STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235327	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Hudsonville (the)	3650 Van Buren Hudsonville, MI 49426

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on interview and record review, the facility failed to designate a legal surrogate for the purpose of healthcare decision-making for one (Resident #82) of 2 residents reviewed for advance directives. Findings include: Review of a Face Sheet revealed R82 admitted to the facility on [DATE]. Review of a Statement of Capacity signed by two different physicians on 6/10/24 and 6/17/24 for R82 revealed the resident is incapable and unable to make her own informed medical decisions. Review of the Electronic Medical Records for R82 revealed there is no legal surrogate appointed to represent the resident. In an interview on 8/13/24 at 11:53 AM, the Director of Social Services (SW) H reported R82's daughter is to bring in paperwork showing she is the legal guardian. She is here all the time visiting R82 but still has not brought it in. SW H reported it is a concern and if they don't have the appropriate documentation, they need to pursue a court appointed guardian.

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are fully informed and understand their health status, care and treatments. 31771 Based on interview and record review, the facility failed to ensure the responsible party for one cognitively impaired resident (R38) of five residents reviewed for antipsychotic medication had been informed of the risks and benefits of an antipsychotic medication and consented to its administration. Findings: R38 originally admitted to the facility 10/5/23 with diagnoses that included bipolar disorder and dementia with psychotic disturbance. The Electronic Medical Record (EMR) reflected a Power of Attorney (POA) for care was in place as R38 was not able to make any medical decisions. Review of the Doctor's Orders for R38 revealed a current order for the antipsychotic medication Lurasidone with a start date of 3/6/24. During a review of the EMR no documentation was located that a Risk versus Benefit for this medication had been completed and conveyed to the Resident's POA. No documentation was found that reflected the POA had consented to the administration of this antipsychotic medication to R38. On 8/14/24 at 10:34 AM the Director of Nursing (DON) was asked for documentation that the POA for R38 had been informed of the risks and benefits and had consented to the use of Lurasidone. On 8/14/24 at 11:48 AM the facility provided documentation from the physician dated 7/17/24 (untimed) that reflected The black box warning for this class of medication has been reviewed and based upon a risk/benefit analysis continued use of this medication is indicated at this time. The Physician's entry did not reflect the POA had been informed of the risks and benefits and had consented to the use of this antipsychotic medication when the medication was started on 3/6/24. On 8/14/24 at 1:23 PM the DON was informed that the documentation provided did not reflect the POA for R38 had been informed or consented to the use of Lurasidone at the onset of the Doctor's Order. The DON indicated further review would be conducted. On 8/14/24 at 2:17 PM the Nursing Home Administrator (NHA) was informed that the requested documentation of a Risk versus Benefit and consent from the POA regarding the antipsychotic use for R38 had not yet been provided. The NHA reported research for this documentation was in progress. As of survey exit on 8/14/24 at 4:35 PM no further documentation had been provided by the facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on interview and record review, the facility failed to update a care plan for an active skin condition for 1 resident (Resident #5), of 22 residents reviewed for accuracy of care plans, resulting in the potential for staff to provide care that is inconsistent with the needs of the resident. Findings include: Review of an Admission Record revealed Resident #5 admitted to the facility on [DATE] with pertinent diagnoses which included dementia, diabetes, and need of assistance with personal care. Review of a Minimum Data Set (MDS) assessment for Resident #5, with a reference date of 5/21/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #5 was cognitively intact. Review of the current Care Plan for Resident #5, revised 6/6/2023, revealed Resident #5 had potential for impaired skin integrity but no care plan for active skin impairment. In an interview on 8/14/2024 at 10:30 AM, Licensed Practical Nurse (LPN) A reported Resident #5 was currently being treated for an infection of his lower legs. In an interview on 8/14/2024 at 11:32 AM, LPN E reported the unit manager typically updated care plans but had recently quit. LPN E reported she believed the Director of Nursing (DON) and MDS nurse were now