from the local hospital approximately 5 hours later at 00:15 AM with a diagnosis of left distal radial fracture. No documentation could be found in the "Fall/Incident Report" of head or neurological assessments being performed on Resident #297 prior to or after her hospitalization. In a telephone interview on 9/13/2023 at 5:00 PM, Licensed Practical Nurse (LPN) "W"	F684		

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F684	Continued From page 61 reported Resident #297 was found on the floor of her room on 8/19/2023 at approximately 7:19 PM with her head toward the door after sustaining an unwitnessed fall. LPN "W" reported Resident #297 denied hitting her head. LPN "W" reported Resident #297 was distraught, hitting her other hand on the floor, and frustrated with herself for falling. LPN "W" stated Resident #297 was "confused a little bit but speaking coherently." LPN "W" reported Resident #297 returned to the facility just after midnight, about 5 hours later. LPN "W" reported she did not perform neurological checks on Resident #297. LPN "W" reported the facility initiates neurological checks with known head injuries or the possibility of head injuries. In an interview on 9/13/2023 at 9:02 AM, Assistant Director of Nursing (ADON) "SS" reported the facility does not always perform neurological checks for residents with unwitnessed falls. ADON "SS" reported they initiate neurological checks if the assessment shows a head injury or if the resident states that they hit their head. ADON "SS" reported the facility did not have a policy requiring neurological checks for all residents with unwitnessed falls and did not have a written procedure to follow for residents who fall and were confused. ADON "SS" reported Resident #297 was confused at her baseline. ADON "SS" reported the facility leadership team had been discussing what other facilities were doing about when to begin neurological checks. ADON "SS" stated, "We've been talking about it, we've seen other facilities are being cited about it." In an interview on 9/13/2023 at 2:21 PM, Director of Nursing (DON) "B" reported the facility did not have a neurological check policy or a head injury policy. DON "B" reported the	F684		

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F684	Continued From page 62 facility had a head involvement protocol that is triggered if a resident has a head injury or is believed to have hit their head. DON "B" reported the facility did not begin the protocol for unwitnessed falls if the resident denied hitting their head, regardless of the cognition level of the resident. DON "B" reported the team discussed requiring neurological checks for unwitnessed falls in the past and decided not to. DON "B" reported the medical director questioned whether staff's time could be spent better monitoring other residents to prevent further falls. According to the "American Journal of Nursing". "When a Fall Occurs: Four Steps to take in response to a fall", (Hendrich, Ann MSN, RN, FAAN, AJN, American Journal of Nursing 107 (11): November 2007. I DOT. 10.1097/01.NAJ. 0000298064.12102.08). "Step one: assessment. 'Alien a panent falls, don't assume that no injury has occurred-this can be a devastating mistake. Before moving the patient, ask him what he thinks caused the fall and assess any associated symptoms. Then conduct a comprehensive assessment, including the following: Check the vital signs and the apical and radial pulses. Check the cranial nerve. Check the skin for pallor. trauma, circulation, abrasion, bruising, and sensation. Check the central nervous system for sensation and movement in the lower extremities. o Assess the current level of consciousness and determine whether the patient has had a loss of consciousness. look for subtle cognitive changes. Check the pupils and orientation.	F684		

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F684	Continued From page 63 Observe the leg rotation, and look for hip pain, shortening of the extremity, and pelvic or spinal pain. Note any pain and points of tenderness. Step three: monitoring and reassessment. After the patient returns to bed. perform frequent neurologic and vital sign checks, including orthostatic vital signs. Fall victims who appear fine have been found dead in their beds a few hours after a fall." "Acute subdural hematomas develop within 48 hours of injury and have an organized clot. Subacute subdural hematomas develop within 3 days to 2 weeks after a head injury. The chronic subdural hematoma can produce symptoms from about 3 weeks to several months after the injury. The damaged area is filled with fluid rather than an organized clot." (Phipps, W. J., Monahan, F. D., Sands, J. K., Marek, J. F., & Neighbors, M. (2003) Medical-Surgical Nursing Health and Illness Perspectives (7th ed.). St. Louis: Mosby.) "Changes in vital signs alone rarely indicate neurologic compromise and any changes should be related to a complete neurologic assessment. Because vital signs are controlled at the medullary level, changes related to neurologic compromise are ominous."(Diseases: Causes and Diagnosis Current Therapy Nursing Management (2nd ed.). Pennsylvania: Springhouse).	F684		
F689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) 483.25(d) Accidents. The facility must ensure that -	F689	Resident #96 has been provided with a wrist call light. 2. All residents have the potential to be affected. 3. Nursing staff have received education	10/6/23

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F689	Continued From page 64 483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and 483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to monitor and ensure the resident safety 1 of 5 residents (Resident #96) reviewed for accidents and hazards, resulting in the potential for falls and injury. Findings include: According to the MDS dated 8/1/2023, R96 scored 7/15 (cognitively impaired) on her BIMS, required limited assistance for transfers, walking in her room, and toileting. Her diagnoses included a recently fractured back from a fall. Review of R96's Care Plan reported she had an alteration in her ability to perform her ADLs independently and be independent with mobility related to age-related physical debility, history of falls, osteoporosis, impaired balance, times of incontinence and vertigo. She was at risk for injury from falls. Effective 2/15/2022 - Present. Her goal was to be clean, odor free, well groomed, and comfortably dressed with encouragement to participate as able. Interventions to meet this goal included "assist me to the bathroom per protocol." "Keep my call light within my reach when I am in my room." "Please offer to assist me to the toilet or provide incontinent care and change in position when I	F689	about the importance of ensuring the call lights are accessible to the resident as well as when to check on the resident. Safety checks may be assigned and individualized or they may be when care is provided to the resident. The Call Light/Systems policy was updated 10/6/23 to include ensuring the call light is within reach, requesting an alternate call light if necessary, such as a wrist call or soft touch pad, and clipping the call light in place to prevent dislocation if needed. Education was completed on October 6, 2023. 4. Weekly audits will be completed on 10-20 residents to ensure resident call lights are within resident reach. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. 5. The Director of Nursing is responsible for compliance.	

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F689	Continued From page 65 am awake" "Transfer and ambulate me per my Resident Care Card instructions. The way I transfer & Ambulate: Assist x 1 for all toileting, dressing tasks and mobility tasks using WW. WC for longer distance mobility" "Assist me to the bathroom per protocol." STATUS: Active (Current) EFFECTIVE: 2/15/2022 - Present During an observation and interview on 9/12/2023 at 9:30 AM R96 was sitting in a wheelchair with a bedside table in front of her. A 2-wheeled walker (2ww) was to her left. No call light or call bell was visible in her bed area. R96's room was the farthest room from the central hall and at the end of the hall. During an observation and interview on 9/12/23 at 9:35 AM, R96's room with Registered Nurse (RN) "RR" who stated, "(R96) does not remember to push her light. Staff tries, we check on her frequently. I do not know the specific time of "frequency" is, at least every hour. The resident transfers herself, she has a sign to tell her to use the call light." The RN left R96's room. After about 10 minutes, RN "RR" came back stating, "I just double checked her care plan and it said to keep her walker within reach, shoes or socks with traction are to be worn, and keep her frequently used stuff within reach. In the bathroom she is to keep her walker with her. She sometimes uses the bathroom by herself. I do not think she is ambulating as much after her last fall. She broke her back that time." At this time Certified Nursing Assistant (CNA) "V", walked by stating, "(R96) quite often uses the bathroom by herself and she is not supposed to." RN "RR" walked back into R96's room and found the resident had gone into her bathroom and had transferred herself from her wheelchair onto the toilet. No walker was with her. R96 stated, "I had to go pee-pee and poop." RN "RR"	F689		

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F689	Continued From page 66 stated, "Oh dear." and assisted resident with toileting. RN "RR" did not educate resident to use the call light or to have a walker with her. During an observation and interview on 9/12/23 at 10:27 AM R96 was in her wheelchair next to her bed stating "I want to go sleepy. I want to go to bed so I sleep and get better." R96 stated, "I do not know where call light is. You go get someone to help me." Call light was found under blankets not visible to resident. Resident was shown call light and she said, "I push the button." Resident used call light at 10:27 AM. At 10:30 AM CNA "S" answered the call light, straightened up resident's bed, assisted resident with a transfer using walker and pivot into bed, and placed the call light around her torso. During an observation and interview on 09/12/23 at 3:56 PM, R96 was ambulating in her wheelchair into her bathroom. No staff was in view of her room from the hall. Resident stated, "I have to use the bathroom. No one here to help me." Resident transferred herself to the toilet and back to her wheelchair. No staff was in the hall or came to check on her during this time. There was no walker with resident while in the bathroom. During an observation and interview on 9/12/23 at 4:05 PM, RN "RR" was in the nursing station behind closed door unable to visually monitor residents in the "circle area" (area where the 4 halls of Birch Unit meet), stated, "I did not realize (R96) was not out here any longer. She was here a while ago." No staff were interacting with 6 residents in the "circle area". The radio was playing with no activities engaging the residents. During an observation on 9/13/2023 at 1:50 PM, R96 was sitting in her wheelchair next to her bed	F689		

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F689	Continued From page 67 with a 2-wheeled walker in front of her. The resident was attempting to stand up from the wheelchair grabbing for the walker. No staff were visible in the hall or the "circle area". Resident's call light was hanging from the left side of the bed. During an interview on 9/13/2023 at 1:50 PM, Licensed Practical Nurse (LPN) "P" stated, "(R96) has had many falls. I check on her with each medication pass. She gets medications from me 3 times a day. I do not know what her care plan says on how often to check on her. If it says to check on her "frequently" there is no definition here for frequently. I know the aides are to toilet her every 2 hours. The best-case scenario would be (R96) is checked on every 2 hours." During an interview on 9/13/2023 at 2:10 PM, CNA "CC" stated, "(R96) had fallen before by trying to get up on her own. There is no set amount of time aides are to check on her. I like to check on my pod (assignment of residents). I cannot be everywhere at once. There are a lot of residents that need a lot of help on this unit. I try to check on (R96) as often as I can." During an interview on 9/13/2023 at 2:15 PM, Occupational Therapist (OT) "I" stated, "(R96) has had falls. Right now, she is getting therapy to work on her balance. She should be monitored because she tries to transfer herself to the toilet and does not always remember to use the call light." During an interview on 9/14/2023 at 9:22 AM, Associate Director of Nursing (ADON) "UU" stated, "(R96's) Care Plan states she should expect a 1-person assist with transfers. Staff should be checking on/monitoring her and	F689		

