STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	114130	A. BUILDING _____ B. WING _____	3/5/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COREWELL HEALTH REHAB & NSG CTR - PINE RIDGE	4368 CLEVELAND AVE STEVENSVILLE, MI 49127

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F0000 SS=	INITIAL COMMENTS Corewell Health Rehab and Nursing Center was surveyed for a Recertification survey on 3/5/2025. Intakes: MI00147507 Census:105	F0000		
F0578 SS= D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident	F0578	Element #1 Resident #37, #312 and #60 Advanced Directives have been updated to reflect patient goals of care. Element #2 Residents that currently reside in the facility have potential to be affected. Element #3 Facility Social Workers have been re-educated on Michigan Do-Not- Resuscitate Procedure Act. Advanced Directives of residents currently residing in the facility have been audited; any identified concerns will be corrected in the moment. Element #4 Social Worker/Designee will complete 5 weekly Advanced Directive audits to ensure they meet requirements of the Michigan Do-not-Resuscitate Act and resident goals of care. Variances to be corrected at time of observation. Audits to be submitted to facility QAPI for review and further recommendations. Element #5 The Administrator is responsible for sustained compliance.	4/9/2025

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

Electronically Signed | 03/24/2025

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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	representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to complete advance directives completely and accurately for 3 residents (Resident #37, Resident #312, Resident #60) of 22 residents reviewed for advance directives resulting in the potential for resident preferences for medical care to not be followed by the facility staff. Findings include: Resident #37 (R37) Review of the Admission Record and Minimum Data Set (MDS) dated 12/21/2024 revealed R37 admitted to the facility on 12/17/2024 with diagnoses including chronic pain, paraplegia (loss or impairment of voluntary movement and sensation in the lower half of the body including both legs due to damage to the spinal cord), left lower extremity amputation and a pressure injury (wound) to right buttocks. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R15 was cognitively intact (13 to 15 cognitively intact). Review of R37's physician orders revealed "Do not resuscitate (DNR)" with a start date of 1/1/2025. Review of R37's chart revealed that there was no paperwork on code status that was signed by R37.			

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	During an interview on 3/04/2025 at 1:46 PM, Social Worker (SW) "M" stated that she wasn't sure if she talked to R37 about his code status when he was admitted and "hopefully the doctor spoke to him." SW "M" was unable to locate code status paperwork in R37's chart. During an interview on 3/04/2025 at 3:21 PM, R37 stated that he probably wants to be a DNR but he wasn't completely sure. R37 also wasn't sure if anyone spoke to him about his code status when he admitted to the facility and he stated that he didn't sign any paperwork related to it. An email from Nursing Home Administrator (NHA) "A" on 3/05/2025 at 10:51 AM revealed that there was "No specific code status paperwork for (R37)." Resident #312 (R312) Review of the Admission Record revealed R312 admitted to the facility on 2/20/2025 with diagnoses including Alzheimer's dementia and failure to thrive. Brief Interview for Mental Status (BIMS) reflected a score of 9 out of 15 which indicated R312's cognition was moderately impaired (8-12 moderately impaired). Review of R312's physician orders revealed "Do not resuscitate (DNR)" with a start date of 2/20/2025. Review of R312's DNR-Michigan Out of Hospital Form revealed that the resident didn't sign the form, the first advocate didn't sign the form and the second advocate signed the form on 2/20/2025. Review of R312's chart revealed that there wasn't a capacity form (form completed by the physician			

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	or psychologist to tell the court about cognitive abilities such as problem solving and critical thinking) indicating that R312 was unable to make his own decisions or the required 2 physician signatures (ensures a higher level of accuracy and objectivity when determining a patient's mental capacity). During an interview on 3/04/2025 at 11:16 AM, SW "M" looked in R312's chart and could not find any paperwork/forms in R312's chart regarding his capacity along with 2 physician signatures. SW "M" also agreed that R312's 2nd advocate signed the DNR instead of the 1st advocate. During an interview on 3/5/2025 at 11:20 AM, NHA "A" stated that the facility was working on a better process to streamline code status when they come from the hospital and making sure appropriate paperwork was filled out. The Resuscitation Status-Adult Policy with an effective date of 7/21/2024 revealed "3. Policy: I ... ...The admitting provider is accountable to discuss and document the patient's resuscitation status within 24 hours of admission ... II. Documentation of Resuscitation Status .... C. The initial and all subsequent discussions with a patient and/or their medical designee about their Resuscitation Status order will be summarized in the medical record. The summary should include who made the decision (patient or designee) and why the decision is appropriate ...." Review of Resident #60's "Physician Orders" dated 12/30/24 revealed, "Do Not Resuscitate (DNR)...Discharge summary 12/08/24 DNR." Review of Resident #60's "DNR paperwork" revealed no paperwork on record.			

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	In an interview on 03/04/25 at 01:36 PM, Social Worker (SW) "M" reported that Resident #60 had an order in place for DNR, but the facility did not have signed documentation from the resident and physician indicating that the resident elected the no code status. SW "M" reported that the facility must discuss the resident's wishes upon admission and ensure that the documentation is in the record, prior to entering the order. SW "M" reported that reviewing hospital discharge paperwork indicating that the resident was DNR in the hospital, cannot be used for a DNR order in the facility. SW "M" reported that at that time she was not aware of the issue for this resident, and would have to discuss advance directives to seek clarification and obtain a signed document of his wishes.			
F0584 SS= D	Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5)	F0584	Element# 1 Medical equipment for resident #75 has been cleaned and sanitized. Gouges, dings and dents on #75 wall have been repaired. Element# 2 Residents residing at the facility have the potential to be affected. All resident mattresses on the floor have been cleaned and sanitized. Facility Maintenance Technician/designee has audited facility resident rooms and work orders were placed for any rooms found with gouges, dings and dents. Element #3 Environmental services have been educated on mattress cleaning protocol. Facility Maintenance technician has been re-educated on the process to track and retrieve work orders. Element #4 Environmental Services lead or designee(s), will conduct random weekly audits of medical equipment cleanliness and wall integrity.	4/9/2025

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	Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain a clean comfortable environment with clean, sanitized medical equipment for 1 resident (Resident #75) of 2 residents, resulting in the potential for cross contamination and bacterial harborage. Findings include: Review of "Facesheet" revealed Resident #75 was a male with pertinent diagnoses which included macular degeneration (loss of in the center of the field of vision), legal blindness, dementia, diabetes, anxiety, kidney disease stage 3, neuropathy (weakness, numbness, and pain from nerve damage), anemia, and stroke. Review of "Resident Care Summary" dated 3/5/25, revealed, "...Safety: Dated 1/24/25...Low bed, bed by wall for increased floor space, bedside mat...Lay down between meals so he doesn't slid (sic) out of w/c (wheelchair)...Dependent for transfers, bed mobility..." During an observation on 03/03/25 at 09:52 AM, Resident #75 was observed lying in bed with a mattress on the floor placed next to the right side of his bed. The mattress was covered with spotted dried liquid stains, dried food, and had dusty shoe prints on it.		Audits will be forwarded to the facility QAPI committee for review and further recommendations. Element #5 The Administrator is responsible for sustained compliance.	

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	During an observation on 03/03/25 at 01:01 PM, the mattress which would go beside Resident #75's bed was leaned up against the far wall and it was covered from end to end with spots of dried liquid, dried spilled food, dusty shoe prints, and white dried material as well. During an observation on 03/04/25 at 11:10 AM, Resident #75 was not in his room, his bed was stripped down, there were gouges on the wall by his enabler bar on the wall side of the bed. The paint was missing and there were gouges in the drywall as well as gouges to the wall where the corner of the head of the bed was placed along the wall. The corner of the wall had approximately 18 inches of plaster/drywall mud broken off and the metal corner guard was exposed. In an interview on 03/05/25 at 12:42 PM, Certified Nursing Assistant (CNA) "III" reported the CNAs would inform the nurse, or if they were able to, they would put in a work order. In an interview on 03/05/25 at 12:44 PM, Registered Nurse (RN) "EEE" reported depended on EVS(environmental) or Maintenance work order. RN "EEE" reported she would verbally tell environmental services as they see then all the time. RN "EEE" reported the staff were able to contact maintenance by calling the service number or if they had access to the computer they were able to submit a ticket there. RN "EEE" reported when they contacted the service number they spoke to someone to report the concern. In an interview on 03/05/25 at 12:20 PM, Housekeeping Manager "AA" reported the housekeepers were responsible for keeping the mattress on the floor clean as well as cleaning under the mattress so it was clean underneath. Housekeeping Manager "AA" reported she would review the housekeeper's responsibilities with			

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	them. In an interview on 03/05/25 at 12:24 PM, Maintenance "L" and this writer went to Resident #75's room to observe his walls. Maintenance "L" reported his boss was in the process of trying to get funding for some room refreshers but it had not come to fruition yet. Maintenance "L" reported when the beds were placed along the wall for resident safety it allowed for the dings and dents in the walls. Maintenance "L" examined the wall next to Resident #75's bed and reported since the bed was moved along the wall when the bed was moved it created the dings and dents in the walls. This writer expressed those were gouges in the wall with exposed drywall or plaster and not a dent or ding in the wall. Maintenance "L" observed the broken off drywall/plaster on the corner and this writer expressed concern with the exposed metal to the corner for resident safety. Maintenance "L" reported he believed this occurred when staff would run equipment into the corner. Maintenance "L" was unable to report if he had received a work order for the gouges, missing paint and missing drywall/plaster concern. He reported he was unable to review the history of the completed work orders. Maintenance "L" reported the staff would file an electronic work order, he would get the notice on his computer screen, he would complete the maintenance request and it would then go into the history. He reported the staff were not completing very many work orders in the system. Maintenance "L" reported he was the only maintenance staff present in the building. The facility had an HVAC person but they were split between multiple buildings. Maintenance "L" reported funds to have the rooms refreshed was the goal and has been on the radar but no movement yet on the capital funds.			

