| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235485 | A. Building<br>B. Wing | 08/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Gladwin Pines Nursing and Rehabilitation Center | 449 Quarter Street<br>Gladwin, MI 48624 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056<br><br>This citation pertains to intake # MI00141875<br><br>Based on interview and record review, the facility failed to thoroughly and promptly investigate an allegation of abuse for 1 resident (Resident #44) out of 3 residents reviewed for abuse, resulting in the potential for ongoing abuse during the investigation<br><br>Findings:<br><br>Review of the State Operations Manual revealed, Injuries of unknown source - An injury should be classified as an injury of unknown source when all of the following criteria are met:<br><br>*The source of the injury was not observed by any person; and<br><br>*The source of the injury could not be explained by the resident; and<br><br>*The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.<br><br>Resident #44<br><br>Review of an Admission Record revealed R44 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: dementia.<br><br>Review of a Minimum Data Set (MDS) assessment for R44, with a reference date of 6/18/24 revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, which indicated R44 was severely cognitively impaired.<br><br>Review of R44's Interdisciplinary Documentation dated 8/2/2024 at 6:24 PM revealed, This nurse was notified by CNA (Certified Nursing Assistant) (name omitted) that resident was complaining of pain on her left side. Resident was taken to the bathroom and a bruise was found on her left ribcage below her left arm. Bruise is tender to touch. Bruise measured and assessed. STCP (short term care plan) started. Skin assessment completed.<br><br>(continued on next page) |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R44's Skin assessment dated [DATE] at 12:42 AM revealed bruising on R44's left ribcage (back) measuring 8cm x 1cm and bruising left ribcage (back) measuring 8cm x 5cm. Resident had c/o (complaints of) pain on left back lower ribcage. found bruising, with deep purple coloring. painful to touch and movement of left arm (stretching). Pain med given.<br><br>Review of R44's Incident Report-Bruise dated 8/2/24 at 6:14 PM (received on 8/7/24 at 9:47 AM) revealed, . Nursing Description: CNA (name omitted) came up to this nurse with concern that resident was complaining of pain on her left side. CNA took resident to the bathroom and notice (sic) a bruise on her left ribcage under her arm. Bruise was assessed and measured .<br><br>Resident Description: Resident declined to describe the occurrence. (Indicating R44 was either unable to recall the injury or was fearful to report the injury) . R44's Incident Report did not reflect interviews or statements had been obtained from facility staff, residents, and/or visitors.<br><br>R44's incident report was completed approximately 18 hours following the Skin Assessment identifying the injury.<br><br>Review of R44's Electronic Health Record revealed no documentation the Director of Nursing or Nursing Home Administrator were notified of the abnormal skin assessment/injury of unknown source on 8/2/24 at 12:42 AM.<br><br>Review of R44's Interdisciplinary Documentation dated 8/7/2024 at 07:58 AM revealed, Supervisor review of an unusual occurrence that occurred on 8.2.24: (R44) is A&O x O (alert and oriented x 0-not to person, place, time, or situation). Her cognition is severely impaired as evidence by her BIMS score of 00 and supported by her diagnosis of Vascular Dementia. She is a long-term resident here related to the prior. (R44) declined to respond to responding nurse. (R44) could not recall any event when interviewed by this writer on 8.2.24, stating I don't think so. (R44) was assessed on 8.2.24. Her skin was warm, dry, pink, and intact with one notable bruise to her left ribcage. This bruise was located under her left arm. Of note, there was no bruising, or any indication of trauma or possible impact observed on her left arm, left elbow, left wrist, left hip, of left knee. She had no areas of swelling and skeletal alignment was appropriate. Upon assessment the bruising matched the location and size of gait belt placement, wrapping around the ribcage under the left arm. (R44) was assessed for psychosocial stress. (R44) did not exhibit any fearful behaviors. She was cooperative with the above assessments to the best of her ability. There are no changes observed or reported from her baseline.<br><br>(R44) is a one assist with ambulation and transfers related to her diagnosis of age-related debility and muscle weakness. Evaluation is congruent with (R44) being transferred with a gait belt on as care planned. During this time, (R44's) legs, particularly her left leg, became weak and she could no longer support her weight as seen with her history of falls. At this time, staff utilized the gait belt to regain and support (R44's) balance until the transfer was safely completed .<br><br>During an interview on 08/06/24 at 03:18 PM, Social Services Director (SSD) C reported she was not aware of R44's injury of unknown source and had not completed resident and family/visitor interviews to identify the potential for abuse. SSD C reported she did not complete ongoing psychological monitoring following the identification of the injury of unknown source.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 08/07/24 at 11:37 AM, Director of Nursing (DON) reported that R44's injury of unknown source investigation was provided in the Incident Report and there were no additional investigation documents. DON reported that on 8/2/24 the nursing staff on duty were interviewed to rule out a fall. DON reported no other residents or visitors/family were interviewed regarding the incident to rule out physical abuse and/or neglect. DON reported that she had completed a skin assessment and did not identify any other trauma related to a fall such as impact or trauma sites and that the area of bruising would have been difficult to injure with a fall. DON reported the injury was unlikely from a fall and felt the injury could have been a result of the use of a gait belt. DON reported that further investigation should have been completed to rule out other potential causes of injury (abuse). DON confirmed the injury of unknown source had not been reported to the State Agency and that the investigation was concluded the morning of 8/7/24. There was no additional information provided to support that a complete investigation had been conducted into R44's injury.<br><br>During an interview on 08/07/24 at 01:55 PM, DON reported that she began interviewing additional staff members to identify the root cause of R44's injury.<br><br>Review of the facility policy Abuse Prevention Overview last revised March 2019 revealed, .1. Alleged incidents are reported immediately to the facility administrator and to the State Agency as required and outlined in the facility policy for reporting abuse. 2. The facility will identify, correct, and intervene in situations in which abuse, neglect and / or misappropriation of resident property is more likely to occur. 3. The facility will identify and investigate all suspicion or allegations of abuse (such as suspicious bruising of residents or injury of unknown origin); reviewing occurrence, patterns and trends that may constitute abuse and will be used to determine the direction of the investigation .