STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235723	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Post-Acute Rehabilitation	2060 Health Drive Wyoming, MI 49519

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intake M100143672. Based on observation, interview and record review, the facility failed to have an effective telephone communication system to the facility for 1 (Resident #5) of 3 residents reviewed for communication from outside the facility. This deficient practice has the potential to affect all residents who reside at the facility. Findings include: Resident #5 (R5) Review of a Face Sheet revealed R5 admitted to the facility on [DATE] with pertinent diagnoses of Parkinsons disease, congestive heart failure, and cognitive communication deficit. Review of the MDS dated [DATE] revealed R5 was moderately cognitively impaired. In an interview on 5/15/24 at 9:28 AM, Designated Power of Attorney (DPOA) J for R5 reported she tried to call R5 in his room when he resided at the facility and his phone did not receive incoming calls. The DPOA J reported she would then call the front desk and the phone would ring for a while and then would get an automated message that did not give the option to leave a message or redirect her call. She reported she talked to the maintenance man regarding the phone system, and he gave her a code to try. DPOA J reported when she tried to use the code, she reached the receptionist at the front desk and was confused. One day DPOA J called the facility and it had been ringing over an hour and used another phone to call the Social Worker to let him know she was trying to reach the charge nurse. The Social Worker told her it was hard to hear her on the phone and was disconnected. She could not talk to the nurse or R5 regarding care concerns. In an interview on 5/15/24 at 10:30 AM, Maintenance Director (MD) F reported there has been some problems with the phones in resident rooms when the DD [Do not Disturb] button is accidentally pushed. No phone calls will go through then. On the 3rd Floor there was a glitch in the programming of the phone for one room specifically and has since been resolved. The phones are very specific to each room and are not interchangeable. MD F had not had any concerns with room [ROOM NUMBER] where R5 resided during his admission and only recalled the DD button being pushed. (continued on next page)

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/15/24 at 10:40 AM, Licensed Practical Nurse (LPN) G reported that sometimes transferring the phone to a resident room can be challenging if the phones are on DD because they won't go through. LPN G reported they have a new phone system and the phone will ring at the nurses station and after a certain amount of time it will go to a message system but the caller cannot leave a message. If nobody is at the nurses' station, the phone will not get answered and she does get concerns reported to her about it. During an observation on 5/20/24 at 2:14 PM- This surveyor called the facility and asked the receptionist to transfer the call to the 3rd floor nurses station. The phone rang approximately 4 times, and then a recording came on and said, Voice Mail disabled for this extension and then disconnected the call. In an interview on 5/20/24 at 2:25 PM, the Nursing Home Administrator (NHA) reported he was not aware of DPOA J not having phone calls go through to the floors and does not have any records of her calling him with any concerns. He denies having any concern forms related to the phone system. NHA reported they are trying to switch tech companies but are locked into a contract right now and when it comes to an end, they can switch. He reported the phones are supposed to recycle to another nursing station if it is not answered on the floor. Informed the NHA that it did not happen when a phone call was just made prior to this interview.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to M100142556, M100143537, and M100143672. Based on interview and record review, the facility failed to provide residents a list of pertinent contact information to the State Agencies (SA), advocacy groups and the like, a description of the requirements and procedures for establishing eligibility for Medicaid, and Medicare/Medicaid coverage, and how to file a complaint with the SA, how to file a grievance, and resources for information regarding returning to the community for 4 (Resident #1, Resident #5, Resident #11, Resident #12) of 4 residents reviewed. This deficient practice affects all 54 residents who reside at the facility. Resident #1 (R1) Review of a Face Sheet revealed R1 admitted to the facility on [DATE]. In an interview on 5/14/24 at 10:28 AM, the Power of Attorney (POA) O for R1 reported the facility was to assist them in finding long-term care placement and was in the process of getting Medicaid which they were approved for. R1 had an acute condition and had to go to the hospital and the facility refused to accept him back. POA O was confused why the facility would not accept him back. She felt it was insurance related concerns because the facility would not accept him. POA O reported she did not receive an admission packet when R1 admitted to the facility that had any information regarding procedures for Medicaid/Medicare coverage or to any State Agency/advocacy groups. She was not aware of any bed hold policies. Resident #5 (R5) Review of a Face Sheet revealed R5 admitted to the facility on [DATE]. In an interview on 5/15/24 at 9:28 AM, Designated Power of Attorney (DPOA) J reported she did not get an admission packet for R5 when he admitted to the facility informing her of pertinent information related to insurance and Medicaid resources, costs/ fees, or bed hold policies. This lack of information caused her to not have the resources to apply for Medicaid timely, be informed about bed hold policies in advance of a transfer to the hospital, or contact/resource information to State Agencies, to help prepare for the needs of the resident. DPOA J reported the process of R5's financial journey has been stressful. DPOA J reported she did not receive any information when R5 was admitted to the facility regarding Medicaid insurance procedures, how to file a grievance or any other pertinent information. When R5 went to the hospital, the facility refused to let him come back to the Facilty. She was not aware of any bed hold policies. R11 Review of an Admissions, Discharges and Transfer report revealed R11 admitted to the facility on [DATE]. In an interview on 5/16/24 at 10:10 AM, R11 reported she did not receive a bed hold policy when she admitted to the facility and did not know what it was. (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R12 Review of an Admissions, Discharges and Transfer report revealed R12 admitted to the facility on [DATE]. In an interview on 5/16/24 at 10:20 AM, R12 reported she did not receive a bed hold policy when she admitted to the facility and did not remember receiving any documents when she admitted . In an interview on 5/16/24 at 10:31 AM, the Nursing Home Administrator (NHA) reported he has very limited beds and all the beds at the facility are dually certified. The NHA reported R5 was pending Medicaid and to re-admit the resident back to the facility, they would not have had a payor source and would have to do an authorization to admit him back. The NHA reported the facility does not have a policy on permitting residents to return to the facility after hospitalization s and does not give the residents admission packets upon admission to the facility. There is no information given to the residents other than the Admission Agreement.