| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235637 | A. Building<br>B. Wing | 05/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Plainwell Pines Nursing and Rehabilitation Communi | 3260 East B Ave<br>Plainwell, MI 49080 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384<br><br>This citation pertains to Intake MI00151548<br><br>Based on observation and interview, the facility failed to maintain dignity for 2 of 4 residents (R29 and R21) reviewed for dignity, resulting in the potential for feelings of embarrassment based on the reasonable person concept.<br><br>Findings include:<br><br>R29<br><br>According to the MDS dated [DATE], R29 scored 4/15 on his BIMS (Brief Interview Mental Status) indicating he was severely cognitively impaired. He required the use of a wheelchair for mobility and had diagnoses that included pressure wounds.<br><br>Review of R29's Care Plan as of 5/8/25, there was no resident-specific treatment plan for the resident to receive his medications in a common area.<br><br>During an observation on 05/06/25 at 11:30 AM, R29 was sitting by the nursing station with other residents and staff at the nursing station. Without removing R29 from the congested area, and providing him privacy, Therapist W pulled up the resident's pant legs and exposed both legs from the knees to his ankles. Therapist W explained out loud about the scabbed over wounds to both legs. At the same time, LPN L walked behind Therapist W and placed a medication (med) cup with pills to R29's mouth and told him to take his medications. R29 stared ahead and did not open his mouth. LPN L took the med cup and used it to open the resident's mouth and again told him to take his medications. When LPN L got R29 to open his mouth she poured the medications in R29's mouth. LPN L stated, He needs his medications, and I don't think he minds getting them out here.<br><br>During an interview on 5/7/25 3:03 PM, Licensed Practical Nurse (LPN) L stated, I never thought about giving meds to a resident in a common area. I just give them their meds where they are at. I've never been told I couldn't give meds to a resident in a common area. I didn't ask where the resident wanted to get his medications.<br><br>R21<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | According to the MDS dated [DATE], R21 scored 99 on her BIMS which indicated she was unable to complete the interview due to cognitive impairment. Section H-Bowel and Bladder stated she had an indwelling catheter but observations throughout the survey (5/8/25) revealed no indwelling catheter. The resident was incontinent of bowel and bladder. Her diagnoses included Alzheimer's disease and dementia.<br><br>Review of R21's Care Plan dated 1/24/25, indicated the resident experienced a communication deficit related to cognitive impairment. The goal was for the resident to be understood and have needs met by staff utilizing interventions that included allowing the resident to express themselves.<br><br>Observed on 5/5/25 at 8:55 AM, R21 was in a high-backed wheelchair, tilted back, sitting with three other residents in front of nursing station. R21 was asking for help and trying to get out of chair. R21 swung her right foot off footrest stating, I feel silly. Again, R21 tried to get out of chair, stating, Hey, Hey, where do I go? I can't sit here all day. Staff replied, You can't? Where are you going to go? Want to listen to some music? Staff turned on the radio to a modern country station, moved R21 in front of radio and walked away.<br><br>Observed on 5/5/25 at 9:24 AM, R21 sitting in front of the nurse's station asking for help because she had stuff in her pad. It was noted in R21's Care Plan when the resident referred to her pad meant she had had a bowel movement.<br><br>Using the reasonable person concept, R29 would not have wanted to be exposed, talked about his medical condition, or treated without dignity to take his medications. R21 would not have wanted to have a soiled brief and have her needs ignored. Furthermore, R21 had a history of skin breakdown and required her needs be met when voiced in a manner she could make known. R29 and R21 were unable to voice evidence of embarrassment or humiliation but it is reasonable to assume that the residents would experience this. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637<br><br>Based on observation, interview, and record review, the facility failed to ensure residents were assessed to determine if self-administration of medication was clinically appropriate in 2 of 2 residents (Resident #9, Resident #17) reviewed for self-administration of medications, resulting in unsupervised administration of medications and the potential for mismanagement of medication and adverse side effects.<br><br>Findings include:<br><br>Resident #9 (R9)<br><br>Review of the Facesheet and Minimum Data Set (MDS) dated [DATE] revealed R9 admitted to the facility on [DATE] with pertinent diagnoses including dementia (decline in mental abilities severe enough to interfere with daily life) and depression. Brief Interview for Mental Status (BIMS) reflected a score of 7 out of 15 which indicated R9 was severely cognitively impaired (00 to 07 is severe cognitive impairment).<br><br>During an observation and interview on 5/5/2025 at 9:31 AM, R9 had a prescription nasal spray on her bedside table {ipratropium bromide solution .03% (percent) with an expiration date of 6/2026}. R9 said she received it from her doctor, and this was the third prescription she had, and she uses it when she has a runny nose. R9 stated that she wants it by her bedside so she can use it when she needs it.<br><br>Review of R9's chart revealed no active order for the nasal spray, a self-administration of medication assessment was not completed, and there was no documentation of R9 being able to self-administer medications in the care plan.<br><br>During an interview on 5/6/2025 at 1:14 PM, Registered Nurse (RN) K reported stated that she thought there were some residents in the facility that have nasal sprays and can self-administer the medication. RN K said if that's the case, a self-administration of medication assessment needs to be completed. RN K wasn't aware that R9 had prescription nasal spray at her bedside.<br><br>During an interview on 5/6/2025 at 1:19 PM, Licensed Practical Nurse (LPN) L reported that she was not aware of any residents that had been assessed as safe to self-administer medications. LPN L said she usually stands right by the resident while the resident takes their medications. LPN L stated that she wasn't aware that R9 had prescription nasal spray at her bedside.<br><br>During an interview on 5/6/2025 at 1:10 PM, Director of Nursing (DON) B reported there were no residents that could self-administer medication in the facility. DON B said she wasn't aware that R9 had prescription nasal spray at her bedside and if she did, a self-administration of medication assessment would have to be completed and the medication would be put in a lock box and a key would be given to her.<br><br>38384<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R17<br><br>According to the Minimum Data Set (MDS) dated [DATE], R17 scored 13/15 on her BIMS (Brief Interview Mental Status) indicating she was cognitively intact with no impairment in her arms and legs. Diagnoses included drug induced constipation.<br><br>Reviewed R17's Orders dated 3/10/25, revealed, Colestipol (cholesterol lowering agent) tablet; 1 gram; amt: 1 tab; Twice A Day 07:00 AM - 11:00 AM, 05:00 PM - 09:00 PM. It was noted there were no orders to self-administer medications.<br><br>Review of R17's Medication/Treatment Administration Record (MAR/TAR) dated 5/1/25-5/31/25, indicated that twice a day from 5/1/25 through 5/8/25 the colestipol was given to the resident.<br><br>Review of R17's Care Plan did not reveal a resident-specific treatment plan for self-administering medications or treatments.<br><br>Review of R17's medical chart did not reveal an assessment to self-administer medications.<br><br>During an observation and interview on 5/5/25 at 10:36 AM, R17 was in bed awake with a medication (med) cup on a bedside dresser with a large off-white pill in it. R17 stated, A nurse gave that to me for when I had diarrhea. I saved it in case I needed it. It's been a few days since I was given it and have kept it right there in case I needed it.<br><br>During an observation on 5/5/25 at 3:25 PM, R17 was in bed awake with a medication (med) cup on a bedside dresser with a large off-white pill in it.<br><br>During an interview on 5/6/25 at 1:30 PM, R17 stated, I took that pill you saw yesterday last night. It was to make me poop.<br><br>During an interview 5/7/25 at 8:12 AM, Registered Nurse (RN) K stated, I think there is only one resident that may be able to do their own meds or treatment. No meds are to be left at bedside unless the resident has an assessment.<br><br>During an interview on 5/7/25 at 8:30 AM, Director of Nursing (DON) B stated, (R17) is not approved to self-administer medications. A resident has to request to self-administer and then myself or a nurse assesses the resident, and if approved, the doctor is contacted to place an order.<br><br>Review of the General Dose Preparation and Medication Administration Policy with a revision date of 1/1/2022 revealed 3.10 Facility staff should not leave medications or chemicals unattended.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Self Administration Policy with a review date of 1/2025 revealed Policy: It is the policy of this facility to honor residents' rights to self-administer medications if a resident verbalizes that he/she wants to self-administer medications and the interdisciplinary team (IDT) has determined that this practice is clinically appropriate and safe based on the individualized resident assessment. Procedure: 1. If a resident requests to self-administer medications, a licensed nurse will complete the Self-Administration of Medication observation in the electronic health record. 2. The IDT will review the Self-Administration of Medication observation during morning meeting on the first business day after the observation has been completed to determine if the resident is safe to self-administer medications. 3. Residents may not exercise their right to self-administer medications until the IDT has determined if the resident is safe to self-administer medications, and which medications may be self-administered. 4. If the IDT determines the resident cannot safely self-administer medications, the reason will be documented in the resident's medical record. 5. A care plan will be initiated for residents who can safely self-administer medications. 6. A physician's order will be obtained for residents who can safely self-administer medications 8. Medications will be stored in a secure location, in resident room in a locked area or with the medication cart until dispensed to the resident for self-administration. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999<br><br>Based on observation, interview, and record review the facility failed to complete advance directives completely and accurately for 1 (Resident #134) of 12 residents reviewed for advance directives, resulting in the potential for resident preferences for medical care to not be followed by the facility staff.<br><br>Findings include:<br><br>Review of an Admission Record revealed Resident #134 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: chronic systolic heart failure (condition in which the heart cannot pump blood effectively), aortic stenosis (narrowing of the aortic valve), tricuspid valve insufficiency (heart valve disease causing insufficiency of blood circulation within the heart), atherosclerotic heart disease (buildup of plaque in artery walls).<br><br>Review of a Care Plan for Resident # 134 with a reference date of [DATE], revealed no focus/goal/interventions related to the resident's wishes for Cardiopulmonary Resuscitation (CPR).<br><br>Review of an Advance Directives facility policy with a reference date of ,d+[DATE] revealed Procedure: Upon admission The Admissions Director or designee will review the advance directive form with the resident .The Advance Directive form will be forwarded to the physician for signature .During a cardiac or respiratory arrest, the staff will reference and follow the residents advance directive wishes as indicated on the advance directive form .<br><br>Review of Physician Orders for Resident #134 revealed code status Full Code dated [DATE].<br><br>Review of an Initial History and Physical form for Resident #134 with a reference date of [DATE] revealed Code Status List: Full Code .Consent: I reviewed the patient's advance care directives in the facility chart. I have signed the advance care directives with the facility.<br><br>During an observation on [DATE] at 1:41pm, no advance directive forms for Resident #134 were present in the facility's CPR Binder.<br><br>In an interview on [DATE] at 1:42pm, Registered Nurse (RN) J reported if a resident's heart stopped, staff would refer to the CPR Binder to determine a resident's wishes for CPR.<br><br>During an observation on [DATE] at 9:18am, the facility's CPR Binder contained a green sheet of paper with Resident #134's name on it with the words FULL CODE typed in bold print. No advance directives were present for Resident #134.<br><br>In an interview on [DATE] at 9:22am, Resident #134 reported he was not given an opportunity to review the advance directive paperwork upon his admission but had decided on [DATE], when he was approached, in the event his heart stopped (cardiac arrest), he did not want to receive CPR. Resident #134 reported he believed the facility had documented his wishes in his medical chart.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on [DATE] at 9:26 am, Social Worker (SW) E reported Resident #134 was admitted the facility on the weekend and the floor nurse should have gone over the resident's wishes regarding CPR with him at that time, but did not do so. SW E reported she reviewed the Advance Directive form with Resident #134 on [DATE] and he indicated at that time that he wanted his code status to be DNR (do not resuscitate). SW E reported it was her responsibility to reach out the physician as soon as a resident completed an Advance Directive form because the resident's DNR status would not be honored until the physician signed the form. When further queried, SW E reported she had not provided Resident #134's advance directive form to the physician for signature as of this date. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384<br><br>Based on interview, and record review, the facility failed to notify the resident representative of a resident exiting the facility in 1 of 2 residents (R15) reviewed for notification of changes, resulting in the responsible party not being made aware that R15 walked out a door observed but unattended and subsequent placement of a wander guard.<br><br>Findings include:<br><br>According to the Minimum Data Set (MDS) dated [DATE], R15 scored 4/15 on her BIMS (Brief Interview Mental Status) indicating she was severely cognitively impaired. Diagnoses included schizoaffective disorder and dementia. Section GG-Functional Abilities and Goal indicated supervision or touching assistance was required when walking at least 150 feet in a corridor or similar space.<br><br>Review of R15's Incident/Accident Report dated 4/23/25, indicated the resident was wandering/exit seeking and opened an exit door and went outside the facility. A wander guard was applied, and care plan was updated. The family member/resident representative was not notified until 5/6/25 which was noted to be after the start of the recertification survey began.<br><br>Review of R15's Care Plan dated 4/24/25 indicated the resident was at risk of elopement from facility related to exit seeking behavior and/or verbalizations of wanting to leave. The goal was to not leave the building unattended. To meet this goal, interventions were put into place that included resident wearing a wander guard.<br><br>Review of R15's Progress Note indicated:<br><br>- 4/23/2025 6:20 PM RN was exiting room [ROOM NUMBER] when she looked at the exit door and saw resident standing outside back door. 2nd shift housekeeper stated he saw resident open the door, and step outside .Wander guard has been placed on resident's right ankle and care plan has been updated with R15 on half-hour checks .<br><br>-4/23/25 6:35 PM, the social worker initiated R15 in the elopement book .wander guard was placed by nurse . care plans initiated<br><br>- 4/24/25 11:25 AM, R15 had a wander guard on her right ankle due to behaviors from the night before<br><br>Review of R15's Progress Note dated 5/6/25 at 3:19 PM, revealed, This social worker called (R15's) son . and left a message regarding elopement risk and wander guard placement .<br><br>During an interview on 5/7/25 at 2:35 PM, Director of Nursing (DON) B stated, (R15's) son was not notified on 4/23/25 of (R15) leaving the facility. Expectations are resident representative/guardian to be notified in a timely manner. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384<br><br>This citation pertains to intake number MI00151548<br><br>Based on observation, interview, and record review the facility failed to: 1.) maintain a clean and homelike environment for 5 residents (R82, R15, R182, R134, and R135), and 2.) maintain comfortable noise level for 2 residents (R134 and R135) of 12 residents reviewed for homelike environment, resulting in potential for dissatisfaction with living conditions for the 5 residents and residents who are able to ambulate in the facility.<br><br>Findings include:<br><br>Facility tour on 5/05/25 at 10:52 AM, revealed the handrail outside of room [ROOM NUMBER] had a hole, approximately 2 inches in width, with exposed sharp-jagged pieces of plastic.<br><br>During a tour of the facility on 5/6/25 at 8:15 AM, observation, interview, and record review were conducted with Maintenance F. Observed a handrail outside of room [ROOM NUMBER] that had a hole, approximately 2 inches in width, with exposed sharp-jagged pieces of plastic. Maintenance F stated, I did not know that was there. That needs to be repaired, it is sharp.<br><br>Observed the handrail outside of room [ROOM NUMBER] to be cracked. Maintenance stated, I did not know about this one either.<br><br>Reviewed the Work Order binder at the nursing station with Maintenance F revealed there were no orders for any handrails to be repaired. Maintenance F stated, It is hard to get staff to document in the book. Mostly staff just yells down the hall what they need. I can't remember everything the staff tells me.<br><br>R82<br><br>During an observation and interview on 5/5/25 at 9:26 AM, a Certified Nursing Assistant (CNA) X entered R82's room to empty the resident's bedside commode. The framing on the front of the bedside commode had a dried-brown substance resembling fecal matter. CNA X went back into the bathroom, retrieved a dry paper towel, and wiped off the bedside commode seat. CNA X did not clean the dried-brown substance off of the bedside commode's frame.<br><br>Observed on 5/5/25 at 2:25 PM, the frame on the front of R82's bedside commode had a dried-brown substance resembling fecal matter.<br><br>Observed on 5/6/25 at 8:30 AM, the frame on the front of R82's bedside commode had a dried-brown substance resembling fecal matter.<br><br>Observed on 5/6/25 at 4:00 PM, the frame on the front of R82's bedside commode had a dried-brown substance resembling fecal matter.<br><br>(continued on next page) |

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|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observed on 5/7/25 at 6:55 AM, the frame on the front of R82's bedside commode had a dried-brown substance resembling fecal matter.<br><br>During an observation and interview on 5/7/25 at 9:00 AM, the frame on the front of R82's bedside commode had a dried-brown substance resembling fecal matter. R82 stated, I am here for rehab. I have my own apartment with a bedside commode. I would not have my bedside commode be dirty like this at home. My boyfriend visits me, and I would be embarrassed if he saw this. That is nasty. Staff should clean that.<br><br>R15<br><br>According to the Minimum Data Set (MDS) dated [DATE], R15 scored 3/15 on her BIMS (Brief Interview Mental Status) indicating she was cognitively impaired. Diagnoses included dementia.<br><br>Further review of R15's MDS dated [DATE], Section H-Bowel and Bladder, indicated the resident was occasionally incontinent of urine and frequently incontinent of bowels.<br><br>Observed on 5/5/25 at 10:48 AM, a straight-backed chair in R15's room with a brown streak, resembling fecal matter, smeared on the seat.<br><br>Observed on 5/6/25 at 9:36 AM, a straight-backed chair in R15's room with a brown streak, resembling fecal matter, smeared on the seat.<br><br>Observed on 5/7/25 at 6:25 AM, a straight-backed chair in R15's room with a brown streak, resembling fecal matter, smeared on the seat.<br><br>During an interview on 5/7/25 at 10:28 AM, Housekeeping U and V reported the straight-backed chair in R15's has feces smeared on it and happens all the time.<br><br>48637<br><br>Resident #182 (R182)<br><br>Review of the Facesheet and Minimum Data Set (MDS) dated [DATE] revealed R182 admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R182 was cognitively intact (13 to 15 cognitively intact).<br><br>During an observation and interview on 5/6/2025 at 10:52 AM, R182 reported that her bedside commode was full of urine and feces. Urine and feces were observed in the commode and urine spilled outside of the commode onto the floor. R182 said she used the commode at :00 AM and again at 9:30 AM and no one came to empty the commode or clean the floor yet.