

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 614020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 5/1/2025
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NAME OF PROVIDER OR SUPPLIER LAKE WOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1684 VULCAN ST MUSKEGON, MI 49442
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F0000 SS=	INITIAL COMMENTS Lake Woods Nursing and Rehabilitation Center was surveyed for a Recertification survey on 5/1/25. Intakes: MI00151546, MI00151635, and MI00152461. Census: 83.	F0000		
F0600 SS= D	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: This citation refers to MI00152461 Based on interview and record review, the facility failed to protect the residents' right to be free from physical abuse for 2 of 18 residents (R58, and R60), resulting in residents being physically abused. Findings include: R60	F0600	ELEMENT #1: Action Taken: Resident #58 and Resident #60 will have a review of the person-centered plan of care review to mitigate further resident to resident interactions. ELEMENT #2: Identification of Other residents: Lake Woods strives to establish clinical and psychological support practices for our residents that limit the opportunity for avoidable interactions. Residents residing in the facility that are identified as having wandering behavior will be identified through a review of MDS section E0900 and will have a review to their person-centered plan of care interventions to mitigate risk of avoidable resident to resident occurrences. Root cause analysis will be completed, and any opportunities that are identified will be care planned. ELEMENT #3: Systemic Changes: Lake Woods will consistently follow Policies and Procedures Protecting our residents from abuse and mistreatment. All staff will be reeducated by 5/26/2025 or prior to their next day worked in the event of a leave of absence or vacationing employee, regarding the abuse and neglect protocols. Specific examples of	5/26/2025

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

TITLE

(X6) DATE

Electronically Signed

05/14/2025

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

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	<p>A review of R60's Admission Record, dated 4/30/25, revealed they were an 83-year-old resident admitted to the facility on 5/09/23. In addition, R60's Admission Record revealed multiple diagnoses that included Dementia, severe with agitation, dementia with psychotic disturbance, unsteadiness on feet, history of falls and dysphagia, and oropharyngeal phase.</p> <p>A review of R60's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 02/04/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of "99" which revealed R60 was severely cognitively impaired.</p> <p>On 04/29/25 at 01:19 PM, an R60 was observed in the TV room sitting in a lazy boy watching TV. R60 was clean, well-groomed, however she did not participate in verbal encounter with this surveyor. During the observation Certified Nurse's Aide (CNA) "C" stated (Name of R60) is now on a 1-1 since she went into the wrong resident's room, and they had an incident."</p> <p>Review of R60's "Interdisciplinary Documentation Note dated 04/12/2025 at 20:57 reflected (Name of R60) entered (Identification Number used for Resident 58's) room and mistakenly got into his bed. A staff member walking past observed resident (Identification Number used for R58) with his hands on (Name of R60's) shoulder and him make contact with an open hand to the side of her face. The staff member immediately intervened. (Name of R60) does not have any injuries and though upset at the time of the interaction, returned to her psychosocial baseline following staff support."</p> <p>Review of the facility two-hour report date 4/12/25 at 8:53 PM, submitted by NHA reflected the following "Immediate Action": "Residents</p>		<p>possible interventions will be included in the education that may reduce the risk of other resident to resident interactions from occurring. The reeducation will include an Abuse prevention overview including a review of policies entitled; Abuse Suspected Abuse Investigations; Abuse Prevention Overview; and Resident to Resident Interactions.</p> <p>ELEMENT #4: Monitoring: The Director of Health Care Services and/or designee will review the implementation of interventions to mitigate the risk of an avoidable event 3-5 times a week for four weeks enquiring with staff to evaluate understanding and implementation of interventions to prevent high risk events. The Director of Health Care Services or designee will provide a report to QAPI for one (1) month. The Administrator assumes responsibility for attained and sustained compliance.</p>	

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	<p>were immediately separated, and (Name of R60) was assisted from the room. Both residents were assessed for injury and neither had any redness, bruising or swelling. One to one supervision was immediately implemented for (Name of R60) due to her propensity to wander into other resident's rooms and inadvertently have undesired interactions."</p> <p>Review of Housekeeper (HK) "K's" handwritten statement dated 4/12/25 reflected, "I heard screaming coming from (Name of Area in the building) so I tried to find out where the screaming was coming from. When I looked in (Name of R58's) room I saw that he had (Name of R60) pinned to his bed using his hands & then releasing his hands to & started slapping her on each side of her face. I yelled for (Name of License Practical Nurse (LPN) "M") and in general "help" and that's when (Name of Certified Nurses Aide (CNA) "L") came in & stopped it."</p> <p>Review of CNA "L's" Witness Statement dated 4/12/25 reflected, "I didn't see the incident I was in room 29 changing resident. I came out as soon as I heard the housekeeper yelling for (Name of LPN "M"). I walked (Name of R60) down to the nurse's station. She said he hit her on his arms, legs, stomach, chest, face."</p> <p>Review of LPN's "M" Witness Statement undated reflected, "(Name of HK "K") yelled and waved me down, reported (Name of R58) had (Name of R60) who was lying down in his bed. He was standing over her had her arms held down then started slapping her alternating sides of her face with the palm of his hand. Upon my observation he was standing in his room on the other side of his bed, and he appeared confused and (Name of R60) was crying."</p> <p>Review of R60's "Interdisciplinary</p>				