responsible for keeping up care plans. In an interview on 8/14/2024 at 11:34 AM, Assistant Director of Nursing (ADON) C reviewed Resident #5's care plan and reported it had not been updated to reflect the active leg infection. ADON C reported care plans were usually updated during the morning clinical meeting, but Resident #5's leg infection had not been discussed at the clinical meeting yet. ADON C reported the Physician's Assistant (PA) did not notify the team that she was treating this infection. In an interview on 8/14/2024 at 12:13 PM, PA D reported she had notified a floor nurse that she initiated antibiotics for Resident #5's leg infection on 8/12/2024 but had not yet discussed this with the interdisciplinary team. Review of facility policy/procedure Care Planning, revised 6/24/2021, revealed .The results of interdisciplinary assessments will be used to develop, review and revise the resident's comprehensive care plans . The care plan and resident Kardex will be updated on Admission, Quarterly, Annually and with significant changes .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intake M100144434. This citation has 2 Deficient Practice Statements (DPS). DPS A Based on observation, interview and record review, the facility failed to assess, monitor, document, and notify physician of changes in condition, and follow physician orders for 1 (Resident #82) of 1 resident reviewed for quality of care, resulting in R82 admitted to the hospital. Findings include: Resident #82 (R82) Review of a Face Sheet revealed R82 admitted to the facility on [DATE] with pertinent diagnoses of chronic kidney disease, overactive bladder. In an interview on 8/13/24 at 3:36 PM, the Family Member (FM) of R82 reported she visited R82 on Friday 4/26/24 and saw the resident with her clothes on backwards and was shaking. R82 has an extensive kidney disease history and always had a foley urine catheter in place. FM of R82 requested the facility to test the resident for a urinary tract infection (UTI) and the nurse told her she would need an order from the physician. When another family member visited R82 on the following Sunday, the resident was so confused the family took her to the hospital themselves. The family thinks the hospitalization could have been avoided had they facility checked the resident for a UTI sooner and treated her. Review of Nursing Progress note dated 4/27/24 at 5:35 PM for R82 revealed she was crying with high anxiety and confusion. She was unusually incontinent of bowel and said staff members were trying to convince her she was crazy. The nurse contacted the nurse manager on duty that night and documented that a urinalysis could be taken to the hospital by the family. Review of a Nursing Progress note dated 4/28/24 at 2:34 PM for R82 revealed the facility staff were unable to obtain a urine sample. Review of a Nursing Progress note dated 4/28/24 at 6:07 PM for R82 revealed a small amount of urine was collected and the urine dip tested positive for leukocytes and nitrates. The daughter took R82 to the hospital because she was worried about a urinary tract infection (UTI). Review of a Nursing Progress note dated 4/28/24 at 8:49 PM for R82 revealed the daughter of R82 called the facility to let them know she was admitted to the hospital. Review of the Electronic Medical Records (EMR) for R82 revealed there were no nursing assessments or pertinent vital signs documented. The last temperature was checked on 4/21/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/13/24 at 4:46 PM, the Assistant Director of Nursing (ADON) reported she was the on-call nurse manager on 4/27/24 when she was notified of R82 potentially having a UTI. She reported she told the nurse to take a urine sample to the hospital on her way home that night because the lab the facility uses does not do labs on the weekends, so they must take it to the hospital. The ADON reported she would never tell the family to do this. The ADON reported she would expect the nurse to assess the resident, obtain vital signs, document the findings, and notify the physician of any concerns in changes of condition and verified this was not done. Review of the August 2024 Medication Administration Record (MAR) for R82 on 8/14/24 revealed an order for a foley catheter change once a month and was due to be changed on 8/11/24 and not documented it was done. In an interview on 8/14/24 at 2:36 PM, Licensed Practical Nurse (LPN) A reported she is taking care of R82 this day and was not aware that the resident did not have her catheter changed on 8/11/24. LPN A reported she was not told in report and the EMR did not alert her that the catheter needed to be changed because it did not show up in red. When she changed the search by dates, the task was in red and verified R82 did not get her catheter changed on 8/11/24 as ordered. LPN A reported the changing of R82s catheter should have been done to help prevent infections. 