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F689	Continued From page 68 anticipating her needs. I cannot quantify a time for frequency of checks. All residents are a fall hazard. The staff cannot stop her from self-transferring. The facility has a Restorative Program that comes to each unit. I do not have a running list on my unit of which residents receive their services. (Infection Control Preventionist (ICP "M") oversees the Restorative Program. The Restorative Aides have not been seen on my unit since we've had a Covid-19 outbreak the last week or so. I would imagine they were not scheduled to come on my unit (Birch) because of the outbreak."	F689		
F690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) 483.25(e) Incontinence. 483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. 483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F690	Resident #98 has been provided with a catheter securement device. 2. All residents with catheters have the potential to be affected. 3. Nursing staff have been educated that all residents with catheters need to have a securement device in place unless otherwise care planned. Additional education includes hand hygiene and proper handling of catheter device. Nursing staff have been educated they should be checking for these when catheter care is performed and reporting any signs or symptoms of discomfort to the nurse. The Catheter policy was updated 10/6/23 to include applying a securement device to those that have a catheter. Education was completed 10/6/23. 4. A weekly QA will be completed to ensure residents with catheters have securement devices. This will be completed on all residents with catheters. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. 5. The Director of Nursing is responsible	10/6/23

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F690	Continued From page 69 prevent urinary tract infections and to restore continence to the extent possible. 483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a leg strap (a device that goes around a leg to comfortably secure a urinary drainage bag in place) was in place for 1 resident (R98) in 1 resident reviewed for urinary catheter care, resulting in pain and injury. Findings include: According to the Minimum Data Set (MDS) dated 8/16/2023, R98 scored 3/15 (severely cognitively impaired) on her BIMS (Brief Interview Mental Status), and required extensive assistance of one person for transfers. She was incontinent of bowel/bladder and had an indwelling catheter. Her diagnoses included neurogenic bladder (unable to control bladder), urinary tract infection (UTI), multiple sclerosis (MS), and anxiety. During an observation and interview on 9/13/2023 at 9:09 AM, Certified Nursing Assistant (CNA) "DD" was performing bowel movement incontinence care for R98. R98 had a urinary foley catheter. Observed with the CNA, R98 did not have a device to secure her foley	F690	for compliance.	

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F690	Continued From page 70 catheter tubing to her leg. CNA "DD" stated, "(R98) is dependent on her cares. She does not have a leg strap to hold her foley catheter tubing secure. She should have one, so the tubing is not pulled on during cares or while she is being moved." As the CNA was cleaning R98's private area around the insertion site of the urinary catheter, there was a tinge of blood on the tubing. R98 stated with a cringe on her face, "Ouch". After the CNA was done cleaning R98, she dressed the resident. While dressing the resident, R98 handled the catheter bag and tubing with bare hands and did not perform hand hygiene after touching them. After R98 was dressed, CNA "DD" used a mechanical lift to transfer the resident from her bed to a wheelchair, hanging the urinary catheter bag above the bladder during transfer. As R98 was being transferred, she stated, "It hurts where the tubing comes out of me. I've had urinary tract infections before and was on antibiotics for them." During the time CNA "DD" was performing care for R98 on 9/13/2023 at 9:09 AM, Licensed Practical Nurse (LPN) "P" entered R98's room to assess her urinary foley catheter. The LPN stated, "(R98) has issues with her catheter and is usually sent out to have it changed. She does not have a leg strap on for her catheter tubing and she should have one to keep it from pulling and causing her pain. There is blood on the tubing at the insertion site." During an interview on 9/14/2023 at 9:22 AM, Unit Manager/Registered Nurse (UM-RN) "UU" stated, "(R98) has a urinary foley catheter. All foley catheters should have a securement device to prevent dislodgment which can cause great pain. (R98) should have had a securement device for her catheter. There is no reason she	F690		

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F690	Continued From page 71 did not have one."	F690		
F697 SS=D	Pain Management CFR(s): 483.25(k) 483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure pain management interventions were implemented for 1 of 24 resident, (Resident #72) reviewed for pain, resulting in Resident #72's complaint of pain and inadequate pain management. Findings include: Review of a "Face Sheet" for Resident #72 dated 1/22/19, revealed the resident was admitted to the facility with the following pertinent diagnoses: Hemiplegia following a Cerebral Infarct (paralysis on one side following a stroke), Generalized Anxiety Disorder, and Major Depressive Disorder, Chronic Pain Syndrome, and Idiopathic Neuropathy (nerve damage of unknown origin). Review of a "Minimum Data Set" (MDS) assessment dated 6/13/23 revealed Resident #72 scored 14/15 on a "Brief Interview for Mental Status" (BIMS) assessment, which indicated the resident was cognitively intact. Section "J" of the MDS revealed Resident #72	F697	. The TENS treatment was reinstated for resident #72. Family was reminded should they take this device home again, to notify nursing when it is returned. Pain is managed with the use of medication and non-pharmacologic interventions. 2. All residents have the potential to be affected. 3. The provider is to be notified when a non-pharmacologic intervention is not being used and alternate therapy may be needed. Nursing education included how best to follow-up when interventions are on hold. The treatment will remain in place until discontinued. Should the staff be waiting on family to supply, family will be communicated with regularly. The Pain policy was updated 10/6/23 to include that if the resident is using a non-pharmacologic intervention that is no longer available or necessary, the provider will be updated as alternate pain control may be needed or it may need to be discontinued. Education completed 10/6/23. 4. A weekly QA will be conducted auditing 10-20 residents with alternative therapies and those receiving PRN or scheduled pain medication to ensure the programs are being completed and pain addressed appropriately. Those citing continued discomfort will be addressed immediately. Results will be forwarded to the Director of Nursing and ADON's, then presented to the QAPI committee for interdisciplinary review. 5. The Director of Nursing is responsible for compliance.	10/6/23

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F697	Continued From page 72 received scheduled pain medication as well as non-medication interventions to assist with pain management. During the MDS "Pain Assessment Interview" Resident #72 reported frequent pain that made it hard to sleep at night and described the pain as "very severe". Review of a "Care Plan Report" for Resident #97 dated 9/13/23, revealed "problem/goal/interventions" that stated: "Hx (history) of multiple CVA's (strokes) with left hemiparesis (loss of movement on one side of the body) and type 2 Diabetes ...Goal: My goal for my care is to ...not be on dialysis while being comfortable. Interventions: I have TENS unit (transcutaneous electrical nerve stimulation device used to activate nerves and decrease pain) with socks. Nursing to administer." Review of a Physical Therapy summary note dated 6/15/23 revealed the following in a section titled Education, Summary and Recommendations: "Nrg (sic) has been trained in maintenance and donning/doffing/adjusting TENS socks. Nsg (sic) will monitor client's response to this pain mgmt. technique ...". In an interview on 9/11/23 at 4:02pm Resident #72 reported she had a "TENS" device that had been helpful in managing her pain, but the unit had not been applied for approximately 1 month. Resident #72 reported having increased pain that woke her up at night during the time that the TENS unit was not in use. Resident #72 reported she wanted to use non-pharmacological interventions for pain management when possible because she was concerned about her risk for nephrotoxicity (process that occurs when kidneys are damaged by a drug, chemical or toxin).	F697		

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F697	Continued From page 73 In an interview on 9/11/23 at 4;15pm, Family Member (FM) "DDD" reported he provided the TENS device for Resident #72 in June 2023, and the facility agreed to apply the device 1 time per day to assist with pain management for the resident. FM "DDD" reported he was told use of the device was on hold approximately one month ago because the device needed maintenance care. FM "DDD" reported he completed the maintenance care on the TENS device and returned it to a staff member on the same day, but use of the device had not resumed. In an interview on 9/13/23 at 10:48am, Assistant Director of Nursing (ADON) "HH" reported the order for Resident #72's TENS device read "nurse to apply daily x 25minutes" however the order was listed as "on hold" in the electronic medical record, and she would need to research the situation further. Review of a Treatment Administration Record for Resident #72 revealed the TENS device was last applied on 8/16/23. Review of a nursing progress note dates 8/7/23 revealed Resident #72 called the unit, stated her feet were painful and requested a "pain pill". Resident #72 requested to be placed on the provider communication board due to continued pain. RN provided menthol topical pain gel, ice packs and massage. In an interview on 9/13/23 at 11:05am, ADON "HH" reported Resident #72's TENS unit was in her room, cleaned and in working order and that use should have resumed when the device was returned, but it must have been overlooked. Review of a "MDS Pain Interview" assessment	F697		

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F697	Continued From page 74 dated 9/12/23 revealed Resident #72 described her pain as "severe", almost constant and mostly in her feet. In an interview on 9/13/23 at 2:38pm, Registered Nurse "RN" "NN" reported she had applied Resident #72's TENS unit several times prior to the unit being placed "on hold". RN "NN" reported the resident voiced significant pain relief from use of the device. RN "NN" stated "(Resident #72) says it reduces her pain even before it's turned on ..., even if it's a placebo effect, it helps". Review of "Potter and Perry Fundamentals of Nursing" book revealed: ... "Pain is a universal but individual experience and a condition that nurses encounter among patients in all settings. It is the most common reason that people seek health care; yet it is often underrecognized, misunderstood, and inadequately treated. A person in pain often feels distress or suffering and seeks relief. One of the major challenges of pain is that as a nurse you cannot see or feel a patient's pain. It is purely subjective. No two people experience pain in the same way, and no two painful events create identical responses or feelings in a person. The International Association for the Study of Pain (IASP) defines it as "an unpleasant, subjective sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (IASP, 2014b)...Pain management should be patient centered, with nurses practicing patient advocacy, empowerment, compassion, and respect. Caring for patients in pain requires recognition that pain can and should be relieved. Effective communication among the patient, family, and professional caregivers is essential to achieve adequate pain management. Recognition of the	F697		

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F697	Continued From page 75 subjective nature of pain and respect for the patient in pain is demonstrated when a nurse accepts McCaffery's classic definition: "Pain is whatever the experiencing person says it is, existing whenever he says it does" (Pasero and McCaffery, 2011). Effective pain management improves quality of life; reduces physical discomfort; promotes earlier mobilization and return to previous baseline functional activity levels; results in fewer hospital and clinic visits; and decreases hospital lengths of stay, resulting in lower health care costs. Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 61535-61556). Elsevier Health Sciences. Kindle Edition ...."	F697		
F804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) 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: Based on observation and interview, the facility failed to provide food in a palatable and appetizing temperature for 4 residents (Resident #80, #74, #36, and #84) of 4 reviewed for food palatability resulting in dissatisfaction with meal service with the potential for decreased food acceptance and nutritional decline.	F804	The Birch and Dogwood units are no longer using the sunrooms. They have transitioned back to using the main dining room for communal dining where the trays are delivered and passed together. While participating in communal dining, meals are served on dishes where their temperature and palatability can be maintained. Should there be another COVID outbreak, the sunroom and Styrofoam containers will be utilized on these floors. The Cherry pavilion does use the sunroom. Should any residents be in the sunroom, at least one staff member will be present. Residents will be fed promptly after being served. Should there be a pavilion in quarantine again, it will be the practice of the facility to separate the meals of those that need to be fed from those that are independent. This would allow staff to quickly run the trays to those that are independent then those that need to be fed, then stay with them to feed. A second microwave has been requested for	10/6/23