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	<p>Documentation" Progress Notes dated 4/14/2025 at 05:23 reflected, "Up wandering a great deal of the night. Would not comply with the suggestion to go to bed. However, she was not crying much this shift."</p> <p>Review of R60's Short Term Care Plan Date 4/12/25 under problem potential for latent injury related to "incident face, chest, and abdomen."</p> <p>Review of R60's Care Plan revealed: "(Name of R60) has altered mobility and ADL's (Activities Daily Living) related to difficulty with motor function and increased confusion, disorientation secondary to advancing dementia, and poor safety awareness. She has a history of wandering and at times will wander in rooms in the facility requiring redirection. ... Date Initiated: 05/09/2023 Revision on: 09/09/2024. Intervention includes 1:1 supervision in place on each shift while (Name of R60) is awake. Date initiated: 06/12/2024 Revision on: 04/18/2025"</p> <p>Further review of R60's medical record reflected she was also involved in another Facility Reported Incident (FRI) on 3/20/25 at approximately 4:00 PM when R60 wandered into another room and began yelling and grasped one of the residents' arms. Facility interventions for this incident included a stop sign for the resident's doorway and a staff member has been added as a companion to (Name of R60) during the evening/sundowning hours to support (Name of R60) during times of increased confusion.</p> <p>Further review of R60's care plan noted that 3/21/25 the resident was placed on 15 minute checks.</p> <p>Review of "Psychological Evaluation" dated March 27, 2025, reflected the following: "Referral Statement: (Name of R60) continues</p>				

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F0684 SS= D	<p>with some abnormal /noxious behaviors. As of late/she had entered another resident's room and there was a mild degree of physical altercation. The patient had actually grabbed that resident. ..."</p> <p>R58</p> <p>Review of R58's face sheet dated 5/1/25 revealed he was admitted on 11/17/23 and had diagnoses that included: cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy (genetic brain disease), vascular dementia, diabetes mellitus 2, and major depressive disorder. He was not his own responsible party.</p> <p>A review of R58's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 04/14/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of "01" which revealed R58 was severely cognitively impaired.</p> <p>R58 was observed in bed on 4/30/25 at 2:11 PM. R58 was lying in bed with his head at the foot of the bed. R58 was slow to respond to his name and questions. R58 had no recall of having any difficulty with other residents or of problems with other residents coming into his room.</p> <p>Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as</p>	F0684	<p>ELEMENT #1: Action Taken: Resident #36 had a Digoxin lab level drawn on 5-13-2025.</p> <p>ELEMENT #2: Identification of Other residents who may have the potential to be affected: All residents residing at the facility that receive Digoxin have the potential to be affected and will be identified through an order listing report. An audit will be completed to validate a lab has been completed as ordered.</p>	5/26/2025	

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	<p>evidenced by:</p> <p>Based on interview and record review, the facility failed to follow a physician order for 1 of 17 sampled residents (R36), resulting in R36 not having a digoxin level checked for over a year.</p> <p>Findings include:</p> <p>A review of R36's Admission Record, dated 5/1/25, revealed R36 was a 79-year-old resident admitted to the facility on 10/5/21. In addition, R36's Admission Record revealed multiple diagnoses that included congestive heart failure and osteoarthritis.</p> <p>A review of R36's Pharmacist Medication Regimen Reviews, dated 6/1/24 to 5/1/25, revealed the pharmacist had noted on 4/3/25 that the last digoxin level that had been obtained on R36 had been on 4/12/24. The pharmacist recommended that a digoxin level be obtained "now then every 6 months for this medication (digoxin) with a narrow therapeutic window (medications where the concentration or dose required to be effective is very close to the concentration or dose that produces a toxic or adverse effect)."</p> <p>A review of R36's medical record, dated 4/12/24 to 5/1/25, failed to reveal that a digoxin level had been obtained, or ordered, per the pharmacist's recommendation on 4/3/25. R36's medical record did confirm that the last digoxin level result that was in the medical record was dated 4/12/24.</p> <p>On 5/1/25 at 11:30 AM, the Nursing Home Administrator (NHA) was notified that the surveyor could not locate documentation in R36's medical record that a digoxin level had been obtained per the pharmacist's recommendation on</p>		<p>Any discrepancies identified will be reviewed with the health care provider.</p> <p>ELEMENT #3: Systemic Changes: Licensed Nursing Staff will be reeducated by 5/26/2025 or prior to their next date worked in the case of the leave of absence or vacationing employee, regarding expectations of following a physician order. Education will include a review of pharmacy recommendations and the facilities process of reviewing them with the provider, the process of ordering labs per provider orders based on the recommendation, and ensuring the labs are completed.</p> <p>ELEMENT #4: Monitoring: The Director of Health Care Services and / or designee will audit medical records with individuals who had pharmacy recommendations to complete labs 3-5 times per week for 4 weeks to verify the labs were completed based on the physician orders. The Director of Health Care Services will provide a summary of the audit to the Quality Assurance performance Improvement Committee monthly for one (1) month and periodically thereafter. The Director of Health Care Service will assume responsibility for attained and sustained compliance.</p>	

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	<p>4/3/25 (or an order for when it will be drawn next). A copy of the digoxin level results or an order for the digoxin level to be obtained was requested from the NHA.</p> <p>A second review of R36's medical record, dated 4/12/24 to 5/1/25, revealed that an order to obtain a digoxin level "now and then q6 months (every 6 months) was written on 5/1/25 at 12:08 PM (after the surveyor had asked for additional information from the NHA).</p> <p>A review of R36's Order Summary Report, dated 5/1/25, revealed the following:</p> <ul style="list-style-type: none"> - R36 had a physician's order, dated 5/10/24, for digoxin 125 mcg (micrograms) to be given once a day. - R36 had an active order (no stop date), dated 5/10/24, for a digoxin level to be obtained every six months. <p>During an interview on 05/01/25 at 01:44 PM, Clinical Support (CS) "G" confirmed that R36's digoxin level for the 4/3/25 pharmacy recommendation was ordered today after the surveyor had requested the information. CS "G" stated that for some reason, the facility had failed to order a digoxin level when they ordered other laboratory values (vitamin B12 and magnesium) that were also recommended on R36's pharmacy recommendation for 4/3/25.</p> <p>During an interview on 05/01/25 at 01:47 PM, the Director of Nursing (DON) confirmed that R36's last digoxin level that had been obtained was on 4/12/24. The DON also confirmed that R36 had an active order that had been written on 5/10/24 and did not know why another digoxin level had not been obtained six months after that (November 2024).</p>			