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0579 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide information about how to apply for and use Medicare and Medicaid benefits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intake M100143672. Based on interview and record review, the facility failed to assist and provide written information on how to apply for and use Medicare and Medicaid benefits for 1 (Resident #5) of 1 resident reviewed, resulting in the resident/representative not having Medicaid coverage in a timely manner and had an out-of-pocket expense. Findings include: Resident #5 (R5) Review of a Face Sheet revealed R5 admitted to the facility on [DATE] with pertinent diagnoses of Parkinsons disease, congestive heart failure, and cognitive communication deficit. In an interview on [DATE] at 9:28 AM, Designated Power of Attorney (DPOA) J reported she did not get an admission packet for R5 when he admitted to the facility informing her of pertinent information related to insurance and Medicaid resources. DPOA J reported the process of R5's financial journey has been stressful. His Medicare insurance ended in January, and the facility tried to discharge him home. She told the facility there was no way he could go to his home when he required a 2-person assistance for care. The facility told her it would cost her $500 a day and they needed 30 days in advance, but she could only give them $1500 for 3 nights. The facility then offered for R5 to apply for Medicaid, and she asked them if she would be able to get the $1500 back then and they told her no. DPOA J reported she had to fill out the paperwork several times because she didn't have any help. She now has a $14,000 bill. She talked to a Medicaid specialist at another facility who told her all the medical bills should have been submitted for payment and they were not. When asked about the NOMNC (Notice of Medicare Non-Coverage), she reported she was told that the insurance will no longer cover his stay because he was released from Physical Therapy and was not getting any better. That is all she could remember about the conversation and was not provided with a copy of the NOMNC. She could not say for sure she was offered to appeal the decision. Review of a Social Services progress note dated [DATE] for R5 revealed: BOM (Business Office Manager) received a check for three days from [POA] for [R5] and was given a Medicaid application to fill out to begin the process for Medicaid. Review of a Nursing Progress note dated [DATE] for R5 revealed: Medicaid pending denies. Looking into spend down and Alternate placement. Review of a Social Worker Progress note dated [DATE] for R5 revealed DPOA J was informed that the facility will not be accepting R5 back from the hospital since he will be needing long term care replacement and a rehab not being the appropriate setting. [DPOA J] expressed frustration with the lack of communication per the progress note. (continued on next page)

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F 0579 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 2:31 PM, the Social Worker (SW) B reported the NHA (Nursing Home Administrator) had input on why R5 could not return to the facility while he was pending Medicaid. R5 no longer qualified for therapy and met his max potential. Therefore, he would no longer be a candidate for SAR (Sub-acute Rehab). If residents need long term care, they contact a company to assist them in finding an open bed for the residents to transfer. Review of a Business Office Manager (BOM) progress note dated [DATE] for R5 revealed: I let (DPOA J) know that once [R5] was admitted to the hospital his Medicaid pending turned to private pay, and in order to readmit into the facility that it would have to be paid. In an interview on [DATE] at 10:31 AM, the Nursing Home Administrator (NHA) reported he is filling in as the BOM since the previous one is no longer there. He reported he has very limited beds and all the beds at the facility are dually certified. He reported R5 did go to the hospital and when it was time for the resident to be discharged from the hospital, the NHA reported he told the hospital R5 was not a good Sub-Acute Rehab (SAR) referral because he needed long term care (LTC). The NHA emphasized this facility was built for SAR not for LTC. The NHA reported R5 was pending Medicaid and to admit the resident back to the facility, they would not have had a payor source and would have to do an authorization to admit him back. The NHA reported the facility does not have a policy on permitting residents to return to the facility after hospitalization s and does not give the residents admission packets upon admission to the facility. Review of NOMNC the for R5 revealed his Medicare services will end on [DATE]. The form is not signed by the DPOA and has a note at the bottom of the form signed by the previous Social Worker who is no longer in that position indicating that he contacted the DPOA and explained her rights to an appeal. In an interview on [DATE] at 2:13 PM, the Regional BOM Consultant (RBOM) K reported the facility was designed to be a SAR and all beds are dually certified to help accommodate those who have their insurance's run out. They can help assist in getting residents on Medicaid if needed and they can stay until they are approved. BOM K reported R5 was pending Medicaid upon discharge to the hospital on [DATE] when he fell off the radar. She confirmed R5's Medicare expired on [DATE] when he was served the NOMNC. The POA should have signed the NOMNC herself either by coming into the facility or have a copy mailed to her and return it. The facility should have assisted the DPOA in applying for Medicaid and is not sure why it was not started sooner than [DATE] when the family was given the application. There was not much follow up when his Medicare stopped.

