STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	254200	A. BUILDING _____ B. WING _____	**4/25/2025**

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BRIARWOOD NURSING AND REHAB	**3011 N CENTER RD FLINT, MI 48506**

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F0000 SS=	INITIAL COMMENTS Briarwood Nursing and Rehab was surveyed for a Combined Standard/Abbreviated Survey exiting on 04/25/2025. EVent ID: VYU511 Intake Number: MI00152040 Census: 84	F0000		
F0584 SS= E	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) 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	F0584	Element One: Soiled Gown, Linen and Blanket for Resident #2 was removed and sent to laundry for cleaning. Walls near the bathroom door have been painted. Therapy Gym equipment was cleaned, repaired or replaced. Hygiene products for Resident #15 were disposed of and room was cleaned. Cluttered items in room 107 were removed from the floor. Rooms on the 100 hall were decluttered. Element Two: Audit completed of rooms on the 100, 200, 300 and 400 halls for cluttered or soiled items in rooms and have been organized and removed as identified. Audit completed of rooms for black markings and paint chips. Any identified areas have been corrected. Audit completed of rooms of discharged residents to ensure all personal hygiene products have been removed. Audit completed of all therapy gym equipment for cleanliness and identification of any repairs needed. Any identified areas of concern were cleaned and/or repaired as needed. New Therapy equipment has been purchased and awaiting arrival.	5/20/2025

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

Electronically Signed | 05/14/2025

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

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	§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: (1) Ensure proper cleaning of therapy gym equipment for all residents utilizing the equipment; (2) Ensure the timely removal of Resident #2's soiled gown, blanket and linen , (3) Ensure the timely disposal of daily hygiene products of a discharged resident (Resident #15) and the cleaning of the room prior to admittance of a new resident and (4) Ensure the decluttering of residents' items throughout the rooms on the 100 Hall. Findings Include: Therapy Gym During initial tour a resident shared a peddle on the bike in the therapy room gym, was not safe for residents to utilize and requested it be observed for functionality and safety. On 4/24/2025 at 1:10 PM, an observation was conducted of the facility therapy gym. Therapy Director "S" provided an overview of the equipment and stated each machine is wiped down between each resident, but deep cleaning is completed by housekeeping. The following was observed: 2- Nu Step Machines:		Element Three: Administrator/Designee completed education with the IDT members who conduct room rounds to ensure any identified cluttered rooms are addressed as well as any black marks or paint chips are identified Housekeeping Supervisor/Designee completed education with the Housekeeping staff to ensure all rooms identified with clutter are addressed immediately and personal belongings are removed timely when residents are discharged from the facility and room is clean and ready for new resident. Administrator/Designee completed education with the Housekeeping staff and Therapy staff on cleaning of gym equipment. Administrator/Designee completed education with the Nursing staff in regards to removal of soiled clothing/gowns and linen are removed from resident beds and placed in appropriate bin to be sent to laundry and removing clutter from rooms. Any staff not educated by May 20, 2025 will be educated on their next scheduled shift. Element Four: Housekeeping Supervisor/Designee will complete random weekly audits X4 weeks of resident rooms to assure rooms are free of clutter, soiled linen has been removed and discharged residents' personal hygiene products have been removed, no black markings or chipped paint with findings submitted to Administrator who will report findings to QAPI for review and recommendations. Therapy Director/Designee will completed random weekly audits X4 weeks of therapy equipment to ensure cleanliness, with findings submitted to QAPI for review and recommendations. Element Five: The Administrator is responsible for	

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	-Foot pedals had debris and sand like build up inside both pedals. -In between the foot pedals (at the base of the machine) there were white flecks of debris, hair and sand like particles. -The seat on one machine was ripped and the yellow foam exposed. -The back part of one machine had green particle dusting from the deteriorating handle covering material. 2-Omni Cycles: -Build up unknown particles in the crevices of the pedals on both omni cycles. On 4/24/2025 at 1:20 PM, Director of Environmental Services "J" stated the therapy gym is deep cleaned once a month. He explained that includes wiping down all the equipment, cleaning the window ledges etc. We went into the gym together to look at the unsanitary state of the Omni Cycles and Nu Steps. When asked exactly what his staff are tasked with cleaning during a deep clean of the machines he stated they would wipe down the machine. Director "J" was asked to provide the deep cleaning schedule and check off list for the therapy gym. On 4/24/2025 at 1:40 PM, Housekeeper "M" was interviewed regarding cleaning of the		maintaining compliance.	