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F0686 SS= G	<p>A review of the article "Digoxin monitoring and toxicity management" in "The Pharmaceutical Journal", dated 1/3/23, revealed, "Digoxin has a narrow therapeutic window, meaning there is a small margin between the benefit of its effects and toxicity; therefore, monitoring is an important part of its use... In serious cases of toxicity, ventricular tachycardia (fast heart rate) and ventricular fibrillation (a life-threatening heart rhythm that results in a rapid, inadequate heartbeat) may occur. Adverse arrhythmias are most common in patients if there is pre-existing heart disease or in electrolyte disturbances, such as hypokalaemia (low potassium levels that can result in fatigue, muscle cramps, and abnormal heart rhythms)..." (https://pharmaceutical-journal.com/article/ld/digoxin-monitoring-and-toxicity-management)</p> <p>Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to prevent a</p>	F0686	<p>ELEMENT #1: ACTION TAKEN: Resident #26 will have a review of positioning devices, and the alternating pressure mattress will be set per manufacturer guidelines. The resident person-centered plan of care will be reviewed to ensure interventions are in place and utilized to promote wound healing and prevent further pressure injury development. Updates will be made to the person-centered plan of care as needed based on this assessment.</p> <p>ELEMENT #2: IDENTIFICATION OF OTHER RESIDENTS Residents residing at Lake Woods have the potential to be affected. The resident's person-centered plan of care will be reviewed to validate interventions are in place and utilized to promote wound healing and prevent pressure injury development. Updates will be made to the person-centered plan of care as needed based on this assessment.</p>	5/26/2025

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	<p>pressure ulcer for 1 Resident (R26) of 2 Residents reviewed for pressure ulcers resulting in R26 developing a stage 3 pressure ulcer.</p> <p>Findings included:</p> <p>Review of R26 Admission Record dated 5/1/25 revealed he was 78 years old, admitted on 4/27/17 and had diagnoses that included: diabetes mellitus 2, abnormal posture, major depressive disorder, muscle weakness, muscle spasms, muscle wasting and atrophy, glaucoma, and dementia. He was his own responsible party.</p> <p>R26 was observed receiving a bed bath on 4/29/25 at 9:47 AM. R26's head was tilted to the left and he was unable to move his neck to an upright position. R26 was able to move his right hand and arm. R26 was not able to move his left hand, left arm or both legs. R26 yelled out in pain every time he was moved. Two Certified Nurse Aides (CNA's) provided the care. Every time they moved R26 they verbally informed him just prior to moving him. Once he was not moving, he stopped yelling. They talked to him about what kind of snack he wanted after they were done with care to distract him from his pain. They elevated his left foot on a pillow when they were completed with care. No other pressure relieving device for the foot was observed. R26's left foot was wrapped with gauze dated 4/29/25. R26's specialty air mattress was set on firm. The CNA's were asked what R26's specialty air mattress was to be set at, and they did not know the setting or change the setting when they completed the care.</p> <p>During an interview with the Director of Nursing (DON) on 5/1/25 at 11:12 AM, R26</p>		<p>ELEMENT #3: MEASURES TAKEN: Lake Woods will provide reeducation to licensed nursing staff and certified nursing assistant by 5/26/2025 or prior to the next day worked in the /case of the leave of absence, vacationing employee. The educational agenda will include application of person-centered interventions, with examples provided of various interventions for utilization to prevent worsening or the development of pressure injuries. The education will include the location of the resident's preference of settings for their alternating pressure mattress to ensure it is followed.</p> <p>ELEMENT #4: MONITORING: The Director of Health Care Services and / or designee will conduct rounds 3-5 times per week for 4 weeks on varying shifts to evaluate the education provided and inspect for the implementation of care planned interventions, including a review of the alternating pressure mattress settings, to prevent worsening or the development of pressure injuries. The Director of Health Care Service will compile a report of this audit for review and recommendation by the Quality Assurance performance Improvement Committee monthly times one (1) month and periodically thereafter. The Director of Health Care Services will assume responsibility for sustained compliance.</p>	

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	<p>had a facility acquired pressure ulcer, stage 3, ulcer on his left heel that was discovered on 3/4/25 and measured 3.0 x 3.0. The DON said R26 had a history of pressure ulcers. The DON provided a timeline of measurements for this wound. The last measurement was dated 4/04/25 and measured 3.0 x 1.1 x 0.2. The next measurement was on 4/10/25 and revealed the pressure ulcer was on the left heel and left lateral foot, measured 3.0 cm x 2.8 cm x 0.2 cm. The last measurement for the left heel and left lateral foot was dated 4/24/25 and measured 1.2 cm x 0.8 cm x 0.2. cm The DON was not able to find the cause for the pressure ulcer. Review of the facility pressure ulcer policy did not reveal any process for determining the cause of a pressure ulcer.</p> <p>During an interview with the DON and Nursing Home Administrator (NHA) on 4/30/25 at 2:49 PM the Surveyor reported that R26's specialty mattress was set on the firm setting yesterday and staff did not know what setting the specialty mattress was supposed to be at. The NHA said she currently had the manuals on her desk for the mattress and they were working on reviewing and implementing a plan to address this. The surveyor requested a copy of the mattress manual. The DON went to R26's room with the surveyor at this time and the mattress was set on comfort and the toggle for alternative or float was in the middle position (not the same settings as observed on 4/29/25). The DON could not say what R26's setting should be or if the toggle switch was to be in the middle position. Upon exit the facility did not provide the mattress manual or provide clarification of the proper settings for R26's mattress. R26 had a pressure-relieving</p>				