45410 DPS B Based on observation, interview, and record review, the facility failed to identify and treat wounds and skin conditions for 1 resident (Resident #5) of 2 residents reviewed for skin conditions, resulting in the potential for deterioration of skin conditions and the potential for residents to not meet their highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #5 Review of an Admission Record revealed Resident #5 admitted to the facility on [DATE] with pertinent diagnoses which included dementia, diabetes, and need of assistance with personal care. Review of a Minimum Data Set (MDS) assessment for Resident #5, with a reference date of 5/21/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #5 was cognitively intact. Further review of same MDS assessment revealed Resident #5 required assistance with personal hygiene and toileting. Review of Resident #5's Total Body Skin Assessment, dated 8/12/2024, revealed no new wounds were identified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 8/14/2024 at 10:30 AM in Resident #5's room, Resident #5 reported he had skin issues that had not been evaluated that needed to be addressed. Resident #5 reported areas on his inner thighs that were painful from chaffing, areas in the folds of his abdomen that were painful, and an area near his anus that had been hurting for months. Resident #5 reported often the care provided by Certified Nursing Assistants (CNA's) was not thorough and did not clean him well. Licensed Practical Nurse (LPN) A evaluated Resident #5's skin concerns. Resident #5 had an approximately two-inch area on his inner thigh near his groin that was reddened, his skin was split near his posterior rectum in the crease of the buttocks and was painful during evaluation, and he had reddened areas in his abdominal folds that appeared raw. These abdominal folds had a gummed up white substance in them that LPN A was unable to identify. LPN A reported she was not aware Resident #5 had these skin concerns. LPN A reported she would expect these conditions to be identified either during the weekly skin assessment or during care provided by CNA's. In an interview on 8/14/2024 at 12:13 PM, Physician's Assistant (PA) D reported she began treating Resident #5 with antibiotics on 8/12/2024 for his chronic lower leg venous stasis dermatitis but she was not aware of his other skin concerns. PA D reported she expected nursing staff to notify the medical providers with any new skin conditions or concerns. In an observation and interview on 8/14/2024 at 12:32 PM in Resident #5's room, PA D evaluated Resident #5's skin concerns on his inner thigh, buttocks, and abdominal folds. PA D reported these skin concerns appeared to have been there for a while and should have been identified during the weekly skin assessment that was performed on 8/12/2024 or during care and referred to the medical providers. In an interview on 8/14/2024 at 1:23 PM, the Nursing Home Administrator reported the facility could not find any documentation that Resident #5's skin concerns on his inner thigh, buttocks, and abdominal folds had been identified or treated prior to 8/14/2024. Review of the facility Skin Management Flow Chart, revised 10/2019, revealed .weekly skin checks by the licensed nurse . Review of the facility policy/procedure Skin Management, revised 7/19/2024, revealed .Residents with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing . A skin and wound total body skin evaluation is completed for each resident by the licensed nurse. The licensed nurse will document findings of the skin evaluation. The (Certified Nursing Assistant) will report any new skin impairment to the licensed nurse that is identified during daily care . If a new area of skin impairment is identified, notify the resident, responsible party, practitioner, DON/designee and treatment team .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 31771 Based on interview and record review, the facility failed to assess and monitor one Resident (R38) of two residents reviewed for nutrition that experienced a significant weight loss. Findings: R38 originally admitted to the facility 10/5/23 with pertinent diagnoses that included: Dementia, Morbid Obesity, Vitamin Deficiency, and Dysphagia (difficulty in swallowing). Review of the EMR weight history for R38 revealed from the date of admission, 10/5/23 to 11/1/23 a weight change from 270 pounds (lbs.) to 236.8 lbs. This reflects a loss of 33 lbs. or 12.3%. The EMR weight history reflected a six-month weight loss of 28.8 lbs. (12.16%) from 11/1/23 to 5/6/24 when the Resident weighed 208 lbs. This reflected a total weight loss since admission of 62 lbs. or 22.69%. Review of the EMR Reentry Nutritional Evaluation dated 12/7/23 reflected continued significant weight losses since admission. The documentation reflected the