<br><br>During an interview on 5/6/2025 at 1:02 PM, Director of Nursing (DON) B reported that the nurse or CNA (Certified Nursing Assistant) should empty and clean the commode when it was dirty. DON B said even if a resident doesn't need help and can use the commode by themself, staff still needs to empty and clean it.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/6/2025 at 1:05 PM, Regional Clinical Consultant (RCC) Y stated that the commode should be checked and emptied every couple of hours.<br><br>During an observation on 5/5/2025 at 9:21 AM, on south hall it was noted that the grip pad on the bottom of the weight scale in the family lounge was torn and flaking.<br><br>During another observation and interview on 5/6/2025 at 10:51 AM, it was noted that the grip pad on the bottom of the weight scale in the family lounge was still torn and flaking. Maintenance Director (MD) F was seen in the family lounge getting a drink from the vending machine and stated that he didn't notice the torn gripper pad on the scale. MD F said he would have to call the company and see if he could get another gripper pad.<br><br>46999<br><br>Resident #134<br><br>In an interview on 5/5/25 at 11:44am, Resident #134 reported the noise level at night made it difficult for him to sleep. Resident #134 reported another resident, in a room across the hall from his, was very vocal at night and he had not been able to sleep well due to the noise level. Resident #134 reported he was awakened at 2am by a resident yelling from across the hall. Resident #134 reported he was admitted to the facility for therapy and planned on returning home after he recovered. Resident #134 stated I've got to get some rest so I can get my strength back and go home. Resident #134 described himself as exhausted from a lack of sleep. When further queried, Resident #134 reported the facility had not offered him ear plugs, a fan for white noise, or consistently closed his door in effort to reduce the noise level and support his need for rest.<br><br>During an observation on 5/6/25 at 11:56am, a female resident, in a room across the hall from Resident #134 was heard yelling. The resident's yelling was audible from approximately 40' away, outside the resident room.<br><br>In an interview on 5/6/25 at 9:21am, Resident #134 reported the resident across the hall began screaming at approximately 4am on this date and continued until breakfast time. Resident #134 reported he told staff several times since his admission on 5/3/25 that the noise level at night was interfering with his sleep but there had been no resolution to the problem. When further queried, Resident #134 reported he would be willing to try using earplugs at night, but none had been offered to him.<br><br>In an interview on 5/7/25 at 8:37am, Resident #134 reported he did not sleep well because the resident across the hall was screaming loudly for an extended period. Resident #134 stated something has to be done. Resident #134 reported the facility moved the resident who was yelling into a vacant room while she was yelling but the noise was still audible from his room, and it kept him awake.<br><br>During an observation on 5/8/25 at 11:14am, a privacy curtain that was soiled with a dried and congealed, reddish-brown liquid splattered across it, hung between the beds in Resident #134's room.<br><br>In an interview on 5/8/25 at 11:13am, Resident #134 reported he expected the noise level at the facility to be managed so that he could sleep at night. Resident #134 also reported he expected the surfaces in his room, including the privacy curtain, to be promptly cleaned if they were soiled. Resident #134 voiced concern regarding the condition of the privacy curtain in his room.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 5/8/25 at 10:55am, Social Worker (SW) E reported a female resident who resided across the hall from Resident #134, was very noisy when she was awake. SW E reported the female resident was routinely awake most of the night and communicated her needs with loud vocalizations. SW E reported several residents had complained about the noise level near the female resident's room. SW E stated other residents are suffering because she's so noisy. SW E reported the staff at night sometimes move the female resident to a room a few doors down the hall when she is vocalizing, although her vocalizations could still be heard down the hall. SW E reported Resident #134 had not been offered earplugs, although the facility did have them.<br><br>Resident #135<br><br>Review of an Admission Record revealed Resident #135 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: depression (persistent sad mood).<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #135 with a reference date of 4/18/25, revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #135 was cognitively intact.<br><br>Review of a Care Plan for Resident #135 with a reference date of 1/28/25, revealed a problem/goal/approaches of: Problem: Resident has a DX (diagnosis) of depression and insomnia and receives hypnotic, antidepressant .Goal: Resident will be prescribed lowest effective dose of medication. Approaches: Administer medication (s) as ordered. Observe for effectiveness .<br><br>In an interview on 5/6/25, at 9:18am, Resident #135 stated The #1 problem (at the facility) is the noise level at night. Resident #135 reported a female resident across the hall from him screamed all the time, including at night. Resident #135 reported he awoke at 4:30am the previous night when he heard the female resident screaming. Resident #135 reported he complained about the noise level interfering with his sleep, but the facility had not resolved the issue. Resident #135 reported he was not offered any earplugs by the facility and had to ask a friend to bring him some. Resident #135 reported he planned on buying his own headphones so he would not hear the screaming during the day.<br><br>In an interview on 5/7/25 at 8:39am, Resident #135 reported he was kept awake by the noise level again during the previous night. Resident #135 reported at times staff closed his room door to reduce the noise but doing so was ineffective and inconsistent.<br><br>In an interview on 5/8/25 at 11:15am, Resident #135 reported he was concerned that the privacy curtain in his room appeared to have dried blood or some other reddish-brown liquid dried on it in several spots. Resident #135 reported he expected anything that appeared to be soiled with bodily fluids would be cleaned/removed immediately from his room.<br><br>Review of a Home Like Environment facility policy with a reference date of 1/2025 revealed Policy: Residents are provided with a safe, clean, comfortable and homelike environment .1. Staff shall provide person-centered care that emphasizes the residents' comfort .2. The facility .shall maximize .the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .a. cleanliness .h. comfortable noise levels. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999<br><br>Based on observation, interview, and record review, the facility failed to ensure psychotropic medications were not used without medical indication for use for 3 (Resident #134, Resident #182, and Resident #29) of 5 residents reviewed for chemical restraints.<br><br>Findings include:<br><br>Review of a Psychotropic Medication Use facility policy with a reference date of 1/2025 revealed Policy: Residents are not given psychotropic medication unless the medication is necessary to treat a specific condition, diagnosed and documented in the clinical record .Pre-admission screening may be used to determine indications for use of psychotropic medications ordered upon admission to the facility.<br><br>Resident #134<br><br>Review of an Admission Record revealed Resident #134was originally admitted to the facility on [DATE] with pertinent diagnoses which included: depression (persistent sad mood), metabolic encephalopathy (brain disorder caused by disruptions in the body's metabolic processes, leading to brain dysfunction).<br><br>Review of a Care Plan for Resident #134 with a reference date of 5/5/25, revealed no interventions related to the resident's use of psychotropic medications or non-pharmacological interventions that had been/could be used to support the resident's psychosocial well-being.<br><br>Review of a History and Physical for Resident #134 with a reference date of 5/5/25 revealed The pharmacy is concerned about the patient's use of quetiapine and aripiprazole (psychotropic medications) The patient denies any history of schizophrenia or hallucinations. There is no supporting diagnosis of psychosis in the medical record.<br><br>Review of Physician Orders for Resident #134 with a reference date of 5/3/25 revealed: aripiprazole tablet: 15mg (milligrams) once a day, buspirone tablet; 10 mg twice a day, quetiapine tablet extended release; 20 mg, 1 tab (tablet), once a morning, trazadone tablet; 50mg, 1 tab at bedtime.<br><br>In an interview on 5/8/25, at 10:43am, Social Worker (SW) E reported Resident #134 was admitted to the facility on quetiapine, aripiprazole, buspirone, and trazadone. SW E reported all 4 medications were considered psychotropic medications and the resident should have diagnoses that supported the use of each medication. SW E confirmed Resident #134 had no known medical condition that would justify the use of these medications and that should have been addressed prior to his admission to the facility.<br><br>48637<br><br>Resident #182 (R182)<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Facesheet and Minimum Data Set (MDS) dated [DATE] revealed R182 admitted to the facility on [DATE] with pertinent diagnoses including spinal stenosis (the space inside the bones of the spine gets too small) and history of falling. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R182 was cognitively intact (13 to 15 cognitively intact).<br><br>Review of R182's physician orders revealed the following current medications Risperdal (risperidone, antipsychotic) tablet; 0.5 mg (milligrams); amt (amount): 1 tablet; oral At Bedtime 07:00 PM - 11:00 PM with a start date of 4/24/2025. Zoloft (sertraline, antidepressant) tablet; 25 mg; amt: 1 tablet; oral Once A Day 07:00 AM - 11:00 AM with a start date of 4/29/2025.<br><br>Review of R182's chart revealed a progress note by Social Services (SS) E dated 4/28/2025 Hospital notes reviewed, (R182) was started on Risperdal 0.5mg 1tab (tablet) HS (evening). Steroid induced agitation and confusion. Post op (post operation) needed a sitter while in the hospital. The hospital ordered Trazadone HS and Haldol. Current medications do not include Haldol or trazadone. Hospital psych recommended Depakote HS<br><br>Review of R182's chart revealed no documentation that a consent form for Zoloft was completed.