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	<p>boot on the end of the bed that was not on him. The DON offered to put the pressure-relieving boot on R26's foot but he refused to let her. R26's left foot was floated up on a pillow.</p> <p>During an interview with the DON on 5/1/25 at 11:12 AM, the DON was not able to locate any physician notes or interdisciplinary notes that discussed the cause of R26's pressure ulcer. The DON referred to R26's care plan that indicated he refuses care at times. The DON was not able to locate any documentation of R26's refusing pressure relief prior to 3/4/25 when he was noted to have a stage 3 pressure ulcer on his left heel or any discussion with R26's guardian about pressure relief refusals. The DON referred to R26's care plan which indicated that he refused care at times. The DON did not have any expectations for staff to document, reapproach or attempt to determine the reason for R26's refusal to allow care or pressure relief.</p> <p>During a telephone interview with R26's guardian on 5/1/25 at 12:31 PM, the guardian was not aware R26 was refusing pressure relief prior to the development of the pressure ulcer on his left heel. The guardian was aware R26 had a pressure ulcer. The guardian was aware R26 gets angry and refuses care at times but said he can get over it quickly and then allows care. The guardian said she has asked the facility to reach out to R26's brother by telephone when he is refusing care as his brother can help calm him down better than she can.</p> <p>Review of R26's care plan dated 4/27/25 revealed, "R26 clinical condition reveals skin integrity impairment is unavoidable</p>				

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	<p>evidenced by his preferred sedentary preference to remain in bed despite education of associated risks. He has muscle wasting and atrophy, exposure of skin to fecal and urinary incontinence, poor nutritional intake and his chronic pain. Other risk factors include his diagnosis of diabetes resulting in altered sensation due to neurological damage and delayed wound healing. He has the propensity to decline cares, treatments and staff members that he is not familiar with. Foot drop to the left foot and pressure injury to the left foot. Hx (history) of pressure to his buttock that is resolved." Interventions included, "alternating pressure mattress at preferred settings (resident and staff were not able to state preferred settings), ensure resident is wearing a (name of pressure relieving) boot while in bed to reduce pressure on heels, initiated 12/2/24 (not offered during observation on 4/29/25 and refused during observation on 4/30/25), Off-load heels in bed onto pillows as he will accept, Inspect with care and report changes promptly to charge nurse, initiated 4/27/25 (No indication to report residents refusal of pressure relief, or devices or time frame to reapproach or best approach were located or to contact guardian or his brother with refusals were located).</p> <p>Review of Fundamentals of Nursing (Potter and Perry) 10th edition revealed, "Repositioning (turning) patients is a consistent element of evidence-based pressure injury prevention (EPUAP, NPIAP, PPPIA, 2019a). The twofold aim of repositioning should be to reduce or relieve pressure at the interface between bony prominence and support surface (bed or chair) and to limit the amount of time the</p>			

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F0689 SS= D	<p>tissue is exposed to pressure (Maklebust and Magnan, 2016). Elevating the head of the bed to 30 degrees or less decreases the chance of pressure injury development from shearing forces (WOCN, 2016). Change the immobilized patient's position according to tissue tolerance, level of activity and mobility, general medical condition, overall treatment objectives, skin condition, and comfort (EPUAP, NPIAP, PPIA, 2019a). A standard turning interval of 1.5 to 2 hours does not always prevent pressure injury development; repositioning intervals are based on patient assessment. Some patients may need more frequent position changes, while other patients can tolerate every-2-hour position changes without tissue injury. When repositioning, use positioning devices to protect bony prominences (WOCN, 2016)." Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia A.; Hall, Amy. Fundamentals of Nursing - E-Book (p. 1255). Elsevier Health Sciences. Kindle Edition.</p> <p>Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to prevent accident hazards by safely transporting a resident in a wheelchair for 1 (R34) and monitoring one resident (R42) known for pocketing food during</p>	F0689	<p>Element #1 ACTION TAKEN: Resident # 34 will have a review of their person-centered plan of care for Locomotion with revisions made based on the review to ensure safe transportation occurs while in a wheelchair. Wheelchair foot pedals were provided to Resident #34.</p> <p>Resident #42 will have a review of their person centered plan of care to ensure safe monitoring is provided during meals and reflected on the plan of care with revisions made based on the review.</p> <p>Element #2 IDENTIFICATION OF OTHER RESIDENTS: Residents residing at the facility requiring assistance for wheelchair mobility have the</p>	5/26/2025