addition of a nutritional supplement to the Resident's diet but did not reveal a referral to the Medical Provider. The entry reflected weekly weights but the EMR did not reveal this had been implemented as the next weight after the 12/4/23 encounter is documented as 1/25/24. The entry did not reflect any further monitoring was implemented. Review of the Care Plan for R38 did not reveal a Care Planned area specifically for weight loss despite the significant change in weight. However, the Care Plan reflected the Need that (R38) is at risk for nutritional decline related to dysphagia with a Goal of .maintain weight at 227 lbs. (times) 90 days initiated 11/23/23 and revised on 12/15/23. A Care Plan intervention for this Need initiated 11/23/23 reflected Observe and evaluate weight and weight changes. Review of the EMR revealed continued weight loss beyond the initiation date of this intervention but did not reflect any further evaluations until eight months later on 7/4/24. On 8/13/24 at 4:30 PM a request was made to the Nursing Home Administrator (NHA) and the Director of Nursing (DON) for documentation the facility had identified and appropriately addressed the weight loss of R38. During an interview conducted 8/14/24 at 10:44 AM the DON reported that the weight loss experienced by R38 was desirable. The DON was asked for this documentation. On 8/14/24 at 1:18 the NHA reiterated that the weight loss of R38 was desirable. This documentation was requested. On 8/14/24 at 2:20 PM the NHA provided a Registered Dietician (RD) Progress Note dated 7/4/24 at 3:40 PM. The documentation reflected Resident triggers for significant weight loss. The Progress Note did not reflect a referral to the Medical Provider. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR documentation from 10/13/23 to 8/14/24 was reviewed. Over this span of time the review did not reveal ongoing nutritional monitoring or nursing documentation of a referral for weight loss to the Medical Provider. As of survey exit no further documentation was provided by the facility.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on observation, interview, and record review, the facility failed to ensure verification of feeding tube placement prior to medication administration according to professional standards of practice and facility policy for one resident (Resident #72), of 2 residents reviewed for care of feeding tubes, resulting in the potential for aspiration pneumonia and the potential for residents to not meet their highest practicable physical, mental, and psychosocial well-being. Findings include: Review of an Admission Record revealed Resident #72 admitted to the facility on [DATE] with pertinent diagnoses which included dementia and dysphagia (difficulty swallowing). Review of a current risk for nutritional decline Care Plan for Resident #72, with a revision date of 7/20/2023, revealed Resident #72 was dependent on percutaneous endoscopic gastrostomy (PEG, a surgical procedure that involves inserting a feeding tube directly into the stomach through the skin and stomach wall) for nutrition related to his dysphagia. Review of Resident #72's Physician's Orders, active 8/13/2024, revealed Resident #72 received periodic feedings through his PEG tube throughout the day. Review of facility policy/procedure Medications Administration-Enteral, revised 10/17/2023, revealed .To administer medications through a . G-tube . in an accurate, safe, timely, and sanitary manner . Verify placement of tube by using a piston syringe to aspirate stomach contents. Replace gastric contents after aspirating. If unable to obtain gastric secretions, hold medication and tube feeding and notify physician for further orders . In an observation on 8/13/2024 at 3:31 PM, Resident #72 was lying on his bed with the head of bed elevated and his PEG tube was clamped. Licensed Practical Nurse (LPN) B administered flushes and medication to Resident #72 via his PEG tube without first verifying tube placement by aspirating stomach contents. In an interview on 8/13/2024 at 3:35 PM, LPN B reported she checked placement of Resident #72's PEG tube earlier in the day but did not check placement prior to giving medications during this observation. LPN B reported she typically listened while flushing the line to verify placement and sometimes air bubbles come out. In an interview on 8/13/2024 at 4:00 PM, LPN B reported she reviewed the facility policy and was required to confirm placement of the PEG tube by aspirating for stomach contents prior to giving medication through the tube. In an interview on 8/13/2024 at 4:10 PM, Assistant Director of Nursing C was not able to confirm the current facility policy or procedure regarding verification of PEG tube placement prior to medication administration. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, PROCEDURAL GUIDELINES Administering Medications Through an Enteral Tube (Nasogastric Tube, G-Tube, J-Tube, or Small-Bore Feeding Tube) .10. Before administration of enteral medications, verify placement of feeding tube according to agency policy and determine that tube is placed in the stomach or small intestine correctly .19. Help patient to sitting position. Elevate head of bed to minimum of 30 degrees and preferably 45 degrees (unless contraindicated) or sit patient up in a chair (Boullata et al., 2017). 20. If continuous enteral tube feeding is infusing, adjust infusion pump setting to hold tube feeding. 21. Perform hand hygiene. Apply clean gloves. Check placement of feeding tube by observing gastric contents and checking pH of aspirate contents. Gastric pH less than 5.0 is a good indicator that tip of tube is correctly placed in stomach (Boullata et al., 2017; [NAME], 2020). 22. Check for gastric residual volume (GRV). Draw up 10 to 30 mL of air into a 60-mL syringe and connect syringe to feeding tube. Flush tube with air and pull back slowly to aspirate gastric contents. Determine GRV using either scale on syringe or a graduated container. If GRV exceeds 500 mL, hold feeding for 2 hours and recheck (Boullata et al., 2017) (check agency policy). When GRV is excessive, hold medication and contact health care provider. Some health care agencies prohibit measurement of GRV for small-bore feeding tubes ([NAME], 2020) . [NAME], [NAME] A.; [NAME], [NAME] G. ; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 651-652). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, A serious complication associated with enteral feedings is aspiration of formula into the tracheobronchial tree. Aspiration of enteral formula into the lungs irritates the bronchial mucosa, resulting in decreased blood supply to affected pulmonary tissue ([NAME] et al., 2020). This leads to necrotizing infection, pneumonia, and potential abscess formation. The high glucose content of a feeding serves as a bacterial medium for growth, promoting infection. Acute respiratory distress syndrome (ARDS) is also an outcome frequently associated with pulmonary aspiration. Some of the common conditions that increase the risk of aspiration include coughing, gastroesophageal reflux disease (GERD), cerebrovascular accident (CVA), Parkinson disease, nasotracheal suctioning, an artificial airway, decreased level of consciousness, and lying flat. Prokinetic medications such as metoclopramide, erythromycin, or cisapride promote gastric emptying and decrease the risk of aspiration (Tatsumi, 2019). Keep the head of the bed elevated a minimum of 30 degrees, preferably 45 degrees, unless medically contraindicated, during feedings and for 30 to 60 minutes after feeding ([NAME], 2018). Many institutional policies still require you to measure gastric residual volumes (GRVs) every 4 to 6 hours in patients receiving continuous feedings and immediately before the feeding in patients receiving intermittent feedings (Boullata et al., 2017). A GRV of between 250 and 500 mL could indicate delayed gastric emptying and may require you to implement measures to reduce the risk of aspiration (Boullata et al., 2017). A literature review found that enteral feedings were typically not held if the GRV was 500 mL or less ([NAME] and [NAME], 2020); however, follow your institution's policy. The North American Summit on Aspiration in the Critically Ill Patient recommends the following: (1) stop feedings immediately if aspiration occurs; (2) withhold feedings and reassess patient tolerance to feedings if GRV is over 500 mL; (3) routinely evaluate the patient for aspiration; and (4) use nursing measures to reduce the risk of aspiration if GRV is between 250 and 500 mL (Boullata et al., 2017). [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1196). Elsevier Health Sciences. Kindle Edition.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 31771 Based on interview and record review, the facility failed to identify a significant weight loss for one Resident (Resident #38 (R38) of two residents reviewed for nutrition and failed to ensure the Resident was evaluated for this weight loss by the Medical Provider. Findings: R38 originally admitted to the facility 10/5/23 with pertinent diagnoses that included: Dementia, Morbid Obesity, Vitamin Deficiency, and Dysphagia (difficulty in swallowing). Review of the Electronic Medical Record (EMR) weight history for R38 revealed from the date of admission, 10/5/23 to 11/1/23 a weight change from 270 pounds (lbs.) to 236.8 lbs. This reflects a loss of 33 lbs. or 12. 3% in less than one month. Review of the EMR Progress Notes do not reflect any documentation by staff that a significant weight change was identified and reported to the Medical Provider. Further review of the EMR weight history for R38 reflected eleven weight checks with weight loss from 236.8 lbs. on 11/1/23 to 200.2 lbs. on 6/13/24. This value reflected a weight loss since admission of 69.8 lbs. or 25. 