<br><br>Review of the facility policy Abuse/Suspected Abuse; Crime Investigation & Reporting last revised February 2023 revealed, .3. When allegations of resident (S483.5) mistreatment, abuse, crime, neglect, exploitation, misappropriation, or injuries of unknown source are reported, the administrator and designees will investigate the allegation with the assistance of appropriate personnel .6. The investigation may consist of:<br><br>a. A review of the completed incident report<br><br>b. An interview with the person (s) reporting the incident<br><br>c. Interviews with any witnesses to the incident<br><br>d. An interview with the resident if possible<br><br>e. A review of the residents' medical record<br><br>f. An interview with staff members having contact with the resident during the period / shift of the alleged incident<br><br>g. Interviews with the resident's roommate, family members, and visitors if applicable<br><br>h. A review of all circumstances surrounding the incident, reenactment of the event if<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | possible .<br><br>8. In accordance with S483.12(b)(c) the facility will report all alleged violations to the state agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigations. The facility will reference The State Licensing and Regulatory Affairs ([NAME]) guidelines to make reporting determinations.<br><br>9. Reports are submitted online into the MI-FRI system:<br><br>(1) Immediately but no later than 2 hours if the alleged violation involves abuse or results in<br><br>serious bodily injury.<br><br>(2) No later than 24 hours if the alleged violation involves neglect, exploitation, mistreatment,<br><br>or misappropriation of resident property; and does not result in serious bodily injury .<br><br>12. Any and all available information that may be relevant to an investigation of any case of suspected resident abuse, neglect, or misappropriation is made available to the Bureau or other authorized agencies upon request .<br><br>16. The facility will thoroughly investigate allegations, prevent further abuse, neglect, exploitation and mistreatment from occurring while the investigation is in progress and take appropriate action as a result of the investigation findings which may include:<br><br>a. Analyze the occurrences(s) to determine abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences;<br><br>b. Defining how care provisions will be changes and / or improved to protect residents receiving services;<br><br>c. Training of staff on changes made and demonstration of staff competency after training is implements;<br><br>d. Identification of staff responsible for implementation of corrective actions.<br><br>e. The expected date for implementation; and<br><br>f. Identification of staff responsible for monitoring the implementation of the plan.<br><br>CMS . |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056<br><br>This citation pertains to intake # MI00141875<br><br>Based on interview and record review, the facility failed to follow professional standards of nursing practice for treatment and medication administration for 4 residents (Resident #27, #32, #56, and #69), out of 10 residents reviewed for the provision of nursing services.<br><br>Findings:<br><br>Resident #27 (R27)<br><br>Review of an Admission Record revealed R27 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: heart failure.<br><br>Review of R27's Order Summary dated 12/29/23 revealed, Weigh daily - If weight increase by more than 2-3 lbs. on consecutive measurements or more than 5 lbs. in a week, let provider know. in the morning for chf (congestive heart failure).<br><br>Review of R27's July and August Weights and Vitals Summary, reviewed on 8/6/24, revealed R27 was not weighed daily as ordered. R27 was weighed on:<br><br>07/02/2024, 07/03/2024, 07/09/2024, 07/12/2024, 07/14/2024, 07/15/2024, 07/18/2024, 07/23/2024, 07/25/2024, 07/28/2024, 07/31/2024, 08/01/2024, and 08/02/2024.<br><br>Review of R27's Electronic Health Record revealed R27's provider was not notified of weight gain as ordered on the following dates:<br><br>On 07/31/2024 R27 weighed 168.2 pounds and on 08/01/2024 15:49 171.4 pounds.<br><br>Resident #32 (R32)<br><br>Review of an Admission Record revealed R32 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: hypertension.<br><br>Review of R32's Order Summary dated 4/27/23 revealed, cloNIDine HCl Oral Tablet 0.1 MG (Clonidine HCl) Give 1 tablet by mouth every 12 hours as needed for hypertension give for SBP greater than 189 or DBP greater than 89.<br><br>Review of R32's December Medication Administration Record revealed:<br><br>Review of R32's December Medication Administration Record revealed:<br><br>*On 12/11/2023 R32's blood pressure was 189/85 and she received clonidine<br><br>*On 12/15/2023 R32's blood pressure was 183/78 and she received clonidine.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | *On 12/20/2023 at 07:12 AM R32's blood pressure was 199/83 and she did not receive clonidine.<br><br>*On 12/21/2023 at 6:19 PM R32's blood pressure was 193/82 and she did not receive clonidine.<br><br>Review of R32's January Medication Administration Record revealed:<br><br>*On 01/18/2024 at 10:23 AM R32's blood pressure was 174/91 and she did not receive clonidine.<br><br>*On 01/27/2024 4:34 PM R32's blood pressure was 195/78 and she did not receive clonidine.<br><br>Review of R32's February Medication Administration Record revealed:<br><br>*On 02/11/2024 at 7:27 PM and at 9:37 PM R32's blood pressure was 195/83 and she did not receive clonidine.<br><br>*On 02/13/2024 at 3:36 PM R32's blood pressure was 197/71 and she did not receive clonidine.<br><br>Review of R32's March Medication Administration Record revealed:<br><br>*On 03/14/2024 at 06:31AM and 07:48 AM R32's blood pressure was 194/82 and she did not receive clonidine.<br><br>*On 03/26/2024 at 09:53 AM R32's blood pressure 162/97 and she did not receive clonidine.<br><br>Review of R32's April Medication Administration Record revealed:<br><br>*On 04/23/2024 07:03 AM and 10:05 AM R32's blood pressure was 194/77 and she did not receive clonidine.<br><br>Resident #56 (R56)<br><br>Review of an Admission Record revealed R56 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: heart failure.<br><br>Review of R56's Order Summary dated 12/11/22 revealed, Weigh daily - If weight increase by more than 2-3 lbs. on consecutive measurements or more than 5 lbs. in a week, let provider know. every day shift for chf (congestive heart failure).<br><br>Review of R56's July and August Weights and Vitals Summary, reviewed on 8/6/24, revealed R56 was not weighed daily as ordered. R56 was weighed on:<br><br>7/1/2024, 7/2/2024, 7/3/2024, 7/8/2024, 7/12/2024, 7/14/2024, 7/15/2024, 7/18/2024, 7/22/2024, 7/24/2024, 7/25/2024, 7/28/2024, 7/30/2024, 7/31/2024, 8/1/2024, 8/2/2024, and 8/5/2024.<br><br>Review of R56's Electronic Health Record revealed R56's provider was not notified of weight gain as ordered on the following dates:<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 8/1/2024 R56 weighed 209.2 pounds. On 8/2/2024 R56 weighed 214.0 pounds. R56 was not re-weighed until 8/5/24.<br><br>During an interview on 08/07/24 at 08:32 AM, Regional Nurse Consultant (RNC) confirmed daily weights were not completed for R27 and R56 and confirmed clonidine was not administered as ordered for R32.<br><br>Review of the facility policy Medication Administration by the various Routes last revised March 2022 revealed, It is the policy of this facility to administer medication in agreement with standards of practice as well as in accordance with applicable state and federal law .<br><br>Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, (Nurses) are also responsible for documenting any preassessment data required with certain medications such as a blood pressure measurement for antihypertensive medications or laboratory values, as in the case of warfarin, before giving the medication. After administering a medication, immediately document which medication was given on a patient's MAR per agency policy to verify that it was given as ordered. Inaccurate documentation, such as failing to document giving a medication or documenting an incorrect dose, leads to errors in subsequent decisions about patient care. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (pp. 643-644). Elsevier Health Sciences. Kindle Edition.