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	<p>meals of 6 residents reviewed for accident hazards.</p> <p>Findings include:</p> <p>A review of R34's Admission Record, dated 4/30/25, revealed R34 was a 61-year-old resident admitted to the facility on 12/13/24. In addition, the Admission Record revealed multiple diagnoses that included unsteadiness on feet, difficulty walking, dementia, bipolar disorder, schizophrenia, Parkinsonism, generalized muscle weakness, and dizziness and giddiness.</p> <p>A review of R34's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 1/7/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of "13" which revealed R34 was cognitively intact. In addition, R34's MDS revealed they had a one-sided lower extremity range of motion impairment and could operate a manual wheelchair with supervision or touching assistance (helper provides verbal cues and/or touching/steadying assistance).</p> <p>A review of R34's functional mobility and ADL's (activities of daily living) care plan, revised 12/13/24, revealed R34 needs encouragement to propel his own wheelchair, but staff can assist him as needed.</p> <p>During an observation on 04/30/25 at 12:05 PM, R34 stopped Scheduling Manager (SM) "A" in the hallway and asked her to take him to the "Bathing" room. SM "A" looked directly at the surveyor as they approached and walked by R34 and herself, stated she would help him after the surveyor had passed by them, and then pushed R34 in his wheelchair without foot pedals from the hallway outside Room 25, down the hall, and to the "Bathing" room next to The Shore Nursing</p>		<p>potential to be affected and will be identified through the care plan item listing report for locomotion. Identified residents will have a review of their person-centered plan of care for Locomotion with revisions made based on the review to ensure safe transportation occurs while in a wheelchair. An audit will be conducted to validate residents requiring assistance for wheelchair mobility have foot pedals available for use.</p> <p>Residents that pocket food have the potential to be affected and will be identified through care plan review. The resident's person-centered pan of care will be reviewed to validate interventions are in place and utilized to promote safety monitoring during meals.</p> <p>ELEMENT #3: SYSTEMIC CHANGES: Lake Woods will provide reeducation to all staff by 5/26/2025 or prior to the next day worked in the /case of the leave of absence, vacationing employee. The educational agenda will include the standard of practice while providing locomotion assistance in the wheelchair with the utilization of the foot pedals. Licensed nursing staff and certified nursing assistants will receive reeducation that residents who pocket food require supervision at meals, and the importance of offering fluids during meals. Examples will be provided when residents may decline assistance and examples of interventions for staff utilization to encourage the residents to accept assistance.</p> <p>ELEMENT #4: MONITORING: The Director of Health Care Services and / or designees will observe staff on various shifts as they provide assistance to residents with locomotion while in their wheelchair, including</p>		

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	<p>Station.</p> <p>During an interview on 05/01/25 at 08:20 AM, Certified Nursing Assistant (CNA) "C" stated, "They (residents) need foot pedals for us to push them." CNA "C" further stated even if a resident can lift their feet and/or legs, staff still need to put foot pedals on their wheelchair before pushing it down the hallway.</p> <p>During an interview on 05/01/25 at 08:25 AM, CNA "E" stated residents need to have foot pedals on their wheelchair before staff can push them down the hallway. CNA "E" also stated that even if a resident can lift their feet and/or legs, staff still need to put foot pedals on their wheelchair before pushing it down the hallway.</p> <p>On 05/01/25 at 09:15 AM, a copy of the facility's policy and procedure on staff transporting residents in their wheelchairs was requested from the Nursing Home Administrator (NHA).</p> <p>During an interview on 05/01/25 at 01:20 PM, SM "A" stated staff are only supposed to push residents in their wheelchairs when they have foot pedals. SM "A" further stated they are never supposed to push them without foot pedals down the hallway.</p> <p>During an interview on 05/01/25 at 01:50 PM, Clinical Support (CS) "G" stated the facility did not have a policy that addressed transporting residents in wheelchairs. She stated it was a standard of practice that they do not push them without foot pedals. CS "G" further stated the facility goes over this subject during orientation with a slide show presentation. The surveyor requested a copy of what new employees are shown at orientation regarding transporting residents in wheelchairs.</p>		<p>utilization of foot pedals 3-5 times a week for four weeks and periodically thereafter to evaluate effectiveness of the education that was provided. An additional observation will be completed during various mealtimes to ensure staff are providing monitoring of residents that are known to pocket food. This audit will be conducted 3-5 times a week for four weeks and periodically thereafter. The Director of Health Care Service will compile a report of this audit for review and recommendation by the Quality Assurance performance Improvement Committee monthly times one (1) month and periodically thereafter. The Director of Health Care Services will assume responsibility for sustaining compliance.</p>	

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	<p>During an observation on 05/01/25 at 03:15 PM, CNA "F" was observed pushing R34 in his wheelchair without foot pedals down the hallway to the main dining room.</p> <p>A review of the facility's "Nursing Orientation" Checklist, undated, revealed under the topic "Safety is everyone's responsibility" the subtopic "No Pedals, No Push."</p> <p>A review of the article "Guidelines for Pushing Wheelchairs", dated 3/28/23, revealed, "When pushing a wheelchair, safety should always be the top priority. Here are some safety guidelines to keep in mind: Always lock the wheelchair brakes before helping the user in or out of the chair. Use a firm grip on the wheelchair handles and keep your back straight and shoulders relaxed. Be aware of your surroundings and avoid obstacles and uneven surfaces. Always use the footrests when the user is sitting in the chair, and make sure they are properly adjusted. When going down ramps or inclines, always walk backward and use your body weight to control the wheelchair's speed..." (https://alzheimerslab.com/guidelines-for-pushing-wheelchairs)</p> <p>R42</p> <p>A review of R42's Admission Record, dated 5/01/25, revealed they were an 84-year-old resident re-admitted to the facility on 04/01/20. In addition, R42's Admission Record revealed multiple diagnoses that included Vascular Dementia with behavioral disturbance, affective mood disorder, insomnia, and dysphagia oropharyngeal phase.</p> <p>A review of R42's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 03/31/25, revealed a Brief Interview for</p>			