85 %. Review of the EMR documentation from 10/13/23 to 7/17/24 was reviewed. Over this span of time the review revealed twenty Medical Provider encounter Progress Notes that included the Resident's current weight and the statement negative for weight loss. While these documented statements reflect that weight loss was addressed the entries are inconsistent with the Resident's weight history. No documentation was found in the Medical Provider's Progress Notes that acknowledged the significant weight loss or how this change impacted the Resident's health. On 8/13/24 at 4:30 PM a record request was made to the Nursing Home Administrator (NHA) and the Director of Nursing (DON) regarding the facility efforts to address the weight loss of R38. During an interview conducted 8/14/24 at 10:44 AM the DON reported that the weight loss for R38 had been desirable but did not provide any documentation to support this. On 8/14/24 at 1:18 PM the NHA reiterated that the weight loss of R38 was desirable. Documentation that the facility addressed this concern was requested. Review of the EMR Reentry Nutritional Evaluation dated 12/7/23 reflected continued significant weight losses since admission. The documentation reflected the addition of a nutritional supplement to the Residents diet. The entry also reflected weekly weights but the EMR did not reveal this had been implemented as the next weight after the 12/4/23 encounter is documented as 1/25/24. The entry did not reflect a referral had been made to the Medical Provider. (continued on next page)

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	235327	A. Building B. Wing	08/14/2024

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 2:20 PM the NHA provided a Registered Dietician (RD) Progress Note dated eight months after the previous nutrition note on 7/4/24 at 3:40 PM. The documentation reflected Resident triggers for significant weight loss. The Progress Note did not reflect a referral to the Medical Provider. Other than the above documentation the EMR did not reveal any additional documentation the significant weight change of R38 had been identified, monitored, or addressed by the Medical Provider in a timely manner. As of survey exit no additional information was provided by the facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based on interview and record review, the facility failed to address pharmacy recommendations for two Residents (R38) and (R59) of four residents reviewed for medications. R38 Review of the Electronic Medical Record (EMR) Admission Record revealed R38 originally admitted to the facility 10/5/23 with pertinent diagnoses that included dementia, dysphagia (difficulty in swallowing), and bipolar disorder. Review of the EMR reflected Pharmacy Medication Reviews with recommendations had been conducted in January and July of 2024. The EMR did not reflect these recommendations had been reviewed by the Physician. On 8/14/24 at 1:44 PM a records request was submitted to the Nursing Home Administrator (NHA) for the Pharmacy Review recommendations for R38 for January and July of 2024. In an interview and record review on 8/14/24 at 4:06 PM the Director of Nursing (DON) reported the Pharmacy recommendation of 1/3/24 for lab values to be obtained for R38 had not been reviewed by the Physician prior to the surveyor request. The DON reported that the Pharmacy recommendation of 7/8/24 for an updated Abnormal Involuntary Movement Scale (AIMS) or other appropriate assessment be completed and documented in the medical record also had not been reviewed by the Physician prior to the surveyor's request. The DON reported that orders to implement these recommendations were now in place. R59 Review of the Minimum Data Set (MDS) dated [DATE] reflected R59 admitted to the facility 3/20/23 with a pertinent diagnosis of history of a stroke. Review of the Electronic Medical Record (EMR) reflected Pharmacy Medication Reviews with recommendations for R59 had been conducted in July and August of 2024. The EMR did not reflect these recommendations were reviewed by the Physician. On 8/14/24 at 1:44 PM a records request was submitted to the Nursing Home Administrator (NHA) for the Pharmacy Review recommendations for R59 for July and August of 2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review conducted with the DON on 8/14/24 at 4:06 PM it was reported the facility process for review of Pharmacy recommendations needed revision. The DON reported the Pharmacy recommendations of July and August 2024 for R59 were not slated for review by the Physician prior to the surveyor's request. Review of these Pharmacy recommendations for R59 reflected one recommendation dated 7/8/24 for reduce the dosage of an anticoagulant. A second Pharmacy recommendation dated 8/7/24 reflected a recommendation questioning the