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F804	Continued From page 76 Findings include: Review of "Meal Times" document provided on 9/12/23, revealed, "...Breakfast: Dogwood - 9:00 - 9:15 AM...Lunch: Dogwood - 1:00 PM - 1:15 PM..." During an observation on 09/12/23 at 09:17 AM, this writer observed the breakfast meal cart in the hallway. Residents #36, #62, #94, #44, #86, #431, #125, and #12 were seated in the center of the unit. Residents #94 and #62 were observed to have their breakfasts in front of them. Resident #12 received his breakfast at 09:37 AM. Residents #36, #44, #431, and #125 had not received their breakfasts yet. Resident #44 was seated next to R#94, Resident #36 was seated next to Resident #62, and Resident #431 was seated next to R#86. In an interview on 09/12/23 at 09:24 AM, CNA "ZZ" reported the residents had not all had breakfast yet and she was grabbing trays from the cart and going by room. CNA "ZZ" reported the unit had a lot of floats as caregivers on the unit. Resident #80: Review of an "Admission Record" revealed Resident #80 was a female with pertinent diagnoses which included dementia, muscle weakness, anxiety, unsteadiness on feet, kidney disease, cognitive communication deficit, and abnormal weight loss. Review of a "Minimum Data Set" (MDS) assessment for Resident #80, with a reference date of 10/27/22 revealed a Staff Assessment for Mental Status indicated Resident #80 was severely cognitively impaired.	F804	the birch and dogwood pavilions to expedite rewarming of food if needed. 2. All residents have the potential to be affected. 3. Education was provided to nursing staff regarding serving and feeding, specifically the importance of beginning feeding after serving the meal. The Meal Service policy was reviewed and updated to include meal service in the sunroom. This includes not putting residents in the sunroom until meal times where staff are preparing to serve the meal and assist with feeding, and providing adaptive equipment as ordered. Nursing education was completed October 6, 2023. 4. The Registered Dietitian will continue to do Meal Rounds and Tray Accuracy Audits 3x per week ongoing. Results of audits will be provided to the Culinary Director and Director of Nursing for review/corrective action. The Registered Dietitian will continue to complete weekly test trays on going, with results reported to the Culinary Director. The Culinary Director, Executive Director and RD will complete audits 3x per week of the full scope of tray service (from the line in the kitchen to delivery by nursing to the resident) x 6 weeks or until compliance is achieved. A weekly QA will be conducted on 10-20 residents weekly auditing the length of time between serving and feeding. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. 5. The Director of Nursing is responsible for compliance.	

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F804	Continued From page 77 Review of current "Care Card" dated as of for Resident #80, revealed "...I eat with assist in the dining room ...I am approved to be assisted by a Paid Dining Assistant...Given my difficulties with communicating and making my needs known, If I am unable to verbalize my meal wishes, staff may make my menu selections for me..." Review of "Diet Change Form" dated 6/29/23 at 4:20 PM, revealed, "...Discontinue all assistive equipment. Needs total assist with eating..." During an observation on 09/11/23 at 01:27 PM, Resident #80 was observed seated in the Dogwood Sunroom. Resident #80 had not received her lunch meal at this time. In an interview on 09/11/23 at 01:27 PM, Certified Nursing Assistant (CNA) "AAA" reported Resident #80 was assisted to eat her meals by staff, and she does not answer you when you talk to her. During an observation on 09/12/23 at 09:10 AM, Resident #80 was observed seated in the Sunroom on the unit and she did not have a meal in front of her. No staff were present in the room. During an observation on 09/12/23 at 09:18 AM, Resident #80 was observed seated in the Sunroom on the unit and she did not have a meal in front of her. No staff were present in the room. During an observation on 09/12/23 at 9:42, Resident #80 was observed seated in the Sunroom on the unit with no breakfast meal, no staff present or other residents.	F804		

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F804	Continued From page 78 During an observation on 09/12/23 at 09:51 AM, CNA "HHH" placed Resident #431's and #80's meal in front of them. At 10:01 AM, CNA "HHH" opened the Styrofoam container and walked over to Resident #84 to check on her as she started to cough. CNA "HHH" went over to Resident #431 to assist her with set up for her meal. During an observation on 09/12/23 at 10:04 AM, CNA "ZZ" started to assist Resident #80 with eating her breakfast. Note: It was 54 minutes until Resident #80 began to eat her breakfast after being seated in the Sunroom since at least 09:10 AM when this writer entered the unit. Note: It was 13 minutes after Resident #80 received her breakfast when she was provided assistance to eat. Resident #74: Review of an "Admission Record" revealed Resident #74 was a female with pertinent diagnoses which included dementia, stroke, end stage renal disease, muscle weakness, physical debility, COPD, diabetes, GERD, anxiety, hypomagnesemia (low magnesium levels), and anemia. Review of "Care Plan Documentation" dated 8/23, revealed, "Quarterly/High risk Review - Continues with nutritionally stability. No changes in weight/intake or appetite. Continues with dialysis three time per week with good weight stability. Cont with current POC..." During an observation on 09/12/23 at 09:55 AM, Resident #74 walked down to the kitchenette area with her breakfast on the seat of her wheeled walker. Resident #74 reported her food was cold, she came down here to have	F804		

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F804	Continued From page 79 someone warm it up for her and requested one of the staff members to heat it up for her. Resident #36: Review of an "Admission Record" revealed Resident #36 was a female with pertinent diagnoses which included dementia, falls, hip fracture, GERD, irregular heartbeat, and renal insufficiency. During an observation on 09/12/23 at 09:53 AM, Resident #84 and R#36' breakfast trays were in the Sunroom dining room area. During an observation on 09/12/23 at 09:54 AM, Resident #36 was brought to the dining room as well as Resident #431. Resident #36's breakfast Styrofoam tray was placed in front of her. In an interview on 09/12/23 at 10:05 AM, Resident #36 was sitting with her breakfast container lid open and had not been assisted with her breakfast meal. In an interview on 09/12/23 at 10:06 AM, CNA "FFF" reported she was going to talk to Resident #36 to determine if she was able to feed herself. CNA "FFF" reported if she couldn't answer she would check her care card in the computer. CNA "FFF" reported she doesn't work over here very often. CNA "FFF" was observed to put on gloves and had begun to assist Resident #36 with her breakfast meal. Note: 13 minutes had passed since Resident #36's breakfast tray was observed in the Sunroom dining room area. Resident #84: Review of an "Admission Record" revealed Resident #84 was a female with pertinent	F804		

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F804	Continued From page 80 diagnoses which included dementia, stroke, muscle weakness, dysphonia (functional voice difficulty), glaucoma (nerve connecting the eye to the brain is damaged), and dysphagia (damage to the brain responsible for production and comprehension of speech). Review of "Weights" for Resident #84 revealed, "...9/13/2023 8:35 AM...116.40...9/1/2023 12:31...116.80... 8/1/2023 2:35 PM...121.40...7/11/2023 7:31 AM...120.00...7/1/2023 7:31 AM...121.40..." During an observation on 09/12/23 at 09:55 AM, Resident #84 was brought to the Sunroom and set up was performed by CNA "HHH." Note: The breakfast Styrofoam container had been sitting on the table since at least 09:42 AM when it was observed by this writer. In an interview on 09/12/23 at 09:50 AM, RN "Z" reported the breakfast does usually get brought to the unit at about 9:00 AM. During an observation on 09/12/23 at 09:46 AM, Licensed Practical Nurse (LPN) "BBB" was observed exiting from the locked nurse's office as the Fire Marshalls were sounding a door alarm. LPN "BBB" reported she was in the nurse's office as she had charting to complete. When queried about breakfast mealtimes she reported breakfast was delivered approximately 09:00 - 09:15 each morning. Review of the "Residents who can be assisted by a "Paid Dining Assistant" document received during survey, revealed, five residents in the facility were assessed to be assisted by a paid feeing assistant with one (Resident #80) on the Dogwood unit.	F804		

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F804	Continued From page 81 Review of the "Staff Who Have Completed the Paid Dining Assistant Course" document received during survey, revealed there were 36 staff members who completed the paid dining assistant course. In an interview on 09/14/23 at 09:41 AM, Director of Nursing (DON) "B" reported the COVID outbreak was something new to the facility and they had never served food on the floor front. DON "B" reported the facility tried to keep up and were dedicated but was not a well-oiled machine. When queried if the paid feeding assistants were utilized, DON "B" reported there were 4 residents on the Dogwood unit where had been evaluated to be assisted with meal by a paid feeding assistant with no response as to why the paid feeding assistants were not utilized. DON "B" reported the facility was rolling out a new electronic medical record system this week and her list of things to do were endless, addressing other issues which come up, donning/doffing, office work and other infections. DON "B" stated "what to prioritize looks different for everybody. Two weeks ago, COVID came and it threw everything off as we had focused so much on the dining room dining experience so much this last year...for many of the staff this was their first experience with a COVID outbreak..." When quivered about whether the nurses and Assistant Director of Nursing (ADON) administrative nurses were assisting with meal delivery, set up and assistance with eating meals, DON "B" replied the ADON "LL" reported she had been on the unit busy answering call lights and addressing other concerns. Note: This writer did not observe ADON "LL" on the unit at the times this writer completed observations on the unit, especially during breakfast mealtime on 09/13/23 and lunch time on 09/14/23. DON "B" reported the	F804		

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F804	Continued From page 82 other ADONs for long term care were not as engaged as the ADON for the rehabilitation unit.	F804		
F812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) 483.60(i) Food safety requirements. The facility must - 483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. 483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to 1) maintain sanitary equipment, 2) date mark potentially hazardous food, 3) and monitor cooler temperatures, resulting in the potential for contamination of equipment and potential for conditions for foodborne illness, affecting all 138 residents who consume food from the kitchen. Findings include:	F812	No specific residents were named in this citation. 2. The deficiency had the potential to affect all residents who received food/fluids from the kitchen or unit pantries. 3. On 9/29/23 The Registered Dietitian and the Culinary Director educated dietary staff on dating and labeling, cleaning of kitchen equipment, notifying the Culinary Director of items in need of servicing/repair, and on safety/sanitation related to the three compartment sink. Dietary staff were educated on completing the temperature logs on unit pantries on the weekends. The nursing staff will be educated by the Staff Development Coordinator. All education as completed on October 6, 2023.The eye wash sink was reviewed on 10/4/23 with the Environmental Services Director. This eye was station was removed from service on 10/6/23. The fans in the walk in cooler were cleaned immediately on 9/11/23 by the Culinary Director. The Maintenance Director cleaned the fans on 10/2/23. The undated milk cartons in the walk in cooler were immediately discarded on 9/11/23 by the Culinary Director. The utensils in the drawer under the three compartment sink were immediately washed on 9/11/23 by the Culinary Director. Scoops will no longer be stored under the sink area. The unit pantries 10/6/23 and all undated foods and fluids removed. The Aspen refrigerator was cleaned 10/4/23 and sanitized 10/5/23. The ice machines were cleaned 10/6/23. The Aspen pantry is not online. The Pantry refrigerator was cleaned on 10/5/23. A sign has been placed on the Aspen refrigerators	10/6/23