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	Using the reasonable person concept, though Resident #75 had decreased ability to verbally express his own thoughts due to his cognitive deficits, he would not prefer to reside in a room with a heavily soiled fall mattress and gouges/scraps with missing paint on the walls, and drywall missing from the corner of the wall.			
F0640 SS= D	Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon	F0640	Element 1 MDS discharge assessment for residents # 82 and #93 were completed and transmitted. Element 2 Residents that discharge from the facility have the potential to be affected. The last 6 months of discharges have been reviewed for MDS completion and transmission. Identified concerns were addressed at time of observation. Element 3 MDS Nurses have been re-educated on encoding and transmitting data requirements of CMS. Element 4 Under the direction of the Quality Assurance Performance Improvement (QAPI) Committee, Director of Nursing or designee (s), will conduct random weekly audits of discharge MDS completion and submission. The QAPI Committee will review findings monthly and determine ongoing need for audits. Element #5 The Administrator is responsible for sustained compliance.	4/9/2025

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	a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to transmit Minimum Data Set (MDS) discharge assessments timely for 2 residents (Resident #82, Resident #93) of 2 reviewed for MDS transmission resulting in the potential for inaccurate tracking of discharges. Findings include: Resident #82(R82) Review of R82's chart revealed that she discharged from the facility on 9/19/2024. Review of R82's chart revealed a MDS discharge assessment -return not anticipated with an ARD of 9/20/2024 was "in progress" and "incomplete: GG, J, M, N, O, P (sections GG, J, M, N, O, P)." The MDS was not transmitted. Resident #93(R93) Review of R93's chart revealed that she discharged from the facility on 9/17/2024. Review of R93's chart revealed a MDS discharge assessment -return not anticipated with an ARD (assessment reference date) of 9/17/2024 was "in			

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	progress" and "incomplete: K (section K)." The MDS was not transmitted. During an interview on 3/05/2025 at 1:23 PM, MDS nurse "D" stated that a discharge assessment should be completed whenever a resident discharges from the facility. Then, it should be transmitted. MDS "D" verified that a MDS discharge assessment for R82 should have been completed on 10/4 and then transmitted. MDS "D" verified that a MDS discharge assessment for R93 should have been completed on 10/1 and then transmitted.			
F0644 SS= D	Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that PASARR (Preadmission Screening and Resident Review) Level II (a comprehensive evaluation completed by the local (state mental health aruthority) was completed for 1 (Resident #16) of 4 residents reviewed for	F0644	Element #1 Resident #16 had a completed PASARR assessment. Resident was assessed for psychosocial well-being and found to be at baseline. Care Plan and Resident Care Summary reviewed and found to be appropriate to reflect resident care needs. Element #2 Residents residing in the facility have the potential to be affected. PASARR assessments for current residents were reviewed for timely completion. Any gaps identified have been addressed. Element #3 The facility Social Workers have been re-educated to the PASARR requirements. Element #4 Under the direction of the Quality Assurance Performance Improvement (QAPI) Committee, Administrator, or designee(s), will randomly audit residents weekly to validate timely completion of PASAAR assessments. The QAPI Committee will review findings and determine ongoing need for audits. Element #5 The Administrator is responsible for sustained	4/9/2025

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	PASARR Level II screening resulting in the potential for unmet mental health care needs. Findings include: Resident #16 Review of a "Face Sheet" revealed Resident #16 was a female who originally admitted to the facility on 3/29/2024 and had pertinent diagnoses which included: recurrent major depressive disorder, dementia with behavioral disturbances, and bipolar affective disorder. Review of a "Minimum Data Set" (MDS) assessment for Resident #16, with a reference date of 1/3/2025 revealed a "Brief Interview for Mental Status" (BIMS) score of 6/15 which indicated Resident #16 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment). Review of Resident #16's electronic medical record revealed no noted PASARR Level II assessment. In an interview on 3/4/2025 at 3:16 PM., "Social Worker" (SW) "M" reported Resident #16's PASARR Level I (an initial pre-screen assessment used to determine if a resident would benefit from state mental health authority involvement) was completed on 7/3/2024 and indicated that Resident #16 needed a Level II assessment completed. SW "M" reported she kept paper copies of the Level I assessments to ensure she would follow up for completion of the needed Level II assessments. SW "M" did not produce a paper copy of Resident #16's Level I assessment. SW "M" accessed the OBRA (Omnibus Budget Reconciliation Act- Nursing home reform act) website and revealed there was no completed Level II assessment nor a recommendation letter		compliance.	

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	available on the OBRA website for Resident #16. No PASARR Level II assessment nor a recommendation letter from OBRA was provided by survey exit.			
F0656 SS= D	Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or	F0656	Element #1 Residents #58 no longer resides in the facility. Element #2 Residents residing in the facility have the potential to be affected. Resident care plans have been reviewed and updated to reflect current care needs. Element# 3 The interdisciplinary team has been re-educated on the Care Planning and Coordination policy. Element #4 Under the direction of the Quality Assurance Performance Improvement (QAPI) Committee, the Director of Nursing or designee(s), will conduct weekly audits of care plans to ensure appropriateness. The QAPI Committee will review findings monthly and determine ongoing need for audits. Element #5 The Administrator is responsible for sustained compliance.	4/9/2025

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	other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a person-centered care plan related to Hospice care for 1 resident (Resident #58) of 22 reviewed for person centered care plans resulting in the potential for unmet care needs of the resident. Findings include: Resident #58 (R58) Review of the Admission Record and Minimum Data Set (MDS) dated 1/21/2025 revealed R58 admitted to the facility on 6/7/2018 with diagnoses including dementia and Alzheimer's disease. Brief Interview for Mental Status (BIMS) reflected a score of 3 out of 15 which indicated R58 cognition was severely impaired (0-7 severe impairment). Review of R58's chart revealed he had a significant change MDS (minimum data set) dated 1/21/2025 due to him declining and starting Hospice care. Review of R58's care plans revealed that there wasn't a Hospice care plan. During an interview on 3/05/2025 at 1:13 PM,			

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	MDS nurse "D" revealed that R58 signed onto Hospice on 1/15/2025. MDS "D" stated that she thought that Social Worker (SW) "M" was responsible for completing the Hospice care plan when a resident goes under Hospice care. After placing a call to the other MDS nurse in the facility, MDS "D" stated that she was wrong and she was supposed to do the Hospice care plans. Review of the Care Planning and Coordination Policy with an effective date of 3/21/2022 revealed "The plan of care is developed, documented, and implemented using an individualized approach. The plan of care is reviewed, and revisions are made as needed according to patient health status .... 3. Policy .... Each patient must receive an individualized written plan of care, including services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the agency in collaboration with the patient, anticipates will occur as a result of implementing and coordinating the plan of care as well as patient specific goals ... ."			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review the facility failed to provide activities of daily living (ADLs) specifically nail care to a dependent resident for 1 (Resident #52) of 5 residents reviewed for activities of daily living,	F0677	Element #1 Nail care was provided for Resident #52. Element #2 Residents' dependent for fingernail grooming/hygiene have the potential to be affected. These Residents who are dependent for fingernail grooming/hygiene will be observed for appropriate fingernail grooming/hygiene and any concerns will be addressed at time of observation. Element #3 Certified Nursing Assistants and Licensed Nurses will be re-educated on ADL standards of care.	4/9/2025

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	resulting in an unkept appearance and the potential for the spread of infection. Resident #52 Review of a "Face Sheet" revealed Resident #52 was a female who originally admitted to the facility on 10/11/2017 and had pertinent diagnoses which included: cognitive deficits following a non-traumatic intracerebral hemorrhage (bleeding in the brain), hemiparesis (paralysis) on the left non-dominate side, and debility. Review of a "Minimum Data Set" (MDS) assessment for Resident #52, with a reference date of 12/4/2024 revealed a "Brief Interview for Mental Status" (BIMS) score of 2/15 which indicated Resident #52 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment). During an observation and interview on 3/3/25 at 10:24 AM., Resident #52 was lying in her bed, and it was noted that her fingernails were long and caked with dirt and debris that appeared black in color underneath her fingernails. Resident #52 reported that she liked her nails clean and trimmed. Review of "Care Plan" for Resident #52 revealed "Problem: ADL maintenance ...this has affected her (Resident #52) ability to completed ADLs independently; requires extensive to total assistance ...interventions assist with ADLs as needed ..."with a start date of 4/11/2024. During an observation on 3/4/25 at 8:14 AM., Resident #52 was lying in her bed, and it was noted that her fingernails were long and caked with dirt and debris that appeared black in color underneath her fingernails.		Element #4 Under the direction of the Quality Assurance Performance Improvement (QAPI) Committee, Nurse Manager, or designee(s), will randomly audit dependent residents for ADL standards of care. The QAPI Committee will review findings monthly and determine ongoing need for audits. Element #5 The Administrator is responsible for sustained compliance.	

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	In an interview on 3/4/25 at 4:23 PM., "Certified Nurse Assistant" (CNA) "JJ" reported nail care should be completed during showers but can be done any time it is needed. During an observation on 3/5/25 at 8:29 AM., Resident #52 was lying in her bed, and it was noted that her fingernails were long and caked with dirt and debris that appeared black in color underneath her fingernails. In an interview on 3/5/25 at 8:30 AM., CNA "HH" reported that nail care should be done on the resident's shower days. During an observation and interview on 3/5/25 at 10:26 AM., CNA "QQ" was in Resident #52's room, providing a bed bath and ADL care. When queried, CNA "QQ" confirmed that Resident #52 was dependent for care, and needed staff to provide nail care. CNA "QQ" confirmed that Resident #52's nails were long and soiled with dirt and debris black in color under her nails. During an observation and interview on 3/5/25 at 10:36 AM., "Licensed Practical Nurse" (LPN) "XX" entered Resident #52's room while CNA "QQ" was providing ADL care and stated "I'm here to cut her (Resident #52's) nails. When queried, LPN "XX" reported that nail care should be done with showers, skin assessments, and any time a resident needs nail care. On 3/5/25 at 10:38 AM., LPN "XX" was observed exiting Resident #52's room without completing nail care. In an interview on 3/5/25 at 10:39 AM., LPN "XX" was queried about completing Resident #52's nail care and LPN "XX" reported she no longer had time to provide nail care to Resident #52. LPN "XX" stated "if I have time, I don't			