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	therapy gym. The housekeeper explained the gym is constantly in use, so typically they will sweep the floors, change the trash, clean the bathroom, replenish paper products, and wipe down surfaces. Housekeeper "M" stated the deep clean must occur after hours. On 4/24/2025 at 2:00 PM, Director "J" provided the monthly cleaning schedule that indicated the therapy gym was last deep cleaned on 4/1/2025. There were no specific deep cleaning tasks to be performed, so it is unknown exactly what takes place during the therapy gym deep clean. It can be noted that the debris/particle buildup is unlikely to have occurred in three weeks from when it was last cleaned to observation. A discussion was held with the director regarding the cleanliness of the equipment, especially given the amount the resident use. Director "J" expressed understanding of the concern. Resident #2: Review of the Face Sheet, care plans and nurses progress notes dated 3/28/25 through 4/23/25, revealed Resident #2 was 60 years old, admitted to the facility on 3/28/25, was totally dependent on staff for all Activities of daily Living/ADL's and was cognitively impaired (BIMS-cognitive assessment score of 3). The resident's diagnoses included, peritoneal abscess, adult failure to thrive, Parkinson, diabetes, lack of normal physiological development, Schizophrenia, Dementia, major depression, Bipolar and anemia. The resident was unable to be interviewed due to their decreased cognition status.			

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	Observation was done on 4/23/25 at 11:23 AM of Resident #2 in his bed dressed. He had a soiled gown sitting on the bottom of his bed and the top white blanket had a large brown smear on the top near his face. Also the resident's room walls near the bathroom and the outside of the bathroom door had several black wheelchair marks on it, with paint chipping off the walls and door. Environment: On 4/23/2025 at 11:20 AM, the bathroom in Room 105 was observed to have a variety of items on the bathroom sink, including an uncovered toothbrush. There was also a bed pan upside down on the floor underneath a commode chair. One resident was in the 2-resident room and said none of the items were hers and they belonged to her roommate who was in the hospital. On 4/23/2025 at 11:32 AM, Room 107 was observed to have cluttered items lying on the floor. During the tour of the 100 hall on 4/23/2025, several resident rooms were noted to have resident items stacked on the floor and sometimes large stacks of items were on other surfaces in the rooms. They appeared very cluttered and unkempt. Some of the rooms had space for additional storage or shelving and some had less room.			
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	F0677	Element One: Resident #52 had her clothes changed and shower schedule was changed to 1st shift. Resident #139 had her fingernails cleaned and hair combed per her preference.	5/20/2025

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	hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide timely assistance with activities of daily living (ADL) including showers, nail care and hair care for two residents (#52 and #139), from a sample of 20 residents. Findings Include: Resident #52: Activities of Daily Living On 4/23/2025 at 1:15 PM, Resident #52 was observed lying in bed in her room. She said she had itching on her face and leg and said it was horrible. She said they gave her something for the itching, but the itching would come back frequently. A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #52 was admitted to the facility on 1/26/2023 and readmitted on 5/18/2023 with diagnoses: Dementia, depression, anxiety, diabetes, chronic kidney disease, arthritis, blindness right eye and hypothyroidism. The MDS assessment dated 1/16/2025 revealed the resident had moderate cognitive loss with a Brief Interview for Mental Status/BIMS score of 10/15 and the resident was independent with most care but needed some assistance and oversight with bathing/showering. On 4/24/2025 at 10:30 AM, Resident #52 was		Element Two: Audit completed of all Residents to ensure fingernails are clean and hair is combed per Resident preferences. Audit completed of Residents who refused showers to ensure alternative was offered and care planned. Element Three: Administrator/Designee completed education with the IDT members who conduct room rounds to ensure Residents fingernails are clean, hair is combed per resident preference and resident is not wearing the same clothing as previous day. Director of Nursing/Designee completed education with the nursing staff to ensure residents who refuse showers are offered an alternative and documented. Director of Nursing/Designee completed education with the nursing staff in regards to ensuring fingernails are clean, clothing has been changed daily and hair is combed per resident preference. Any staff not educated by May 20, 2025 will be educated on their next scheduled shift. Element Four: Nurse Manager/Designee will complete random weekly audits X4 weeks of residents to ensure Residents are dressed appropriately, fingernails are clean and hair is combed, with findings submitted to the Director of Nursing who will report findings to QAPI for review and recommendations. Element Five: The Director of Nursing is responsible for maintaining compliance.	

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	observed in the hallway with the same dress that she had on the day before. On 4/25/2025 at 12:45 PM, Resident #52 was observed in the hallway sitting in a wheelchair with the same dress she had worn for the past 3 days. She was rubbing her face and there was a strong odor noticed near the resident. A record review of the electronic medical record/EMR "Tasks" tab for "Shower/bed bath" for Resident #52 over a 30 day time period from 3/27/2025 to 4/24/2025, revealed the resident had not had a shower or bed bath since 4/14/2025. It indicated her Shower/Bath days were Monday/Thursday evenings and as needed. There were 2 dates: 4/17/2025 and 4/24/2025 with the heading "No bath given attempted x2" and one entry dated 4/21/2025 for "Resident Refused". A review of the progress notes for Resident #52 identified the following: 4/14/2025, a nursing clinical note, "Pt (patient) receive shower today, today tolerated, offers no concerns up ad lib walking." 4/18/2025 at 11:28 AM, a nursing/clinical note, "Pt alert and was encouraged to do adl's (activities of daily living), was given wash cloths and towels and cued to go into restroom to clean up, pt stated 'Am sleeping." Will continue to encourage ..." 4/19/2025 at 3:18 PM, a nursing/clinical note, "Pt encourage to participate in her own adl's, bathing material given to pt and she went in bathroom ..."			