<br><br>Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Daily weights are an important indicator of fluid status ([NAME], 2021c). Each kilogram (2.2 lb) of weight gained or lost overnight is equal to 1 L of fluid retained or lost. These fluid gains or losses indicate changes in the amount of total body fluid, usually ECF, but do not indicate shift between body compartments. Weigh patients with heart failure and those who are at high risk for or actually have ECV excess daily .Interpretation of daily weights guides medical therapy and nursing care. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1059). Elsevier Health Sciences. Kindle Edition.<br><br>29073<br><br>Resident #69 (R69)<br><br>Review of an Admission Record reflected R69 admitted to the facility with diagnoses that included acute respiratory failure with hypoxia, severe protein calorie malnutrition, dysphagia, nutritional deficiencies, anxiety and a need for assistance with personal care.<br><br>Review of a Care Plan initiated on 5/14/2024 reflects (R69) is at risk for altered nutritional status r/t (related to) dysphagia and requiring mechanically altered diet. He has a history of poor food acceptance PO (orally) however he has a PEG (percutaneous endoscopic gastrostomy) tube that meets 100% of his nutritional needs. Interventions on the care plan included: Monitor/Cleanse PEG tube site daily.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a Care Plan initiated on 5/14/2024 indicated R69 has Potential for impaired skin integrity related to: History of fragile skin, history of or actual impairment, poor nutritional intake, impaired functional mobility and or incontinence. The goal was for R69 to show improvement of impaired skin integrity as evidenced by no signs or symptoms of infection and decreased measurements and/or prevention of avoidable impaired skin integrity. Interventions to reach the goal of the care planned focus included: Skin inspections with am/pm care and showering; report abnormal to the charge nurse.<br><br>During an interview and observation on 8/7/2024 at 8:39 AM, the dressing around the insertion site of R69's feeding tube was not dated or initialed and was soiled with dried bloody drainage on top of and underneath the flange of the tube feeding insertion site. R69 reported the nurse did not change the dressing the day before and that sometimes the skin around the area was painful.<br><br>Review of a Nurse Practitioner Progress Notes dated 7/12/2024 reflected R69 was being seen for a follow-up of PEG tube pain. The note indicated R69 reported the drain sponge has not been changed x 3 days. Drain sponge at PEG tube site noted with dry crusty drainage.<br><br>Review of R69's August 2024 Treatment Administration Record (TAR) reflects the order Peg tube site: cleanse with soap and water, pat dry, apply non-sting skin prep around insertion site, cover with drain sponge q (every) shift, every shift for wound care. The treatment is not documented as done on the day shift on 8/4/2024.<br><br>Review of R69's July 2024 TAR reflects the order Peg tube site: cleanse with soap and water, pat dry, apply non-sting skin prep around insertion site, cover with drain sponge q (every) shift, every shift for wound care. The order was not documented as completed on the day shift 7/21/2024. |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056<br><br>This citation pertains to intake # MI00141875<br><br>Based on interview and record review, the facility failed to 1.) implement the facility policy for pressure injury/wound management 2.) ensure pressure injury/wound assessments were comprehensive and accurate, and 3.) ensure treatments were ordered and completed, for 3 of 6 residents (Resident #42, #44, and #17) reviewed for alterations in skin integrity, resulting in incomplete wound assessments, a delay in wound healing, and the worsening of wounds.<br><br>Findings:<br><br>Resident #42 (R42)<br><br>Review of an Admission Record revealed R42 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: dependence on ventilator, heart failure, and pressure injuries.<br><br>Review of R42's Wound Measurement dated 5/1/24 revealed, .right heel 3.2 x 3.4 unstageable . Heel has large eschar cap . Consider wound care clinic referral . No additional wound description reflected in the wound assessment.<br><br>Comprehensive wound assessments are to include location, dimensions, description of wound bed, exudate type, exudate amount, presence of odor, wound edges, peri-wound assessment, tunneling/undermining, and pain.<br><br>Review of R42's Wound Measurement dated 5/21/24 revealed no measurements. The right heel was documented as unstageable, however, documentation then showed .The following questions apply to: abdomen, right and left lower leg, heel .Pressure wounds have beefy red granulation tissue at base . (The wound base on R42's right heel was documented as unstageable and therefor staff would be not be able to visualize the wound base). No additional wound description reflected in the wound assessment.<br><br>Per [NAME] and [NAME], Unstageable pressure injury: Obscured full-thickness skin and tissue loss *Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (see Fig. 48.4F). If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.<br><br>Review of R42's Wound Measurement dated 6/5/24 revealed R42's right heel measured 3 x 3.1 x 0.2 and was documented as a Stage 4 pressure injury.R HEEL- sharp debridement of black eschar tissue completed by provider, lidocaine 4% applied 5 minutes prior to procedure, 80% of slough tissue to wound bed noted, minimal bleeding controlled with pressure, Vaseline gauze covered with dry gauze wrapped with Kerlix. resident tolerated well. No additional wound description reflected in the wound assessment. Debridement is the removal of non-viable/dead tissue: necrotic material, slough and biofilm. (15 days after the last wound assessment.)<br><br>(continued on next page) |

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|---|---|
| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of R42's Wound Measurement dated 6/12/24 revealed, .R (right) HEEL- 3.5 X 3.2 X 0.5 sharp debridement of slough tissue completed by provider, see updated orders. resident tolerated well . No additional wound description reflected in the wound assessment.<br><br>Review of R42's Order Summary dated 6/12/24 revealed, Right heel: cleanse with normal saline, apply santyl, cover with gauze, wrap with kerlix. every shift for wound.<br><br>Review of R42's Wound Measurements revealed no comprehensive wound assessment was completed on 6/19/24.<br><br>Review of R42's Wound Measurement dated 6/26/24 revealed the right heel measured 3.0 x 2.5 x 1.8 and was documented as a Stage 4 pressure injury.R HEEL- (nurse practitioner name omitted) performed sharp debridement to right heel immediately prior to wound measurements. no s/s of infection. no change to tx . No additional wound description reflected in the wound assessment. (14 days after the last wound assessment)<br><br>Review of R42's Wound Measurements revealed no comprehensive wound assessment was completed on 7/3/24.<br><br>Review of R42's Skin assessment dated [DATE] revealed R42's right heel was documented as vascular indicating an inaccurate wound assessment.<br><br>Review of R42's Wound Measurement dated 7/10/24 revealed the right heel measured 3 x 2 x 1.5 N/A stage. R HEEL- after wound measurements were taken by writer, (nurse practitioner name omitted) performed sharp debridement to right heel and obtained cultures r/t (related to) odor and purulent (pus filled) drainage . Indicating the worsening of the wound from the previous assessment. No additional wound description reflected in the wound assessment. (14 days after the last wound assessment).<br><br>Review of R42's Wound Measurements revealed no comprehensive wound assessments were completed after the assessment dated [DATE] through her transfer to the hospital.