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	have time now, I'm going to finish my work before I do her (Resident #52) nails." In an interview on 3/5/25 at 10:49 PN., "Clinical Nurse Supervisor" (CNS) "I" reported nail condition was a specific question during a weekly skin assessment completed by nurses. Review of Resident #52's record revealed no documentation related to nail care. In an interview on 3/5/25 at 11:27 AM., "Director of Nursing" (DON) "B" reported her expectations were that the nails of residents were cut and clean and that nail care was done as needed, and/or during showers, and/or as requested by the resident. DON "B" reported CNAs were responsible for resident nail care unless otherwise recommended that nail care be done by a nurse.			
F0684 SS= D	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 evidenced by: Based on observation, interview and record review the facility failed to ensure residents received care in accordance with physician orders for medications and professional standards in 1 resident (Resident #49) of 22 residents reviewed for quality of care, resulting in a delay in treatment and worsening of a medical condition, and the potential for residents not attaining or	F0684	F684 Element #1 Resident #49 physician orders and treatment reviewed and appropriate. Element #2 Residents that reside in the facility have the potential to be affected. Residents have been reviewed for significant change in condition with physician notification. Element #3 Licensed Nurses have been educated on the facilities Change in Condition Notification of Clinician policy. Element #4 Under the direction of the Quality Assurance Performance Improvement (QAPI) Committee, the Director of Nursing or designee(s), will conduct weekly audits for residents who have significant change in condition physician communication. The QAPI Committee will review findings monthly and	4/9/2025

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	maintaining their highest practicable level of wellbeing. Findings include: Resident #49 Review of an "Admission Record" revealed Resident #49 was originally admitted to the facility on 12/5/24, with pertinent diagnoses which included: CHF (congestive heart failure) (when your heart can't pump blood well enough to give your body a normal supply; over time blood and fluids collect in the lungs and legs causing swelling) and pacemaker (a device placed under the skin that stimulates the heart to beat regularly.) Review of a "Minimum Data Set" (MDS) assessment for Resident #49, with a reference date of 2/5/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #49 was cognitively intact. In an interview on 03/03/25 at 03:51 PM, Resident #49 reported that when he admitted into the facility in December, they failed to order his lasix (diuretic medication used to reduce excessive fluid build up due to CHF) and that's why he gained so much weight and ended up in the hospital. Resident #49 reported that it was his cardiology doctor that figured it out on 12/11/24 when he was there for a pacemaker check. Resident #49 reported that he tried to relay the information back to the nursing staff that he needed to take lasix, but they would not listen. Resident #49 reported that he had went to the hospital to have his pacemaker replaced on 1/14/25, and his cardiologist made him stay until 1/19/25 because he had gained so much weight due to not having his lasix regularly. Resident		determine ongoing need for audits. Element #5 The Administrator is responsible for sustained compliance.	

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	#49 was observed seated in his wheelchair, with an enlarged abdomen and significant swelling in his legs. In an interview on 03/05/25 at 12:26 PM, Clinical Nurse Supervisor (CNS) "I" reported that Resident #49 had a diuretic listed on his hospital paperwork when he admitted, but it was not administered as ordered upon admission to the facility; the medication was administered only 1 time on 12/6/24. CNS "I" reported that there was no indication as to why the medication was discontinued and/or not administered as needed for the increased edema, and it was not anything that she was aware of at that time. CNS "I" reported that all newly admitted residents had their weight monitored every day for 3 days, then once weekly for 4 weeks, and then monthly. CNS "I" reported that Resident #49 had a CHF, therefore his weight was obtained daily, and significant changes should have been reported to the physician; there should be documentation in the provider notes if the nursing staff had talked to the provider. CNS "I" reported that Resident #49 had a couple "3 or more pounds" increase in his weight during December and a significant increase in his weight in January that was not addressed by the facility. Review of Resident #49's "Weight Record" indicated a multiple increases in the resident's weight, from admission on 12/5/24 to re-hospitalization on 1/14/25: 12/5/24 94.2 kg (207 pounds) 12/9/24 95.5 kg (210 pounds) 12/17/24 97.4 kg (214 pounds) 1/1/25 102.9 kg (226 pounds)			

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	1/4/25 103.5 kg (228 pounds) 1/9/25 104.3 kg (229 pounds) 1/10/25 "possible error" 1/11/25 "error" 1/12/25 "error" 1/13/25 "possible error with hoyer (mechanical lift)" 1/14/25 at 7:00 AM (at facility) 106 kg (233 pounds) "possible error with hoyer" 1/14/25 at 5:50 PM (at hospital) 104 kg (229 pounds) In an interview on 03/05/25 at 01:24 PM CNS "I" reported that she had spoken to the provider and there was no documentation of the provider being notified of Resident #49's significant weight changes, and there were no adjustments to his diuretic medications. CNS "I" reported that Resident #49 saw his cardiologist on 12/11/24; there was no record that the provider reviewed the cardiology recommendations at that time. CNS "I" reported that Resident #49 went to the hospital on 1/14/25 for a scheduled pacemaker replacement and was admitted due to worsening of CHF and the need for diuresis (removal of excessive fluids by medical interventions). In an interview on 03/05/25 at 01:36 PM, Nurse Practitioner (NP) "NNN" reported that according to the notes in the computer, Resident #49 saw the facility Medical Doctor (MD) "OOO" on 12/10/24 and his medication list included Lasix 40 mg as needed, but he was not getting it. Resident #49 then saw his cardiologist on 12/11/24 for a pacemaker check and it was noted			

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	that the resident had not been receiving his usual Lasix dose and would require hospitalization for further diuresis. NP "NNN" reported that normally with CHF, residents are on a diuretic regularly and weights are monitored closely, but that it did not appear that this was addressed for the resident. NP "NNN" reported that she had seen Resident #49 on 1/13/25, but that she was made aware of his weight gain at that time; Resident #49 was admitted to the hospital the following day. Review of Resident #49's "After Visit Summary (discharge from hospital to facility)" dated 12/5/24 revealed, "...Medication list: ...furosemide (generic name for lasix) 40 mg take 1 tablet by mouth daily as needed for (weight gain more that 3 pounds with LE (legs) edema (swelling cause by excessive fluid collection)..." Review of Resident #49's "Physician Note" dated 12/6/24, by MD "OOO" revealed, "...Admission History and Physical...Assessment & Plan: Chronic combined systolic an diastolic congestive heart failure: ...Continue furosemide...Medications: ...furosemide (lasix) tablet 40 mg daily PRN (as needed)...Physical exam: ...lower extremity scaling consistent with episodes of edema...Wt (weight): 94.2 kg (207 pounds)" Review of Resident #49's "Physician Note" dated 12/10/24, by MD "OOO" revealed, "...staff reported coughing more...Assessment & Plan: (listed by diagnoses) ... #1. Chronic combined systolic and diastolic congestive heart failure (HCC):...Continue furosemide...#23. Cough: given his heart failure history, discussed with him my concerns he may have pulmonary edema contributing to his cough. Recommended furosemide (lasix) for three days...Medications: ...Start on 12/11/24 furosemide (lasix) tablet			

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	10mg...Wt: 95.5 kg (210 pounds)..." The note does not list that the resident was receiving furosemide at the time of visit, but indicates that the resident should continue the furosemide that he had been taking for his heart failure, and receive furosemide 10mg for three days for cough. The resident's weight increased by 3 pounds and was not addressed. Review of Resident #49's "Medication Administration Record (MAR)" for the month of December 2024 indicated that Lasix 40 mg was given 1 time on 12/6/24, Lasix 10mg was given 3 times (12/11/24, 12/12/24, 12/13/24). There were no other diuretic medications administered for December. Review of Resident #49's "Cardiology Provider Progress Note" dated 12/11/24 revealed, "...he (Resident #49) has not received his usual lasix while at (facility name) and has gained wt and developed severe edema (swelling caused by collection of excessive fluids). Will admit to hospital service after generator change for diuresis and management of his skin breakdowns." This note was entered by the provider following the resident's visit for his pacemaker check. Review of Resident #49's "Physician Note" dated 12/20/24, by MD "OOO" revealed, "...He stated he didn't think increased lasix helped with cough. He coughs up light yellow...Assessment & Plan: (listed by diagnoses) ... #1. Chronic combined systolic and diastolic congestive heart failure (HCC)...continue furosemide...Medications: ...Wt: 97.5 kg (214 pounds)..." The medication list did not include furosemide. There was no order in place for furosemide at that as indicated in the visit note. The resident's weight increased by an additional 4 pounds and was not addressed, nor was lasix administered.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of Resident #49's "Physician Note" dated 1/2/25, by MD "OOO" revealed, "...report of left arm swelling...Lymphedema left arm (fluid accumulation)...Assessment & Plan: (listed by diagnoses) ... #1. Chronic combined systolic and diastolic congestive heart failure (HCC)...continue furosemide...Medications: ...Wt: 102.7 kg (226 pounds)..." The medication list did not include furosemide. There was no order in place for furosemide at that as indicated in the visit note. The resident's weight increased by an additional 12 pounds and was not addressed, nor was lasix administered. Review of Resident #49's "Physician Note" dated 1/6/25, by MD "OOO" revealed, "...left arm swelling...possible DVT (blood clot)...Assessment & Plan: (listed by diagnoses) ... #1. Chronic combined systolic and diastolic congestive heart failure (HCC)...continue furosemide...Medications: ...Wt: 103.5 kg (228 pounds)..." The medication list did not include furosemide. There was no order in place for furosemide at that as indicated in the visit note. The resident's weight increased by an additional 2 pounds and was not addressed, nor was lasix administered. Review of Resident #49's "MAR" for the month of January 2025 indicated that Lasix 40 mg was given 1 time on 1/9/25 and twice daily on 1/12/25 and 1/13/25. Review of Resident #49's "Physician Note" dated 1/13/25, by NP "NNN" revealed, "...no new complaints...Assessment & Plan: (listed by diagnoses) ... #1. Chronic combined systolic and diastolic congestive heart failure (HCC)...continue furosemide...Medications: ...Furosemide (lasix) tablet 40mg 2 times per day...Wt: 106 kg (233 pounds)..." The resident's weight increased by an additional 5 pounds but			

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	114130	A. BUILDING _____ B. WING _____	3/5/2025