<br><br>During an interview on 5/7/2025 at 12:17 PM, SS E reported that consents need to be discussed and signed by resident/responsible party and signed by the physician before any resident starts on an antipsychotic or antidepressant medication. SS E said that the consent form for Risperdal was completed but the consent for Zoloft was missed and not done at the time it was started.<br><br>Review of Behavior Log for Certified Nursing Assistants (CNAs) to document R182's behavior indicated 5/2 Zoloft added-crying-thoughts of dog-active listening with SS E's initials under staff initials. No behaviors were documented on the log.<br><br>Review of the Medication Administration Record (MAR) for nurses to document R182's behaviors indicated Behavior Monitoring: Yelling=1, Refusal of Care/Services=2, Combative=3, Hallucinations=4, Agitation=5, Delusions=6, Other=7 (if other please note specific behavior), None-8. No behaviors were noted on the MAR.<br><br>Review of Nurse Practitioner (NP) progress note dated 4/25/2025 revealed History Patient underwent C2-C6 posterior spinal fusion due to central cord syndrome. Course was complicated by hospital induced delirium which improved Medication List: medications reviewed, please see MARS Diagnosis, Assessment and Plan: . ICD Codes: R41.0 Delirium: in hospital, now improved, continue with Risperdal .5 mg (milligram) nightly.<br><br>Review of the physician progress note dated 4/30/2025 revealed History: Medication List: medications reviewed, please see MARS. There was no mention of R182 being on Risperdal and Zoloft and no diagnoses supporting the continued use of these medications.<br><br>During a phone interview on 5/7/2025 at 1:41 PM, NP CC stated that R182 had delirium in the hospital after surgery and was started on Risperdal so she decided to continue with Risperdal for now. NP CC stated that her delirium was a diagnosis and it wasn't safe to take her off Risperdal upon admission to the nursing home.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a phone interview on 5/7/2025 at 3:46 PM, Pharmacist (P) DD stated that delirium was a symptom and wasn't a diagnosis. P DD said that he didn't complete the monthly pharmacy review for R182 yet but the hospital discharge notes indicated that she had delirium due to her medical condition and P DD stated there was no diagnosis to support the antipsychotic use.<br><br>Review of R182's current care plan for antipsychotic and antidepressant use revealed there were no non-pharmacological interventions in place.<br><br>During an interview on 5/7/2025 at 3:15 PM, Director of Nursing (DON) B stated that delirium was a symptom of a problem, it's not a diagnosis. DON B said she was aware that there wasn't a diagnosis for use of the antipsychotic Risperdal and that they didn't have a consent for the antidepressant Zoloft. DON B and Regional Clinical Consultant (RCC) Y stated that they were aware that nonpharmacological interventions needed to be tried first and listed in the care plan and realized they were missing. DON B and RCC Y also stated that there were aware that there wasn't any documentation by the NP or Physician of why she was on the antipsychotic and what the plans were for it. DON B said she wasn't sure if she put anything in the physician book regarding the medical justification of R182 being on the antipsychotic and then stated, I probably didn't since the doctor didn't address it in his note. DON B and RCC Y were aware that the Behavior Log for the CNAs and the MAR documentation for the nurses displayed no behaviors since admission and stated they needed to discuss whether the need to continue the antipsychotic was justified.<br><br>Review of Psychotropic Medication Use Policy with a review date of 1/2025 revealed Policy Explanation and Compliance Guidelines .2. The indications for use of any psychotropic drug will be documented in the medical record. a. Pre-admission screening may be used to determine indications for use of psychotropic medications ordered upon admission to the facility. b. For psychotropic medications initiated after admission to the facility, documentation is to include the specific condition as diagnosed by the physician. c. Psychotropic medications will be initiated after other causes have been ruled out or addressed, and nonpharmacological interventions have been attempted. 3. Residents and/or representatives will be educated on the risks and benefits of psychotropic medication use, as well as alternative treatments/non-pharmacological interventions.<br><br>38384<br><br>R29<br><br>According to the Minimum Data Set (MDS) dated [DATE], R29 scored 4/15 on his BIMS (Brief Interview Mental Status) indicating he was severely cognitively impaired. Diagnoses included dementia, mood disturbance, and anxiety.<br><br>Review of R29's Order Summary dated 4/11/25, revealed Risperidone (antimanic) 0.5 mg 1 tablet PO (by mouth) twice daily (DX (diagnoses) Unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety).<br><br>Review of R29's Care Plan dated 4/22/25, indicated no non-pharmacological interventions that had been/could be used to support the resident's psychosocial well-being were listed.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R29's Progress Note dated 4/24/25 11:47 AM, indicated the resident experienced behaviors of cussing, hitting, yelling and biting staff, resistive to care, and refusing medications due to thinking medications were poison. No non-pharmalogical approaches were listed to support the resident's psychosocial well-being.<br><br>During an interview on 5/8/25 at 12:15 PM, Director of Nursing (DON) B stated, It is a standing order the nurse that does the admission, myself when double-check orders, or with a new order of antipsychotic/antimanic that monitoring of adverse side affects should be done per shift. It is a simple button to push that initiates this order to monitor for side effects.<br><br>Review of facility policy, Psychotropic Medication Use reviewed 1/2025, reported psychotropic medications will be initiated after nonpharmacological interventions have been attempted. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637<br><br>Based on interview and record review, the facility failed to provide a written bed hold notice and transfer/discharge notice for 1 of 1 resident (Resident #5) reviewed for hospitalization s, resulting in the potential of residents and/or resident representatives being uninformed of the reason for transfer and not being able to hold a bed in the facility.<br><br>Findings include:<br><br>Resident #5 (R5)<br><br>Review of the Facesheet and Minimum Data Set (MDS) dated [DATE] revealed R5 admitted to the facility on [DATE] with pertinent diagnoses including hypoglycemia (low blood sugars), lupus (illness that occurs when the immune system attacks healthy tissues and organs) and epilepsy (disorder in which nerve cell activity in the brain is disturbed causing seizures). Brief Interview for Mental Status (BIMS) reflected a score of 13 out of 15 which indicated R5 was cognitively intact (13 to 15 cognitively intact). R5 had a legal financial guardian.<br><br>During an interview on 5/5/2025 at 10:13 AM, R5 stated that she had been in and out of the hospital several times due to low blood sugars/seizure like activity. R5 couldn't recall if staff spoke to her about the bed hold notice or if they contacted her guardian about the bed hold and transfer/discharge notice.<br><br>Review of R5's chart revealed that she was transferred to the hospital on 8/7/2024 due to hypoglycemia and seizure like activity and returned on 8/10/2024. She was also transferred to the hospital on 12/26/2024 for chest pain and coughing and returned on 12/28/2025.<br><br>Review of R5's chart revealed that there was no documentation that bed hold notices or transfer/discharge notices were given to R5 or her guardian.<br><br>During an interview on 5/6/2025 at 10:32 AM, Licensed Practical Nurse (LPN) L discussed the paperwork that was sent out with a resident when they were transferred/discharged to the hospital and she couldn't remember if a bed hold policy or transfer/discharge notice was part of the paperwork.<br><br>On 5/6/2025 at 9:38 AM, an email was received from Nursing Home Administrator (NHA) A which stated, We have not been able to locate any bed holds for (R5) .<br><br>On 5/06/2025 at 11:47 AM, another email was received from NHA A which stated, We have not been able to locate the transfer/discharge notices for (R5).<br><br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 05/7/2025 at 2:59 PM, Director of Nursing (DON) B stated that the nurses know about the bed hold and transfer notice paperwork that must go with a resident/contact the guardian when they are transferred/discharged to the hospital. DON B verified that R5 did not have any documentation that a bed hold policy and transfer/discharge notice was given to R5/R5's guardian on 8/7/2024 and 12/26/2024. DON B also verified that an interact form (information that the hospital gets when a resident is transferred from the nursing home) was not documented in the chart.<br><br>Review of the Bed Hold Policy with a review date of 1/2025 revealed Procedure: 1. The facility Social Worker or designee will provide a copy of the bed hold policy to the resident and/or the resident representative at the time of admission and again prior to a transfer due to hospitalization or therapeutic leave 2. The facility shall provide the bed hold policy Acknowledgement to the resident or the resident representative with any resident initiated therapeutic leave or transfer to alternative healthcare community including a hospital admission. This acknowledgement will provide information to the resident and/or resident representative that explains the duration, the reserved bed payment policy and also facility permitting return to the resident of the next available bed 3 . Documentation of the bed hold decision will be completed in the resident's medical record . 7. A copy of the resident's bed hold or release record will be filed in the resident's medical record.<br><br>Review of the Resident Transfers and Discharge Notification Policy with a review date of 1/2025 revealed Transfer and Discharge: residents that are transferred due to emergency care or a physician planned transfer to a hospital or clinic setting in which a resident is expected to return will have a transfer form completed and communicated to the receiving facility. The resident medical record will have documentation or evidence that the following information has been provided to the receiving provider For facility initiated transfer or discharge of a resident the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing in a language and manner they understand . |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999<br><br>Based on observation, interview, and record review the facility failed to provide meaningful activities to promote psychosocial well-being for 1 (Resident #27) of 12 residents reviewed for activities. This deficient practice resulted in social isolation, feelings of loneliness, frustration and boredom.