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F812	Continued From page 83 On 9/11/23 at 12:10 PM, during an inspection of the kitchen, the dual check valve with an atmospheric port (a backflow prevention device commonly used in plumbing to prevent backflow of contaminated liquid into the domestic water supply), provided for the waste disposal submerged inlet, was observed to not have an air gap provided for the atmospheric port. According to the manufacturer's installation directions, it notes, "It is important to install a discharge line downward from the vent to a floor drain, sump, or other safe place of disposal that will not result in property damage. A physical air gap must be maintained between the discharge line and the drain or sump. Create the air gap by cutting the pipe on a 45 bevel, at a distance of 12" maximum and a mini mum of 1" above the floor." On 9/11/23 at 12:15 PM, heavy dust accumulation was observed on the walk-in cooler fan grids. At this time, General Kitchen Manager "EEE" stated that the fans should be getting cleaned monthly and that they need to be cleaned. On 9/11/23 at 12:17 PM, four milk cartons were observed to be open, with no open date or expiration date label. At this time, General Kitchen Manager "EEE" stated that the milks should be dated. On 9/11/23 at 12:21 PM, significant water accumulation was observed in the utensil drawer next to the three-compartment sink. At this time, General Kitchen Manager "EEE" immediately took the utensils out of the drawer to have them washed. Additionally, the hand sink next to the three-compartment sink was observed to be	F812	letting staff know they are not to be used. The Food Service Sanitation Policy was reviewed on 10/3/23 and is up to date. Education was completed on 10/6/23. 4. The Executive Chef and Culinary Director will complete audits of the kitchen safety and sanitation twice per week x 4 weeks, and then weekly x 4 weeks or until compliance is achieved. The Registered Dietitian will complete weekly sanitation audits ongoing. The unit pantries will be Audited by the Diet Clerk or Registered Dietitian for temperature logs, dating and labeling, and sanitation 1x per week ongoing. Results of pantry audits will be provided to the ADONs, the DON, and the Culinary Director. A weekly QA will be conducted auditing all the pantries to ensure items are being labeled, dated, the temperature log is being used, and there is sanitation. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. 5. The Culinary Director/DON will be responsible for ensuring compliance.	

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F812	Continued From page 84 blocked by a waste container. At this time, Registered Dietician "Y" stated that the eye wash assembly fixed to the hand sink is not working and the hand sink is currently not in use. In an observation on 9/12/23 at 12:40 PM., Noted the refrigerator on the "Birch" unit main dining room. On the outside door of the refrigerator/freezer was a magnet holding a piece of paper titled "Temperature Logs" there were no logged temperatures for the dates of 9/6/23, 9/8/23-9/12/23. On 9/11/23 at 1:45 PM, two milk cartons, located in the Birch Hall Kitchenette reach-in refrigerator, were observed to be open with no date label to identify the discard date. A carton of thickened beverage and a carton of nutritional shake were observed to be open with no date label. Additionally, the ice machine ice chute was observed to have black biofilm accumulation. In an observation on 9/11/23 at 1:20 PM., noted the refrigerator on the "Cherry" unit main dining room. On the outside door of the refrigerator/freezer was a magnet holding a piece of paper titled "Refrigerator Temperature Logs" there were no logged temperatures for the dates of 9/6/23, 9/8/23-9/11/23. On 9/11/23 at 1:56 PM, five opened milk cartons, located in the Cherry Hall Kitchenette reach-in refrigerator, were observed to not be provided with a date label to identify the discard date. Two nutritional shake cartons and four thickened beverage cartons were observed to be open with no date label. Additionally, the ice machine ice chute was observed to have black biofilm accumulation.	F812		

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F812	Continued From page 85 On 9/11/23 at 3:25 PM, four opened milk cartons, located in the Dogwood Hall Kitchenette reach-in refrigerator, were observed to not be provided with a date label to identify the discard date. On 9/11/23 at 3:32 PM, one opened milk carton and one thickened beverage carton, located in the Elm Hall Kitchenette reach-in refrigerator, were observed to no be provided with a date label to identify the discard date. According to the thickened beverage manufacturer's label, it states, "After opening, may be kept up to 7 days under refrigeration." Additionally, the freezer in the kitchenette was observed to have a large spill covering more than half of the interior freezer floor. On 9/11/23 at 3:40 PM, three opened milk cartons, located in the Maple Hall Kitchenette reach-in refrigerator, were observed to not have a date label to identify the discard date. During an interview on 9/12/23 at 12:30 PM, General Kitchen Manager "EEE" stated that nursing staff are responsible for dating opened food and beverages in the kitchenette refrigerators and that the Dietary Department is responsible for stocking the kitchenette's. During an interview on 9/12/23 at 1:50 PM, General Kitchen Manager "EEE" was queried on cleaning ice machines and stated that Maintenance is responsible for cleaning the ice machines. In an observation on 9/12/23 at 12:20 PM., noted the refrigerator on the "Aspen" unit main dining room freezer when opened had a foul	F812		

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F812	Continued From page 86 smell. Inside the freezer were 2 mason jars filled with a red frozen jam or juice also noted a restaurant (name of restaurant omitted) bag with individual one pint size ice creams labeled by the restaurant. The pint size ice creams packaging revealed "packed on date 9/14/22 and use by 10/29/22"...Noted the freezer was heavily soiled in various areas with dried stuck on food spillage and crumbs inside the freezer area. Inside the refrigerator noted a gallon of ice tea, unopened with no expiration date or delivery date noted. Noted on the top shelf was a plastic grocery bag with 2 baggies of food items. One of the baggies appeared to have a ground meat, and the other a hard boiled egg. Neither of the baggies were dated, or labeled and the food items were visibly moldy/rotten. Inside the door of the refrigerator was an unopened box of "Caramel Cashew" chocolates, no date or expiration date was noted on the box. On the outside door of the refrigerator/freezer was a magnet holding a piece of paper titled "Refrigerator Temperature Logs" there were no logged temperatures for the dates of 9/6/23, 9/8/23-9/12/23. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." According to the 2017 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature	F812		

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F812	Continued From page 87 Control for Safety Food, Date Marking. "(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5C (41F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety ..." According to the 2017 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. "(A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A),	F812		

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F812	Continued From page 88 except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) ..."	F812		
F842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) 483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. 483.70(i) Medical records. 483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized 483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F842	The note documented in resident #95s chart could not be addended as we no longer have access to that EMR. A note has been placed in the progress notes of PointClickCare referencing that note and that it was in the wrong patients chart. A care conference was held with resident #381 and his mother. He confirmed it was ok for her to sign paperwork on his behalf as well as his brother. He completed a PHI form stating that with signature authorization for his mom, dad, and brother. A new code status form was completed by resident #381. Resident #381 remains his own decision maker. Family was provided education about DPOA proceedings and activation should this come up in the future. 2. All residents have the potential to be affected. 3. Nursing and Social Work have been provided with education regarding the process of completing a code status form on admission. The process of which they were educated on includes that residents that are their own decision maker shall sign the code status form or sign the PHI form stating whom they would like to sign their paperwork on their behalf. Residents shall not be listed as having a DPOA until DPOA and activation paperwork has been received. The Code Status Order policy was updated 10/6/23 to include if signing as the DPOA, DPOA paperwork and proof of activation must be present. If the	10/6/23

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F842	Continued From page 89 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. 483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. 483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. 483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under 483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain complete and accurate medical records for 2 residents (Resident #95,	F842	resident wishes to have someone else complete their paperwork, they may complete the PHI form stating this. 4. A weekly QA will be conducted on 10-20 residents weekly auditing their code status, PHI form, DPOA, and activation paperwork. It will be verified in the QA who the decision maker is and that they have completed the proper paperwork. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. 5. The Director of Nursing is responsible for ensuring compliance.	

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F842	Continued From page 90 #381) of 2 residents reviewed for medical records, resulting in the potential for facility staff and providers not having all of the pertinent information to care for residents and track the history of abuse allegations. Findings include: Resident #95 Review of an "Admission Record" revealed Resident #95, was originally admitted to the facility on 8/30/22 with pertinent diagnoses which included: chronic kidney disease. Review of a "Minimum Data Set" (MDS) assessment for Resident #95, with a reference date of 8/24/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 11/15 which indicated Resident #95 was mildly cognitively impaired. Review of Resident #95 "Electronic Medical Record" (EMR) revealed: "On 6/25/2023 at 18:29 (EDT) CNA came up to med cart and informed this nurse that resident (Resident #95) had accused CNA of punching him (Resident #95). CNA stated that resident (Resident #95) said "you punched me." This nurse gave resident (Resident #95) his medications and asked him what happened. The resident (Resident #95) stated "I got punched in the eye by the CNA today." When I asked which CNA the resident (Resident #95) responded with "go look whose on the floor today geez." This nurse called and reported the incident to the CM (CM-weekend on-call manager). The CM questioned the resident (Resident #95) as well. Resident (Resident #95) had no observable injuries. Resident (Resident #95) later calmed down during lunch and told the CM that he (Resident #95) "does not think the punch was malicious."	F842		

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F842	Continued From page 91 The CM reported the incident to their higher up and was informed this was not a reportable even, in which, CM informed this nurse that the event was not reportable. This nurse filled out a witness statement..." During an interview on 9/14/23 at 10:53 AM., Director of Nursing (DON) "B" reported the progress note in (Resident #95's) EMR dated 6/25/23 was for a different resident who no longer resides in the facility. DON "B" reported she did not report the allegation for the "other resident" either. DON "B" reported the actual resident who no longer resides in the facility does not have a progress note from 6/25/23 with the same information. DON "B" reported no corrections were made to either Resident #95's EMR to indicate there was a mistake with the information documented on 6/25/23, nor was a progress note put into the other residents (no longer residing in the facility) EMR to ensue accuracy of documentation. Resident #381 Review of an "Admission Record" revealed Resident #381, was originally admitted to the facility on 8/29/23 with pertinent diagnoses which included weakness and diabetes. Review of a "Minimum Data Set" (MDS) assessment for Resident #381, with a reference date of 8/29/23 revealed "Staff Assessment for Mental Status" noted that Resident #381 had a memory problem, and had moderately impaired cognitive skills for daily decision making." Review of Resident #381's "Code/No Code Status order " dated 9/6/2023 revealed, "Resident #381 code order status: No code-Discontinuance of life prolonging treatment	F842		