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	was not addressed in the visit note.			
F0686 SS= D	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: Based on observation, interview and record review, the facility failed to provide preventative care, consistent with professional standards of practice for 2 residents (Resident #98 & #65) of 5 residents reviewed for at risk for the development of pressure injuries, resulting in the potential for worsening of pressure wounds, the development of an avoidable pressure ulcer, infection, and overall deterioration in health status. Findings include: Resident #98 Review of Resident #98's "Braden Assessment (risk of developing pressure ulcers)" dated 12/16/24 revealed, "17" indicating that resident was at a mild risk.	F0686	Element# 1 Braden assessment for resident #65, and #98 have been completed, and interventions implemented based on identified risk areas. Element #2 Residents at risk for skin breakdown have the potential to be affected. Resident Braden assessment identifying residents at risk have been reviewed as well as appropriate interventions in place. Element #3 Licensed Nurses and CNAs have been educated on Pressure ulcer prevention including repositioning and support surface implementation. Element #4 Under the direction of the Quality Assurance Performance Improvement (QAPI) Committee, the Director of Nursing or designee(s), will conduct weekly observation audits to ensure appropriate skin interventions are in place. The QAPI Committee will review findings monthly and determine ongoing need for audits. Element #5 The Administrator is responsible for sustained compliance.	4/9/2025

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	Review of Resident $98's "Skin Integrity Care Plan" revealed, "Start 9/18/24...at risk for compromised skin integrity r/t (related to) impaired mobility and incontinence ...History of skin problem: PI (pressure injury) to L (left) and R (right) buttock...Interventions: Assist with repositioning...Utilize appropriate lift or transfer devices...Toileting Plan, Observe and relieve pressure to bony prominences." Review of Resident #98's "Pressure Ulcer Care Plan" revealed, "Start 12/16/24...has a pressure ulcer location right heel. Interventions: Pad appropriate medical devices... Assist with positioning..." During an observation on 03/03/25 10:01 AM Resident #98 was seated in her wheelchair in the hall outside of her room, leaning to her left side, with blue boots (to reduce pressure) on both feet that were resting directly on the foot pedals. During an observation on 03/04/25 at 10:40 AM Resident #98 was sleeping in her wheel chair in the common area by the nurse's station. The blue boot from her left foot was laying on the floor next to her wheelchair. Resident #98's left foot/back of ankle is resting directly on the foot pedal. In an interview and observation on 03/04/25 at 01:53 PM Resident #98 was lying in her bed and reported that her feet hurt. Resident #98 was observed with blue boots on both feet, but they were turned to the side and not securely attached. During an observation on 03/05/25 at 08:54 AM Resident #98 was seated in her wheelchair in the dining room. During an observation on 03/05/25 at 10:22 AM Resident #98 was seated in her wheelchair in the			

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	common area by the nurse's station; she is slouched down in her chair with her eyes closed. During an observation on 03/05/25 at 11:27 AM Resident #98 was seated in her wheelchair in the common area by the nurse's station. Resident #98's position had not changed from the previous observation. During an observation on 03/05/25 at 12:01 PM Resident #98 was seated in her wheelchair in the dining room, still slouched down, and her left blue boot is turned to the side and not fully attached. In an interview on 03/05/25 at 12:03 PM, CNA "NN" reported that Resident #98 had been in her chair since about 7:00 AM (5 hours). CNA "NN" reported that the resident did not get toileted because she had a catheter. CNA "NN" reported that Resident #98 had a wound on her right heel from the wheelchair foot pedal. During an observation on 03/05/25 at 12:48 PM in Resident #98's room, CNA "NN" was preparing to transfer the resident from chair to bed. CNA "NN" wrapped her arms around Resident #98, lifted her up and sat the resident on the bed. Resident #98 tried to bear weight on her right foot (pressure wound on heel), but did not stand upright during the transfer. CNA "NN" changed Resident #98's incontinence brief, but did not perform catheter care. Resident #98's right foot was observed with a gauze wrap covering the heel. In an interview on 03/05/25 at 12:06 PM, Registered Nurse (RN) "SS" reported that Resident #98 had a pressure ulcer on her heel, and that she could not reposition herself while in her chair.			

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	Resident #65 Review of Resident #65's "Braden Assessment (risk of developing pressure ulcers)" dated 3/2/25 revealed, "15" indicating that the resident was at a mild risk. Review of Resident #65's "Care Plan" revealed, "...at risk for compromised skin integrity related to vascular dementia, hx (history) of CVA (stroke). Interventions: Assist with repositioning: See Resident Care Summary (RCS)...Observe and relieve pressure to bony prominences..." Review of Resident #65's "RCS" revealed, "...Skin care and precautions: cream-barrier; turn schedule-remind and assist to turn every 2 to 3 hours; W/C (wheelchair) cushion-pressure reducing 10/18/24..." In an interview on 03/03/25 at 03:44 PM, CNA "KKK" reported that Resident #65 spent most of his time in his wheelchair. During an observation on 03/04/25 at 10:49 AM Resident #65 was seated in his wheelchair in the dining room. The resident was sitting on a hoyer (mechanical lift) sling and there was not a pressure reducing cushion on the seat of the wheelchair. During an observation and interview on 03/04/25 at 02:09 PM CNA "JJJ" transferred the resident into bed using the hoyer (mechanical lift). CNA "JJJ" finished incontinence care, and then applied a clean brief on Resident #65 and transferred him back to his wheelchair. In an interview on 03/04/25 at 02:28 PM, CNA "JJJ" reported that Resident #65 did not have a cushion for his wheelchair and she had not ever seen one.			

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	During an observation on 03/05/25 at 08:53 AM Resident #65 was seated in his wheelchair in the dining room. He was sitting on the hoyer sling, and there was not a pressure reducing cushion in his wheelchair. During repeated observation on 03/05/25 at 10:33 AM, 11:24 AM, and 12:13 PM the resident was in the same location, seated in his wheelchair without a pressure reducing cushion in place. Review of Fundamentals of Nursing (Potter and Perry) 9th edition revealed, "The presence and duration of moisture on the skin increases the risk of ulcer formation. Moisture reduces the resistance of the skin to other physical factors such as pressure and/ or shear force. Prolonged moisture softens skin, making it more susceptible to damage. Immobilized patients who are unable to perform their own hygiene needs depend on nurses to keep the skin dry and intact. Skin moisture originates from wound drainage, excessive perspiration, and fecal or urinary incontinence." Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 71334-71338). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing (Potter and Perry) 9th edition revealed, "Usually the time that a patient sits uninterrupted in a chair is limited to 1 hour. This interval is shortened in patients who are at very high risk for skin breakdown. Reposition patients frequently because uninterrupted pressure causes skin breakdown. Teach patients to shift their weight in a chair every 15 minutes." Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 28081-28083). Elsevier Health Sciences. Kindle Edition.			

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F0689 SS= D	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: This citation has 2 DPS statements. DPS A: Based on observation and interview the facility failed to minimize the risk of scalding and burns by allowing domestic hot water to exceed 120°F. This resulted in an increased risk of injury among residents in the facility. Findings Include: During a tour of the facility, at 10:23 AM on 3/4/25, observation of the back 100 spa room found that the hot water reached 128F when tested with a rapid read thermometer. Further observation found that the sink had a point of use mixing valve that should temper the water under the maximum 120F in resident care areas. During an interview with Maintenance "K" and Regional Maintenance "HHH", at 10:45 AM on 3/4/25, it was found that the facility does not take regular hot water temperatures to ensure excessive hot water does not exist in resident care areas. DPS B	F0689	DPS A Element #1 No residents were mentioned in the citation. Element #2 No residents have been identified at risk. 100 Spa rooms are not currently utilized by facility residents. Element #3 Mixing Valve in spa room 100 was removed and delimed. Spa room 100 hot water temperature post deliming was under 120 degrees. Facility Maintenance technician has been re-educated on appropriate safe water temperatures in patient care areas. Element #4 Facility Maintenance tech/ Designee will complete 5 random weekly temperature checks in resident care areas. Any variances will be addressed at time of observation. Audits to be forwarded to facility QAPI for review and further recommendations. Element #5 The Facility Administrator is responsible for compliance. DPS B Element #1 Resident #98 and #65 have been re-evaluated to determine the amount of assistance needed to transfer safely. Resident care summaries have been updated to reflect current care needs. Element# 2 All residents who require assistance with transfers have the potential to be affected by the same deficient practice. Element #3 Licensed nurses and certified nursing assistants have been re-educated on resident care plan/resident care summary regarding	4/9/2025

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	Based on observation, interview, and record review, the facility failed to ensure resident safety with chair to bed transfers for 2 residents (Resident #98 & #65) of 5 residents reviewed for accident hazards, resulting in the potential for avoidable accidents and serious injury. Findings include: Resident #98 Review of a "Minimum Data Set" (MDS) assessment for Resident #98, with a reference date of 1/23/25 revealed, under "Functional Abilities" that Resident #98 required substantial/maximum assistance (helper does more than half of the effort) for transfers from chair to bed. Review of Resident #98's "Care Plan" revealed, "...potential for falls and fall related injuries: ...Interventions: ...Use gait belt for all transfers..." Review of Resident #98's "Resident Care Summary (RCS)" revealed, "...Transfer: substantial/maximal..." Review of Resident #98's most recent "Physical Therapy Discharge Summary" dated 12/23/24 revealed, "...Assessment/Plan: ...Patient has made no progress...continues to require ...dependent with max A of 2 (staff) for bed to/from w/c (wheelchair) t/fs (transfers) and unable to ambulate. Barriers during skilled physical therapy have included... R (right) hip pain, R heel wound... and overall weakness..." The documentation indicates that the resident requires assistance from 2 staff for transfers. In an interview on 03/05/25 at 12:03 PM, Certified Nursing Assistance (CNA) "NN" reported that Resident #98 had been in her chair		the amount of assistance required for a safe transfers and mechanical lift operation. Element #4 Under the direction of the Quality Assurance and Performance Improvement Committee, the Director of Nursing or designee(s) will conduct weekly observation audits of resident transfers including those that use mechanical lifts to assure the correct transfer technique followed. Audits will be forwarded to the Facility QAPI Committee for review and further recommendations. Element #5 The Director of Nursing is responsible for sustained compliance.	