<br><br>Findings include:<br><br>Review of an Admission Record revealed Resident #27 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: depression (persistent sad mood).<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #27 with a reference date of 3/18/25, revealed a Brief Interview for Mental Status (BIMS) score of 11/15 which indicated Resident #27 was moderately cognitively impaired. Section D of the MDS revealed Resident #27 reported he rarely felt lonely or isolated from those around him. Section E of the MDS revealed Resident #27 displayed no behaviors during the 14-day assessment period. Section F revealed the resident reported it was somewhat important to him to be around animals and to go outside when the weather was good.<br><br>Review of Resident #27's Activity Assessment with a reference date of 3/17/25 revealed the resident was a high school graduate, had no religious preference and was a registered voter. The assessment did not include identification of any leisure interests that were important to Resident #27, either in the past or currently.<br><br>Review of a Care Plan for Resident #27 with a reference date of 5/5/25, revealed a problems/goals/approaches of: 1. Problem: Resident displays physical behavioral symptoms of hitting his own head on the wall in his room .Goal: Resident will maintain appropriate behavioral functioning . Approaches: provide opportunity for resident to vent feelings, listen in non-judgmental manner . 2. Problem: (Resident #27) chooses not to engage in scheduled activities. Goal: Resident will appear comfortable, satisfied and content with their personal daily facility activities/routine. Approaches: Offer setting in which activities are preferred: such as own room .going outside .ensure through social visits that resident has what she (sic) needs .will provide social visits to provide companionship .<br><br>In an interview on 5/5/25 at 11:58am, Resident #27 reported he felt lonely and depressed due to his admission to the facility. Resident #27 reported he told staff several times that he felt lonely, and nothing had been done to support his psychosocial well-being. Resident #27 reported he tried to attend a few group activities, but his legs became painful as he sat with them in a dependent position, and he had to leave the activity. Resident #27 reported staff did not talk to him much and he recently became very frustrated and slammed his head against the wall because staff were socializing with his roommate but didn't include him in the conversation.<br><br>During an observation on 5/5/25 at 2:31pm, Resident #27 was lying in his bed. The curtains were closed in his room, no lights were on.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 5/6/25 at 9:37am, Activity Director (AD) G reported Resident #27 had no leisure interests, and didn't really like anything. When further queried, AD G reported Resident #27 did not like to read because he had a visual deficit, was not interested in playing cards, had only come to 1 or 2 table game activities since his admission, was not religious, and did not like pet visits. AD G reported Resident #27 often said he was lonely. AD G reported she provided Resident #27 with a 1:1 visit once a week for 10-15 minutes.<br><br>During an observation on 5/6/25 at 9:52am, Resident #27 was lying in his bed. The curtains were pulled closed in his room, no lights were on.<br><br>In an interview on 5/6/25 at 9:53am, Resident #27 reported the only time he felt happy was when he was in the rehabilitation gym because the staff there joked with him and seemed to like him.<br><br>Review of a Resident #27's Activity Participation Records from 3/15/25- present revealed the resident attended a Yahtzee game once, was observed socializing with another resident (frequency not indicated) and received an unknown number of social visits from the Activity Director.<br><br>In an interview on 5/6/25 at 1:36pm, AD G reported she did not track the frequency or duration of social visits for Resident #27. AD G reported Resident #27 was receptive to socializing with her at times. When asked what interventions would be appropriate for a resident who regularly expressed loneliness, AD G reported she would try to talk to them more often but she was the only activity staff for the building. AD G reported the facility did not have volunteers that could offer social visits or additional activities. When queried about what types of activities were provided to the residents on the weekend, AD G reported residents could attend a volunteer lead church service on Saturdays and that nothing (activities) is going on on Sundays at this time.<br><br>In an interview on 5/7/25 at 9:38am, Social Worker (SW) E reported Resident #27's sister requested the resident receive regular staff visits because the resident reported he was lonely. SW E reported she recently began visiting the resident but had not documented the visits. SW E reported she was also working with the resident to support him getting outdoors. SW E reported Resident #27 appeared receptive to a plan for him to go outside but asked how he would do so as he had not been outdoors since he was admitted to the facility.<br><br>During an observation on 5/7/25 at 1:25pm, Resident #27 sat supported in his bed, the lights were off, and the curtains were pulled. When approached, the resident welcomed this writer and began talking.<br><br>In an interview on 5/7/25 at 1:26pm, Resident #27 reported he worked at a car wash for [AGE] years and really enjoyed being physically active with his work because it made him feel good. Resident #27 smiled and reminisced about what he accomplished at his job.<br><br>Review of an Activity Calendar with a reference date of April 2025 revealed the only weekend programming offered throughout the month were 2 religious activities, one of which was a televised church service. No activities were offered in the evening. Only 2 physical activities were offered for the entire month. No outdoor activities were offered. 1 craft activity was offered. No pet visits were offered. No social activities were offered. No reminiscing activities were offered.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of an Activity Programming facility policy with a reference date of 6/2017 revealed Activity programs designed to meet the needs of each resident are available on a daily basis. Our activity programs are designed to encourage maximum individual participation and are person-appropriate to the individual resident. Procedure: 1. Activities are scheduled 7 days a week .2. Our activity programs .are designed to meet the needs and interests of each resident and include, as a minimum: activities that stimulate the range of motion, such as exercise .season and weather permitting, an outdoor activity that is held on a regular basis, at least one evening activity is offered per week .group activities are offered on Saturday, Sunday and holidays .social activities .<br><br>Review of an Activity Director Job Description revealed General Purpose: Responsibility for developing, planning, implementing and evaluation of activity programs for residents .ensure that the spiritual, emotional, recreational, leisure and social needs of the residents are maintained on a group and individual basis. Duties .plan, develop, organize, implement, direct and evaluate the activity programs to ensure all residents' assessed needs are met .record and maintain .record of residents' activities .<br><br>Review of Loneliness and Social Isolation- Tips for Staying Connected, published by the National Institute of Health, July, 2024 revealed Loneliness is the distressing feeling of being alone .Social isolation is the lack of social contacts .Older adults are at higher risk for social isolation and loneliness due to changes in health and social connections that can come with growing older .People who are lonely experience emotional pain . Emotional pain can activate the same stress responses in the body as physical pain.<br><br>Review of The Needs of Older People with Dementia in Residential Care, [NAME] G. A. Woods B. [NAME] D. , & [NAME] M. (2006). Published by in the International Journal of Geriatric Psychiatry, 21, 43-49. doi:10. 1002/gps.1421 revealed Determining which activities have high degrees of meaningfulness can aide recreation staff in creating programs more likely to promote health and wellness for persons with dementia. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384<br><br>Based on observation, interview, and record review, the facility failed to adequately assess, monitor, and treat a change of skin condition in 1 of 1 resident (R21) reviewed for quality of care, resulting in a delay in assessment, treatment, pain, and the potential for worsening of condition and infection.<br><br>Findings include:<br><br>According to the Minimum Data Set (MDS) dated [DATE], R21 scored 99/15 on her BIMS (Brief Interview Mental Status) indicating the resident was severely cognitively impaired, was dependent on cares and mobility with diagnoses including Alzheimer's disease and dementia.<br><br>Observed on 5/5/25 at 8:55 AM, R21 with a gauze dressing covering the top of her right hand with three spots of red drainage showing through. The dressing was not dated.<br><br>Review of R21's Order Summary indicated an order to treat a wound on resident's right hand was not made until after survey began (5/5/25).<br><br>Review of R21's Care Plan did not have a resident-specific treatment plan for the injury to top of right hand.<br><br>Observed on 5/6/25 at 10:00 AM, R21 with a gauze dressing covering the top of her right hand dated 5/6.<br><br>During an interview on 5/7/25 at 6:00 AM, Director of Nursing (DON) B stated, (R21) had a small scab on top of her hand and no one knows where it came from or when it happened. The nurse was looking at the wound, the scab came off, and pus oozed out of it.<br><br>During an interview on 5/7/25 at 11:16 AM, Assistant Director of Nursing (ADON) II stated, My Jjb duties include being the wound nurse. I do rounds with the wound doctor. I make care plans and treatments. I did not know R21 had a wound on her hand until yesterday, (5/6/25). I scanned R21's medical records and cannot tell you how the skin event happened. No one notified me of it. No skin event was created, and it is policy it is to be completed.<br><br>Review of R21's Progress Note dated 5/1/25 at 2:44 PM revealed, Resident had scabbed area on dorsal (top) R (right) hand. When touched, a bit of pus came out. During turn, that scab came off. No bleeding. Cleansed with Dakins and bandage applied.<br><br>Review of R21's Physician Note dated 5/2/25 reported an evaluation of a right had scab with purulent drainage from the scab that was covered with gauze.