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	<p>Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of "99" which revealed R42 was severely cognitively impaired. Further review of R42's quarterly MDS reflected the resident only needed assistance with "Setup or Clean-up" for eating.</p> <p>During a lunch observation on 4/29/25 at 11:37 AM, R42 was observed sitting on a couch in the "fishbowl" (Name of the lobby located by entrance door) waiting for lunch. Certified Nursing Assistant (CNA) "N" was observed placing a gown and clothing protector on the resident. CNA "N" provided R42 a spoon and a bowl of mechanically altered potpie and then left R42 to assist other residents with their lunch. R42 was only provided the one bowl. No beverages were provided. Staff were not observed in the immediate area due to assisting other residents with their lunch trays. After approximately 20 minutes CNA "N" was asked why R42 did not have anything else to eat or drink. CNA "N" stated, "(Name of Resident) likes to mix her drinks in her food, so I will start her off with one bowl and then give her drinks in-between. CNA "N" provided R42 a glass of orange juice a few minutes later that she fully consumed.</p> <p>Further observation of R42's 4/29/25 meal service reflected that she gave up eating with her plastic spoon and switched over to using her fingers. R42 had been unsuccessful at getting the spoon into her mouth. A large portion of residents lunch was observed on her hands, down the front of her gown and clothing protector and on the table. R42 was left on her own until staff cleaned her up.</p> <p>Review of R42's 3-26-2025 08:22 Interdisciplinary Care Conference Documentation reflected, "She remains on a puree diet with regular liquids. She has a history of pocketing food and chewing on it for a few hours after she</p>				

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	<p>is done eating. She enjoys her snacks and treats."</p> <p>Review of R42's "Dietary Order" dated 2/24/25, reflected resident was on "Regular diet. Pureed texture. Thin consistency. Allow mechanical soft snacks per approved list.</p> <p>During a lunch observation on 04/30/25 at 11:37 AM, R42 was observed being brought down to the fishbowl to eat at the table. Staff placed a gown and clothing protector over the resident prior to placing her lunch in front of her (a single bowl no beverage) and handed her a plastic spoon. R42 is observed struggling to eat with the plastic spoon and would drop her food down the front of her and on the table. Resident ate approximately one in every three bites attempted.</p> <p>During the 4/30/24 lunch observation R42 was observed chewing the same bite of food for approximately 4 minutes. Staff were noted walking through the fishbowl delivering lunches, however, none of them appeared to be monitoring R42.</p> <p>Further dining observation of R42 on 04/30/25 at 12:13 PM, a concern was brought to the DON's attention about (Name of R42) possibly pocketing food in her mouth and that the resident (still) had nothing to drink. (R42 had just placed a bite in her mouth approximately a minute prior to talking with the DON.) DON stated she would get her something to drink and have someone come sit with her. DON further stated, "(Name of R42) does not like anyone touching her food or assisting her with eating she does not do well with that." Staff had not been observed interacting with R42 after her lunch had been placed in front of her.</p> <p>On 4/30/25 at 12:18 PM, Unit Manager (UM) "O" sat down at the table next to R42. R42 had</p>			

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F0842 SS= D	<p>been chewing on the same bite of food for approximately 7 minutes when UM "O" asked (Name of R42) to open her mouth. UM "O" upon observation of residents' mouth stated, "you still have quite a bit of food in there, why don't you take a drink." (Staff had just dropped off a beverage in front of the resident.) R42 proceeded to chew on the same bite for several more minutes before finally swallowing.</p> <p>Observation of R42 after finishing her lunch on 4/30/25, reflected most of residents' lunch had ended up on the table and on the gown, she was wearing to protect her clothing.</p> <p>Review of R42's Interdisciplinary Care Conference Documentation at 10:59 on 4/30/25 (Effective Date) reflected a Care Conference was held with (Name of R42's son) and the IDT. Further review of the document appeared similar to R42's 3/27/25 Interdisciplinary Care Conference Documentation.</p> <p>During an interview on 05/01/25 at 01:17 PM, Social Services (SS) "P" was asked if they had a Care Conference with (Name of R42's Son) yesterday? SS "P" stated, "No we did not meet with him yesterday, but I did try to get a hold of him." SS "P" further stated she wanted to review residents care due to losing weight, and to review her code status.</p> <p>Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p>	F0842	<p>ELEMENT 1 ACTION TAKEN: Resident #26 pharmacy recommendations from 8/6/2024, 11/4/2024, and 4/3/2025 are in the medical record.</p> <p>Element #2 Identification of other Residents: Each resident residing in the facility has the potential to be affected. Pharmacy recommendations conducted at the facility in the last 30 days will be completed to validate</p>	5/26/2025	

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	<p>§483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's,</p>		<p>the recommendations are in the residents medical record.</p> <p>Element #3 Measures Taken: Reeducation will be provided to the Director of Health Care Services and Health Information Manager by 5/26/2025 or prior to the next day worked in the /case of the leave of absence, or vacationing employee. The educational agenda will include the requirement of all pharmacy recommendations, including recommendations made to nursing, to be uploaded in the medical record in a timely manner once completed.</p> <p>Element #4 Monitoring Measures Taken: The Nursing Home Administrator and / or Designees will conduct an audit of medical records 3-5 times a week for four (4) weeks and periodically thereafter to ensure pharmacy recommendations, including those made to nursing, are in the medical record in a timely manner once completed. The Nursing Home Administrator will provide a summary of the audit to the Quality Assurance Performance Improvement Committee monthly for one (1) month and periodically thereafter. The Nursing Home Administrator will assume responsibility for attained and sustained compliance.</p>		

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	<p>nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to maintain complete medical records for 2 of 17 sampled residents (R26 and R36).</p> <p>Findings include:</p> <p>Timely documentation of the following types of information should be made and maintained in a patient's (resident's) EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care- Assessments; Clinical problems; Communications with other health care professionals regarding the patient... Order acknowledgement, implementation, and management; Patient clinical parameters... Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org).</p> <p>R26</p> <p>A review of R26's Admission Record, dated 5/1/25, revealed R26 was a 78-year-old resident admitted to the facility on 6/13/22. R26's Admission Record revealed they had multiple</p>			