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	since about 7:00 AM (5 hours). CNA "NN" reported that the resident does not get toileted because she has a catheter. CNA "NN" reported that Resident #98 had a wound on her right heel from the wheelchair foot pedal. During an observation on 03/05/25 at 12:48 PM in Resident #98's room, CNA "NN" was preparing to transfer the resident from chair to bed. CNA "NN" did not use a gait belt or have assistance from a second staff member. CNA "NN" wrapped her arms around Resident #98, and lifted her up holding onto her pants and sat the resident on her bed. Resident #98 tried to bear weight on her right foot (pressure wound on heel), but did not stand upright during the transfer. Resident #98's right foot was observed with a gauze wrap covering the heel. In an interview on 03/05/25 at 01:01 PM, CNA "NN" reported that they should have been using a gait belt during the resident's transfer to bed. In an interview on 03/05/25 at 02:00 PM, Restorative CNA (RCNA) "MMM" reported that Resident #98 does not help to stand or bear weight. RCNA "MMM" reported that the resident was not safe to transfer with one staff member, and at times required the mechanical lift. In an interview on 03/05/25 at 03:12 PM, Director of Nursing (DON) "B" reported that Resident #98 required substantial/maximum assistance, based on the documentation in flowsheet. DON "B" reported that it meant that the resident required almost total assistance, but that the documentation did not specify if the resident required 1 or 2 staff for transfers. Resident #65 Review of Resident #65's "Care Plan" revealed,			

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	"...Requires assistance with ADLs (activities of daily living) related to dementia:...has declined in his abilities...requires hoyer (mechanical) lift for transfers. Review of Resident #65's "RCS" revealed, "...Weight Bearing/Activity: None. Transfer: Lift-Mechanical..." In an interview on 03/03/25 at 03:44 PM, CNA "KKK" reported that Resident #65 spent most of his time in his wheelchair. During an observation and interview on 03/04/25 at 02:09 PM in Resident #65's room, CNA "JJJ" wheeled the hoyer into the resident's room. CNA "JJJ" attached the hoyer lift sling that was under the resident, to the hoyer handle bar, then used the remote to lift the resident out of his chair. During the transfer, Resident #65's right hip/leg were hanging down lower than the left side, and the right leg section of the hoyer sling was observed not looped under the resident's right thigh. The left side of the hoyer sling was looped under his left thigh, and in place between the legs. The hoyer lift was a "Maxi-Move" lift. In an interview on 03/04/25 at 02:10 PM, CNA "JJJ" reported that the hoyer sling leg sections were supposed to be looped under both thighs and then attached to the hoyer bar to ensure that the resident does not slide out. Review of "Maxi-Move (hoyer lift) instruction manual" dated 1/2014 revealed, ..."Bring attachment loops "B" (picture reference) and the leg sections of the sling underneath the patient's thighs. Ensure that the leg sections of the sling are not twisted underneath the patient. Hook the attachment loops onto the hooks on the opposing side of the spreader bar..."			

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	In an interview on 03/04/25 at 11:01 AM, Licensed Practical Nurse (LPN) "LLL" reported that Resident #65 is a serious fall risk, and required the hoyer lift for a safe transfer from bed to chair. In an interview on 03/05/25 at 03:28 PM, DON "B" reported that Resident #65's transfer status was currently via hoyer.			
F0690 SS= D	Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel	F0690	Element #1 For resident #65 and #98 securement devices have been provided per the plan of care. Element #2 Residents residing in the facility receiving assistance with incontinence care and/or have foley catheters have the potential to be affected. Element #3 Licensed nurses and certified nurse assistants will be re-educated to ensure incontinence care and foley catheter care is consistent to professional standards of practice. Element #4 Under the direction of the Quality Assurance Performance Improvement (QAPI) Committee, Nurse Manager, or designee(s), will perform randomly weekly audits of dependent residents for appropriate foley catheter care and incontinence care Weekly audits to be submitted to the facility QAPI committee for review and further recommendations. Element #5 The Administrator is responsible for sustained compliance.	4/9/2025

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	function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure foley catheter (a tube inserted into the bladder through the urethra to drain urine) tubing was secured to prevent pulling and perform incontinence care per standards of practice in 2 residents (Resident #98 & #65) of 5 residents, reviewed for bowel and bladder incontinence, resulting in the potential for dislodgement of the catheter tubing with pain and urethral damage, and the potential for skin breakdown, cross-contamination and development/spread of infection. Findings include: Resident #98 Review of Resident $98's "Skin Care Plan" revealed, "Start 9/18/24...at risk for compromised skin integrity r/t (related to) impaired mobility and incontinence ...Toileting Plan..." Review of Resident #98's "Catheter Care Plan" revealed, "...Indwelling Catheter Maintenance: ...Nursing staff will provide foley catheter care every (sic) twice daily and as needed..." During an observation on 03/05/25 at 08:54 AM Resident #98 was seated in her wheelchair in the dining room. In an interview on 03/05/25 at 12:03 PM, CNA "NN" reported that Resident #98 had been in her chair since about 7:00 AM (5 hours). CNA "NN" reported that the resident does not get toileted because she has a catheter.			

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COREWELL HEALTH REHAB & NSG CTR - PINE RIDGE	**4368 CLEVELAND AVE STEVENSVILLE, MI 49127**

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	In an interview on 03/05/25 at 12:06 PM, Registered Nurse (RN) "SS" reported that Resident #98 should be toileting every 2 hours, or possibly less often due to her having a catheter. RN "SS" reported that it was her responsibility to ensure the resident received appropriate care, and that she was not aware the resident had not received incontinence care since 7:00 AM. During an observation on 03/05/25 at 12:48 PM in Resident #98's room, CNA "NN" was preparing to transfer the resident from chair to bed. There was a catheter bag observed and attached to the bed frame. CNA "NN" changed Resident #98's incontinence brief, but did not perform foley catheter care. Resident #98 was complaining that her catheter was causing her pain. It was observed that Resident #98's catheter was pulled tight, and not secured to her leg with an anchor device. Resident #65 Review of Resident #65's "Care Plan" revealed, "...has an indwelling foley catheter related to bladder outlet obstruction. Interventions: ...Nursing staff to offer toilet every two hours as needed. ...Nursing staff will ensure foley catheter leg strap (securement device) is in use. Nursing staff will provide catheter care every shift and as needed..." In an interview on 03/03/25 at 03:44 PM, CNA "KKK" reported that Resident #65 spent most of his time in his wheelchair. During an observation and interview on 03/04/25 at 02:09 PM signage was observed outside of Resident #65's room, indicating enhanced barrier precautions were in place. CNA "JJJ" entered the room, and donned gloves, but did not put a gown on. CNA "JJJ" transferred the resident into bed			

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	using the hoyer (mechanical lift). CNA "JJJ" moved the resident's catheter bag from the wheelchair and attached it to the bed frame. CNA "JJJ" removed Resident #65's incontinence brief, and wash the resident's front side and then the back side. Resident #65 was yelling that the wipes were cold. There was a small amount of feces noted on the disposable wipe. CNA "JJJ" finished incontinence care, and then applied a clean brief on Resident #65 and transferred him back to his wheelchair. A barrier cream was not applied to the resident. While still wearing the same gloves, CNA "JJJ" emptied the urine from Resident #65's catheter bag into a urinal. In an interview on 03/04/25 at 02:28 PM, CNA "JJJ" reported that she put gloves on when she entered a resident room and kept them on the entire time, unless there was feces visible on the gloves. CNA "JJJ" reported that she had folded the disposable wipe that she used during Resident #65's incontinence care, so that the feces would not get on her gloves. In an interview on 03/05/25 at 09:05 AM, Staff Educator/Infection Preventionist (SE-IP) "O" reported that nurses and CNA's should be ensuring that all foley catheters are secured with an anchor on the resident's leg. SE-IP "O" reported that there was no known reason for Resident #98 to not have an anchor; all catheters should have a securement devices. SE-IP "O" reported that staff are frequently audited for hand hygiene related to in and out of resident rooms, but it is not often that glove use during incontinence care is audited. In an interview on 03/05/25 at 10:47 AM, Clinical Nurse Supervisor (CNS) "I" reported that Resident #65 should have a catheter securement anchor in place on his leg, and that she would see to it that one was applied.			

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	Review of Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 68514-68515). Elsevier Health Sciences. Kindle Edition. revealed "...Securing indwelling catheters reduces risk of urethral trauma, urethral erosion, CAUTI (Catheter-Associated Urinary Tract Infection), or accidental removal..." Review of a "Centers for Disease Control and Prevention" (CDC) presentation titled "Indwelling Urinary Catheter Insertion and Maintenance", no date, revealed "...Maintenance: Catheter Care Essentials...Properly secure catheters to prevent movement and urethral traction...Maintain Unobstructed Urine Flow... Use a catheter securement device to anchor the catheter..." Retrieved from https://www.cdc.gov/infectioncontrol/pdf/strive/CAUTI104-508.pdf			
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure oxygen delivery equipment was monitored for 1 (Resident #16) of 2 residents reviewed for oxygen administration resulting in the potential for	F0695	Element #1 Residents #16□s oxygen delivery equipment water humidifier bottle has been replaced. Element #2 Residents residing in the facility requiring oxygen therapy have the potential to be affected. Their equipment has been inspected and serviced as identified. Element #3 Licensed nurses were re-educated on oxygen equipment usage and appropriate maintenance of equipment. Element #4 Under the direction of the Quality Assurance Performance Improvement (QAPI) Committee, Nurse Manager, or designee(s), will conduct random weekly audits on resident□s who require oxygen therapy to ensure proper equipment is available and	4/9/2025

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	ineffective performance of improperly maintained oxygen delivery equipment. Findings include: Resident #16 Review of a "Face Sheet" revealed Resident #16 was a female who originally admitted to the facility on 3/29/2024 and had pertinent diagnosis which included: COPD (chronic obstructive pulmonary disorder). Review of a "Minimum Data Set" (MDS) assessment for Resident #16, with a reference date of 1/3/2025 revealed a "Brief Interview for Mental Status" (BIMS) score of 6/15 which indicated Resident #16 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment). During an observation on 3/3/25 at 9:29 AM., Resident #16 was in bed, sleeping, with a nasal cannula (tubing that is inserted into the nostrils and delivers supplemental oxygen) in place on her face. The plastic water bottle connected to the oxygen concentrator (a machine that provides supplemental oxygen) was noted to be empty and the concentrator was running. Noted on the top of the bedside stand were two plastic water bottles, one open, and one sealed in plastic, for the oxygen concentrator. In an observation and interview on 3/3/25 at 10:34 AM., "Oxygen Tech" (OT) "DDD" was observed replacing a water bottle on an oxygen concentrator in a resident's room. OT "DDD" reported he changes all oxygen nasal cannulas, oxygen tubing, water bottles, and completes the maintenance on the concentrators weekly, on Thursday or Friday. OT "DDD" reported he should have completed the oxygen equipment		utilized. Element #5 The Administrator is responsible for sustained compliance.	