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F842	Continued From page 92 would not include food, liquid or other routine procedures. No CPR (Cardiopulmonary Resuscitation) or heroic measures will be initiated. The consequence of this decision could result in death. The order was signed by Resident #381's family member under Legal Health Care/ Decision Maker..." Review of Resident #381's "Code/No Code Status order " dated 8/29 /2023 revealed, "Resident #381 code order status: No code-Discontinuance of life prolonging treatment would not include food, liquid or other routine procedures. No CPR (Cardiopulmonary Resuscitation) or heroic measures will be initiated. The consequence of this decision could result in death. The order was signed by Resident #381's family member under Legal Health Care/ Decision Maker..." Review of Resident #381's "Facesheet" revealed that Resident #381 was listed as his own responsibly party, and did not have a legal guardian or durable power of attorney in place. During an interview on 9/12/23 at 11:18 AM, ADON "UU" reported that Resident #381's family member had reported that they were the durable power of attorney (DPOA) for Resident #381, but the facility was not able to verify if Resident #381's DPOA had been activated because they did not have the form. ADON "UU" reported that the family member that signed Resident #381's Code/No Code Status order on 9/6/23 was not Resident #381's guardian or DPOA, and she was unsure why that family member had signed Resident's Code/No Code Status order. On 9/13/23 at 11:37 AM , Social Worker (SW) "FF" reported that when Resident #381 was first admitted to the facility in August 2023, Resident	F842		

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F842	Continued From page 93 #381's parents and brother had reported that each of them were Resident #381's DPOA, but they were not able to confirm if the DPOA was currently activated. SW "FF" reported that Resident #381 was "in and out of it" during the admission process, so SW "FF" allowed Resident #381's family members to sign and complete the admission forms for Resident #381.SW "FF" reported that Resident #381 gave permission for his family member to complete the admission paperwork for him. SW "FF" reported that Resident #381 did request to be listed as do not resuscitate by stating "No code" during the conference. SW "FF" reported that she never received the DPOA paperwork from Resident #381's family, and she was unaware if the DPOA was activated or not. SW "FF" did not know what the facility policy was for residents family members completing advance directive forms if there was not proof of guardianship or DPOA. SW "FF" reported that the facility staff were currently utilizing Resident #381's parents as point of contact for care decisions, even though the facility had not confirmed if Resident #381 had lost his decision making capability. During an interview on 9/13/23 at 12:40 PM, Admissions Coordinator (AC) " K" reported that she had completed the admission paperwork on 9/6/23 when Resident was readmitted to the facility. AC "K" reported that she had been unable to reach Resident #381's parents, so she completed the paperwork with Resident #381's brother. AC "K" reported that she was unaware that the facility had not confirmed if Resident #381 had lost his decision making capacity, and that the DPOA forms had not been reviewed by the facility. AC "K" reported that the facility would have required an activation letter for the DPOA to allow anyone but Resident #381 to sign the Code/No Code Status order forms. AC	F842		

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F842	Continued From page 94 "K" reported that usually the social worker completed the admission paperwork with residents, which is why this was missed. Review of facility's "Advance Directive" policy revealed, " 1. The Facility, under Patients Rights Act 312 December 18, 1990, will inquire concerning advance directives already executed and will inform the patient/resident and responsible party of the right to execute an advance directive prior to or upon admission. 2. The Facility will offer assistance if a patient/resident and responsible party wishes to execute an advance directive. 3. The (Facility), recognizing that patients/residents have the right to make advance directives including withholding or withdrawing life sustaining treatment and including designation of a patient/resident advocate who may be authorized to exercise any powers which would have been exercisable by the patient/resident, will comply with the Patient Rights Act 312, December 18, 1990, providing that the Facility is provided with a copy of the legally executed directive...." Review of "Potter and Perry and Fundamentals of Nursing" revealed: ...."The Professional Standard of Quality for documentation" of the resident's health care in a medical record is the information must be true and complete. Under no circumstances should erroneous records be removed from the overall record and new pages submitted. (Fundamentals of Nursing, Concepts, and Practice. Mosby. Potter, P.A., Perry, A.G., 1985).."	F842		
F880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) 483.80 Infection Control	F880	The tape on the lift was to help alert staff that this lift had wider bars for bariatric residents. It was removed. The remaining adhesive on the lift was removed from the	10/6/23

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F880	Continued From page 95 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	F880	lift. The lifts were cleaned with soap and water 10/6/23. Environmental Services is placing a cover over the personal laundry carts. Signage at the entrance of a quarantine unit will include PPE requirements to be worn on the unit should PPE be necessary. The folders containing the required signage for various infections has been updated to include appropriate signage. The mask in a tattered bag has been disposed of. 2. All residents have the potential to be affected. 3. A non-adhesive tag that can be disinfected was placed on the lift in effort to identify it as being the one with a wide spreader bar. Education for nursing staff including the importance of refraining from using adhesive materials on surfaces as they cannot be properly disinfected and pose a risk for cross contamination. Staff received education on a new process for cleaning and disinfecting lifts with Quat and that in the future it may include the use of Force wipes of which includes taking the lift to the soiled utility room and wiping it down. Laundry and Nursing staff have been educated on the process of delivering clean clothing to resident rooms of which no longer includes placing clothing outside the residents room. Education and guidance has been provided to staff on where to keep their masks during an outbreak. Additionally, staff were educated about how to maintain the integrity of their mask, when to seek a new one, and proper donning and doffing procedures. The Disinfection of Multiuse Durable Medical Equipment policy has been updated to include sanitization may include spraying the lift with QUAT, then waiting ten minutes	

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F880	Continued From page 96 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. 483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. 483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. 483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement effective infection control measures related to sanitization of shared equipment, the delivery and storage of personal laundry, hand hygiene in between resident contact, effective use of personal protective equipment (PPE), and implementation of isolation precautions, resulting in the potential for the transmission/transfer of pathogenic organisms and cross contamination between residents and staff. Findings include:	F880	before wiping and using, or cleaning the lift with Force swipes stored in the soiled utility room and waiting for four minutes before putting back into use. Education has been provided about hand hygiene or sanitization while feeding. 4. A weekly QA audit will be conducted on 10-20 residents weekly. This audit will include assessing the following& Correct PPE/masking for should the unit be in quarantine Ensuring lifts are being cleaned between use and free from debris or residue. Ensuring laundry is not placed outside the resident such as on the back of a chair or hanging on a cart. Ensuring hand hygiene or sanitization is performed while feeding residents. Results will be forwarded to the Director of Nursing and ADONs, then presented to the QAPI committee for interdisciplinary review. 5. The Director of Nursing is responsible for compliance.	

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F880	Continued From page 97 During an observation on 9/12/23 at 11:08am, a resident shared lifting device was removed from Room #304 (an isolation room). Tattered, rainbow colored tape was visible on the sections of the device where residents place their hands during a transfer. Portions of the tape were pealing off, exposing the adhesive side of the tape. In an interview on 9/14/23 at 10:32am, Infection Preventionist (IP) "M" confirmed that tape should not be placed on equipment because it cannot be properly disinfected and thus poses a risk of cross contamination/transfer of pathogenic organisms. During an observation and interview on 9/12/23 at 9:15 AM on Birch Unit a resident-shared transfer device that had a dried white substance on the foot-controlled brake controller and the deck where resident feet would be placed. Splattered on the deck, legs, and arms of the device was different shades of brown substances. On the seat of the device were smudges and smears of a white substance. CNA "V" stated, "That device is called a "Sara Steady". It is used to transfer residents. Once the resident stands on the deck and holds onto the bar in front of them, the staff can fold the seat behind them and transfer them to the bathroom or a chair. The transfer devices should be disinfected and cleaned after each resident use. There is a spray disinfectant, "Quat" something." During an observation on 9/12/23 at 10:52 AM there was a mechanical lift on Birch Hall outside room 202. On the base of the lift and the arms that connect to the sling was a dried white substance that was flaking. On the base of the lift and control was dirt and debris. No	F880		

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F880	Continued From page 98 disinfectant in a spray bottle or container of wipes was seen in the vicinity of the lift. Observed on 9/12/2023 at 10:55 AM mechanical lift (sit to stand), was outside room 224 with debris and dirt on the deck with dried substances on the arms of the lift. During an observation on 9/13/23 at 9:09 AM, CNA "DD" was transferring R98 from bed to a wheelchair with a mechanical lift. The lift had a dried white substance splattered on it. The wheelchair seat cushion was splattered with a dried white substance, the foot pedals had hair, dirt, and debris on them, and the head rest was torn and ripped. During an interview on 9/13/2023 at 2:15 PM, CNA "DD" stated, "Shared equipment should be cleaned with the spray "Neutral Quat" disinfectant after used with each resident and it needs to be left to dry for 10 minutes. On each machine there is a timer staff are to set for 10 minutes to let it dry. After staff use a lift, they have to walk down to the clean utility room, get a bottle of the spray, walk back to the room with the lift, spray it, set the timer, and take the spray back to the clean utility room. I did not clean the lift this morning after I used it with (R98). There is Covid on her unit." In an observation on 9/11/23 at 1:16 PM., noted 2 sit to stand lifts (lift that assist residents to stand and transfer) parked on the 400 unit near room 433. The bases (where residents plant their feet) of the lifts were noted to be soiled with dust, debris and food crumbs. There were no sanitizing wipes near or attached to the lifts. In an observation on 9/11/23 at 3:09 PM., noted	F880		

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F880	Continued From page 99 2 sit to stands parked on the 400 unit near room 433. The bases of the lifts were noted to be soiled with dust, debris and food crumbs. A dark brown dried smeared substance was noted on the knee area of one of the lifts. There were no sanitizing wipes near or attached to the lifts. In an observation 09/12/23 at 3:00 PM., noted 2 sit to stands parked on the 400 unit near room 433. The bases (where residents plant their feet) of the lifts were noted to be soiled with dust, debris and food crumbs. A dark brown dried smeared substance was noted on the knee area. There were no sanitizing wipes near or attached to the lifts. In an observation on 9/12/23 at 3:03 PM., noted a sit to stand lift parked outside room 417. The base of the lift was noted to be soiled with dust, debris and food crumbs. There were no sanitizing wipes near or attached to the lifts. During an interview on 9/12/23 at 4:10 PM., "Registered Nurse" (RN) "F" reported resident shared equipment should be cleaned and sanitized between uses. RN "F" reported staff members using the equipment to transfer residents get the sanitizing spray from the utility room. RN "F" reported the utility rooms are locked but each staff has access to the utility rooms. RN "F" reported she was unsure how long the "sanitizing spray" was suppose to have contact (stay wet/contact time needed to destroy contaminates-harmful organisms). In an observation on 9/13/23 01:08 PM., noted a sit to stand lift parked outside room 430. The base of the lift was noted to be soiled with dust, debris and food crumbs. there were no sanitizing wipes near or attached to the lifts.	F880		

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	235088	A. BUILDING _____ B. WING _____	C 09/14/2023