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	<p>diagnoses that included depression and diabetes.</p> <p>A review of R26's Pharmacist Medication Regimen Reviews, dated 6/1/24 to 5/1/25, revealed the pharmacist had noted potential medication and/or medication-related (e.g., reason for use of a medication, adequate monitoring of a medication, etc.) irregularities on 8/6/24, 11/4/24, and 4/3/25. However, a review of R26's medical record failed to reveal what those irregularities and/or pharmacist recommendations were.</p> <p>On 5/1/25 at 11:30 AM, the Nursing Home Administrator (NHA) was notified that the surveyor could not locate in R26's medical record the pharmacist's recommendations for the irregularities that were noted in the Pharmacist Medication Regimen Reviews for 8/6/24, 11/4/24, and 4/3/25. Copies of those recommendations were requested from the NHA, if they were located.</p> <p>On 5/1/25 at 1:15 PM, the facility provided the surveyor with copies of R26's pharmacist recommendations with supporting documentation for 8/6/24, 11/4/24, and 4/3/25. However, a second review of R26's medical record failed to reveal that these recommendations were present in the medical records.</p> <p>During an interview on 05/01/25 at 02:57 PM, Clinical Support (CS) "G" stated that R26's 8/6/24, 11/4/24, and 4/3/25 pharmacy recommendations were not in R26's medical record. CS "G" stated the 8/6/24 recommendation was a nursing one and they were previously not entering them into residents medical records. CS "G" further stated the 11/4/24 recommendation was in the pharmacy computer system, and they had to get it from there today. In addition, CS "G" stated the 4/3/25 recommendation had been signed by the physician but was still waiting to be</p>			

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	<p>uploaded into R26's medical record (it had been signed on 4/7/25- 24 days prior to this interview).</p> <p>R36</p> <p>A review of R36's Admission Record, dated 5/1/25, revealed R36 was a 79-year-old resident admitted to the facility on 10/5/21. In addition, R36's Admission Record revealed multiple diagnoses that included congestive heart failure and osteoarthritis.</p> <p>A review of R36's Pharmacist Medication Regimen Reviews, dated 6/1/24 to 5/1/25, revealed the pharmacist had noted a potential medication and/or medication-related irregularity on 12/3/24. However, a review of R36's medical record failed to reveal what the irregularity and/or pharmacist recommendation was for 12/3/24.</p> <p>On 5/1/25 at 11:30 AM, the Nursing Home Administrator (NHA) was notified that the surveyor could not locate in R36's medical record the pharmacist's recommendation for the irregularity that was noted in the Pharmacist Medication Regimen Review for 12/3/24. A copy of the 12/3/24 pharmacist's recommendation with supporting documentation (if applicable) was requested from the NHA.</p> <p>On 5/1/25 at 12:10 PM, the facility provided the surveyor with a copy of R36's pharmacy recommendation for 12/3/24 with supporting documentation. However, a second review of R36's medical record failed to reveal that the pharmacist's recommendation for 12/3/24 was present in the medical record.</p> <p>During an interview on 05/01/25 at 01:44 PM, CS "G" stated R36's pharmacy recommendation for 12/3/24 was not in R36's medical record. CS "G" stated the recommendation had been in the</p>			

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F0880 SS= F	pharmacy's computer system and the facility was able to obtain information from that system. Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a) (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The	F0880	ELEMENT 1 ACTION TAKEN: The facility will conduct a review of the plan to reduce the risk of legionella and other opportunistic pathogens of premise plumbing. An audit will be completed by 5/26/2025 of hot and cold water fixtures regardless of room vacancy. Fixtures that have not been flushed will be at that time, including the one in the soiled utility room near the salon. The hopper and the mop sinks hot and cold water fixtures in the soiled utility room near room 40 will be flushed by 5/26/2025. The shower in the corner of the spa room will be deep cleaned by 5/26/2025 and repairs will be made to rectify the flow of water to ensure flushing of the fixture can be completed. A repair will be made by 5/26/2025 to apply the cold handle to the sink in the janitors closet, and once repaired the faucet will be flushed. The hot water faucet on the same sink will be flushed. A repair to the handle of the hot water line in the laundry room will be made by 5/26/2025, and once repaired the faucet will be flushed. The facility will complete a free chlorine test of hot water by 5/26/2025, any abnormal results will be rectified. ELEMENT 2 IDENTIFICATION OF OTHER RESIDENTS: All residents residing in the facility have the	5/26/2025

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	<p>circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility.</p> <p>Findings include:</p> <p>During a tour of the facility, with Maintenance Director (MD) "I", at 1:44 PM on 4/29/25, observation of the Soiled Utility room, near the salon, found brown discolored water dispensed out of the hot and cold-water fixtures when the faucet above the hopper was turned on. When asked if this was an area that is regularly flushed, MD "I" stated they were not flushing this fixture and have been focusing on vacant rooms.</p>		<p>potential to be affected. All residents will be reviewed for waterborne illness. The health care practitioner will be notified of any residents identified to have signs or symptoms for further medical assessment and treatment.</p> <p>ELEMENT #3 MEASURES TAKEN: Members of the Water Management Committee, to include the Administrator, Director of Health Care Services, Infection Prevention, Environmental Services and Maintenance staff will be reeducated by or prior to 5/26/2025 to the next day worked in the case of a leave of absence or vacationing employee related to water management plan and services to reduce the risk Legionella and other opportunistic pathogens of premise plumbing, and water quality measures and disinfectant residual practices.</p> <p>ELEMENT #4 MONITORING: The Nursing Home Administrator and or designee will conduct an audit through observation of Environmental Services and or Maintenance staff flushing faucets throughout the facility, regardless of room vacancy 3-5 times a week for four weeks and periodically thereafter. The water management plan will be reviewed under the direction of the Quality Assurance Performance Improvement (QAPI) Committee, the Administrator, or designee(s), will audit as adherence to the policy and procedure to prevent Legionnaires Disease potential sources weekly for four (4) weeks. A summary report of the findings will be provided to the QAPI Program/Committee for review. The Administrator will assume responsibility for attained and sustained compliance.</p>	