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intakes M100143672 AND M100142556. Based on interview and record review, the facility failed to have an admission policy and procedure and provide admission packets for 3 (Resident #5, Resident #11, Resident #12) of 3 residents reviewed, resulting in residents being uninformed of their rights and resources, and the absence of written information available to the resident/responsible party regarding costs, policies, procedures, and services. This deficient practice affects all residents admitted to the facility. Findings include: In an interview on 5/15/24 at 9:28 AM, Designated Power of Attorney (DPOA) J reported she did not get an admission packet for R5 when he admitted to the facility informing her of pertinent information related to insurance and Medicaid resources, costs/ fees, or bed hold policies. This lack of information caused her to not have the resources to apply for Medicaid timely, be informed about bed hold policies in advance of a transfer to the hospital, or contact/resource information to State Agencies, to help prepare for the needs of the resident. DPOA J reported the process of R5's financial journey has been stressful. There was a lack of assistance and timing of his Medicaid application that cost her money out of her pocket and did not know there was such a thing as a bed hold policy. When he went to the hospital on 3/25/24, he was not allowed back to the facility. Resident #5 (R5) Review of a Face Sheet revealed R5 admitted to the facility on [DATE] with pertinent diagnoses of Parkinsons disease, congestive heart failure, and cognitive communication deficit. Review of the MDS dated [DATE] revealed R5 was moderately cognitively impaired and required substantial to maximum assistance for most Activities of Daily Living (ADLs) and dependent for toileting, bathing, and mobility. Review of the Electronic Medical Record (EMR) for R5 revealed no Consent to Treat or Admission Agreement on file. In an interview on 5/16/24 at 10:00 AM, the Nursing Home Administrator (NHA) reported the facility did not have an admission policy and did not provide the residents with an admission packet that informs them of their rights, bed hold policies, costs, contact information, facility information, services and fees, and other pertinent information. The NHA reported they have a Consent to Treat & Admission Agreement only. The NHA reported they currently did not have a Business Office Manager and he was stepping in until they hire a new one. He reported that the facility was a Sub-Acute Rehab (SAR) and that was what this building was made for. The NHA reported all the beds at the facility were dually certified. Resident #11 (R11) (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of an Admissions/Discharge Summary revealed R11 admitted on [DATE]. In an interview on 5/16/24 at 10:10 AM, R11 reported when she admitted to the facility, she did not receive an admission packet. Review of the electronic medical records for R11 revealed no Consent to Treat or Admission Agreement on file. Resident #12 (R12) Review of an Admissions/Discharge Summary revealed R12 admitted on [DATE]. In an interview on 5/16/24 at 10:20 AM, R12 reported she did not receive an admission packet when admitted to the facility and looked around in her room to make sure. Review of the electronic medical records for R12 revealed no Consent to Treat or Admission Agreement on file. Review of a Notice of Bed Hold Policy revealed ***This document must be signed by the patient upon discharge to the hospital or therapeutic leave*** If unable to sign, notification from the patient and/or family/DPOA (Designated Power of Attorney) must be documented. Complete top section upon admission with resident or responsible party. This NOTICE OF BEDHOLD POLICY is provided to _____ on the effective date of admissions as well as upon any subsequent transfer to a hospital for a therapeutic leave, the date of which is applicable, is _____

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intakes M100142556, 143537, and 143672. Based on interview and record review, the facility failed to prepare for discharges, provide a safe home discharge, and allow a readmission post hospitalization for 2 (Resident #4 and Resident #5) of 3 residents reviewed for discharges, resulting in both residents needing to find placement at another long-term care facility. Findings include: Resident #4 (R4) Review of a Face Sheet revealed R4 admitted to the facility on [DATE] with pertinent diagnoses of acute kidney failure, muscle weakness and cognitive communication deficit. Review of the Minimum Data Set (MDS) dated [DATE] for R4 revealed he was moderately cognitively impaired and required partial to moderate assistance with mobility. Review of the discharge MDS dated [DATE] revealed R4 required supervision or touching assistance with some mobility. He was dependent for bathing, ambulation greater than 150 feet or walking 10 feet on uneven surfaces and picking up objects. He had a manual wheelchair. Review of the discharge MDS dated [DATE] for R4 revealed he required the same assistance documented on the 1/3/24 assessment. Review of an email correspondence reported to the State Agency revealed R4 was discharged home and could not care for himself. When the outpatient home care services arrived at his home the next day on 3/15/24, they sent him back to the hospital and reported R4 was not discharged home safely. In an interview on 5/20/24 at 10:09 AM, the Home Healthcare Agency Director (HAD) N reported they had a Physical Therapist (PT) visit R4 on 3/15/24, the day after he was discharged from the facility. When the PT arrived, the resident was not able to care for himself and the Home Care did not admit him. His sister told them they had a hard time getting him from the car to the house a fell a couple times getting to the door after he was discharged from the facility. His sister could not toilet him, transfer him or meet his needs. Review of a Hospital Progress note for an admission of 3/15/24 for R4 revealed: [R4] presented to [Emergency Department] via EMS (emergency medical services) due to concern for weakness and inability for him to care for himself. Patient presented with his sister and brother-in-law who stated he was discharged from rehab the day prior to presentation. They dropped him off at home and when home nursing came the next morning, he was still in the same position stating he could not get up. Admission diagnoses was Generalized weakness and urinary tract infection. R5 was discharged to another long-term care facility. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Hospital Physical Therapy Progress notes dated 3/16/24 for the 3/15/24 hospital admission for R4 revealed: At baseline, patient is independent with mobility prior to last rehab stay and typically uses 4WW (wheeled walker) for mobility. Pt (patient) reports that prior to rehab was completing all basic cares independently but sister was helping with grocery laundry and meal prep as well as providing transport. At this time, patient is requiring increase level of assist and shows moderate balance and coordination deficits impacting pt safety with activity. Pt shows mild cognitive deficits and safety awareness deficits that are impacting independence with mobility at this time as well indicating that further skilled Physical Therapy is required. Clinical Impression: per pt presentation pt shows potential to progress with continued skilled therapy but level of family assist may be a barrier to return home due to safety concerns. Otherwise pt shows good potential to improved with balance and strength to improve functional independence. (sic) Review of the Notice of Medicare Non-Coverage (NOMNC) for R4 revealed his services were scheduled to end on 3/13/24 and he signed the form on 3/11/24. The Business Office Manager at the time witnessed his signature. In an interview on 5/15/24 at 2:30 PM, Social Worker (SW) B reported R4 was able to appropriately answer questions and had no concerns of his cognitive status even though his BIMS (Brief Interview for Mental Status) showed he was moderately cognitively impaired. SW B did remember the resident wanted to go home. R5 was independent and lived at home alone. Review of Discharge Instructions and Recap of Stay for R4 with an effective date of 3/11/24 and discharge date of [DATE] revealed he discharged to home with his sister because his condition improved. Nursing services recap of medical stay included R5 needing assistance with ADLs (Activities of Daily Living) and medication administration. Rehabilitation recap of stay included At discharge, resident functioning with Supervision utilizing wheeled walker for all self-care and ambulatory tasks utilizing wheeled walker. Review of the Physical Therapy (PT) Discharge Summary from the facility for R4 revealed he was discharged from services on 3/13/24. Upon discharge, he required supervision or touching assistance with bathing, grooming/hygiene, and the assistance of 1 CGA (contact guard assistance), posterior lean for stand pivot transfers with a walker. He was dependent walking 10 feet on uneven surfaces. Discharge instructions: continue PT with home health care and 24-hour care recommended. Review of the Care Plan for R4 revealed a Focus: I am in the facility for a short term stay for acute kidney failure. I have the potential for difficulty with ADL functioning and pain, initiated 3/4/24. Focus: I wish to return to my home in the community. My current needs are assistance with ADL's, initiated 3/4/24. No Focus for discharge planning. Review of a Care Plan for R4 revealed a Focus: I have an ADL Self Care Performance Deficit [related to] Chronic Vertigo, [hypertension], weakness, initiated 2/23/34 and canceled 3/19/24. Interventions included: Bathing- 1 person assist, Bed Mobility-1 person assist, personal hygiene- staff participation, dressing- staff participation, toileting- 1 staff participation, mobility- wheeled walker, transfers- 1 person assist. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 5/16/24 at 2:13 PM, the Regional Business Office Manager Consultant (RBOM) K reported R4's NOMNC showed his last covered day as 3/13/24 and went home on 3/14/24. The facility was designed to be and Sub-Acute Rehab (SAR) meaning a short-term rehab facility and then the residents are to go home. Resident #5 (R5) Review of a Face Sheet revealed R5 admitted to the facility on [DATE] with pertinent diagnoses of Parkinsons disease, congestive heart failure, and cognitive communication deficit. Review of the MDS dated [DATE] revealed R5 was moderately cognitively impaired and required substantial to maximum assistance for most Activities of Daily Living (ADLs) and dependent for toileting, bathing, and mobility. In an interview on 5/15/24 at 9:28 AM, Durable Power of Attorney (DPOA) J reported she did not get an admission packet for R5 when he admitted to the facility informing her of pertinent information related to insurance and Medicaid resources, costs/ fees, or bed hold policies. This lack of information caused her to not have the resources to apply for Medicaid timely, be informed about bed hold policies in advance of a transfer to the hospital, or contact/resource information to State Agencies, to help prepare for the needs of the resident. DPOA J reported the process of R5's financial journey has been stressful. DPOA J reported the facility tried to discharge R5 home on 1/8/24 when his Medicare insurance ran out. She got to the facility just in time when the ambulance showed up to take him home and told the facility there was no way he could go home by himself. The Social Worker told her R5 was a 2 person assist and in order to keep him there at the facility, it would cost $500 a night and the facility needed 30 days pay in advance. She had to make an on-the-spot decision and the facility let her pay $1500 to keep him there, then offered for him to apply for Medicaid. She did not sign a NOMNC form and did not recall being told she could appeal the decision. DPOA J reported she did not know there was such a thing as a bed hold policy when R5 went to the hospital for a urinary tract infection on 3/25/24. The hospital asked her if she signed one when the facility would not let him go back. She was told by the facility that since he was released from Physical Therapy, insurance will no longer cover his care because he was not getting any better. The Social Worker at the hospital was able to find him placement at another long-term care nursing facility and that is where he is now. Review of the NOMNC for R5 revealed his Medicare services ended 1/7/24 and was not signed by the DPOA. A note at the bottom of the form has a handwritten note that the previous acting Social Worker notified the DPOA on 1/5/24 and explained her rights to appeal the process. Review of a Practitioner Short Progress Note dated 3/25/24 for R5 revealed: abrupt onset of peripheral vision, light-headedness, cervicalgia, send out to ED (emergency department). Review of a Social Worker Progress note dated 3/25/24 for R5 revealed DPOA J was informed that the facility will not be accepting R5 back from the hospital since he will be needing long term care replacement and a rehab not being the appropriate setting. [DPOA J] expressed frustration with the lack of communication per the progress note. (continued on next page)

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	235723	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Post-Acute Rehabilitation	2060 Health Drive Wyoming, MI 49519

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 5/15/24 at 2:31 PM, the Social Worker (SW) B reported the Nursing Home Administrator (NHA) had input on why R5 could not return to the facility while R5 was pending Medicaid. R5 no longer qualified for therapy and met his max potential. Therefore, he would no longer be a candidate for SAR (Sub-acute Rehab). If residents need long term care, they contact a company to assist them in finding an open bed for the residents to transfer to. However, the facility does have some long-term care residents. Review of a Business Office Manager (BOM) progress note dated 3/26/24 for R5 revealed: I let (DPOA J) know that once [R5] was admitted to the hospital his Medicaid pending turned to private pay, and in order to readmit into the facility that it would have to be paid. In an interview on 5/16/24 at 10:31 AM, the Nursing Home Administrator (NHA) reported he is filling in as the BOM since the previous one is no longer there. He reported he has very limited beds and all the beds at the facility are dually certified. He reported R5 did go to the hospital and when it was time for the resident to be discharged from the hospital back to the facility, the NHA reported he