<br><br>Review of R42's Provider Progress Note dated 7/10/24 revealed, .multiple chronic wounds, measurements in (Electronic Health Record), right heel noted with foul smelling drainage . Sharp debridement completed to right heel, after procedure minimal bleeding was controlled with light pressure, wound measures 3.0 cm x 2.5 cm x 1.8 cm. Indicating the worsening of the wound. No additional wound description reflected in the progress note.<br><br>Treatment changes for R42's right heel were not made despite the deterioration of the wound with increased exudate and odor documented. The treatment order had been in place since 6/12/24 (4 weeks).<br><br>Review of R42's Provider Progress Note dated 7/11/24 revealed, There is open skin on the heel with foul odor . No additional wound description or measurements reflected in the progress note.<br><br>Review of R42's Skin assessment dated [DATE] revealed R42's right heel was documented as vascular indicating an inaccurate wound assessment.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of R42's Provider Progress Note dated 7/15/24 revealed, .Start cefepime 1 g IV x 1 then cefepime IV 500 mg every 24 hours for wound infection . No additional wound description or measurements reflected in the progress note.<br><br>Review of R42's Provider Progress Note dated 7/17/24 revealed, .Patient is being seen today for wound evaluation . right heel wound measures 2.2 cm x 2.5 cm x 1.5cm . No additional wound description reflected in the progress note.<br><br>Review of R42's Skin assessment dated [DATE] revealed R42's right heel was documented as vascular indicating an inaccurate wound assessment.Right heel has been recently debrided as well as continuing with Santyl application BID (twice a day) with noted signs of improvement . There were no measurements or further wound descriptions reflected in the skin assessment. (Improvement was noted despite the lack of assessment and inaccurate staging of the pressure injury.)<br><br>Review of R42's Provider Progress Note dated 7/22/24 revealed, .Patient is being seen for irregular lab results .Nursing has no acute concerns at this time . There was no wound assessment and measurements reflected in the progress note.<br><br>Review of R42's Skin assessment dated [DATE] revealed no measurements or wound assessments.wound to right heel dressing bid wound is odorous and no improvement noted .<br><br>Review of R42's Provider Progress Note dated 7/29/24 revealed, .worsening odor of wound (Rt heel) .staff reports of worsening right heel wound .Right heel noted with foul smell, boggy, skin is very thin and fragile . Right heel wound culture C&S (culture and sensitivity) if indicated . Indicating the worsening of the wound. A debridement was completed to remove dead tissue during this visit. This assessment was completed 12 days after last provider wound assessment.<br><br>Review of R42's Skin assessment dated [DATE] revealed the right heel was documented as vascular and measured 7.5 x 8 (centimeters). No additional wound description or measurements reflected in the skin assessment.<br><br>Review of R42's Provider Progress Note dated 8/1/24 revealed, .Patient is being seen today for irregular labs and worsening heel wound .right lower extremity, without measurements .start cefepime 2g IV q 24 hours x 10 days .right heel xray stat . No treatment changes noted.<br><br>Review of R42's vital signs dated 08/01/24 at 8:59 AM revealed a blood pressure of 82/50, a pulse of 100, and respirations of 30. R42's vital signs were indicative of sepsis.<br><br>Review of R42's xray results revealed the xray was obtained on 8/1/24 and was reviewed by the radiologist on 8/3/24. Ulceration at the posterior aspect of the heel with underlying calcaneal osteomyelitis and extensive soft tissue gas that is concerning for necrotizing/gas-forming infection .<br><br>Review of R42's Interdisciplinary Documentation dated 8/2/24 revealed, Wound care completed to BLE (bilateral lower extremities) and Right heel. right heel noted increased brown drainage and increased involvement of entire heel area. Notified on-call provider (name omitted) of findings .<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of R42's Interdisciplinary Documentation dated 8/3/24 revealed, Received orders to send [NAME] to ER for an evaluation of x-ray results showing possible osteomyitis (sic). Osteomyelitis is an infection in the bone.<br><br>Review of R42's Interdisciplinary Documentation dated 8/3/24 revealed, Called (emergency department) for update on resident. Spoke with RN who stated that resident was slated to be transferred to [NAME] Ford Hospital in Detroit for further evaluation d/t (due to) necrotizing fasciitis in Right heel . Necrotizing fasciitis is a severe, rapidly spreading bacterial infection of the skin.<br><br>During an interview on 08/07/24 at 01:25 PM, Regional Nurse Consultant (RNC) D confirmed R42 did not have wound assessments completed weekly and the wound assessments were not complete/comprehensive. RNC D reported that wound assessments were to be completed weekly utilizing the Wound Measurement assessment tool and should include a comprehensive description of the wounds, not just the measurement of the wound.<br><br>There were no treatment changes for R42's right heel from 6/12/24 through her discharge to the hospital despite the deterioration of the wound and/or lack of wound healing. Wound assessments were not completed weekly, and the assessments were not thorough/comprehensive as required to promptly identify the deterioration of the wound.<br><br>A time related assessment has also been applied to the process of healing of a wound that is diagnosed as chronic. If during 4 weeks of standard of care, the wound surface area is reduced by 50%, it is likely to heal on the same treatment in 12 weeks. If less than a 50% reduction occurs, it is unlikely to heal on this treatment and a reassessment and change of treatment should be considered. [NAME] E, [NAME] PY, [NAME] GS, [NAME]-Green MM, [NAME] R, [NAME] D, Gould LJ, [NAME] DG, [NAME] GW, [NAME] R, Olutoye OO, [NAME] RS, [NAME] GC. Chronic wounds: Treatment consensus. Wound Repair [NAME]. 2022 Mar;30(2):156-171. doi: 10.1111/wrr.12994. Epub 2022 [DATE]. Erratum in: Wound Repair [NAME]. 2022 Jul;30(4):536. doi: 10.1111/wrr.13035. PMID: 35130362; PMCID: PMC9305950.<br><br>Chronic wounds are those that do not progress through a normal, orderly, and timely sequence of repair. They are common and are often incorrectly treated .The mainstay of treatment is the TIME principle: tissue debridement, infection control, moisture balance, and edges of the wound. After these general measures have been addressed, treatment is specific to the ulcer type .<br><br>Assessment of wounds should begin with a thorough physical examination. A more focused examination of the wound itself can then help guide treatment. The wound location, size, and depth; presence of drainage; and tissue type should be documented. Based on the location and appearance, most chronic wounds can be categorized by etiology, which allows for adequate workup and treatment recommendations .<br><br>Venous ulcers are the Moisture balance is an essential part of wound care. Chronic wounds should never be exposed to air to dry out, as is often recommended. Moist wounds heal more quickly and have less risk of infection. If a wound appears dry, moisture needs to be added; this is accomplished by choosing an appropriate dressing (Table 3). Conversely, if a wound is draining, the drainage needs to be controlled and kept off of the periwound. The proper dressing should hold the moisture on the wound bed to prevent desiccation. [NAME] S, [NAME] E. Chronic Wounds: Evaluation and Management. Am Fam Physician. 2020 [DATE];101(3):159-166. PMID: 32003952.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident #44<br><br>Review of an Admission Record revealed R44 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: dementia.<br><br>Review of R44's Skin assessment dated [DATE] revealed R44 had redness identified on her coccyx . Addendum 07/06/24: Res has a red area near her coccyx approximately 4cm round. It is not open at this time .