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	maintenance last Thursday, but due to scheduling he was not able to get to the building until today, Monday. OT "DDD" reported he restocked oxygen supplies in the facility, and that water bottles for oxygen concentrators were included. OT "DDD" reported all concentrators in the building had a water bottle on them. Review of "Respiratory Orders" for Resident #16 revealed "Oxygen therapy (LTC) (long term care)1 L/min (liter per minute) nasal Cannula continuous started on 4/18/24 and oxygen therapy (LTC) 2 L/min Nasal Cannula PRN (as needed) started on 1/15/25." In an observation on 3/4/25 at 10:12 AM., Resident #16's oxygen concentrator had a water bottle present with water in it and the concentrator was powered on. Noted on the top of the bedside stand were two plastic water bottles, one open, and one sealed in plastic, for the oxygen concentrator. In an interview on 3/5/25 at 8:01 AM., "Registered Nurse" (RN) "WW" reported all oxygen should be humidified, and the water bottle on the concentrator should be changed by the nurse if it is empty. RN "WW" reported that the concentrator should be monitored for liter settings and water level in the bottle. RN "WW" reported that replacement water bottles were available in the oxygen supply closet if needed. RN "WW" reported an oxygen company came in weekly, but it was the responsibility of the nurse every day to monitor a resident's oxygen equipment. In an interview on 3/5/25 at 10:53 AM., "Clinical Nurse Supervisor" (CNS) "I" reported oxygen concentrators should always have water in the bottle, they should never be dry. CNS "I" reported the oxygen supplies were available to the nurses			

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	to change a water bottle when needed. In an interview on 3/5/25 at 11:12 AM., "Director of Nursing" (DON) "B" reported she expected the nurses to change a water bottle if they noticed it was empty, but she did not expect the nurses to monitor a resident's oxygen concentrator or water bottle as there was a company that monitored the facility's oxygen delivery equipment. DON "B" stated "when I complete my rounds, I do not look a resident's oxygen concentrator or water bottle, I don't even notice it when I am in the room."			
F0756 SS= D	Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical	F0756	Drug Regimen Review Element #1 Resident #15 has not had any negative outcomes related to observation. Resident #15's Pharmacy Recommendations have been reviewed by the facility provider and new orders placed as deemed by the provider. Element #2 Residents residing in the facility have the potential to be affected. Element #3 Facility provider that is designated to complete Drug Regimen Review have been re-educated on facility medication management policy. Medication management policy has been reviewed by Director of Nursing and Administrator and deemed appropriate. Element #4 Director of Nursing/designee will complete random monthly audit on completion of Drug Regimen Review recommendations. Variances will be corrected at the time of observation. Audits will be forwarded to the facility QAPI committee for further review and recommendations. Element #5 The Administrator is responsible for sustained compliance.	4/9/2025

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	record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the physician documented review of pharmacy recommendations/follow up occurred for 1 resident (Resident #15) of 5 residents reviewed for unnecessary medications resulting in the potential for medication side effects and/or unnecessary medications for residents. Findings include: Resident #15 (R15) Review of the Admission Record and Minimum Data Set (MDS) dated 2/5/2025 revealed R15 admitted to the facility on 7/16/2016 with diagnoses including depression, pain and type 2 diabetes {metabolic disease characterized by high blood glucose (sugar) in the bloodstream}. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R15 was cognitively intact (13 to 15 cognitively intact). Review of R15's monthly pharmacy review dated 10/7/2024 revealed "Comment: (R15) currently has an order for Lidoderm 4% (percent), 1 patch to the lower back and 1 patch to each shoulder. Per review of the medication administration record, patient often refuses to have the Lidoderm patches applied. Recommendation: Please			

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	consider changing Lidoderm orders to PRN (as needed) use secondary to frequent refusals." The Physician/Prescriber Response with whether they agreed, disagreed or other was left blank and the signature and date was blank. Review of R15's monthly pharmacy reviews dated 11/6/2024 and 1/9/2025 revealed "Comment: (R15) receives potentially duplicate therapy of Elderberry Immune Complex (which contains vitamin C) and Vit C 1000 mg (milligrams) daily. Recommendation: Please re-evaluate the need for both agents, perhaps discontinuing Elderberry Immune Complex. If dual therapy is to continue, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensure ongoing monitoring for effectiveness and potential adverse consequences." The Physician/Prescriber Response with whether they agreed, disagreed or other was left blank and the signature and date was blank. Review of R15's monthly pharmacy reviews dated 12/5/2024 and 1/9/2025 revealed "Comment: (R15) currently receives Linzess along with Peri-Colace. Linzess is a guanylate cylclase C agonist. Its mechanism of action results in increased intestinal fluid and accelerated transit. Because of this mechanism of action, other laxatives should not be necessary. Recommendation: Please consider discontinuation of Peri-Colace." The Physician/Prescriber Response with whether they agreed, disagreed or other was left blank and the signature and date was blank. Another recommendation from R15's monthly pharmacy reviews dated 1/9/2025 and 2/6/2025 revealed "Comment: (R15) frequently requires			

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	insulin per sliding scale, despite routine therapy with Lantus 33 units daily and routine use of Humalog and has a recent glycosylated hemoglobin level of 7.7% from 09/27/2024. Recommendation: Please consider improving glycemic control by discontinuing sliding scale insulin and increasing Lantus to 40 units daily , if appropriate for this individual. Glucose monitoring should continue following any change in diabetic therapy. Rationale for recommendation: Prolonged use of sliding scale insulin is not recommended in most individuals since it is ineffective for long-term glycemic control, can lead to hypo- or hyperglycemia, increase resident discomfort, increases cost, requires more nursing time, may increase morbidity and has not been shown to improve glycemic control in the long-term care population. If this therapy is to continue, it is recommended that the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual." The Physician/Prescriber Response with whether they agreed, disagreed or other was left blank and the signature and date was blank. Review of R15's monthly pharmacy review dated 2/6/2025 revealed "Comment: (R15) has received Zoloft 50 mg daily for over one year. Recommendation: Please consider a gradual dose reduction, perhaps decreasing to Zoloft 25 mg daily while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing why a dose reduction is clinically contraindicated. Rationale for Recommendation: Federal nursing facility regulations require that a gradual dosage reduction (GDR) be attempted in two separate quarters within the first year in which an individual is admitted on a psychopharmacologic			

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	medication or after the facility has initiated such medication, and then annually UNLESS CLINICALLY CONTRAINDICATED." The Physician/Prescriber Response with whether they agreed, disagreed or other was left blank and the signature and date was blank. During an interview on 3/05/2025 at 2:42 PM, Nurse Liaison (NL) "L" stated that she was aware that the physician did not review/follow-up and sign the monthly pharmacy recommendations for R15. NL "L" said that they have a plan in place now to make sure follow up occurs on all pharmacy recommendations. NL "L" stated that typically the Director of Nursing (DON) and/or pharmacist follows up on any pharmacy recommendations not reviewed and signed by the physician. Review of the Medication Management-Continuing Care (Rehab and Nursing Centers) Policy with an effective date of 4/21/2023 revealed "4. Policy .... Medication Regimen Review ... 4.14.5. The pharmacist must report any irregularities to the attending physician, the facility's medical director and director of nursing on a separate, written report ...within 24 hours if urgent (representing a risk to life, health, or safety), or within 7 days if not urgent, including the resident's name, the relevant drug, and the irregularity the pharmacist identified ... Pharmacists' reports of medication irregularities, per the list above must be acted upon within 24 hours if urgent (representing a risk to life, health or safety), within 30 days if not urgent ....If the attending physician or designee does not provide a pertinent response, or the Pharmacist identifies that no action has been taken, they will then contact the Medical Director, or, if the Medical Director is the Physician of Record, the Administrator ...The attending physician or designee will document that the identified medication irregularity has been reviewed and all			

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	appropriate actions in the medical record. If changes are not made based on the pharmacist's recommendation, the attending physician should document their rationale in the resident's permanent medical record ..."			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: During an initial tour of the kitchen, at 10:32 AM on 3/3/25, an interview with Certified Dietary Manager (CDM) "Z" found that the maintenance staff takes care of the ice machine cleanings and has a vendor that comes and deep cleans the	F0812	Element #1 No specific Residents were identified in citation. Ice Machine and Dish Machine were serviced/cleaned by vendor, microwave was replaced. Utensil drawers were cleaned of debris, floor area behind ice machine has been cleaned. Soy Sauce disposed of at time of observation. Observed gallon of chili, vegetable soup and pork loin discarded at time of observation. Element #2 Residents residing in facility who have food prepared in the dietary department have potential to be affected. Element #3 Nutrition Services staff have re-educated on 2017 FDA food Code sections 4-601.11, Food Contact, Section 3-501.16 Time/Temp control for safety food hot/cold handling by CDM. Element #4 Nutrition Services Manager/designee will complete random weekly sanitation audits, cooling log and Dish Temperature audits. Variances will be addressed at the time of observation. Weekly audits to be forwarded to the facility QAPI committee for review and further recommendations. Element #5 The Administrator is responsible for sustained compliance.	4/9/2025