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F880	Continued From page 100 In an observation on 9/13/23 01:16 PM., noted 2 sit to stand lifts parked outside room 434. Both lift bases were soiled with dust, debris and food crumbs. Noted on one of the lifts was a brown smeared dried substance on the knee pad area. During an interview on 9/13/23 at 3:16 PM., "Certified Nurse Aide" (CNA) "PP" reported resident shared equipment should be cleaned and sanitized between each use. CNA "PP" reported there are disinfectant spray bottles in the utility rooms along with clean clothes. CNA "PP" reported the lifts do not get wiped down every time they are used, because the spray cleaner that was used to clean the lifts takes 15 minutes to "disinfect". CNA "PP" reported the staff are suppose to sanitize/clean the lifts, but they "might" be cleaned once a week or so, but she (CNA "PP") wasn't sure. CNA "PP" reported she does not always wipe the lifts between uses because "15 minutes" was too long to wait for sanitizing time and staff are too busy with resident call lights and transfers to the bathroom when residents call for assistance. Review of a facility "Policy and Procedure" dated 11/12/21 revealed: "Disinfection of Multiuse Durable Medical equipment .... POLICY...PURPOSE ...Durable medical equipment (DME) shall be cleaned and disinfected routinely and following resident use .... PROCEDURE 1. Disinfection solutions shall be high level germicides and shall be used in accordance with manufacturers' labeled use and directions. 2. Protocols for disinfection of DME should be in accordance with Organizational procedure. 3. Disinfection is to prevent cross-contamination and transmission of disease. 4. Cleaning and disinfection of DME should be after resident use. 5. DME is for SINGLE RESIDENT USE and then it must be	F880		

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F880	Continued From page 101 shall be cleaned/disinfected should include (but not limited to): iv poles, electronic and mechanical infusion devices, non-disposable infusion related equipment, bladder scanners, vital machines, lifts, etc. 7. The assignment of cleaning/disinfection responsibility shall be completed by assigned nursing staff ..." Personal Laundry Carts/Laundry In an observation and interview on 9/12/2023 at 3:58 PM, Laundry Employee "OO" delivered personal laundry to resident rooms in the rehabilitation unit using a rolling laundry cart that was open to the air and not enclosed. Resident specific laundry was hanging from the cart, separated by resident. Laundry Employee "OO" reported it was not the facility process to use enclosed carts for delivery of personal laundry to the units. In an interview on 9/14/2023 at 10:01 AM, Environments Services (ES) Director "J" reported covers were used to deliver general laundry carts to the units to keep laundry clean. ES Director "J" reported the facility had never used covered carts when delivering clean resident specific laundry to the units. ES Director "J" reported it made sense to use covered carts when delivering resident specific laundry to the units. Observed on 9/12/2023 at 3:45 PM clean laundry consisting of shirts and slacks on hangers, hanging on doors labeled with Transmission-Based Isolation Precautions signage, straight backed chairs in the hall between rooms 206/207, and on top of isolation cart in front of rooms 206/207.	F880		

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F880	Continued From page 102 During an observation on 9/12/23 at 3:49pm, clean personal resident laundry was left sitting on top of the Personal Protective Equipment (PPE)cart outside of Room #305 (isolation room). During an observation on 9/12/23 at 3:52pm, clean personal resident laundry was left hanging from the PPE cart, clothing items rested against the cart, outside room #312/#313 (isolation rooms). In an interview on 9/14/23 at 10:32am, Infection Preventionist (IP) "M" confirmed that resident laundry being left on PPE carts posed a risk of cross contamination because the laundry was touching the PPE cart and left open to air PPE/Mask use/Hand Hygiene During an observation on 9/11/2023 at 12:00 PM Birch unit of 36 residents had 4 positive residents with Covid-19. On their doors were Transmission-Based Airborne Precautions signage. No other signage was on the door. During an observation on 9/11/23 at 1:05 PM, Medical Director "XX" entered Birch unit wearing a blue surgical mask, stopped and spoke to a resident in the hall outside of rooms 206-207, and entered the nursing station. During an interview on 9/11/23 at 1:20 PM, CNA "KK" stated, "There is Covid on the building. All staff are to wear N95 masks. Fit-tested N95 masks when entering a Covid positive resident's room." During an observation and interview on 9/11/23 at 1:24 PM, observed LPN "JJ" administering	F880		

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F880	Continued From page 103 medications to a resident in the 200 hall of Birch Unit wearing a blue surgical mask. LPN stated, "There is Covid on the unit. I am the nurse for the unit. We were told that we had to wear fitted N95 when in a room with Covid but can wear these ones, surgical masks, when out on the unit." During an interview on 9/11/23 at 1:27 PM, Housekeeping (HSKG) "T", stated, "When staff are on a Covid positive unit we are to wear a N95 mask." During an observation on 9/11/23 at 1:29 PM, LPN "JJ" was wearing a blue surgical mask entered resident room 214. During an observation on 9/11/23 at 1:35 PM, LPN "JJ" was wearing a blue surgical mask at his medication cart next to the "circle area" (where the 4 halls of Birch Hall met). There were multiple vulnerable residents sitting in the area which made it congested. During an observation and interview on 9/11/23 01:42 PM, two staff were donning (putting on) PPE for rooms 206 and 207 that were designated as Transmission-Based Airborne Precautions. CNAs "KKK" and "CC" stated, "All staff on this unit are to wear N95 masks whether they are in a resident room or out in the hall." It was noted there was no other Transmission-Based Precautions signage on the Covid-19 positive resident door. It is further noted, staff were to wear fit-tested N95 masks when entering a Covid-19 positive resident room. During an observation and interview on 9/12/23 at 8:20 AM rooms 203 and 204 had an isolation cart outside the rooms and Transmission-Based Airborne Precautions (TBP) signage on the	F880		

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F880	Continued From page 104 doors. Observed to have gowns, hand sanitizer, and gloves in the isolation cart but no N95 masks. In a paper bag that appeared to be used as evidenced by being torn and wrinkled, 3 wadded N95 masks with traces of make-up like smudges on them. CNA "LLL" stated, "When entering a TBP room you are to wear a gown, gloves, and a N95 mask. Staff just keep a N95 in their pocket and switch out when going into and come out of a TBP room. Some might keep them somewhere else." During an observation and interview on 9/12/2023 at 8:25 AM, CNA "S" was donning PPE to enter room 203 that had TBP signage on the door. The CNA had taken the paper bag out of the isolation cart and took out a used N95 mask. The CNA had on a face shield. The CNA stated, "Staff was just told by the ADON we could wear the same N95 in a Covid room, out in the halls, and into other resident rooms. We did not have to change our masks." During an observation on 9/12/2023 at 8:30 AM, Birch unit had 4 residents positive with Covid-19. On their doors were Transmission-Based Airborne Contact, and Droplet Precautions signage. The Contact and Droplet Precautions signage were not viewed there the day before, 9/11/2023. Observed on 9/12/23 at 10:18 AM, CNA "LLL" donned PPE without using hand sanitizer before donning gloves and entering rooms 206/207 with Transmission-Based Isolation Precautions signage stating to perform hand hygiene. Review of an email dated 9/13/2023 at 9:12 AM from Infection Control Preventionist (ICP) "M" stated "I am not aware of any current staff who have been exempted from their N-95 (mask).	F880		

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F880	Continued From page 105 During an observation on 9/13/23 at 10:35am, Resident #97 exited the unit via stretcher, 2 staff assisted. Resident #97 was unmasked as his stretcher was wheeled down the hallway, through a common area where several residents sat, eating their breakfast. In an interview on 9/13/23 at 10:40am, Assistant Director of Nursing (ADON) "HH" Resident #97 was being transferred to the hospital due to increased sputum, coughing and shortness of breath. ADON "HH" reported the resident should have worn a mask in communal areas of the facility. During an observation on 9/13/23 at 2:38pm, Registered Nurse (RN) "NN" exited room #236, a room under isolation precautions, while wearing a potentially soiled personal protective gown, gloves, N95 mask and face shield and walked to the personal protective equipment (PPE) cart in the corridor. RN "NN" opened the vinyl covering of the cart with gloved hands, moved clean gowns aside and retrieved a new red biohazard waste bag for use in the isolation room, then returned to the room. In an interview on 9/13/23 at 2:40pm, Registered Nurse (RN) "NN" reported she should not have exited an isolation room while wearing potentially soiled personal protective equipment (PPE) due to the risk of cross contamination. RN "NN" reported she did not follow proper isolation precautions in that situation because there was not an efficient process for her to get a new biohazard bag. In an interview on 9/14/23 at 10:32am, Infection Preventionist (IP) "M" reported staff should doff PPE prior to exiting a resident room to avoid	F880		

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F880	Continued From page 106 possible transfer of pathogenic organisms. During an interview on 9/14/2023 at 9:22 AM, Assistant Director of Nursing (ADON) "UU" stated, "I am the Unit Manager for Birch Hall. There are 36 residents on the unit. Right now, on this unit there are 5 residents that have tested positive for Covid-19 with another resident in the hospital because of Covid-19. Hand hygiene should be done before entering and after exiting a resident's room, and donning/doffing (putting on and taking off) gloves and gowns. Hand hygiene should be the #1 concern of all staff. All staff should be wearing a N95 mask while the facility has an outbreak of Covid-19. All staff should be wearing a fit-tested N95 when entering a resident's room that has test positive for the virus and when entering their roommate's/suitemate's area. (LPN "JJ) came to me and told me he did not know he had to wear a N95 mask on the unit and a fit-tested N95 in a Covid-19 positive resident room. I sent all staff on my unit an email on what masks were required, he should have known. I heard (Medical Director "XX") wore a surgical mask when walking through the unit on the first day of survey (9/11/2023). (Infection Control Preventionist (ICP "M") clarified with signage on Covid-19 positive resident doors on what PPE had to be worn when entering the room. The first day of survey, there was only airborne precautions signage on the doors, there should have been droplet precautions signage on the doors, so staff had on all the PPE required to keep them, the resident, and all residents safe. When clean laundry is delivered, it should not be left outside a resident's room, on a chair, hanging on the outside of a door, or on the isolation cart just because the resident has Covid-19. Laundry aides can put on PPE just like any other staff to go in an isolation room.	F880		

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F880	Continued From page 107 Resident-shared equipment should be cleaned in-between resident use. When staff get done using the equipment, they must go to the soiled utility room, get a spray bottle of Neutral Quat disinfectant, go back to the equipment, spray on the disinfectant and wait for 10-15 minutes before that equipment can be used on the next resident. The spray has to be taken back to the soiled utility room. There are 36 residents on this unit (Birch) and quite a few of them require lifts and sit-to-stands devices for transfers. There are 2 mechanical lifts and I think 2 sit-to-stands on the unit." During an observation on 9/13/23 at 9:31 AM, Certified Nursing Assistant (CNA) "KK" was assisting Resident #106, Resident #16, and Resident #1 in the Cherry Sunroom Dining Room. CNA "KK" had assisted Resident #16 to eat by grabbing his dining utensils and placing a few spoonfuls of food to Resident #16's mouth. CNA "KK" then wiped off Resident #16's mouth with a napkin, and rolled the chair she was sitting on over to Resident #1's table. It was noted that Resident #1 had attempted to grab at his silverware before CNA "KK" came over to assist Resident #1. CNA "KK" then picked up Resident #1's dining utensils and placed a few spoonfuls of food to Resident #1's mouth. CNA "KK" did not sanitize her hands in between contact with Resident #16 and Resident #1. CNA "KK" then rolled the chair she was sitting in over to Resident #106 and grabbed Resident #106's dining utensils and placed a few spoonfuls of food to Resident #106's mouth. CNA "KK" did not sanitize her hands in between contact with Resident #1 and Resident #106. CNA "KK" then returned to Resident #16 and grabbed his dining utensils to place a few spoonfuls or food to Resident #16's mouth. CNA	F880		