<br><br>Review of R44's Electronic Health Record revealed no documentation that R44's responsible party or the wound nurse were notified. There was no treatment ordered/initiated at that time. A short term care plan was not initiated and/or the care plan was not updated.<br><br>Review of R44's Provider Progress Note dated 7/8/24 revealed, .nickel-sized area over coccyx that needs to be 'watched' per nursing XXX[AGE] year-old female with a long-term care resident being seen for staff reporting redness over coccyx .Skin: 1 cm x 1 cm x 0.1 cm circular open area noted to right buttock, skin is very thin and fragile . No treatment ordered for the Stage II open area.<br><br>Review of R44's Skin assessment dated [DATE] revealed no breakdown to coccyx.<br><br>Review of R44's Provider Progress Note dated 7/17/24 revealed, .Nursing reports no significant concerns. Seen earlier this month by nurse practitioner (name omitted); had a nickel sized area over coccyx she started some treatment to the area . Skin not fully examined today but there is mention of her stage II buttock sore . No treatment ordered for the Stage II open area.<br><br>Review of R44's Skin assessment dated [DATE] revealed, .Redness to bilateral buttocks .<br><br>Review of R44's Skin assessment dated [DATE] revealed no breakdown to coccyx.<br><br>Review of R44's Skin assessment dated [DATE] revealed, .Res (resident) has an area of less than one cm in diameter open area where epidermis is missing on the inner aspect of the right buttock . Review of R44's Electronic Health Record revealed no documentation that R44's responsible party or the wound nurse were notified.<br><br>Review of R44's Skin assessment dated [DATE] revealed an open area Stage II to her right buttock measuring 1cm x 1cm.Res has an area of less than one cm in diameter open area where epidermis is missing on the inner aspect of the right buttock .<br><br>Review of R44's Order Summary dated 7/31/24 revealed, right buttocks: cleanse with normal saline or soap and water, pat dry apply TAO and 2x2 q 2 (every 2) days and prn one time a day every 3 day(s) for wound care.<br><br>Resident #17 (R17)<br><br>Review of an Admission Record revealed R17 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: stroke.<br><br>Review of R17's Skin assessment dated [DATE] revealed, .Redness to bilateral buttocks .<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of R17's Provider Progress Note dated 6/26/24 revealed, .being seen today for staff reported impaired skin integrity . Skin: 1.5cm x 1.0cm x 0.2 area of shearing noted to left buttocks, minimal drainage noted to dressing, skin is very thin and fragile . Indicating a Stage II pressure injury.<br><br>Review of R17's Order Summary dated 6/26/24 revealed, Left buttocks: cleanse with soap and water, pat dry, apply TAO, cover with border foam dressing q day. one time a day for wound care.<br><br>Review of R17's Electronic Health Record revealed no documentation that R17's responsible party or the wound nurse were notified or that a short term care plan was initiate/care plan was updated.<br><br>Review of R17's Skin assessment dated [DATE] revealed, .Skin is unremarkable other than on going (sic) redness to bil buttocks .<br><br>Review of R17's Skin assessment dated [DATE] revealed, .ADDENDUM; During care this morning it was observed that the inner aspect of res right thigh and groin area is excoriated, and has an open area. The first few layers of skin have open related to excoriation .<br><br>Review of R17's Interdisciplinary Documentation dated 7/6/24 revealed, During personal care it was observed that res had excoriation with an open area to her inner right thigh/peri area. Area cleansed with mild soap and water, barrier cream applied and moisture wicking pad placed to help relieve some of the moisture that is causing the excoriation. Review of R17's Electronic Health Record revealed no documentation that R17's responsible party or the wound nurse were notified or that a short term care plan was initiate/care plan was updated.<br><br>Review of R17's Skin assessment dated [DATE] revealed R17 had redness noted to bilateral buttocks. There was no documentation of open areas.<br><br>Review of R17's Provider Progress Note dated 7/11/24 revealed, .Skin: Treatment in place for groin excoriation, left buttock wound, treatment in place .<br><br>Review of R17's Skin assessment dated [DATE] revealed R17 had redness noted to bilateral buttocks. Coccyx-other (specify) was documented with no additional assessment findings.<br><br>Review of R17's Skin assessment dated [DATE] revealed R17 had redness noted to bilateral buttocks. Coccyx-other (specify) was documented with no additional assessment findings.<br><br>Review of R17's Skin assessment dated [DATE] revealed R17 had redness noted to bilateral buttocks. Coccyx-other (specify) was documented with no additional assessment findings.<br><br>Review of R17's June Treatment Administration Record revealed the left buttock treatment was not completed on 6/28/24 or 6/30/24.<br><br>Review of R17's July Treatment Administration Record revealed the left buttock treatment was not completed on 7/11/24, 7/17/24, 7/18/24, 7/20/24, 7/21/24, 7/27/24, 7/28/24, or 7/31/24.<br><br>Review of R17's August Treatment Administration Record revealed the left buttock treatment was not completed on 8/3/24.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 08/07/24 at 02:37 PM, Director of Nursing (DON) and RNC D confirmed the R44 and R17's care plans were not updated/STCP initiated following the identification of the skin impairment. RNC D reported that changes in resident condition, including skin breakdown, was discussed in the managers morning meetings utilizing a 24-hour report. An addendum was made to R44 and R17's Skin Assessments and a progress note was not completed causing it to be missed by management in the morning meeting. Additionally, the nurse did not notify the responsible party and wound nurse of the skin breakdown.<br><br>Review of the facility policy Skin at Risk Assessment Documentation, Staging & Treatment last revised January 2020 revealed, Policy: It is the policy of this facility to assess resident risk factors for the development of impaired skin integrity and intervene as indicated utilizing the admission assessment, plan of care, and Minimum Data Set as formal assessment tools. It is the policy of this facility to assess skin on a regular basis to determine whether changes in the patient's skin condition have occurred. Weekly measurements and narrative assessments are conducted on existing pressure injuries. Purpose: To provide prompt identification and intervention for residents at risk of impaired skin integrity corresponding to risk factors. To limit the development of avoidable pressure ulcers and provide evidenced based guidance on effective strategies to promote pressure ulcer healing .<br><br>6. The following guidelines are reviewed and implemented as indicated for each individual risk factors: a. Daily skin inspections with am and pm care<br><br>b. C.N.A. reporting of abnormal skin inspections to the charge nurse .<br><br>h. Communication of skin concerns to other team members on the 24 hour report summary .<br><br>q. Implement standing orders for impaired skin and / or Consult the physician prn for treatment and orders for impaired skin integrity .<br><br>9. Re-assess and measure a pressure ulcer a minimum of weekly. a. Whenever possible assign a consistent licensed nurse to an individual wound measurement to improve the uniformity, accuracy and reliability of the measurement and documentation.