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	machines. Observation of the dispensing spout of the ice machine found an increase accumulation of black and brown debris on the surface of the inside spout. During a tour of the main kitchen, at 10:35 AM on 3/3/25, observation of the microwave found increase accumulation of debris on the inside top portion of the unit. Further review of the unit found chipping and degrading surfaces on the inside. During a tour of the main kitchen, at 10:39 AM on 3/3/25, an interview with CDM "Z" found that staff clean the utensil drawer weekly. Observation of the three utensil drawers found that two of the drawers, containing tongs and mechanical scoops, were found with increased accumulation of crumb debris on the back portion of the drawers. During a tour of the hallway ice machine, at 11:23 AM on 3/3/25, it was observed that on the floor behind the ice machine found an increased accumulation of items and debris. Items on the floor included a box of single use straws, a package of plastic lids, and a stack of Styrofoam cups. Portions of old wet pieces of broken ceiling tile were also found behind the ice machine. CDM "Z" stated that there was a leak in that area and some tiles were replaced. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue,			

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	and other debris." During a tour of the kitchen, at 10:37 AM 3/3/25, it was observed that an open gallon container of soy sauce was stored under the preparation table. A review of the container found that it stated to "Refrigerate After Opening". According to the 2022 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. "(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11 (B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54C (130F) or above; or (2) At 5C (41F) or less." During a tour of the dish machine area, at 10:48 AM on 3/3/25, an interview with CDM "Z" found that staff have been working with a new log, but have not been great about routinely filling it out to help ensure the dish machine is working properly. At this time, a staff member was de-liming the dish machine and only one day worth of dish machine log was available to review. When asked if the dish machine was tested regularly, CDM "Z" stated they were using the an irreversible registering dish plate thermometer, but staff stated the device was not working properly. During a revisit to the kitchen, at 11:46 AM on 3/3/25, it was observed that the dish machine's data plate, which shows its minimum operational requirements, states the machine has a "Wash tank minimum temperature: 160F". Through			

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	running five cycles of the dish machine, it was not able to achieve the minimum wash temperature as well as the FDA food codes minimum internal contact temperature of 160F. The wash temperature gauge was observed between 150F-160F and two irreversible registering thermometers read between 150F-158F through the five cycles. CDM "Z" stated that she would reach out to their vendor and have it checked out. During a revisit to the kitchen, at 11:45 AM on 3/4/25, observation of the dish machine found the same results as the day before. CDM "Z" stated the vendor was coming in today to look over the machine. A revisit to the kitchen, at 3:02 PM on 3/4/25, found the vendor working on the dish machine. After that the vendor turned up and adjusted the booster heater, the machine was observed achieving temperatures above the minimum requirements. According to the 2017 FDA Food Code section 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. The temperature of hot water delivered from a warewasher sanitizing rinse manifold must be maintained according to the equipment manufacturer's specifications and temperature limits specified in this section to ensure surfaces of multiuse utensils such as kitchenware and tableware accumulate enough heat to destroy pathogens that may remain on such surfaces after cleaning. The surface temperature must reach at least 71ºC (160ºF) as measured by an irreversible registering temperature measuring device to affect sanitization. When the sanitizing rinse temperature exceeds 90ºC (194ºF) at the manifold, the water becomes volatile and begins to vaporize reducing its ability to convey			

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	sufficient heat to utensil surfaces. The lower temperature limits of 74ºC (165ºF) for a stationary rack, single temperature machine, and 82ºC (180ºF) for other machines are based on the sanitizing rinse contact time required to achieve the 71ºC (160ºF) utensil surface temperature. According to the 2017 FDA Food Code section 4-501.15 Warewashing Machines, Manufacturers' Operating Instructions. "(A) A WAREWASHING machine and its auxiliary components shall be operated in accordance with the machine's data plate and other manufacturer's instructions ..." During an interview with CDM "Z" at 9:40 AM on 3/3/25, it was found that staff do not cool food from service or preparation and do not keep cooling logs. During a review of the walk-in cooler, at 9:41 AM on 3/3/25, it was observed that the following items were found saved from meal service the previous day, a gallon container of chili, creamy vegetable soup, and a cooked pork loin. All three items were 42F when a temperature of the items were taken with a rapid read thermometer. When asked how these items were cooled, CDM "Z" stated they probably used the walk-in freezer, but we don't usually save food, so I am going to discard. During a revisit to the kitchen, at 3:25 AM on 3/4/25, it was observed that a six-inch deep 1/4 pan of pork gravy was found in the walk-in cooler, tightly covered in tin foil and dated 3/4. At this time, a temperature of the food product was found to be 69F. When asked if she knew about the pork gravy or what it was saved for, CDM "Z" was unsure and discarded the product. According to the 2017 FDA Food Code section 3-			

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	501.14 Cooling. "(A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57ºC (135ºF) to 21ºC (70°F); and (2) Within a total of 6 hours from 57ºC (135ºF) to 5ºC (41°F) or less ..." According to the 2017 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under § 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD.			
F0880 SS= F	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)	F0880	DSP A Element #1 No residents identified. Element #2 Residents residing in the facility have the potential to be affected. Front and Back 200 Spa rooms have been flushed to include tubs and commodes. Front and Back 100 soiled utility rooms have been flushed to include hopper sprayers. Element #3	4/9/2025

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	(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 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		Maintenance Technician and EVS supervisor have been re-educated on facility Water Safety and Management plan to include routine flushing and commissioning of portable water systems and Wednesday Water flushing protocols. Element #4 EVS/Designee to complete random weekly audit of required Wednesday flushing to include Spa and soiled utility areas. Variances will be addressed at the time of observation. Weekly audits to be submitted to the facility QAPI committee for review and further recommendations. Element #5 The Administrator is responsible for compliance. F880 DSP B Element #1 Residents #1, #29, #52, and #65, have had no adverse outcomes related to observations. Element #2 Residents residing in the facility have potential to be affected. Element #3 Licensed nursing staff have been reeducated on Infection Prevention and Control policy, Including hand hygiene, peri care, enhanced barrier precautions and g-tube care. Infection Control and prevention policy has been reviewed by DON and Administrator and deemed appropriate. All staff were re-educated on hand hygiene and enhanced barrier precautions. Element #4 Don/Designee will complete random weekly audits to ensure appropriate PPE, infection control practices including EBP, hand hygiene, peri care/catheter care and g-tube care are followed. Variances will be addressed at the time of	

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	update their program, as necessary. This REQUIREMENT is not met as evidenced by: This citation has two Deficient Practice Statements DPS A 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 water borne 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. Findings include: During a tour of the facility with, Maintenance "K" and Regional Maintenance "HHH", starting at 9:50 AM on 3/4/25, it was found that Maintenance "K" is newer to the facility and has not been involved much in the water management plan. When asked if he was aware of regular flushing the facility is doing on minimum use or unused domestic water fixtures, Maintenance "K" was unaware. Regional Maintenance "HHH" stated some facilities do a wasting water Wednesday, but he is not sure what's done here. During a tour of the front 200 soiled utility room, at 9:52 AM on 3/4/25, observation of the hopper spray found brown and discolored water momentarily came out of the hose when flushed. During a tour of the front 200 spa room, at 9:55 AM on 3/4/25, it was observed that a wheelchair		observation. Weekly audits to be submitted to the facility QAPI committee for review and further recommendations. ELEMENT #5 The Administrator is responsible for sustained compliance.	

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	washer was in the process of being installed and the rooms is not currently used for showers, as residents have personal showers in their rooms. When asked if this area is flushed, Maintenance "K" was unsure. During a tour of the back 200 spa room, at 10:15 AM on 3/4/25, it was observed that brown water was found in the spa commode. Further observation found that there were multiple dried brown lines in the basin of the commode indicating that the water evaporated slowly over time with no routine flushing. A spa tub was observed in this room, when asked if this tub is regularly used, Maintenance "K" stated he didn't think it was used much. When asked if it was flushed regularly, he was unsure. During a tour of the back 200 soiled utility room, at 10:29 AM on 3/4/25, it was observed that brown water was flushed out of the hopper spray. Brown and discolored water remained for roughly three seconds before starting to run clear into the hopper. During an interview with Regional Environmental Health and Safety (EHS) "GGG", Regional Maintenance "HHH", and Maintenance "K", at 10:44 AM on 3/4/25, regarding the water management plan, it was found that the facility did not have an active team onsite that oversaw the plan and provided an annual review of the program. When asked if the facility uses supplemental disinfection or secondary treatment of the domestic water supply, Regional EHS "GGG" stated that they do. When asked if the treatment system is permitted through the state department of Environment Great Lakes and Energy, Regional EHS "GGG" was unsure and said she would have to reach out and see. When asked about routine flushing, it was stated that the housekeeping department flushes fixtures in the			

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	facility. During a tour of the back 100 soiled utility room, at 11:25 AM on 3/4/25, it was found that the spray wand was turned off at the foot pedal. The surveyor used the plumbing key on the foot pedal to turn the water on to flush the spray wand. At this time, the spray wand ran brown and discolored water for roughly 5 seconds before running clear. When the hopper was attempted to be flushed, it was found with a stuck flush valve and didn't allow the hopper to remove the discolored water from its basin. A follow up interview with Regional EHS "GGG", at 2:47 PM on 3/4/25, found that she had reached out about the permit and found they were in the process of obtaining the permit, but there was not currently a permit for the secondary treatment in use. During a tour of the back 100 spa room, at 2:43 PM on 3/4/25, found that the commode was empty with no water in the basin. When flushed, the commode refilled with water, indicating that the fixture had not been used in so long that all of the water had evaporated from the commode between since last flush. During a tour of the front 100 spa room, at 2:50 PM on 3/4/25, found that it had a spa tub available for use. An interview with the Nursing Home Administrator (NHA) at this time found that residents don't use the tubs regularly. A review of the document entitled "Water Safety and Management Plan", revised 3/23/24, found that under section "5.8 Potable Water Systems Preventative Maintenance and Operation Procedures" it states that, "If distal outlets (sinks, showers) are in a room or space that has been unoccupied for seven consecutive days the outlets			