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	<p>During a tour of the facility, at 2:00 PM on 4/29/25, observation of the Soiled Utility room, near resident room 40, found little to no water filling the basin of the commode, indicating the hopper had not been flushed in so long the water had evaporated from the basin. Water dispense from the mop sinks hot and cold fixtures were found discolored before running clear.</p> <p>During a tour of the Spa room near the end of the hall, at 2:05 PM on 4/29/25, it was observed that a shower in the corner of the spa room was found with equipment and supplies on the floor of the shower area. Further review of the shower found dust accumulation on the shower hose and spray wand. When asked if this was an area that gets flushed, MD "I" stated that its not. When the surveyor tried to flush the water from the shower, neither the surveyor nor MD "I" could get the water to run. MD "I" stated he would look into it.</p> <p>During a tour of the janitors sink near the end of the hall, at 2:11 PM on 4/29/25, it was observed that no cold handle was available to turn on the cold supply on. Upon turning the hot supply into a bucket, the water was brown and discolored and turned clear. Using a Leatherman tool to open on the cold supply, dark black turning to brown water dispensed from the fixture for five to ten seconds.</p> <p>During a tour of the laundry room, at 2:25 PM on 4/29/25, it was observed that a hot water line near the washing machine was found not in use, with no handle and with a cap covering the hose bib where the water would dispense. When asked if this is something that gets routinely flushed, MD "I" stated it does not.</p> <p>During an interview with MD "I" and Director of Facilities (DOF) "J" it was found that the facility currently does an annual test for free chlorine.</p>			

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F0921 SS= D	<p>When asked if any of the free chlorine measurements are taken from the hot water supply. DOF "J" stated he has only been doing cold water samples. When asked if any testing is done on the two hot water systems that service the residents of this facility, Director of Facilities "J" stated that they will start to incorporate readings in those areas as well.</p> <p>A review of the facility provided document entitled " ...Executive Summary and Risk Assessment", dated 2021, found that: "The (Water Management) team considers the water distribution system for adherence to control measure and critical limits listed in the CDC Toolkit for Controlling Legionella in Potable Water Systems which include: ...Water Age, Flushing, Flush low-flow pipe runs and dead legs at least weekly. Flush infrequently used fixtures regularly."</p> <p>Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interviews, the facility failed to maintain a safe, functional, sanitary, and comfortable environment. This resulted in an increased potential for contamination and a possible decrease in satisfaction of living.</p> <p>Findings Include:</p> <p>During a tour of the facility with Maintenance Director "I", starting at 1:29 PM on 4/29/25,</p>	F0921	<p>ELEMENT 1 ACTION TAKEN: The spa room near the activities center was deep cleaned and the area of the floor where there were missing tiles will be repaired by 5/26/2025.</p> <p>The floor in the clean linen room was cleaned. A solid surface shelf was installed on the bottom shelf of the clean linen cart in the clean linen room.</p> <p>The spa room at the end of the hall was deep cleaned including the padding of the plumbing pipe under the sink that was also sanitized.</p> <p>ELEMENT 2 IDENTIFICATION OF OTHER RESIDENTS: The facility will conduct a resident council meeting by 5/26/2025 where residents will have the opportunity to express any concerns</p>	5/26/2025

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	<p>observation of the spa room near activities, found a strong odor and bowel movement in the commode with clean folded towels stacked next to the sink. Further observation of the shower floor found an area near the front of the shower where roughly a dozen one-inch square tiles were missing. When asked if he was aware of the floor, MD "I" stated he was not. While looking for the missing tiles, MD "I" picked up a piece of trash on the shower floor and found it to be a gold tooth filling. When asked if he knew of any residents missing one, MD "I" was unsure.</p> <p>During a tour of the clean linen room, at 1:35 PM on 4/29/25, it was observed that the bottom rack of the clean linen cart was open wire shelving, leaving clean linens at the bottom of the cart open and exposed to contamination. Further observation under the linen cart found an accumulation of trash, dust, and dirt. When asked if the cart ever gets moved out of the room, MD "I" stated it usually stays there.</p> <p>During a tour of the spa room near the end of the hall, at 2:05 PM on 4/29/25, it was observed that bowel movement was in the commode and found smeared on the padded cover for the plumbing under the sink. Further observation of the room found a corner shower area not in use with dust accumulation on equipment and the shower fixture.</p>		<p>related to their living environment. Any identified concerns will be addressed through the resident grievance process.</p> <p>ELEMENT 3 MEASURES TAKEN: All staff will receive reeducation by or prior to 5/26/2025 or the next day worked in the case of a leave of absence or vacationing employee related to the standards of providing a safe, functional, sanitary, and comfortable environment to ensure satisfaction of the living environment is maintained for residents, staff, and visitors.</p> <p>ELEMENT 4 MONITORING: The Nursing Home Administrator and or designee will conduct an audit through observation during rounds in the facility 3-5 times a week for four weeks, and periodically thereafter. The observations will be of various areas and rooms throughout the facility to ensure a safe, functional, sanitary, and comfortable living environment is maintained. Examples of locations to audit are shower rooms, resident rooms, storage rooms, linen closets, dining rooms, etc. A summary report of the findings will be provided to the QAPI Program/Committee for review. The Administrator will assume responsibility for attained and sustained compliance.</p>		