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F880	Continued From page 108 "KK" did not sanitize her hands in between contact with Resident #106 and Resident #16. During an interview on 9/13/23 at 9:48 AM, CNA "KK" reported that if she was the only person touching residents silverware, it was not necessary to sanitize her hands in between contact with each resident. During an interview on 9/13/23 at 10:33 AM, ADON "HH" reported that staff should be sanitizing their hands in between resident contact, even if the staff member was the only person touching the resident's silverware. Review of facility policy "DISINFECTION OF MULTIUSE DURABLE MEDICAL EQUIPMENT " dated 11/12/21, revealed, "PURPOSE Durable medical equipment (DME) shall be cleaned and disinfected routinely and following resident use...Disinfection is to prevent cross-contamination and transmission of disease ...Cleaning and disinfection of DME should be after resident use ...Equipment that shall be cleaned/disinfected should include (but not limited to): iv poles, electronic and mechanical infusion devices, non-disposable infusion related equipment, bladder scanners, vital machines, lifts, etc." According to 3M (Trademark) Neutral Quat Disinfectant Cleaner Concentrate 23A, 23H and 23L Ver C.fm, "3M (Trademark) Neutral Quat Disinfectant Cleaner Concentrate Disinfection/Cleaning/Deodorizing Directions ...For sprayer applications, use a coarse spray device. Spray 6-8 inches from the surface; rub with a brush, cloth or sponge ...Let solution remain on surface for a minimum of 10 minutes ... For SARS-CoV-2, treated surfaces must	F880		

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E000	Initial Comments On September 11 - 12, 2023, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Grand Traverse Pavilions was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E000		
E025 SS=F	Arrangement with Other Facilities CFR(s): 483.73(b)(7) 403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 460.84(b)(8), 482.15(b)(7), 483.73(b)(7), 483.475(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at 418.113(b), PRFTs at 441.184,(b) Hospitals at 482.15(b), and LTC Facilities at 483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.	E025	1. a. Corporate names on the transfer agreements were updated on 10/6/23. b. Memorandums of understanding will be updated by 10/06/23. 2. An annual review of the emergency preparedness manual has been scheduled through our work order system to ensure all information is up to date. 3. All staff responsible for updating the emergency preparedness manual will be in-serviced on the protocol for updates by 10/6/23. 4. The Environmental Services Director will perform annual reviews of the emergency preparedness manual. 5. The Environmental Services Director will ensure compliance.	10/6/23

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	Electronically Signed	10/06/2023

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E025	Continued From page 1 *[For PACE at 460.84(b), ICF/IIDs at 483.475(b), CAHs at 486.625(b), CMHCs at 485.920(b) and ESRD Facilities at 494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at 403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop arrangements with other LTC facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. This deficient practice could affect all occupants in the event of an emergency. Findings Include: On September 11, 2023 between the hours of 2:15 PM and 3:45 PM, record review of facility transfer agreements and contact information revealed two facilities had a previous corporate name still listed in the contact information of the plan. The two corporations listed are no longer under the same corporation name. In addition, record review at this time of multiple	E025		

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	235088	A. BUILDING _____ B. WING _____	09/12/2023

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E025	Continued From page 2 memorandum of understandings (MOUs) between multiple facilities revealed they were established in 2006, 2012, and 2014, respectively, and no evidence was provided to show MOUs were reviewed recently and still in place. This finding was confirmed by the Environmental Services Director and Environmental Services Manager via interview at the time of record review.	E025		

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K000	INITIAL COMMENTS On September 11 - 12, 2023, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Grand Traverse Pavilions was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility is a 2 story building of type II (111) construction, built in 1997. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 240 certified beds. At the time of the survey the census was 138. The requirement at 42 CFR, subpart 483.90(a) is NOT MET as evidenced by:	K000		
K222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the	K222	1. a. The delayed egress door sign on the Birch resident unit rear egress door was replaced on 10/6/23. b. The delayed egress door sign on the Dogwood resident unit rear egress door was replaced on 10/6/23. c. The delayed egress door sign on the Cherry resident unit rear egress door was replaced on 10/6/23. 2. Inspection of the door signs has been added to the existing work order for	10/6/23

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K222	Continued From page 1 clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING	K222	the quarterly testing of the delayed egress door operation. 3. Maintenance staff will be in-serviced on the door signage requirements by 10/6/23. 4. Environmental Services Director will conduct periodic inspections of the facility and assure quarterly inspections have been completed. Any concerns identified will be addressed immediately. The ES Director will report the findings of the inspections to the QAPI Committee quarterly. 5. The Environmental Services Director will ensure compliance.	

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K222	Continued From page 2 ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors in a required means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side unless meeting the special locking arrangements for clinical needs in accordance with 19.2.2.2.5.1 and 19.2.2.2.6, special needs locking arrangements in accordance with 19.2.2.2.5.2, delayed egress locking in accordance with 19.2.2.2.4, access-controlled egress doors in accordance with 19.2.2.2.4, or elevator lobby exit access in accordance with 19.2.2.2.4. This deficient practice could affect approximately 110 out of 240 occupants in the event of a fire emergency. Findings Include: 1. On September 12, 2023, at approximately 9:40 AM, observation revealed the Birch resident unit rear egress door has a 15 second delayed egress locking system and the required sign stating, push until alarm sounds door can be opened in 15 seconds was unreadable due to fading per NFPA 101, 7.2.1.6.1 (4). 2. On September 12, 2023, at approximately 10:00 AM, observation revealed the Dogwood resident unit rear egress door has a 15 second delayed egress locking system and the required	K222		

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K222	Continued From page 3 sign stating, push until alarm sounds door can be opened in 15 seconds was unreadable due to fading per NFPA 101, 7.2.1.6.1 (4). 3. On September 12, 2023, at approximately 9:50 AM, observation revealed the Cherry resident unit rear egress door has a 15 second delayed egress locking system and the required sign stating, push until alarm sounds door can be opened in 15 seconds was unreadable due to fading per NFPA 101, 7.2.1.6.1 (4). These findings were confirmed through interview with the environmental services director at the time of observation.	K222		
K271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure exit discharge was arranged in accordance with 7.7, provides a level walking surface in accordance with 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface as required by 18.2.7, 19.2.7. This deficient practice could affect approximately 76 out of 240 occupants in the event of a fire	K271	1. a. The exterior path of egress in the Rehab resident unit to the public way was cleared of obstructions on 9/14/23. b. The exterior path of egress in the Aspen resident unit to the public way was cleared of obstructions on 9/14/23. 2. A monthly work order has been created to inspect the egress walkway on all exits from the building to the public way, to ensure an obstruction free path. 3. Environmental Services Staff will be in-serviced on the requirement to always keep the exterior paths of egress clear to the public way by 10/6/23. 4. Environmental Services Director will conduct periodic inspections of the facility and assure monthly inspections have been completed. Any concerns identified will be addressed immediately. The ES Director will report the findings of the inspections to the QAPI Committee quarterly. 5. The Environmental Services Director will ensure compliance.	10/6/23

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K271	Continued From page 4 emergency. Findings Include: 1. On September 12, 2023, at approximately 11:10 AM, observation revealed the facility failed to maintain the egress walkway free of obstructions located at the south exit from Rehabilitation resident unit to the public way. The walking surface had overgrown vegetation causing an unsafe walking surface to traverse per NFPA 101, 7.1.6. 2. On September 12, 2023, at approximately 12:45 PM, observation revealed the facility failed to maintain the egress walkway free of obstructions located at the north exit from Aspen resident unit to the public way. The walking surface had overgrown vegetation causing an unsafe walking surface to traverse per NFPA 101, 7.1.6. These findings were confirmed through interview with the environmental services director at the time of observation.	K271		
K324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or	K324	1. The kitchen equipment was placed in the proper locations on 9/14/23. 2. Inspection of the kitchen equipment has been added to the monthly owners hood inspection checklist. 3. Maintenance staff will be in-serviced on the requirement of keeping the equipment in the proper locations by 10/6/23. 4. Environmental Services Director will conduct periodic inspections of the facility and assure monthly inspections have been completed. Any concerns identified will be addressed immediately. The ES Director will report the findings of the inspections to the QAPI Committee quarterly.	10/6/23

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K324	Continued From page 5 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure cooking facilities are protected in accordance with NFPA 96, unless meeting the requirements of 19.3.2.5.2, 19.3.2.5.3 or 19.3.2.4.4, as required by 19.3.2.5.1 through 19.3.2.5.5, 9.2.3 and TIA 12-2. This deficient practice could affect 240 out of 240 occupants in the event of a fire emergency. Findings Include: On September 12, 2023, at approximately 10:15 AM, observation revealed the kitchen cooking equipment at hood #1 was not in line with the hood suppression nozzles. This could affect the ability for the hood suppression system to extinguish a fire as designed. These findings were confirmed through interview with the environmental services director at the time of observation.	K324	5. The Environmental Services Director will ensure compliance.	
K353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K353	1. A written inventory list of the types of sprinkler heads in the spare sprinkler boxes was completed on 10/6/23. 2. A quarterly work order has been created to review the spare sprinkler head inventory. 3. Maintenance will be in-serviced on the spare sprinkler head requirements	10/6/23

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K353	Continued From page 6 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the automatic sprinkler and standpipe systems are inspected, tested and maintained in accordance with NFPA 25, and records are readily available as required by 9.7.5, 9.7.7, 9.7.8 and NFPA 25. This deficient practice could affect 240 out of 240 occupants in the event of a fire emergency. Findings Include: On September 12, 2023, at approximately 11:15 AM, observation revealed there was no written inventory list of all types of sprinkler heads located in the three spare sprinkler boxes per NFPA 13, 6.2.9.7. These findings were confirmed through interview with the environmental services director at the time of observation.	K353	by 10/6/23. 4. Environmental Services Director will conduct quarterly reviews of the fire suppression inspection reports. Any concerns identified will be addressed immediately. The ES Director will report the findings of the inspections to the QAPI Committee quarterly. 5. The Environmental Services Director will ensure compliance.	
K363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors	K363	1. a. The latching mechanism on resident room 230/231 was repaired on 9/12/23.	10/6/23

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K363	Continued From page 7 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K363	b. The latching mechanism on resident room 222/223 was repaired on 9/12/23. c. The latching mechanism on resident room 212/213 was repaired on 9/12/23. d. The black tape over the latching mechanism on resident room 327 was removed on 9/12/23. e. The latching mechanism on resident room 620/621 was repaired on 9/12/23. 2. An inspection step has been added to the existing monthly room inspection work order to inspect the latching mechanisms on resident doors to ensure proper latching. 3. All staff will be in-serviced on the requirement of proper door latch operation by 10/6/23. 4. Environmental Services Director will conduct periodic inspections of the resident door latches and assure monthly inspections have been completed and properly documented. Any concerns identified will be addressed immediately. The ES Director will report the findings of the inspections to the QAPI Committee quarterly. 5. Environmental Services Director will Ensure compliance.	