continued need for a nutritional supplement to manage to an iron deficiency based on a lab value. The DON reported these have since been acted upon. The policy provided by the facility titled (Long Term Care) Facility Pharmacy Services and Procedure Manual , 9.1 Medication Regimen Review (MRR) last revised 6/1/24 was reviewed. The policy reflected: 8. The consultant pharmacist will provide required recipients of residents' MRRs on the MRR report to the Director of Nursing and/or the attending physician, and to the Medical Director. Facility staff should ensure that the attending physician, medical director, and director of nursing are provided with copies of the MRRs 9. Facility should encourage physician/prescriber or other responsible parties receiving the MRR and the director of nursing to act upon the recommendations contained in the MRR. And 9.1 For those issues that require physician/prescriber intervention, facility should encourage physician/prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected, as outlined in the State Operations Manual Appendix PP. And 9.2 The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it 9.2.1 If the attending physician/prescriber has decided to make no change in the medication, the attending physician should document the rationale in the residents' health record. 10. Facility should alert the medical director where MRRs are not addressed by the attending physician in a timely manner.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on interview and record review, the facility failed to maintain complete and accurate medical records for 1 resident (Resident #5) of 22 residents reviewed for accuracy of medical records, resulting in the potential for miscommunication and an unclear picture of the resident's health care status. Findings include: Resident #5 Review of Resident #5's Electronic Health Record (EHR) on 8/14/2024 at 10:20 AM revealed an antibiotic order to treat Resident 5's lower legs but no further documentation from nursing staff or medical providers regarding this skin condition. In an interview on 8/14/2024 at 11:34 AM, Assistant Director of Nursing (ADON) C reported there should be documentation in Resident #5's EHR from Physician's Assistant (PA) D regarding his lower leg infection and evaluation. ADON C reported she did not currently have documentation available regarding why antibiotics were started for Resident #5. ADON C reported PA D was pulled to another facility on 8/12/2024 and might not have been able to complete documentation. In an interview on 8/14/2024 at 12:13 PM, PA D reported she began treating Resident #5 with antibiotics on 8/12/2024 for chronic lower leg venous stasis dermatitis. PA D reported she had not yet finished documenting in the electronic medical record regarding this encounter with Resident #5. PA D reported she tried to complete documentation within two days. Review of facility policy/procedure Documentation Expectations, revised 6/21/2023, revealed .All facts and pertinent information related to an event, course of treatment, resident condition . must be documented . chart events as they occur and maintain chronological order . According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing.High-quality documentation is necessary to enhance efficient, individualized patient care. Quality documentation has five important characteristics: it is factual, accurate, complete, current, and organized . Accessed from: Kindle Locations 24106-24108). Elsevier Health Sciences. Kindle Edition.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview and record review, the facility failed to 1) have an appropriate infection surveillance program for tracking and trending infections. This deficient practice can affect all 89 residents in the facility. And 2) provide appropriate hand hygiene during a wound assessment for 1 (Resident #5) of 2 residents reviewed for skin conditions Findings include: In an interview and record review on 8/14/24 at 8:52 AM, the Director of Nursing (DON) and the Infection Preventionist/Assistant Director of Nursing (ADON) C provided their infection control surveillance tracking book. During the time of this review, the July 2024 resident infection tracking was not available because it was not done. She had a pharmacy printout of antibiotics that was ordered from the pharmacy and reported she prints out the list at the beginning of the following month to cross reference her list of residents on antibiotics. At this time, she did not have a line listing of resident infections that was current up to this date. When asked for a current list of residents on antibiotics, the ADON did not know how to collect the data. The ADON reported they have a new infection control system that is hard to explain and is non sensical. She had a map of the facility but did not track the infections and resident locations on it. The ADON