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of facility policy, Skin Care reviewed 1/2025, reported the policy was intended to supplement the clinical staff's knowledge and provide a resource to guide on wound prevention and management procedures. The purpose was to promote and facilitate skin integrity with appropriate interventions and treatment of skin impairments to promote resolution of impaired areas. Nurse was to complete a skin body assessment as needed with CNAs (Certified Nursing Assistant) to inspect resident's skin and report irregularities or concerns to the licensed nurse for evaluation. Interventions are to be implemented, and care planned based on individualized resident needs. Non-pressure-related skin impairment will be assessed and documented upon discovery. Physicians and responsible parties are to be notified of skin impairment upon identification. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for 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** 38384<br><br>Based on observation, interview, and record review, the facility failed to follow physician's orders to complete a wound dressing in 1 of 1 resident (R29) reviewed for pressure ulcer care, resulting in a missed opportunity to provide care needed to heal a pressure wound and prevent infection.<br><br>Findings include:<br><br>According to the Minimum Data Set (MDS) dated [DATE], R29 scored 4/15 on his BIMS (Brief Interview Mental Status) indicating he was severely cognitively impaired. Section M-Skin Conditions revealed R29 was not at risk for a pressure ulcer and had an unhealed pressure wound. Diagnoses included dementia and anxiety.<br><br>Review of R29's Wound Management Report created 4/14/25, reported the resident had a right trochanter wound measuring 5.5 cm x 3.5 cm. Mild amount of serosanguinous (bloody fluid) drainage noted. 100 percent of wound covered by slough tissue (by-product of inflammation and can be a barrier to healing).<br><br>Review of R29's Medication/Treatment Administration Report (MAR/TAR) dated 5/1/25-5/31/25 revealed, 4/25/25 Open area to right trochanter: Cleanse with wound cleanser/NS, pat dry, apply Medi honey, cover with bordered gauze. Change daily and PRN as needed for soilage of dislodgment.<br><br>Further review of R29's MAR/TAR dated 5/1/25-5/31/25 revealed Licensed Practical Nurse (LPN) L documented the resident refused wound treatment on 5/6/25.<br><br>Review of R29's Care Plan dated 4/25/25, the resident was identified as having a stage 3 (pressure ulcer) (full-thickness skin loss that involves damage or necrosis of subcutaneous tissue (fat)) to trochanter with potential for infection and discomfort to area. The goal was for the ulcer to heal without complications using interventions that included treatment as ordered and to keep area clean and dry.<br><br>During an interview on 5/7/25 at 6:00 AM, Director of Nursing (DON) B stated, (R29's) dressing is to be changed every day on first shift, 6a-2p.<br><br>Observed on 5/7/25 at 7:00 AM, R29's dressing to right hip dated 5/5. Two areas of wound drainage were seen through the gauze dressing.<br><br>During an interview on 5/7/25 at 11:16 AM, Assistant Director of Nursing (ADON) II stated, My Job duties include wound nurse. I do round with the wound doctor. I make care plans and treatments. (R29) was admitted with a right hip wound and the wounds on his legs. He is followed by the outside wound care service. The wound is healing. (R29) is ordered for a daily dressing change on first shift by the nurse that is assigned to him. Yesterday, (LPN L) was assigned. When surveyor told ADON II R29's wound dressing to right hip was dated for 5/5, ADON II stated, You found my dressing from Monday, 5/5. The wound has slough. The ordered Medihoney (medical grade honey-based product, specifically a wound and burn dressing, used to promote healing in various types of wounds) eats the slough and if not applied every day it does not heal the wound.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/7/25 3:03 PM, Licensed Practical Nurse (LPN) L stated, I was unable to do (R29's) wound care yesterday (5/6/25). I was very busy and just didn't get to it. I did not tell the (DON B) or another nurse. It is very important to the physical well-being and healing of wounds to make sure the treatment is done. LPN L did not explain why the medical record reflected that R29 refused the treatment on 5/6/25. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384<br><br>Based on observation, interview, and record review, the facility failed to: 1.) implement interventions to ensure a safe environment in 1 of 1 resident (R15) and, 2. ensure the safety of residents during wheelchair transport in 2 of 3 residents (R134 and R182) reviewed for safety, resulting in the potential for R15 to elope from the facility and increase potential for injury for R134 and R182.<br><br>Findings include:<br><br>R15<br><br>According to the Minimum Data Set (MDS) dated [DATE], R15 scored 3/15 indicating she was cognitively impaired. Diagnoses included dementia, manic depression (bipolar disease), and schizophrenia. Her mobility status was evaluated to require supervision or touching assistance for sitting standing, toilet transfer, and walking for at least 150 feet.<br><br>Review of R15's Progress Note dated 9/18/24 at 4:22 PM indicated around 2:30 PM, R15 was pulling on the slider door in the dining room. Approximately 2 hours later, R15 was taken outside and stood with her for a few minutes which seemed to take care of her need to go outside.<br><br>Review of R15's Care Plan dated 9/18/24, did not have a resident-specific focus and interventions to prevent another incident of the resident attempting to leave the facility.<br><br>Review of R15's Incident/Accident Report dated 4/23/25 reported R15 opened an exit door and left the facility. Behavioral factors included schizoaffective disorder and dementia with behavioral disturbance. Interventions/Corrections Implemented included increased monitoring, updated care plan, and wander guard applied.<br><br>Review of R15's Care Plan, 4/24/25, indicated the resident was at risk for elopement from facility related to exit seeking behavior and/or verbalizations of wanting to leave. The goal was for R15 not to leave the building unattended using interventions that included 30-minute checks and a wander guard to right ankle with no end date.<br><br>Review of R15's Progress Note dated 4/23/25 at 6:20 PM, revealed, .Wander guard has been placed on resident's right ankle and care plan has been updated. The resident is now on half hour checks .<br><br>Review of R15's Elopement Risk assessment dated [DATE] indicated the resident left the facility unattended on 4/23/25 at 3:51 PM. R15 was physically capable of eloping out of the facility and had a history of wandering or elopement. R15 had stood or sat at a locked door and waited for someone to let them out when that person was going through the door and had left the facility unattended.<br><br>Review of R15's Order Summary dated 5/1/25, eight days after the resident exited the door, a wander guard was placed to the resident's right ankle.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview and record review on 5/6/25 at 3:50 PM, DON B reviewed R15's 30-minute monitoring dated 4/22/25 starting at 6:00 PM until 4/23/25 ending at 2:30 PM. It was noted this was less than 24-hours of monitoring for leaving the facility unattended.<br><br>Review of R15's Behavioral Log Flow Sheet dated 1/27/25 to 4/20/25 had been documented 11 times in 120 days. Behaviors included screaming, yelling, throwing cups of water at peers, frustration, escalating behaviors, excessive restlessness, anxiety, and wandering. No behaviors had been recorded by staff in R15's Behavioral Log Flow Sheet immediately before the elopement on 4/23/25 or after through 5/5/25 to continue monitoring the resident's behavior and potential to elope.<br><br>R134<br><br>Review of R134's Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy.<br><br>Review of R134's Baseline Care Plan was not dated, and indicated the resident's mode of ambulation was the independent use of a wheelchair due to an existing above the knee amputation.<br><br>Observed on 5/7/25 at 7:14 AM, Registered Nurse (RN) K pushing R134 in wheelchair with no footrest on the wheelchair in the South Hall. R134's bare foot was brushing against the floor. Halfway down the hall RN K asked R134 to pick up his foot and did not apply a footrest to the wheelchair.<br><br>R182<br><br>According to the Minimum Data Set (MDS) dated [DATE], R182 scored 15/15 on her BIMS (Brief Interview Mental Status) indicating she was cognitively intact.<br><br>Observed on 5/7/25 at 10:46 AM, Certified Nursing Assistant (CNA) Q pushing R182 in a wheelchair from the shower room to the resident's room without footrests. R182 was bare foot with her toes skimming the hall floor.<br><br>During an interview on 5/8/25 at 9:58 AM, Regional Clinical Director Y stated, No resident should be transported in a wheelchair without footrests. The resident's feet could be trapped under the wheelchair and cause an injury, or the resident could fall out of the chair.<br><br>Review of Mosby's Textbook for Long-Term Care Nursing Assistants by [NAME] Kostelnick, 6th Edition 2014 titled Wheelchair safety revealed, Make certain the persons feet are on the footplate's (foot pedals) before moving the chair. The person's feet must not touch or drag on the floor when the chair is moving. Never push a person in a wheelchair without feet resting on footplates (foot pedals). |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384<br><br>Based on observation, interview, and record review, the facility failed to provide adequate urinary catheter care and assessment for the need of an indwelling catheter (catheter inserted in through the urethra and into the bladder) for 1 of 1 resident (R29) reviewed for catheter care, resulting in the potential for the dislodgement, injury, pain, development of urinary infection and decline in overall health status.<br><br>Findings include:<br><br>According to the Minimum Data Set (MDS) dated [DATE], R29 scored 4/15 on his BIMS (Brief Interview Mental Status) indicating he was severely cognitively impaired. Diagnoses included urinary retention.<br><br>Review of R29's Order Summary dated 4/22/25, revealed:<br><br>-Ensure urinary catheter fixation device is in place to prevent trauma and irritation Q shift<br><br>- Catheter Care every shift Type: Indwelling Size: 16 French Balloon: 10 cc<br><br>Review of R29's Medication/Treatment Administration Record dated 5/1/25-5/31/25 indicated the licensed nurses for all shifts verified a catheter fixation device was in place from 5/1/25 through first shift on 5/8/25.<br><br>During an observation and interview on 5/7/25 at 6:58 AM, Certified Nursing Assistants (CNAs) Q and FF performing bowel incontinence care for R29. No leg fixation device was in place. CNA Q stated, A leg fixation device should be used to secure the tubing to prevent accidental tugging. (R29) also will try to pull out the catheter if he feels it pulling.<br><br>During an interview on 5/7/25 at 7:11 AM, Director of Nursing (DON) B stated, Leg straps/fixation devices are to be worn so the indwelling catheter does not get pulled out.<br><br>During an interview on 5/8/25 at 12:20 PM, DON B stated regarding a indwelling catheter Void Trial, Physician Z has not talked to me about nor has attempted a void trail for removal of (R29's) urinary catheter. (R29) came with catheter on 4/11/25 for urinary retention. I do not know how long he had the catheter before he came here. There should be a void trial within the first month and there has been no talk of one for (R29).<br><br>(continued on next page) |