<br><br>b. With each treatment observe the ulcer for signs that indicate a change in treatment is indicated (e.g., wound improvement, wound deterioration, more or less exudate, signs of infection or other complication)<br><br>10. Document the appearance of the wound with considerations to the physical characteristics as applicable to the resident; a. Location<br><br>b. Stage<br><br>c. Size<br><br>d. Color<br><br>e. Peri-wound condition<br><br>f. Wound edges<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | g. Sinus tracts or tunneling<br><br>h. Exudate<br><br>i. Odor<br><br>11. Reassess the resident, the pressure ulcer and the plan of care if the ulcer does not show signs of healing as expected despite appropriate local wound care, pressure redistribution, and nutrition. a. Expect some signs of pressure ulcer healing within two weeks.<br><br>b. Adjust expectations for healing in the presence of multiple factors that impair wound healing .<br><br>Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, When you care for a patient with a chronic complex wound, contact the wound care team if you note a change in the volume and/or consistency of the drainage, a presence of a strong odor in the drainage, and change in wound-healing status. It is also important to plan a dressing change with the wound care team to assess the wound together to determine effectiveness of the treatment plan and if the wound is showing progress toward healing. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1338). Elsevier Health Sciences. Kindle Edition.<br><br>Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, A wound assessment provides the foundation for developing a care plan, revealing data that aid in identification of nursing diagnoses and the selection of wound therapies best targeted for the condition of the patient's wound. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1384). Elsevier Health Sciences. Kindle Edition.<br><br>Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, When you identify the presence of a skin wound or pressure injury, closer assessment is required. Assess the type of tissue in the wound base and the factors influencing the patient's risks for poor healing so that you can plan appropriate interventions. The assessment includes the amount (percentage) and appearance (color) of viable and nonviable tissue .Measurement of the wound size provides information on overall changes in dimensions, which is an indicator for wound-healing progress ([NAME], 2016). This includes measuring the length and width of a wound, as well as determining its depth (see Skill 48.2). Use a disposable wound-measuring device to measure wound width and length. This approach offers a uniform, consistent method for measuring meaningful comparisons of wound status across time (EPUAP/NPIAP/PPPIA, 2019b). Measure depth by using a cotton-tipped applicator in the wound bed . Assessment of wound exudate should describe the amount, color, consistency, and odor of wound drainage. Normally a closed surgical wound has minimal serosanguineous drainage immediately after surgery (see Chapter 50). Excessive exudate indicates the presence of infection. Wound pain, including the location, distribution, type, quality, and intensity, and any aggravating or relieving factors also should be assessed ([NAME], 2016) (see Chapter 44). Examine the skin around a wound (periwound) for redness, warmth, and signs of maceration, and palpate the area for signs of pain or induration. The presence of any of these factors on the periwound skin indicates wound deterioration. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1333). Elsevier Health Sciences. Kindle Edition.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Unstageable pressure injury: Obscured full-thickness skin and tissue loss o Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (see Fig. 48. 4F). If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1322). Elsevier Health Sciences. Kindle Edition. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073<br><br>Based on interview and record review, the facility failed to ensure that policies and procedures were developed and implemented for one resident (R47) of five reviewed for Medication Regimen Review (MRR) that address time frames for steps in the MRR process and steps the pharmacist must take when an irregularity requires urgent action.<br><br>Findings:<br><br>Resident #47 (R47)<br><br>Review of a Significant Change Minimum Data Set assessment dated [DATE] reflected R47 admitted to the facility on [DATE] with diagnoses that included high blood pressure, thyroid disorder, anxiety and depression.<br><br>Review of R47's Pharmacist Medication Review 2.0 assessments in the Electronic Medical Record (EMR) reflected that in March and April 2024 the pharmacist documented potential irregularities noted. The Miscellaneous tab in the EMR did not include a written notice from the pharmacist to the physician indicating what potential irregularity was identified.<br><br>During an interview on 8/7/2024 at 1:30 PM, the Nursing Home Administrator (NHA) was able to produce the memo distributed to the facility by the pharmacist pertaining to the irregularities, however the Physician/Prescriber Response section was left blank. The NHA reported at this time the facility did not have a written policy or procedures in place pertaining to Medication Regimen Reviews. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577<br><br>This citation pertains to intake # MI00141875<br><br>Based on observation, interview, and record review, the facility failed to secure 2 of 5 medication carts and date opened insulin pens.<br><br>Findings:<br><br>During an observation on 08/05/24 at 10:48 AM the 500 hall medication cart was unlocked and unattended by nursing staff. During the same observation, the following opened medications for the resident in bed 512-B were found undated: (1) Humalog Kwik pen, (2) Basaglar pen, and (3) Lantus solostar insulin pen.<br><br>During an interview on 08/05/24 at 10:55 AM, Licensed Practical Nurse (LPN) D indicated that all medication carts were to be locked when nursing staff were not working at the cart and that insulin was to be dated when opened.<br><br>During an observation on 08/07/24 at 8:05 AM the 600 hall medication cart was unlocked and unattended by nursing staff. During the same observation, a Humalog Kwik pen prescribed to the resident in room [ROOM NUMBER]-A was opened and not dated.<br><br>Review of a facility policy titled Medication Storage and Stabilization, last reviewed April 2021, reflected . medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073<br><br>Based on observation, interview and record review, the facility failed to ensure one resident (Resident #11) out of 18 residents reviewed for dental services, was promptly assisted in replacing dentures lost at the facility.<br><br>Findings:<br><br>Resident #11 (R11)<br><br>Review of an Admission Record reflected R11 admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), acute respiratory failure with hypoxia, depression, anxiety, protein calorie malnutrition, and cachexia (wasting syndrome).<br><br>Review of an undated Inventory of Personal Possessions reflected R11 had an upper denture. The inventory was scanned into the Electronic Medical Record (EMR) on 11/23/2023.<br><br>Review of a Care Plan initiated on 11/21/2023 reflected R11 has Altered functional mobility and ADLs (Activities of Daily Living) related to weakness, weight loss and pain; (R11) is experiencing a end of life prognosis, declines are expected and unavoidable. The goal was for R11 to remain pain free and comfortable. Interventions listed indicated R11 was dependent for ADLs; Oral Hygiene: Edentulous (lacking teeth), assist with oral care; Oral Hygiene: Upper and Lower dentures assist with cleaning, inspect oral cavity and gums prn (as needed).<br><br>Review of a Task menu in R11's EMR did not reflect staff documented specifically on the provision of oral hygiene, including denture care.<br><br>During an observation and interview on 8/5/2024 at 12:46 PM, R11 was observed lying in bed, no dentures or teeth were seen in R11's mouth. R11's Power of Attorney (POA B) reported at this time that R11 used to have dentures but lost them at the facility some time ago and nothing was ever done about it. POA B said that she signed R11 onto a new dental service and that hopefully R11 would be fitted for dentures then.