confirmed that as of the time of this interview, there is no infection control tracking and trending report for July and August. Review of a Month End Operations / Antibiotics Pharmacy report for June revealed a 5-page report of residents with more than 50 orders for antibiotics, antivirals, antifungals, and anti-effectives. July 2024 revealed a six-page list of residents with more than 60 orders for antibiotics, antivirals, antifungals, and anti-effectives. The ADON reported she cross references this list to make sure all the antibiotics are accounted for in her infection control report. Review of a resident line listing Infection Surveillance Monthly Report for June 2024 revealed incomplete data collection of residents and the type of infections. The facility mapping of infections does not correlate to the line listing of resident infections. The ADON did not have an answer for why this mapping was not completed. Review of an Employee Call Off Report for June and July 2024 revealed there were more than 70 front line staff who called in sick and no tracking of what type of illness. The ADON reported she did not track and trend employee illnesses. Upon entrance to the facility on [DATE] at approximately 9:00 AM, the facility reported they had one resident in COVID isolation that was to come off isolation later this day. The DON reported a staff member came to work tested positive for COVID on 7/26/24 and waited until the end of her shift to tell the DON she was positive for COVID. The facility still uses a screening kiosk for staff to screen themselves before working. On 7/31/24 there was one resident who tested positive for COVID who was also cared for by the COVID positive staff member. There has been no other COVID positive staff or residents. The ADON could not verify what illnesses the staff who called in June and July had. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Infection Prevention Program Overview policy last revised 10/11/23 revealed: The infection prevention and control program (IPCP) must include, at minimum, the following elements: The facility establishes a program under which it: -Investigates, identifies, prevents, reports and controls infections and communicable diseases for all residents, staff, contractors, consultants, volunteers, visitors and others who provided care and services to the residents on behalf of the facility . maintains a record of incidents and corrective actions related to infections. Antibiotic Stewardship is addressed and maintained. The major activities of the program are: A. Surveillance of infections with implementation of control measures and prevention of infections. - There is ongoing monitoring to identify possible communicable diseases or infections among residents and personnel and subsequent documentation of infections that occur. - Preventing the spread of infections is accomplished by use of standard precautions and other barriers, appropriate treatment and follow-up, and employee work restrictions for illness. - Staff and resident education will focus on risk of infection and practices to decrease the risk. Policies, procedures and aseptic practices are followed by personnel in performing procedures and in disinfection of equipment. Immunizations are offered as appropriate to residents and personnel to decrease the incidence of preventable infectious diseases. B. Policy and Procedure Review and Revision - Policies and procedures for infection prevention are reviewed annually and updated as needed. Review of an Infection Prevention Surveillance policy dated 9/29/23 revealed: The Infection Preventionist does surveillance of infections among residents and employees. I. The Infection Preventionist does surveillance of healthcare-associated infections and community acquired infections by: A. Review of culture reports and other pertinent lab data. B. Chart review C. Review of the 24-hour report, or morning stand-up meeting and walking rounds throughout the facility. F. Maintenance of the employee infection record. J. Interdepartmental Surveillance. 45410 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #5 In an observation and interview on 8/14/2024 at 10:30 AM in Resident #5's room, Licensed Practical Nurse (LPN) A assessed Resident #5's skin. LPN A performed hand hygiene and donned gloves before evaluating Resident #5' inner thigh. LPN A then evaluated Resident #5's rectal area, directly touching stool covered areas with gloved hands. Without removing her gloves, LPN A then assessed Resident #5's legs, directly touching reddened and scabbed areas with the contaminated gloves. With the same gloves, LPN A then assessed Resident #5's abdominal folds, touching contaminated gloves to abdominal folds with reddened and raw areas. After care was complete, LPN A reported she should have removed gloves and performed hand hygiene after touching Resident #5's anal area.