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| Plainwell Pines Nursing and Rehabilitation Communi | 3260 East B Ave<br>Plainwell, MI 49080 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of facility policy, Incontinence Management reviewed 1/2025 revealed, .Residents using catheters must have Medical Justification with periodic assessment to justify continued usage. Every attempt must be made to discontinue the usage of catheters .The resident will be placed on an individualized toileting program which may include bladder retraining .Through the completion of the Initiation/Discontinuation of the Indwelling Urinary Catheter Event in the electronic medical record, the following items will be achieved and documented .will have documentation of the involvement of the resident/representative in the discussion of the .removal of the catheter when the criteria or indication for use is no longer present .timely and appropriate assessments related to the indication for use of an indwelling catheter will be completed . |

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| | 235637 | A. Building<br>B. Wing | 05/08/2025 |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999<br><br>Based on observation, interview and record review, the facility failed to provide ongoing communication and collaboration with the contracted dialysis facility regarding dialysis care for 1of 1 resident (Resident #135) reviewed for dialysis, resulting in the potential for unmet medical needs.<br><br>Findings include:<br><br>Review of a Dialysis Policy and Procedure facility policy with a reference date of 1/2025, revealed Policy: It is the policy of (name of organization omitted) to meet the needs of those residents undergoing dialysis treatment. Procedure .There must be communication between the facility and the dialysis center weekly .The (nutrition specialist) should review the residents pre and post weights and labs from the dialysis center and notify the dietitian if the resident is at nutritional risk or if the resident and labs vary significantly.<br><br>Review of an Admission Record revealed Resident #135 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: end stage renal disease and dependence on renal dialysis.<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #135 with a reference date of 4/18/25, revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #135 was cognitively intact.<br><br>Review of a Care Plan for Resident #135 with a reference date of 4/15/25, revealed a problem/goal/approaches of: 1. Problem: Potential for fluid imbalance r/t (related to) .ESRD (end stage renal disease) on dialysis. Goal: Resident will not exhibit signs of side effects or complications secondary to fluid imbalance. Approaches: Asses for fluid excess: wt (weight) gain, elevated BP (blood pressure) . 2. Resident is at risk for complications D/T (due to) dialysis r/t ESRD. Goal: Resident will not exhibit s/s (signs and symptoms) complication R/T dialysis. Facility will communicate with dialysis center. Approaches: Assess for fluid excess (weight gain, increased BP .increased urinary output .Communicate with dialysis center weekly and prn (as needed) .monitor weight as ordered .<br><br>In an observation on 5/6/25 at 9:59am, a binder labeled Dialysis Communication Forms revealed no communication sheets for Resident #135 in recent months.<br><br>In an interview on 5/6/25 at 9:18am, Resident #135 reported he received a monthly report from a dietitian at the dialysis facility, but he was unsure if that information was shared with the dietitian at the nursing facility. Resident #135 reported the nursing facility did send a communication sheet with him to the dialysis center.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 5/6/25 at 10:03am, Registered Nurse (RN) K reported prior to each dialysis appointment, Resident #135 should be assessed with a complete set of vital signs. RN K reported the facility was responsible to document Resident #135's vital signs and recent medications given on a communication sheet that was then sent with the resident to the dialysis center. RN K reported the facility, and the dialysis center communicated a variety of resident needs on the communication form, including pre and post dialysis weights, dietitian recommendations, medications given prior to and during dialysis.<br><br>In an interview on 5/6/25 at 1:55pm, Director of Nursing (DON) B reported the facility should complete a communication sheet prior to each dialysis appointment and send the information with the resident. The communication sheet should be returned to the facility with the resident after the dialysis appointment and be placed in the dialysis binder until it was uploaded into the resident's electronic medical record.<br><br>Review of Dialysis Communication Form for Resident #135 with a reference date of 1/2/7/25, revealed the nursing facility was responsible for assessing and communicating the resident's vital signs, including body temperature, oxygen level, heart rate, blood pressure and blood glucose level as well as any dietary concerns, or psychosocial concerns to the dialysis center prior to dialysis. In turn, the dialysis center documented and communicated the resident's pre-dialysis and post-dialysis weight, changes in the dialysis regimen, changes in medication, laboratory results and physician orders to the facility with the communication form.<br><br>In an interview on 5/7/25 at 12:02pm, DON B reported the facility could not provide any Dialysis Communication Forms for Resident #135. DON B reported the lack of forms meant there was no proof of the required ongoing communication between the facility and the dialysis center. DON B reported it was the expectation that the floor nurse called the dialysis center if the communication sheet was not returned to the facility with the resident after each dialysis treatment, but she did not believe the floor nurses had done so. DON B reported she contacted the dialysis center and confirmed that the dialysis center did not always complete the communication form and return it to the skilled nursing facility. DON B reported without documented communication between the facility and the dialysis center there was an increased risk for a resident's medical needs to go undetected and untreated.<br><br>In an interview on 5/7/25 at 12:07pm Dietitian Technician (DT) HH reported she relied on the Dialysis Communication Forms to coordinate nutritional services for Resident #135. DT HH reported the resident's nutritional assessment was pending and she would need to review the Dialysis Communication Forms during her assessment process, and weekly thereafter to ensure Resident #135 needs were met. |

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| F 0727<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>48637<br><br>Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was on duty for 8 consecutive hours a day, seven days a week, resulting in the potential for inadequate coordination of routine or emergency care affecting all residents in the facility.<br><br>Findings include:<br><br>Review of the October 2024 weekend schedule on Sunday, October 20, 2024, revealed there was no RN coverage.<br><br>During an interview on 5/7/2025 at 9:57 AM, Scheduler (S) I stated that when there wasn't a RN available to work on the weekend, she tries to get an agency RN to come in and if she can't get agency staff in either Director of Nursing (DON) B or the Assistant Director of Nursing (ADON) would go into the facility.<br><br>During an interview on 5/7/2025 at 10:15 AM, Regional Clinical Consultant (RCC) Y stated that she couldn't find any evidence that a RN worked on 10/20/2024. |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>48637<br><br>Based on interview and record review, the facility failed to employ a staff member with appropriate credentials to supervise and manage the dietary department, resulting in the potential for food service sanitation failures, food borne illness and for clinical areas of dietary needs of all residents being compromised and unmet.<br><br>Findings include:<br><br>During the initial kitchen tour on 5/5/2025 at 8:33 AM, Dietary Manager (DM) H stated that he had been at the facility for over a year now (date of hire 1/23/2024) and had his food manager certification. He said he was trying to complete the Certified Dietary Manager course but had been so busy with the facility.<br><br>Review of DM H's certification revealed that he completed the Food Protection Manager certificate on 4/25/2025 which was a certificate that could be completed in a day instead of completing a full course of study in management which takes a year plus to complete.<br><br>During another interview on 5/6/2025 at 9:17 AM, DM H stated that the Dietetic Technician, Registered (DTR) comes to the facility every week to do clinical work and the Registered Dietitian (RD) who was based in Ohio came in every few months.<br><br>During an interview on 5/06/2025 at 11:27 AM, Nursing Home Administrator (NHA) A stated that she thought DM H had the right credentials and completed the right certification to run the kitchen. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>48637<br><br>Based on observation, interview, and record review, the facility failed to ensure proper label and dating of foods and discarding of foods in the kitchen resulting in the potential to spread food borne illness to all residents that consume food from the kitchen.<br><br>Findings Include:<br><br>During the initial tour of the kitchen on 5/5/2025 at 8:33 AM, the following was observed:<br><br>The reach in refrigerator had a pitcher of iced tea, half full with a use by date of 5/4/2025.<br><br>The walk-in refrigerator had 3 trays of individual juices in 12 oz plastic glasses with no label and date.