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	shall be flushed to move fresh water through the system ..." The policy goes on to state that "Flushing and commissioning of potable water systems is performed to remove physical debris, sediment, and air from the piping system and to provide a level of disinfection to reduce the presence of microorganisms in the water system ..." DPS B Based on observation, interview, and record review the facility failed to maintain proper infection control practices as evidenced by failure to 1. Ensure proper hand hygiene was completed during incontinence care for 2 (Resident #52 and Resident #65); 2. Ensure proper PPE (personal protective equipment) for enhanced barrier precautions were used during medication administration via a G-tube (a tube placed directly into the stomach and used for nutrition, hydration, and medication administration) in 2 (Resident #1 and Resident #29); 3. Ensure proper PPE for enhanced barrier precautions were used during a G-tube dressing change in 1 (Resident #1); and 4. Ensure the cleanliness of a feeding pump pole in 1 (Resident #1) of 22 total sampled residents reviewed for infection control practices resulting in the potential for the introduction of infection, cross-contamination, and disease transmission. Findings include: Resident #52 Review of a "Face Sheet" revealed Resident #52 was a female who originally admitted to the facility on 10/11/2017 and had pertinent diagnoses which included: cognitive deficits following a non-traumatic intracerebral hemorrhage (bleeding in the brain), hemiparesis			

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	(paralysis) on the left non-dominate side, and debility. Review of a "Minimum Data Set" (MDS) assessment for Resident #52, with a reference date of 12/4/2024 revealed a "Brief Interview for Mental Status" (BIMS) score of 2/15 which indicated Resident #52 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment). On 3/5/25 at 10:29 AM., "Certified Nurse Assistant" (CNA) "QQ" was observed providing incontinent care to Resident #52. CNA "QQ" was wearing gloves, and removed Resident #52's soiled brief, retrieved a washcloth, soaked it in soapy water in a basin, and proceeded to provide peri-care (cleaning of the private area of a body). CNA "QQ" then assisted Resident #52 to roll onto her left side, and with the same gloved hands reached for a clean washcloth, soaked it in the same soapy water in the basin, and provided peri-care again. CNA "QQ" removed the soiled brief, placed a clean brief, and assisted Resident #52 to roll to her right side. CNA "QQ" then, with the same gloved hands, positioned the clean brief and secured it. CNA "QQ" was observed with the same gloved hands adjusting Resident #52's gown, and blankets on the bed. At no time during incontinence care (dirty to clean) did CNA "QQ" change her gloves or perform hand hygiene. Resident #1 Review of a "Face Sheet" revealed Resident #1 was a female who originally admitted to the facility on 5/29/2009 and had pertinent diagnoses which included: dysphagia (difficulty swallowing), functional quadriplegia (no purposeful or intentional movement of the arms or legs), and G-tube feedings (nutrition supplies to the G-tube).			

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	Review of a "Minimum Data Set" (MDS) assessment for Resident #1, with a reference date of 11/26/2024 revealed a "Brief Interview for Mental Status" (BIMS) score of 0/15 which indicated Resident #52 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment). Review of "Medication Order" for Resident #1 revealed "Promote 1.0 with fiber liquid per G tube, 75mg/hour daily with a start date of 12/3/24." Review of "Other Orders" for Resident #1 revealed "initiate Enhanced Barrier Precautions continuous with a start date of 4/23/24." In observations on 3/3/25 at 9:27 AM., 3/4/25 at 7:49 AM., and 3/5/25 at 7:58 AM., the feeding pump pole present in Resident #1's room next to the head of her bed was noted to be soiled with dried formula on the pole and base. In an observation on 3/5/25 at 7:58 AM., "Registered Nurse" (RN) "EEE" while wearing gloves, disconnected the feeding tube, and then removed the split gauze dressing from Resident #1's G-tube, RN "EEE" soaked down gauze with normal saline, cleansed around the G-tube insertion site, retrieved dry gauze, dried around the G-tube site, and applied a new split gauze around Resident #1's G-tube. RN "EEE" then secured the dressing to Resident #1's skin with tape. RN "EEE" then repositioned the over the bed table with the same gloved hands, opened drawers on the bed side stand and rummaged through the drawers to locate the piston syringe. RN "EEE" then used the piston syringe (a type of syringe used for medical purposes with a G-tube) to check residual (formula that had been undigested in the stomach) from Resident #1's G-tube with the same gloved hands. RN "EEE" then			

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COREWELL HEALTH REHAB & NSG CTR - PINE RIDGE	4368 CLEVELAND AVE STEVENSVILLE, MI 49127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administered medications through Resident #1's G-tube wearing the same gloves. While RN "EEE" was administering Resident #1's medication through her G-tube, Resident #1's feeding pump began alarming. RN "EEE" reached with her gloved hand to push the button to silence the alarming pump. When RN "EEE" was done administering Resident #1's medications, with the same gloved hands, RN "EEE" repositioned the fall mat on the floor next to Resident #1's bed. At no time during this observation did RN "EEE" wear a gown or change her gloves or perform hand hygiene. In an interview on 3/5/25 at 8:05 AM., RN "EEE" confirmed that Resident #1's feeding pump pole was soiled and reported that it would not come clean, and the dried formula wound need to be scrapped off. When queried about who cleaned the feeding pump poles RN "EEE" stated "night shift nurse or EVS (environmental services personnel). I don't have time to read their job descriptions, I have enough to do." In an interview on 3/5/25 at 8:14 AM., upon exiting Resident #1's room with RN "EEE" this surveyor queried RN "EEE" about the signage noted on the door frame to Resident #1's room that indicated Resident #1 was in enhanced barrier precautions (EBP), RN "EEE" reported that the enhanced barrier precautions were for when the CNAs performed care for Resident #1. This surveyor queried RN "EEE" about wound care as indicated on the sign as a time to use (EBP), and RN "EEE" reported there was a difference between a wound and a stoma. Resident #1 had a stoma (permanent surgical opening through the skin {for her G-tube placement}) and that was not a wound, and since it was not a wound, she did not have to wear a gown when performing a G-tube dressing change, nor when administering medications through a G-tube. When further queried, regarding glove use,			

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	glove changes, and hand hygiene during the observed care for Resident #1, RN "EEE" stated "I don't see the need to change my gloves if I'm working on the same resident." Resident #29 Review of a "Face Sheet" revealed Resident #29 was a female who originally admitted to the facility on 4/9/2014 and had pertinent diagnoses which included: dysphagia, feeding via G-tube and functional quadriplegia. Review of "Medication Order" for Resident #29 revealed "Jevity 1.5 Cal with fiber liquid per G tube daily volume to be delivered 1000ml (milliliters) with a start date of 2/17/25." Review of "Other Orders" for Resident #29 revealed "initiate Enhanced Barrier Precautions continuous with a start date of 4/29/24 and 2/28/25." During an observation and interview on 3/4/24 at 11:21 AM., "Licensed Practical Nurse" (LPN) "XX" entered Resident #29's room, applied gloves, stopped Resident #29's feeding, disconnected the feeding tube, retrieved a stethoscope from her scrub shirt pocket, and used a piston syringe to check Resident #29's residual all while wearing the same gloves. LPN "XX" was then observed administering one medication and a water rinse via a piston syringe into Resident #29's G-tube with the same gloved hands. LPN "XX" then reconnected the feeding and started the pump. LPN "XX" did not wear a gown during the administration of medications via Resident #29's G-tube. When queried, LPN "XX" reported that the EBP sign on the door frame of Resident #29's room was for the CNAs when they performed care, they needed the gown incase of splashing. LPN "XX" reported she did			

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	not need to wear a gown to administer medications via G-tube. In an interview on 3/5/25 at 11:24 AM., "Director of Nursing" (DON) "B" reported an EBP sign was posted on a resident's door to inform staff of the need for and what PPE to wear. DON "B" reported her expectations were that the appropriate PPE was worn during cares. Review of facility policy "Isolation Precautions for Continuing Care- Rehab and Nursing Centers" with a last revision date of 7/10/2024 revealed " ...Enhanced Barrier Precautions require gown and glove use for certain residents during specific high-contact resident care activities that have been found to increase MDRO (multi-drug resistant organism) transmission such as ...device care or use: ... feeding tube ...enhanced barrier precautions will also be implemented when Resident has wounds and/or indwelling medical devices (e.g. central line, urinary catheter, feeding tube ...) regardless of MDRO colonization status..." Resident #65 Review of Resident #65's "Care Plan" revealed, "...has an indwelling foley (a tube inserted into the bladder through the urethra to drain urine) catheter related to bladder outlet obstruction. Interventions: ...Nursing staff will provide catheter care every shift and as needed..." Review of Resident #65's "Resident Care Summary" revealed, "...Initiate enhanced barrier precautions 1/30/25..." During an observation and interview on 03/04/25 at 02:09 PM signage was observed outside of Resident #65's room, indicating enhanced barrier precautions were in place. Certified Nursing			

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	Assistant (CNA) "JJJ" entered the room, and donned gloves, but did not put a gown on. CNA "JJJ" transferred the resident into bed using the hoyer (mechanical lift). CNA "JJJ" moved the resident's catheter bag from the wheelchair and attached it to the bed frame. CNA "JJJ" removed Resident #65's incontinence brief, and washed the resident's front side and then the back side. There was a small amount of feces noted on the disposable wipe. CNA "JJJ" finished incontinence care, and then applied a clean brief on Resident #65 and transferred him back to his wheelchair. While still wearing the same gloves, CNA "JJJ" emptied the urine from Resident #65's catheter bag into a urinal. In an interview on 03/04/25 at 02:28 PM, CNA "JJJ" reported that she puts gloves on when she enters a resident room and keeps them the entire time, unless she gets feces on them. CNA "JJJ" reported that she had folded the disposable wipe that she used during incontinence care, so that the feces would not get on her gloves. CNA "JJJ" reported that enhanced barrier precautions were new for Resident #65 due to testing that the facility was doing. In an interview on 03/05/25 at 09:05 AM, Staff Educator/Infection Preventionist (SE-IP) "O" reported that she conducts a lot of on the spot education to staff regarding Enhanced Barrier Precautions, and the expectation is that staff wear a gown and gloves at all times with those residents during high contact care, including transfers, incontinence care, catheter care, etc. SE-IP "O" reported that staff are frequently audited for hand hygiene related to in and out of resident rooms, but it is not often that glove use during incontinence care is audited.			