<br><br>During an interview on 8/6/2024 at 1:18 PM, the Social Services Director (SSD) C reported that she was not aware that R11 was missing dentures but would look for any information about them. SSD C said she has had a set of dentures in her office that were found on the unit where R11 used to live a few months ago but did not know who they belonged to. SSD C said that if the facility could not find R11's dentures, the facility would replace them.<br><br>During a follow-up interview on 8/6/2024 at 2:01 PM, POA B said that she and R11's daughter reported R11's missing dentures to facility staff when they were first noticed missing. POA B said that she and R11's daughter looked everywhere for them and that the dentures had been missing for 4-5 months.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a facility policy Ancillary Services effective November 2016 reflected 1. Dental Services . c. The facility will not charge a Medicare/Medicaid resident for the loss or damage of dentures in those instances when the loss or damage is the facilities responsibility e.g., accidental breakage by a caregiver, improper storage, d. The facility will make a prompt referral, within 3 business days, and provide an assessment and care plan interventions for providing nutrition during the interim; e. in collaboration with dental services, recommendations will be considered regarding replacement of the dentures in accordance with the highest practicable function, and the resident's ability to cooperate and tolerate with services. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>39056<br><br>Based on interview and record review, the facility failed to implement an effective and current system of surveillance for staff illnesses to identify possible communicable diseases and infections to prevent the spread of an illness/outbreak, resulting in the potential for an outbreak to go undetected.<br><br>Findings:<br><br>During an interview on 08/07/24 11:14 AM, Regional Nurse Consultant (RNC) D and Director of Nursing (DON) reported that they had been without an Infection Control Preventionist since July 15th/July 16th. RNC D reported that the infection control program had been a collaborative effort with the herself, the DON and the Regional Infection Control Preventionist (ICP). RNC D reported that the ICP was responsible for the tracking/surveillance of employee illness.<br><br>RNC D reported that the process for employee call offs was for the personal taking the call to fill out a call-off slip and submit it to the Human Resource Director. The Human Resource Director would then turn the slips over to the ICP for tracking.<br><br>RNC D reported that employee call offs were reviewed weekly in the Interdisciplinary Team meetings and were tracked in real time by the Infection Control Preventionist.<br><br>Review of the February employee Nosocomial Infections Monthly Report revealed 2 employees had called off of work sick.<br><br>Review of the February Employee Call-Off Log revealed:<br><br>On 2/27/24 a CNA called off as sick. The employee last worked on 2/25/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 2/28/24 a CNA called off as sick. The employee last worked on 2/25/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 2/29/24 a CNA called off as sick. The employee last worked on 2/25/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 3/1/24 a CNA called off as sick. The employee last worked on 2/25/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Further review of the February Employee Call-Off Log revealed that 2 additional CNAs called off on 2/27/24 and 2/28/24 for vomiting. Both CNAs last worked on 2/25/24. There was no documentation of the unit those CNAs last worked on and no investigation into 6 CNAs calling off for illness with the date of 2/25/24 as their date last worked.<br><br>Review of the March employee Nosocomial Infections Monthly Report revealed 6 employees had called off of work sick.<br><br>Review of the March Employee Call-Off Log revealed:<br><br>On 3/1/24 a CNA called off as sick. The employee last worked on 2/25/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 3/3/24 a CNA called off as sick. The employee last worked on 2/28/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 3/4/24 a housekeeping staff member called off as sick. The employee last worked on 2/26/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the residents they came in contact with, or a specific date the employee could return to work.<br><br>On 3/11/24 a dietary staff member called off as sick. The employee last worked on 3/7/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the residents they came in contact with, or a specific date the employee could return to work.<br><br>On 3/12/24 a dietary staff member called off as sick. The employee last worked on 3/10/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the residents they came in contact with, or a specific date the employee could return to work.<br><br>On 3/27/24 a nurse called off as Not feeling good. The employee last worked on 3/24/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 3/28/24 a CNA called off as sick. The employee last worked on 3/24/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>A total of 7 employees called off of work without adequate tracking and surveillance from the Infection Control Preventionist in the month of March.<br><br>There were no April employee Nosocomial Infections Monthly Reports or Employee Call-Off Logs available for review in the Infection Control Binder.<br><br>There was no May employee Nosocomial Infections Monthly Report to review in the Infection Control Binder.<br><br>Review of the May Employee Call-Off Log revealed:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 5/1/24 a medical records staff member called off as sick. The employee last worked on 4/29/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the residents/staff they came in contact with, or a specific date the employee could return to work.<br><br>On 5/2/24 a CNA called off as In ER (emergency room ). The employee last worked on 4/27/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 5/5/24 a CNA Left at 11:30 AM and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 5/7/24 a dietary staff member called off as Not feeling good. The employee last worked on 4/27/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the residents they came in contact with, or a specific date the employee could return to work.<br><br>On 5/8/24 a nurse called off as sick. The employee last worked on 5/5/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 5/9/24 a CNA called off as sick. The employee last worked on 5/5/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 5/13/24 a CNA called off as sick. The employee last worked on 5/6/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 5/17/24 a CNA called off as Not feeling good. The employee last worked on 5/15/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 5/19/24 a nurse called off but there was No slip (call off slip). The employee last worked on 5/17/24 and could return to work on their Next Shift. There was no documentation of follow up to rule out illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 5/21/24 a CNA left at 10PM. There was no documentation of follow up to rule out illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 5/22/24 a CNA called off as Not feeling good. The employee last worked on 5/21/24 and could return to work on their Next Shift. There was no documentation of the type of illness, the unit last worked, or a specific date the employee could return to work.<br><br>On 5/24/24 a CNA called off for In ER. The employee last worked on 5/23/24 and could return to work on their Next Shift. There was no documentation of follow up to rule out illness, the unit last worked, or a specific date the employee could return to work.