told the hospital he was not a good Sub-Acute Rehab (SAR) referral because he needed long term care (LTC). The NHA emphasized this facility was built for SAR not for LTC. The NHA reported R5 was pending Medicaid and to re-admit the resident back to the facility, they would not have had a payor source and would have to do an authorization to admit him back. The NHA reported the facility does not have a policy on permitting residents to return to the facility after hospitalization s and does not give the residents admission packets upon admission to the facility. In an interview on 5/16/24 at 2:13 PM, the Regional Business Office Manager Consultant (RBOM) K reported R5's NOMNC showed his last covered day as 1/7/24. The facility was designed to be and Sub-Acute Rehab (SAR) meaning a short-term rehab facility. All the beds at the facility are dually certified to help accommodate those whose insurance runs out and assists residents applying for Medicaid. The company they use to assist in finding open beds at other long term care facilities cannot place residents until they get approved for Medicaid. R5 was pending Medicaid when he went to the hospital and fell off the radar. Review of an unsigned Discharge Instructions and Recap of Stay for a discharge date of [DATE] for R5 revealed R5 was able to make his needs known. No concerns or barriers to discharge. [R5] and his sister/patient advocate discussed desire to move to the ALF (Assisted Living Facility) side of (Independent Living Facility) and will be coordinating with (Assisted Living Facility) to have this evaluation and move POST discharge. They are agreeable to discharging home and utilizing HHC (Home Health Care) services. -Summary of Medical stay: Assist with ADL's, medication administration, catheter care and management. -Rehabilitation-Recap of Stay: Resident received physical, occupational and speech therapies. At discharge, resident functioning with Maximum assistance for all self-care and transfer tasks utilizing wheeled walker/wheelchair. Speech focusing on attention to task and safety awareness. -Physician summary: He lives in [Independent Living] . He has continued to progress well with therapy and is stable for discharge to [Independent Living] today. He is instructed to follow up with his PCP (primary care physician) within 1-2 weeks of discharge, signed 1/8/24. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Care Plan for R5 revealed he had an indwelling urinary catheter; he required a 2-person assistance with ADL's. No Focus for discharge planning included in the Care Plan. Review of an undated policy titled Transfer or Discharge, Preparing a Resident for referencing the old survey tag revealed: Our facility shall prepare a resident for a transfer or discharge. 1. When a resident is scheduled for transfer or discharge, the business office will notify Nursing Service of the transfer or discharge so that appropriate procedures can be implemented. Responsibilities of Nursing Services 2. Nursing Services will be responsible for: 1. Packing and collecting personal possessions (if the resident is not expected to return); 2. Assisting with transportation as applicable (i.e., calling for an ambulance); 3. Escorting the resident to transportation; 4. Preparing the discharge summary and post-discharge plan; 5. Preparing medications (as permitted by law); 6. Forwarding charge slips to the business office; 7. Directing the resident or representative (sponsor) to the business office prior to the transfer or discharge; 8. Providing the resident or representative (sponsor) with required documents; and 9. Forwarding completed records to the business office. The business office will be responsible for: 1. Informing appropriate departments of the resident's transfer or discharge; 2. Informing the resident, or his or her representative (sponsor) of our facility's readmission appeal rights, bed-holding policies, etc.; and 3. Others as appropriate or as necessary. Review of a Discharge: Notice of Intent Transfer of Discharge policy dated 1/1/23 revealed: (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	is the policy of this center that residents and/or responsible parties will be notified prior to transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Office of the State Long-Term Care Ombudsman will be notified via written communication of discharge or transfer. discharged residents will have documentation related to discharge or transfer in clinical record. Procedure: 2. Notify the resident and the responsible party of the transfer or discharge and reasons for the move in writing and in a language and manner they understand. 3. The written notice will include: a) Notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged b) Notice must be made as soon as practicable before transfer or discharge when the safety of individuals in the facility would be endangered. The health of individuals in the facility would be endangered. The resident's health improves sufficiently to allow a more immediate transfer or discharge. An immediate transfer or discharge is required by the resident's urgent medical needs. A resident has not resided in the facility for 30 days 5. The facility will send a monthly listing, may be written or electronic notification, of residents discharged to the Office of the State Long-Term Care Ombudsman which will include reason for transfer or discharge, date and receiving entity 7. Discharges that are initiated by the resident or resident representative, either in writing or verbally, do not require notification of transfer or discharge. However, the resident or resident representative desire or intent to leave the facility must be documented in the resident medical record. Review of a Notice of Bed Hold Policy revealed ***This document must be signed by the patient upon discharge to the hospital or therapeutic leave*** If unable to sign, notification from the patient and/or family/DPOA (Designated Power of Attorney) must be documented. Complete top section upon admission with resident or responsible party. This NOTICE OF BEDHOLD POLICY is provided to _____ on the effective date of admissions as well as upon any subsequent transfer to a hospital for a therapeutic leave, the date of which is applicable, is _____

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 37573 This citation pertains to intakes M100142556, M100143537, and M100143672 Based on interview and record review, the facility failed to operationalize policies and procedures and notify the Office of the State Long-Term Care Ombudsman of monthly discharges that includes the reason for transfer or discharge, date and the receiving entity. This deficient practice affects all residents discharged from the facility since July 2023. Findings include: Review of a policy titled Discharge: Notice of Intent Transfer or discharge date d 1/1/23 revealed: It is the policy of this center that residents and/or responsible parties will be notified prior to transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Office of the State Long-Term Care Ombudsman will be notified via written communication of discharge or transfer. discharged residents will have documentation related to discharge or transfer in clinical record. 