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K363	Continued From page 8 failed to ensure doors protecting corridor openings in other than required enclosures of vertical openings, exits or hazardous areas are 1 3/4 inch solid-bonded core wood or capable of resisting the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed as required by 19.3.6.3, and 42 CFR 403, 418, 460, 482, 483 and 485. There is no impediment to the closing of doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. This deficient practice could affect all occupants in the event of a fire. Findings Include: 1) On September 11, 2023 at approximately 1:24 PM, observation revealed the latching mechanism of resident room 230/231 failed to achieve a positive latch when tested. 2) On September 11, 2023 at approximately 1:26 PM, observation revealed the latching mechanism on resident room 222/223 failed to achieve a positive latch when tested.	K363		

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K363	Continued From page 9 3) On September 11, 2023 at approximately 1:29 PM, observation revealed the latching mechanism on resident room 212/213 failed to achieve a positive latch when tested. 4) On September 11, 2023 at approximately 1:31 PM, observation revealed black tape over the latching mechanism on resident room 327 preventing the door from achieving a positive latch when tested. 5) On September 11, 2023 at approximately 1:32 PM, observation revealed the latching mechanism of resident room 620/621 failed to achieve a positive latch when tested. These findings were confirmed by the Environmental Services Director and Environmental Services Manager via interview at the time of observation.	K363		
K711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by:	K711	1. All dietary staff will be in-serviced on fire safety by 10/6/23. 2. All dietary staff will have quarterly fire safety in-services as a requirement of employment. 3. Of the quarterly fire drills we currently run in the facility, a sub-set of at least two of these drills will be performed in the kitchen to ensure dietary staff know the proper fire procedures. 4. Environmental Services Director will conduct periodic reviews of the dietary staff training records. Any concerns identified will be addressed immediately. The ES Director will report the findings of the inspections to the QAPI Committee quarterly. 5. The Environmental Services Director will ensure compliance.	10/6/23

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K711	Continued From page 10 Based on observation and interview, the facility failed to ensure there is a written plan for the protection of all residents and for their evacuation in the event of an emergency, employees are periodically instructed in their duties under the plan, the plan is readily available, addresses the basic response required by staff and provides all components as required by 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2 and 19.7.2.3. This deficient practice could affect all occupants in the event of a fire. Findings Include: On September 12, 2023 at approximately 10:24 AM, observation and interview revealed the contracted kitchen staff failed to demonstrate and explain appropriate action to take in the event of a kitchen grease fire. During interview, a kitchen cook (identified as "FS1" who has been employed at this facility for approximately 3 weeks) was asked if they have received any fire safety training since their date of hire. FS1 responded, "no". In addition, on this date at approximately 10:26 AM, interview with a kitchen food prep worker (identified as "FS3" who has been employed at this facility for approximately 8 months) was asked, "how would you respond if there was a grease fire on the stove?" FS3 responded, "...I would grab the fire extinguisher...". FS3 was then asked, "what fire extinguisher would you grab?". FS3 then walked and pointed to the Class ABC extinguisher. FS3 was unaware of the Class K fire extinguisher and made no mention of activating the remaining portions of the established fire response plan. Additionally, FS3 was asked if they have received any fire	K711		

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K711	Continued From page 11 safety training since their date of hire. FS3 responded, "no". This finding was confirmed by the Environmental Services Director and Environmental Services Manager via interview.	K711		
K916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure a remote annunciator that is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator as required by 6.4.1.1.17, 6.4.1.1.17.5, NFPA 99. This deficient practice could affect 240 out of 240 occupants in the event of an electrical failure requiring emergency generator power. Findings Include: On September 12, 2023, at approximately 9:15	K916	1. Generator Annunciator was moved on 10/6/23 to the Birch pavilion common area. 2. A facility work order has been created to inspect the annunciator quarterly to ensure proper operation and that the location is occupied 24 hours per day. 3. All staff will be in-serviced on the function of the generator annunciator and its importance in our operation by 10/6/23. 4. Environmental Services Director will conduct periodic inspections of the generator annunciator and assure quarterly inspections have been completed and properly documented. Any concerns identified will be addressed immediately. The ES Director will report the findings of the inspections to the QAPI Committee quarterly. 5. Environmental Services Director will assure compliance.	10/6/23

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K916	Continued From page 12 AM, observation revealed the generator remote annunciator panel for the installed generator is not installed at a location readily observed by operating personnel at a regular workstation as required by NFPA 99, 6.4.1.1.17, NFPA 110, 5.6.6 and NFPA 70. The facility has two generator remote annunciators, one in the electrical room and one in Aspen resident unit nurse's station. Aspen resident unit was unoccupied with residents and staff at the time of survey. These findings were confirmed through interview with the environmental services director at the time of observation.	K916		
K920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.	K920	a. The extension cord was removed from the CDN office on 9/14/23. b. The extension cord was removed from the HR reception desk on 9/14/23. c. The multi-plug outlet adapter was secured to the wall in the Dogwood Social Workers Office on 9/14/23. d. The multi-plug outlet adapter was secured to the wall behind the decorative fireplace in Dogwood unit on 9/14/23. e. The extension cord was removed from the Physical Therapy Main Directors office on 9/14/23. 2. A facility work order has been created to survey the building quarterly to ensure there are no extension cords in use, and any multi-plug adapters are secured properly. 3. All staff will be in-serviced in the use of extension cords and power strips by 10/6/23. 4. Environmental Services Director will conduct periodic inspections of the facility and assure quarterly inspections	10/6/23

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K920	Continued From page 13 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure power strips are listed for the area in which they are used as required by 10.2.3.6 of NFPA 99, 400-8 of NFPA 70 and TIA 12-5, and extension cords are placed in use only temporarily as required by 10.2.4 of NFPA 99 and 590.3(D) of NFPA 70. This deficient practice could affect approximately 10 out of 240 occupants in the event of a fire emergency. Findings Include: 1. On September 12, 2023, at approximately 10:24 AM, observation revealed CDN office was using an extension cord to power a fan mounted to the wall. Extension cords are for temporary use only. 2. On September 12, 2023, at approximately 10:42 AM, observation revealed HR reception desk had an extension cord plugged into a power strip powering computer equipment. Extension cords are for temporary use only. 3. On September 12, 2023, at approximately 9:47 AM, observation revealed a multi-plug adapter hanging from the power cord and not properly mounted under the desk in the Dogwood Social Workers Office. 4.On September 12, 2023, at approximately 9:49 AM, observation revealed a multi-plug adapter hanging from the power cord and not properly mounted/secured behind the decorative fire place in Dogwood unit. 5.On September 12, 2023, at approximately 11:	K920	have been completed and properly documented. Any concerns identified will be addressed immediately. The ES Director will report the findings of the inspections to the QAPI Committee quarterly. 5. Environmental Services Director will assure compliance.	

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K920	Continued From page 14 06 AM, observation revealed an extension cord powering a multi-plug adapter in the Physical Therapy Main Directors office. Extension cords are not a substitute for permanent wiring and multi-plug adapters must be plugged directly into the wall receptacle. These findings were confirmed through interview with the environmental services director at the time of observation.	K920		
K923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES)	K923	1. The unsecured oxygen cylinders were secured in a metal rack on 9/14/23. 2. A facility work order has been created to inspect the oxygen storage area monthly to ensure all tanks are secured. 3. Environmental Services staff will be in-serviced in the storage of oxygen cylinders by 10/6/23. 4. Environmental Services Director will conduct periodic inspections of the oxygen storage area and assure monthly inspections have been completed and properly documented. Any concerns identified will be addressed immediately. The ES Director will report the findings of the inspections to the QAPI Committee quarterly. 5. Environmental Services Director will assure compliance.	10/6/23

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K923	Continued From page 15 STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure storage of nonflammable gasses meet all requirements of 11.3.1 through 11.3.4 and 11.6.5 of NFPA 99. This deficient practice could affect more than an isolated number of occupants. Findings Include: On September 12, 2023 at approximately 12:39 PM, observation revealed three unsecured oxygen cylinders in the outdoor oxygen storage area. This finding was confirmed by the Environmental Services Manager via interview at the time of observation.	K923		
K925 SS=E	Gas Equipment - Respiratory Therapy Sources CFR(s): NFPA 101 Gas Equipment - Respiratory Therapy Sources of Ignition Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within	K925	1. a. The oxygen concentrator in resident room 329 was turned off on 9/11/23. b. The oxygen concentrator in resident room 424 was turned off on 9/12/23. 2. All residents that use oxygen concentrators have the potential to be	10/6/23

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K925	Continued From page 16 in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure when oxygen is being used, all sources of ignition are eliminated as required by 11.5.1.1 and TIA 12-6 of NFPA 99. This deficient practice could affect more than an isolated number of occupants in the event of a fire. Findings Include: 1) On September 11, 2023, at approximately 1:30 PM, observation revealed an oxygen concentrator in resident room 329 was left on while the resident was not in the room. The oxygen was being delivered through oxygen tubing and the oxygen was flowing into the room unattended. This practice puts an oxygen rich environment in the room and susceptible static and electrical sources for ignition. 2) On September 12, 2023, at approximately 9:55 AM, observation revealed an oxygen concentrator in resident room 424 was left on while the resident was eating breakfast. The oxygen was being delivered through oxygen tubing laying on the residents bed and the oxygen was flowing into the room unattended.	K925	affected. 3. Nursing and certified nurse aides will be in-serviced by 10/6/23 to turn the concentrator off once the resident has transitioned to using a portable oxygen tank. Upon their return to the room, the staff will need to turn on the concentrator, wait for the indicator light to show that the concentrator is ready to be used, and then transition the patient to the concentrator. 4. The pavilion ADONs and management staff will observe the residents room to ensure the concentrators are not running with them not in the room. Concerns will be addressed immediately. The results of these audits will be provided to the QAPI committee for further review. 5. The pavilion ADONs will ensure compliance.	

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K925	Continued From page 17 This practice puts an oxygen rich environment in the room and susceptible static and electrical sources for ignition. These findings were confirmed by the Environmental Services Manager via interview at the time of observation.	K925		

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