<br><br>During a full kitchen tour on 5/6/2025 at 9:17 AM, the following was observed in the dry storage room:<br><br>An open crystal light lemonade packet in a plastic bag with an open date of 3/13/2025 and use by date of 4/12/2025<br><br>An open fruit punch packet in a plastic bag with an open date of 3/13/2025 and use by date of 4/12/2025<br><br>An open big bag of sugar flakes cereal with no label and date.<br><br>On 5/6/2025 at 9:45 AM, the following was observed in the walk-in refrigerator:<br><br>A small open container of ham base with an open date of 3/3/2025 and a use by date of 4/1/2025.<br><br>On 5/6/2025 at 10:05 AM, the nurses station freezer was observed to have the following:<br><br>A single serving ice cream in a bowl with no label and date.<br><br>A frozen water bottle stuck to the bottom of the freezer.<br><br>During an interview on 5/6/2025 at 11:45 AM, Dietary Manager (DM) H stated that he had completed education with his staff many times regarding labeling/dating and throwing food out past the use by date and he was very frustrated since issues were identified during the survey.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety .<br><br>Review of the Storage Procedures Policy with a revision date of 1/2025 revealed .Refrigerated Storage: .11. Leftovers are refrigerated immediately and used within 5-7 days with a use by date clearly marked. Staff will follow Food Code Requirements for storage and dating.12. All foods in the freezer are to be labeled and dated with use by dates clearly marked |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384<br><br>Based on observation, interview, and record review, the facility failed to ensure an effective infection control program that included: 1. cleaning of resident equipment for 1 of 16 residents (R82), 2. appropriate hand hygiene and glove use (PPE-Personal Protection Equipment) during resident care in 2 of 16 residents (R82 and R29), 3. implementation of Enhanced Barrier Precautions (EBP) per standards of practices for 2 of 16 residents (R29), reviewed for infection control, resulting in the potential for cross-contamination, harborage of bacteria, and increased infections in a vulnerable population.<br><br>Findings include:<br><br>Upon entering facility, 5/5/25, Nursing Home Administrator (NHA) A announced all staff in resident areas were to wear masks due to a staff testing positive for Covid-19.<br><br>Tour of facility on 5/5/25 at 9:14 AM, revealed outside of room [ROOM NUMBER] a high-backed wheelchair splattered with a dried white substance on seat cushion, foot cushion, and frame of chair. The nuts on the frame had a buildup of dark colored debris. The wheelchair did not have a resident identifier.<br><br>During an observation and interview on 5/5/25 at 10:58 AM, CNA GG exited room [ROOM NUMBER], with a surgical mask off and immediately placed it back on when noticing surveyor. CNA GG placed mask over mouth but not nose reporting she was waiting for resident to finish having a bowel movement. CNA GG reported she was agency staff and had not received infection control training from facility.<br><br>Observed on 5/7/25 at 6:00 AM upon entering facility, CNA JJ greeted surveyor at front door after walking through facility without wearing a mask. One housekeeping staff and two contract staff were not wearing masks until the surveyor entered the facility. Director of Nursing (DON) B was standing at the nursing station with a mask under chin. When the surveyor was seen, DON B mask placed her mask over her mouth and nose.<br><br>R82<br><br>According to R82's Face Sheet, the resident was admitted to the facility 5/1/25 for rehabilitation due to a stroke and acquired a pressure wound to her ischium.<br><br>Review of R82's Order Summary dated 5/6/25 indicated Enhanced Barrier Precautions (targeted gown and gloves use) during high contact resident care activities. Every Shift; 06:00 AM - 02:00 PM, 02:00 PM - 10:00 PM, 10:00 PM - 06:00 AM<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 - Some | During an observation and interview on 5/5/25 at 9:15 AM, Physician Z reported he was going to make his new admit assessment with R82. Outside of R82's room was a CDC (Centers for Disease Control) EBP sign and an isolation cart. Physician Z donned a gown retrieved from the isolation cart. No gloves were in the isolation cart, so Physician Z went to the isolation cart outside of room [ROOM NUMBER] and did not find gloves. Physician Z then went towards the nursing station to find gloves while wearing the disposable gown. Physician Z returned with a box of gloves and donned a pair without performing hand hygiene. Physician Z reported he did not know why R82 was on EBP due to his first time meeting her.<br><br>During an observation and interview on 5/5/25 at 9:26 AM, Certified Nursing Assistant (CNA) GG entered R82's room, donning only gloves without first performing hand hygiene. CNA GG removed the bedside commode bucket that contained urine, emptied it into the toilet, and replaced it on the bedside commode. The framing on the front of the bedside commode had a dried-brown substance resembling fecal matter. CNA GG went back into the bathroom, retrieved a dry paper towel, and wiped off the bedside commode seat while wearing the same gloves she used to empty the bucket. CNA GG did not clean the dried-brown substance off the bedside commode's frame. CNA GG stated, I do not know why (R82) is on Enhanced Barrier Precautions.<br><br>R29<br><br>According to the Minimum Data Set (MDS) dated [DATE], R29 scored 4/15 on his BIMS (Brief Interview Mental Status) indicating he was severely cognitively impaired. Diagnoses included stage 3 pressure wound and urinary retention (indwelling catheter).<br><br>Review of R29's Order Summary revealed:<br><br>-4/11/25 Enhanced Barrier Precautions (targeted gown and gloves use) during high contact resident care activities. Every Shift; 06:00 AM - 02:00 PM, 02:00 PM - 10:00 PM, 10:00 PM - 06:00 AM<br><br>-4/22/25 catheter care every shift 26 fr ((French) size of tubing) 10 ml balloon (to keep placement in bladder)<br><br>-4/25/25 open area to right trochanter (hip area)<br><br>Review of R29's Care Plan dated 4/22/25, indicated the resident was placed on Enhanced Barrier Precautions (targeted gown and gloves use) related to urinary catheter and pressure wound.<br><br>During an observation and interview on 5/5/25 at 9:35 AM, R29 was taken down the [NAME] Hall to his room by Therapist W. R29's catheter bag was in a pillow case dragging underneath wheelchair. A privacy bag was attached to the frame of R29's wheelchair but not in use. EBP signage with an isolation cart was outside of R29's door. Therapist W did not use hand sanitizer before donning a gown or gloves before placing a pillow behind resident in wheelchair. Therapist W stated R29 had a urinary catheter in the pillowcase and had no idea why it was not in the privacy bag. Therapist W then doffed gloves and re-donned gloves and got down on knees to look at privacy bag and pillowcase. After initially touching the pillowcase and catheter tubing, Therapist W stood up, doffed gloves, donned a gown, then donned clean gloves without performing hand hygiene.<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 - Some | Observed on 5/6/25 at 8:00 AM, 1:30PM, and 5:14PM, R29 was in the dining room with catheter bag in privacy bag with tubing resting on the floor.<br><br>During an observation and interview on 5/7/25 at 6:58 AM, CNAs Q and FF performing incontinence care for R29's. An indwelling catheter was observed with urinary tubing filled with urine. On R29's right trochanter was a wound dressing. CNA Q stated the resident had a pressure wound. Both CNAs were wearing gloves, but neither were wearing a gown. CNA FF moved R29's urinary tubing and catheter bag multiple times throughout the procedure. Posted outside of R29's room was CDC EBP signage and an isolation cart.<br><br>During an interview on 5/7/25 at 10:48 AM, CNA Q stated, I should have worn a gown when providing incontinence care for (R29). He is on EBP which requires staff to wear gown, gloves, mask, and goggles to protect against contamination.<br><br>During an interview on 5/7/25 at 11:16 AM, Assistant Director of Nursing (ADON) II stated, I am the wound nurse. Staff should be following EBP for catheter care to prevent transmission of infection.<br><br>Observed on 5/7/25 at 1:00 PM, R29 by the dining room with his urinary catheter tubing dragging on the floor underneath his wheelchair.<br><br>Observed on 5/8/25 at 9:15 AM, R29 by the nursing station with his urinary catheter tubing dragging on the floor underneath his wheelchair.<br><br>During an interview on 5/8/25 at 12:15 PM, DON B stated, A urinary catheter tube should not be touching the ground to prevent contamination and infection control purposes. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999<br><br>Based on interview and record review, the facility failed to ensure COVID-19 immunizations were offered to 1 (Resident #21) of 5 residents reviewed for COVID-19 immunizations, resulting in an increased risk for infection, and the potential spread of COVID-19 infection to other residents, staff, and visitors.<br><br>Findings include:<br><br>Upon entering facility, 5/5/25, Nursing Home Administrator (NHA) A announced all staff in resident areas were to wear masks due to a staff testing positive for Covid-19.<br><br>Review of an Admission Record revealed Resident #21 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease (disease resulting in a progress decline in cognitive abilities). The Admission Record also revealed Resident #21 had a durable power of attorney (DPOA) for medical decision making.<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #21 with a reference date of 1/20/25, revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated Resident #21 could not complete the assessment.<br><br>Review of an Preventive Health Report for Resident #21 with a reference date of 1/20/25-5/625 revealed the resident had no record of receiving a covid vaccination.<br><br>In an interview on 5/7/25, at 11:05am, Infection Preventionist/Registered Nurse (IPRN) C reported Resident #21 was not current on the covid vaccination. IPRN C reported she had reached out to the resident's activated DPOA via the telephone to seek consent for Resident #21 to receive the covid vaccination. IPRN reported she had not received a return phone call from Resident #21's DPOA. When further queried, IPRN C reported she had no proof of her attempts to contact Resident #21's DPOA.<br><br>In an interview on 5/7/25 at 11:20am, Regional Clinical Consultant (RCC) Y reported the facility should have reached out the Medical Director to determine if it would be appropriate to provide Resident #21 with the covid vaccination, given the fact that the resident had received the vaccination a few years prior to her admission to the facility.<br><br>Review of the facility's Covid-19 Vaccine Administration policy, with a reference date of 1/20/25 revealed: It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine. |