5. The facility will send a monthly listing, may be written or electronic notification, of residents discharged to the Office of the State Long-Term Care Ombudsman which will include reason for transfer or discharge, date and receiving entity During an interview and a record review, the facility failed to notify the Long-Term Care (LTC) Ombudsman of all facility-initiated discharges of all residents in the last 10 months. This deficient practice could affect all past residents and the current 54 residents who reside at the facility. In an interview on 5/14/24 at 9:30 AM, a request for a list of the LTC Ombudsman discharge notifications from the Nursing Home Administrator (NHA) was made and he reported they did not have a list and did not report discharges to the Ombudsman. Review of an email correspondence dated 5/15/24 from the LTC Ombudsman L revealed the last Emergency Transfer Tracking reported was in June and July of 2023. There has not been any communication of facility-initiated discharges since then. The Ombudsman reported the Director of Nursing (DON) reached out to her the day before when this survey started to ask about this and was informed of the regulation and information needed to go forward.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 37573 This citation pertains to intakes M100142556 and M100143672. Based on interview and record review, the facility failed to provide Bed Hold policies to residents upon admission and transfers to acute care or therapeutic leave for 12 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, Resident #11, and Resident #12). This deficient practice affects all residents admitted to the facility and residents who get sent out for acute care or therapeutic leave. Findings Include: Review of a Notice of Bed Hold Policy revealed ***This document must be signed by the patient upon discharge to the hospital or therapeutic leave*** If unable to sign, notification from the patient and/or family/DPOA (Designated Power of Attorney) must be documented. Complete top section upon admission with resident or responsible party. Complete top section upon admission with resident or responsible party. This NOTICE OF BEDHOLD POLICY is provided to _____ on the effective date of admissions as well as upon any subsequent transfer to a hospital for a therapeutic leave, the date of which is applicable, is _____ Review of the Electronic Medical Records (EMR) for R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12 revealed no documentation they received a bed hold policy before or upon admission to the facility. R1 In an interview on 5/14/24 at 10:28 AM, the Power of Attorney (POA) O for R1 reported the facility was to assist them in finding long-term care placement and was in the process of getting Medicaid which they were approved for. R1 had an acute condition and had to go to the hospital and the facility refused to accept him back. POA O was confused why the facility would not accept him back. She felt it was insurance related concerns because the facility would not accept him. POA O was unaware of any Bed Hold policies. Review of a Bed Hold Policy for R1 dated 2/2/24 revealed two staff signed off as they received a verbal consent from R1 who is moderately cognitively impaired and did not get consent from his guardian. The box was marked to Not hold his/her bed with the understanding that the resident's readmission to the Facility is subject to bed availability, the Resident's needs for skilled nursing services and the Facility ability to provide the services required by the Resident. Review of a Late Entry Nursing Progress note entered 2/5/24 (for 2/2/24) for R1 revealed: spoke with patient (in person) and daughter (POA) (by phone) regarding bed hold policy. both expressed they were not interested in holding a bed at [Facility] for the patient at this time. R5 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 5/15/24 at 9:28 AM, Designated Power of Attorney (DPOA) J reported R5 went to the hospital on 3/25/24 for a urinary tract infection and was not allowed to return to the facility. R5 was pending Medicaid and the hospital asked her if she signed a Bed Hold policy and told her the facility will not accept him back because he did not sign a Bed Hold policy. DPOA J said she didn't know there was such a thing. He went to the hospital before for a fall and didn't know anything about a Bed Hold policy, but they accepted him back then. The facility refused to let R5 readmit back to the facility and caused a lot of financial stress on the family. He eventually was placed at another long-term care facility. Review of the EMR revealed no Bed Hold policy. R11 In an interview on 5/16/24 at 10:10 AM, R11 reported she did not receive a bed hold policy when she admitted to the facility and did not know what it was. R12 In an interview on 5/16/24 at 10:20 AM, R12 reported she did not receive a bed hold policy when she admitted to the facility and did not remember receiving any documents when she admitted . In an interview on 5/16/24 at 10:00 AM, the Nursing Home Administrator reported he does not have admission packets that are provided to the residents upon admission. They only have an Admissions Agreement the residents are provided with indicating they do not receive a copy of the Bed Hold policy. The NHA reported R1 was not interested in a bed hold at the facility and could not find a bed hold policy for R5.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intakes M100142672 AND M100142556. Based on interview and record review, the facility failed to readmit 1 (Resident #5) of 3 residents reviewed for readmissions after hospitalization , resulting in a resident who was pending Medicaid needing to find placement at another facility. Findings include: Resident #5 (R5) Review of a Face Sheet revealed R5 admitted to the facility on [DATE] with pertinent diagnoses of Parkinsons disease, congestive heart failure, and cognitive communication deficit. Review of the MDS dated [DATE] revealed R5 was moderately cognitively impaired and required substantial to maximum assistance for most Activities of Daily Living (ADLs) and dependent for toileting, bathing, and mobility. In an interview on [DATE] at 9:28 AM, Designated Power of Attorney (DPOA) J reported she did not get an admission packet for R5 when he admitted to the facility informing her of pertinent information related to insurance and Medicaid resources, costs/ fees, or bed hold policies. This lack of information caused her to not have the resources to apply for Medicaid timely, be informed about bed hold policies in advance of a transfer to the hospital, or contact/resource information to State Agencies, to help prepare for the needs of the resident. DPOA J reported the process of R5's financial journey has been stressful. She did not know there was such a thing as a bed hold policy when the hospital asked her if she signed one. When R5 went to the hospital on [DATE] for a urinary tract infection, he was not allowed back to the facility. She was told that since he was released from Physical Therapy, insurance will no longer cover his care because he was not getting any better. The Social Worker at the hospital was able to find him placement at another long term care nursing facility and that is where he is now. Review of a Practitioner Short Progress Note dated [DATE] for R5 revealed: abrupt onset of peripheral vision, light-headedness, cervicalgia, send out to ED (emergency department). Review of a Social Worker Progress note dated [DATE] for R5 revealed DPOA J was informed that the facility will not be accepting R5 back from the hospital since he will be needing long term care replacement and a rehab not being the appropriate setting. [DPOA J] expressed frustration with the lack of communication per the progress note. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 2:31 PM, the Social Worker (SW) B reported the Nursing Home Administrator (NHA) had input on why R5 could not return to the facility while R5 was pending Medicaid. R5 no longer qualified for therapy and met his max potential. Therefore, he would no longer be a candidate for SAR (Sub-acute Rehab). If residents need long term care, they contact a company to assist them in finding an open bed for the residents to transfer to. However, the facility does have some long-term care residents. Review of a Business Office Manager (BOM) progress note dated [DATE] for R5 revealed: I let (DPOA J) know that once [R5] was admitted to the hospital his Medicaid pending turned to private pay, and in order to readmit into the facility that it would have to be paid. In an interview on [DATE] at 10:31 AM, the Nursing Home Administrator (NHA) reported he is filling in as the BOM since the previous one is no longer there. He reported he has very limited beds and all the beds at the facility are dually certified. He reported R5 did go to the hospital and when it was time for the resident to be discharged from the hospital back to the facility, the NHA reported he told the hospital he was not a good Sub-Acute Rehab (SAR) referral because he needed long term care (LTC). The NHA emphasized this facility was built for SAR not for LTC. The NHA reported R5 was pending Medicaid and to re-admit the resident back to the facility, they would not have had a payor source and would have to do an authorization to admit him back. The NHA reported the facility does not have a policy on permitting residents to return to the facility after hospitalization s and does not give the residents admission packets upon admission to the facility. Review of the NOMNC (Notice of Medicare Non-Coverage) for R5 revealed his Medicare services will end on [DATE]. The form is not signed by the DPOA and has a note at the bottom of the form signed by the previous Social Worker who is no longer in that position indicating that he contacted the DPOA and explained her rights to an appeal. In an interview on [DATE] at 2:13 PM, the Regional BOM Consultant (RBOM) K reported the facility was designed to be a SAR and all beds are dually certified to help accommodate those who have their insurance's run out. They can help assist in getting residents on Medicaid if needed and they can stay until they are approved. BOM K reported R5 was pending Medicaid upon discharge to the hospital on [DATE] when he fell off the radar. She confirmed R5's Medicare expired on [DATE] when he was served the NOMNC. The DPOA should have signed the NOMNC herself either by coming into the facility or have a copy mailed to her and return it. The family should have been assisted in applying for Medicaid and is not sure why it was not started sooner than [DATE] when the family was given the application. Review of the Electronic Medical Record (EMR) for R5 revealed there is no notice of transfer and discharge and no bed hold policy on file. Review of a Notice of Bed Hold Policy revealed ***This document must be signed by the patient upon discharge to the hospital or therapeutic leave*** If unable to sign, notification from the patient and/or family/DPOA (Designated Power of Attorney) must be documented. Complete top section upon admission with resident or responsible party. This NOTICE OF BEDHOLD POLICY is provided to _____ on the effective date of admissions as well as upon any subsequent transfer to a hospital for a therapeutic leave, the date of which is applicable, is _____

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intake M100144078. Based on observation, interview and record review, the facility failed to provide care and services for pressure ulcers for 2 (Resident #8 and Resident #6), that required repositioning, assessment and monitoring, daily dressing care and/or wound vac (vacuum) care (a treatment that uses a special dressing and a pump to apply suction to a wound and promote healing). Findings include: Resident #8 (R8) Review of a Face Sheet revealed R8 readmitted to the facility on [DATE] with pertinent diagnoses of a sacral pressure ulcer, unspecified disruption of wound, and paraplegia. During several observations on 5/15/24, R8 was observed in his room in bed lying in the same position, flat on his back with his upper body and head dominantly towards the right corner side of his bed, middle torso toward the center of the bed, and the lower limbs towards the right lower side of the bed in a semi C position. The times were as followed; 8:37 AM, 10:45 AM, 11:00 AM, 2:15 PM, and 4:14 PM. In an interview on 5/15/24 at 4:15 PM, Licensed Practical Nurse (LPN) C was asked about R8's pressure ulcers and how often he is repositioned. LPN C reported he refuses cares a lot and had not been told today by any staff that he refused to be repositioned. LPN C could not find any documentation to show he refuses to be repositioned. She reported she had not done his dressing changes yet for his wounds yet this day either. In an interview on 5/15/24 at 4:30 PM, Certified Nursing Assistant (CNA) H was observed standing in the hallway on his phone. He reported his shift started at 2:00 PM and was told by the previous shift they did R8's cares about 1:50 PM. CNA H reported R8 does not like to be repositioned and refuses. We both went to R8s room and asked the resident if he has been offered to be repositioned and he answered no. CNA H told R8 he did not like to be turned to his side. R8 said he did not like to turn completely on his side but did like to have pillows under him to relieve the pressure from his pressure ulcers. CNA H left the room to get supplies to reposition the resident. In an interview on 5/15/24 at 4:45 PM, Licensed Practical Nurse (LPN)/Unit Manager (UM) I reported R8 likes to refuse care a lot and will cuss at staff at times. She could not provide any documentation of the resident refusing to be repositioned, reapproached, or the physician being notified of refusals of treatments. She reported R8's refusals are not on the task list for the aides but will find a way to put it on there. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the May 2024 Treatment Administration Record (TAR) for R8 revealed dressing change orders to start on 5/8/24 for a left ischial (left lower back region of hip bone) pressure injury once a day, the left thigh and lower leg wounds were to have dressing changes once a day and the sacral area pressure wound dressing is to be done twice a day and as needed for contamination. Wedges with turns for pressure reduction for all wounds. Missed treatments for the pressure ulcers on 5/10, 5/14, 5/15 and 5/18 are either documented as refused, not documented, or to see nurses notes but no notes are documented. No documentation that the resident was reapproached, or the physician was notified or aware he did not receive dressing changes. Review of the last Wound assessment dated [DATE] for R8 revealed a coccyx stage III pressure injury that measured 50 (cm) x 35 (cm) x 30 (cm). No other pressure injuries assessed/documented as they exist on the TAR. In an interview on 5/16/24 at 3:52 PM, the Director of Nursing (DON) reported R8 refuses to be turned and will get grouchy. He has his favorite staff and has refused his wound clinic appointments in the past. When informed of observations during this survey, the DON reported staff should at least try to approach him for repositioning, and if he still refuses, the nurses should approach him. The DON reported providers are in the daily staff meetings and are aware of his refusals but could not provide documentation they acknowledged or were informed of refusals for wound care. Review of a risk for impaired skin integrity [related to] decreased immobility, [chronic kidney disease stage 4], anxiety, lumbar spinal bifida Care Plan last revised on 4/4/24 included, but not limited to the following interventions: o Assist me to position body with pillows/support devices, protect bony prominences, as I allow. Date Initiated: 02/19/2023. o Assist me to turn &/or reposition routinely during CNA rounds while in bed and frequently redistribute my weight if/when I am up in my chair. Date Initiated: 02/19/2023. o Assist/encourage me to elevate my heels off the bed. Date Initiated: 02/19/2023. o I have been known to refuse cares, assistance w/ ADL's (Activities of Daily Living), treatments, and certain staff members. Date Initiated: 05/03/2023. o Patient is known to refuse having wound care done and is known to refuse the weekly wound measurements stating that the wounds are measured when he goes to the wound care clinic. Date Initiated: 10/01/2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235723	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Post-Acute Rehabilitation	2060 Health Drive Wyoming, MI 49519

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the I have had flap surgery over coccyx Care Plan revealed I have a pressure injury to my left posterior thigh pressure ulcer, posterior left knee pressure ulcer. I will refuse to be turned, refuses certain floor staff, and then refuses to let a different nurse care for his urostomy and chooses to do it myself unsuccessfully causing the R side and flap to become saturated. I often refuse to let staff turn bed to stop the airflow temporarily causing more difficulty to turn and get to his wounds. (sic) Date Initiated: 10/30/2023 Revision on: 01/12/2024. No interventions to reapproach or address refusals. Review of the ADL (Activities of Daily Living) Care Plan for R8 revealed I have an ADL Self Care Performance Deficit [related to] paraplegia, lumbar spinal bifida Date Initiated: 10/30/2023 Revision on: 11/16/2023. BED MOBILITY- dependent on a Hoyer lift with 2 staff for transfers. Date last revised on 2/14/24. Review of a policy titled Skin Treatment-Guidelines for Pressure Injuries (undated) revealed: It is the policy of this center to utilize treatment guidelines when providing care for residents with pressure injury and to prevent further deterioration of pressure injury. Note: These are treatment suggestions, and do not supersede a Physician's order for any treatment. A physician order will be obtained for the pressure injury treatment and will be specific for each site. Each pressure injury must have a separate order. Each pressure injury site must be identified by location. (Example: left elbow, coccyx, etc.) 4. Reposition/turn the resident at least every two (2) hours day and night based on residents specific positioning needs per care plans and physician orders. Resident #6 (R6) Review of a Statement reported to the State Agency from a Confidential Informant revealed R6 admitted to the facility on [DATE] with a pressure ulcer but the pressure ulcer was never noted and he is supposed to have a wound vac. He did not have a treatment to his wound the entire weekend until Monday 4/15/24. Review of a Face Sheet revealed R6 readmitted to the facility on [DATE] with pertinent diagnoses of unstageable pressure ulcer. Review of Nursing Progress notes dated 4/12/24 at 2:00 PM for R6 revealed he arrived back at the facility from the hospital and did not want to the nurse to turn him to look at his wound. The nurse attempted three times and declined and said maybe later. He has a wound vac that is to be placed. Will try again later. Review of Nursing Progress notes dated 4/13/24 at 1:29 AM for R6 revealed old dressing removed, and sight cleaned with wound cleanser. Seal applied at 125 mmHg (millimeter of mercury, a measure of pressure) continuous suction. (sic) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235723	A. Building B. Wing	05/21/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 5:53 AM Resident's wound/wound vac is on the center of his bottom; however he refuses to lay on either his left or right side. Therefore, this keeps the wound vac from flowing. It was explained to the resident, and he was given his options. The resident refused to respond. The only option we were left with was to turn the Wound Vac off. At 11:49 PM Pt (patient) supine in bed; he says he will not allow side to side turning. Wound VAC in place but machine turned off. No documentation showing the physician was notified of wound vac not functioning or resident refusing care. Review of Physician orders revealed no wound care orders in place for R6 when he arrived back to the facility on [DATE]. On 4/15/24 orders for a Sacral Wound Vac and alternative dressing changes started on 4/15/24 for every Monday, Wednesday, and Friday. There is no documentation of missed treatments or any refusals. Review of the Treatment Administration Record (TAR) for R6 revealed no documented dressing changes or wound vac treatments documented from Friday, 4/12/24 (readmission) until Monday 4/15/24. In an interview on 5/16/24 at 3:52 PM, the Director of Nursing (DON) reported R6 had a pressure ulcer on the upper cleft of his buttocks and was challenging to get the wound vac to stay in place especially when he had a bowel movement. At this time the DON had to collect more information regarding his wound care. In an interview on 5/20/24 at 10:25 AM, the DON reported R6 did have a wound vac on 4/12/24 and 4/13/24 but it was not sealing right. It was a large wound and the physicians attend the morning standup meetings daily and should have been aware. The DON could not provide any documentation that the physicians were aware of the wound vac not working this weekend or that the resident did not receive wound care. The facility has standard orders for when wound vacs are not functioning after 2 hours, to place a wet to dry dressing on the pressure ulcer to avoid compromising the integrity of the wound. That was not done for this resident. Review of a Wound Vac Broken Seal Guidance provided by the DON revealed: If bedside nursing cannot maintain seal, all parts of wound vac should be removed and normal saline (NS) wet to dry dressing placed, . Review of a Wound VAC Clinical Guideline, A Reference Source for Clinicians provided by the DON revealed on page 25 Warning: Never leave a V.A.C.(R) Dressing in place without active V.A.C.(R) Therapy for more than two hours. If therapy is off for more than two hours, remove the old dressing and irrigate the wound. Either apply a new V.A.C.(R) Dressing from an unopened sterile package and restart V.A.C.(R) Therapy; or apply an alternative dressing, such as wet to moist gauze, as approved during times of extreme need, by treating clinician. Procedures included how to troubleshoot the system.