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A total of 12 employees called off of work without adequate tracking and surveillance from the Infection Control Preventionist in the month of May.<br><br>Review of the June employee Nosocomial Infections Monthly Report revealed 5 employees had called off of work not feeling good.<br><br>Review of the June Employee Call-Off Log revealed:<br><br>On 6/3/24 a nurse called off for Not feeling good. The employee last worked on 5/29/24 and could return to work on their Next Shift. There was no documentation of the type of illness or a specific date the employee could return to work.<br><br>On 6/12/24 a CNA called off for Not feeling good. The employee last worked on 6/11/24 and could return to work on their Next Shift. There was no documentation of the type of illness or a specific date the employee could return to work.<br><br>On 6/27/24 a nurse called off for illness. The employee last worked on 6/19/24 and could return to work on their Next Shift. There was no documentation of the type of illness or a specific date the employee could return to work.<br><br>There were no August Employee Call-Off Logs available for review in the Infection Control Binder.<br><br>During an interview on 08/07/24 at 01:25 PM, RNC D reported she would look for the missing employee surveillance for April and May. No reports/logs for April were received prior to survey exit. RNC D reported employee surveillance had not been completed for the month of August.<br><br>Review of the facility policy Reportable health Symptoms; Return to Work Guidelines last revised May 2023 revealed, Employees are required to report information about their health and activities as they relate to transmissible diseases .1. The following symptoms are reportable to your supervisor or designated person in charge to receive a call-off notice; a. Vomiting b. Diarrhea c. Jaundice d. Sore throat with fever, or e. A lesion containing pus such as a boil or infected wound that is opening or draining .5. The infection control practitioner and/or the designated person in charge shall assume responsibility for excluding or restricting employees from work according to the guidelines set forth in Attachment A .<br><br>Review of the facility policy Infection Prevention and Control Plan last updated March 2024 revealed, .1. The infection control committee incorporates the following on an ongoing basis: a. Surveillance, prevention and control of infections throughout the facility .d. Continually evaluates and monitors the results and presents recommendations for revision to policies and techniques as indicated. 2. Surveillance includes HAIs among staff and residents. Infections are monitored when a treatment plan is ordered by a Health Care Practitioner. a. Continuously collect and screen data to identify potential outbreaks . |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056<br><br>Based on interview and record review, the facility failed to 1.) implement, and operationalize an antibiotic stewardship program and 2.) ensure accurate monitoring and documentation of an infection for 1 resident (Resident #32) out of 3 residents reviewed for antibiotic use and treatment.<br><br>Findings:<br><br>Resident #32 (R32)<br><br>Review of an Admission Record revealed R32 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: hypertension.<br><br>Review of R32's Interdisciplinary Documentation dated 5/26/2024 revealed, Questionable result of urine dipstick showed possible Leuk. and Nit. Urine specimen collected and sent to lab for u/a (urinalysis). She has had frequency and urgency with low (out)put during those voids. (she) has had a possible change in cognition level.<br><br>Review of R32's Provider Note dated 5/28/24 revealed, XXX[AGE] year-old female is a long-term care resident being seen today for positive UA (urinalysis). Patient is up in chair in no acute distress. Patient denies dysuria. Staff reports that patient has been having urinary frequency and urgency with decreased urine output and urine dipstick was positive for nitrates and leukocytes. Reviewed UA results with resident and education completed related to ciprofloxacin. Also reviewed that medication may need to be changed pending sensitivity results .Discussion/Summary-Start ciprofloxacin 500 mg 1 tab every 24 hours .Encourage p.o. (oral) fluids- Pending urine sensitivity results .<br><br>Review of R32's Laboratory Services report dated 5/26/24 revealed a urinalysis was completed with no urine culture results.<br><br>Review of R32's Electronic Health Record and the Infection Control Binder revealed no documentation of McGeer Criteria (McGeer Criteria is a national standard for infection surveillance in long-term care facilities) to ensure R32's urinary infection symptoms were tracked and appropriate treatment/testing was indicated.<br><br>R32's Electronic Health Record did not reflect that at least one of the following microbiologic criteria had been met per McGeer Criteria . ? 105 cfu/mL of no more than 2 species of organisms in a voided urine sample and ? 102 cfu/mL of any organism(s) in a specimen collected by an in-and-out catheter.<br><br>Review of R32's Medication Administration Record revealed, Ciprofloxacin HCl Oral Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth every 24 hours for + UA for 3 Days. Ciprofloxacin was administered on 5/28/24, 5/29/24, and 5/30/24.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 08/07/24 at 08:32 AM, Regional Nurse Consultant (RNC) D reported that the facility followed McGeer Criteria for infection surveillance and if an antibiotic was ordered prior to the results of a culture and sensitivity a risk vs benefit would be completed by the provider. RNC C reported that the provider note (referenced above) was the risk vs benefit documentation for the initiation of an antibiotic prior to culture results and confirmed there was no other McGeer Criteria documentation available.<br><br>During an interview on 08/07/24 at 11:22 AM, Director of Nursing (DON) reported that R32's urinalysis was incorrectly ordered and did not automatically prompt the laboratory to conduct a culture and sensitivity. Indicating the Infection Control Preventionist did not review the urinalysis results and identify that further testing (culture and sensitivity) needed to be ordered to ensure an appropriate antibiotic was prescribed.<br><br>Review of the facility policy Antimicrobial Stewardship last revised March 2020 revealed, .2. Antimicrobial therapy should only be prescribed if clinically indicated according to signs and symptoms of infection and/or sepsis .make every attempt to obtain appropriate cultures prior to administering antimicrobials .d. Document indications for antimicrobial therapy in the interdisciplinary note and or medication administration record including the indication for treatment .4. The infection control practitioner, pharmacist and/or licensed nurses will perform a prospective audit evaluating antibiotic orders to provide direct intervention and prescriber feedback if the order is deemed inappropriate for the condition, culture and sensitivity, renal function, and/or presentation of signs and symptoms. a. Microbiology reports will be reviewed to identify which residents may require changes to ordered anti-infective therapies .<br><br>Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Many laboratory studies are often necessary when a patient is suspected of having an infectious or communicable disease (Box 28. 14). You collect body fluids and secretions suspected of containing infectious organisms for culture and sensitivity tests. After a specimen is sent to a laboratory, the laboratory technologist identifies the microorganisms growing in the culture. Additional test results indicate the antibiotics to which the organisms are resistant or sensitive. Sensitivity reports determine which antibiotics used in treatment are effective and need to be ordered for treatment. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 475). Elsevier Health Sciences. Kindle Edition. |