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	4/19/2025 at 9:54 PM, a nursing/clinical note, "Resident participated with her ADL's with help, cueing, and supervision of CNA (certified nursing assistant). Resident accepted help and guidance." 4/21/2024 at 8:57 PM, a nursing/clinical note, "Resident encouraged by RN and CNA to take a shower to perform ADLs. Resident adamantly refused each attempt. Not participating with own ADLs." 4/22/2025 at 12:33 PM, "Patient was assisted by staff to complete personal hygiene." A review of the Care Plans for Resident #52 identified the following: "Resident requires staff oversight for safety and to ensure ADL needs are met due to dementia with severe cognitive deficits. Resident will be clean and dressed appropriately. Often refuses assistance from caregivers ... Patient will frequently refuse a shower stating she does not like being cold and does not need a shower too often," date initiated 5/19/2023 and revised 7/27/2023. The interventions were all dated 2023 and were last updated 10/4/2023. On 4/25/2025 at 1:00 PM, during an interview with the Director of Nursing/DON reviewed with her Resident #52 was observed scratching her face in the hallway. The DON reviewed the orders for the resident and said she had Benadryl oral and Cetaphil face cream for the itching. Also discussed the resident had a strong body odor and had been wearing the same dress for 3 days. The DON said the resident refused a bath or shower at times and would put on soiled clothes. Reviewed the care plan , does not suggest			

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	alternate options for encouraging the resident to bathe. Does the resident still prefer evening baths/showers. Does she prefer certain staff members. Tasks reviewed: resident's last bath or shower was 4/14/2025. The notes were reviewed, and there were no alternate suggestions for encouraging the resident to bathe and change her clothes. Prior to 4/14/2025 it appeared in the "Task" charting the resident was bathing/showering twice a week and after 4/14/2024 was not. A review of the facility policy titled, "Activities of Daily Living (ADL), Supporting," dated reviewed 12/2024 provided, "Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL). Resident who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene ... If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate ... The resident's response to interventions will be monitored, evaluated and revised as appropriate." Resident #139: Review of the Face Sheet, care plans dated 4/22/25 and 4/23/25, nursing notes dated 4/22/25 through 4/23/25, revealed Resident #139 was 77 years old, admitted to the facility on 4/22/25, was confused, had a tube feeding and was dependent			

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	on staff for Activities of Daily Living/ADL's. The resident's diagnosis included diabetes, Dementia, stroke, and hemiplegia and hemiparesis. Observation of the resident was done on 4/24/25 at 10:28 a.m., she was in her wheelchair ready for her facility care conference; staff had gotten her up and got her ready for the conference. The resident's hair was not combed at all, sticking up and her fingernails had black under them. The resident was presented in this manner for the care conference. A second observation of the resident was done on 4/24/25 at approximately 12:20 p.m., the resident was in her room, in her bed and her hair was still not combed and he nails still had black underneath them. Review of the facility Activities of Daily Living (ADL's) policy dated 12/24, stated "Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: Hygiene (bathing, dressing, grooming, and oral care)."			
F0692 SS= D	Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F0692	Element 1 Resident #62's weight was obtained. Physician was notified. She was assessed by Dietitian for nutritional needs and nutrition plan of care was reviewed. Weight obtained showed weight gain and that interventions were successful. Resident will continue to be followed by Dietitian. Element 2 An audit was completed for Residents who returned from the hospital to ensure weekly weights were completed x4 weeks and all Residents with significant weight loss had interventions in place.	5/20/2025

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	preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to monitor weights timely for a Resident who had a hospitalization and return with a Percutaneous Endoscopic Gastrostomy) (PEG) tube for feeding for one resident (Resident #62) of two residents reviewed for weight loss. Findings include: Resident #62: A review of Resident #62's medical record revealed the Resident had an admission into the facility on 6/26/24 and readmission on 3/20/25 with diagnoses that included intracerebral hemorrhage (stroke), gastrostomy, abdominal aortic aneurysm, dysarthria, aphasia, hemiplegia and hemiparesis affecting the left non-dominant side, Alzheimer's disease, and muscle wasting and atrophy. A review of the Minimum Data Set assessment revealed the Resident had severely impaired cognition and was dependent on staff for activities of daily		An audit was completed for Resident on enteral feeding to ensure any weight loss or changes in orders were addressed with weekly weight monitoring in place. Any concerns identified were corrected. Element 3 Director of Nurses/Designee completed re-education to Nursing staff in obtaining weekly weights x4 weeks for any new admits or any Residents who were recently admitted to the hospital and re-admitted to the facility. Director of Nursing/Designee completed education to Registered Dietitian on tracking and requesting weekly weights for new admits as well as for any Resident showing weight loss or had changes in enteral feeding. Any staff members not educated by May 20, 2025 will be educated on their next scheduled shift. Unit Managers/Designee will verify that there are no missing weekly weights for new admits x4 weeks. Registered Dietician will provide a list to nursing for Residents with weight changes or enteral feeding changes. Nurse Managers will review medical record for new admits as well as re-admits during morning meeting to ensure all weights are obtained. Nurse Managers will review medical record for Residents with weight changes or enteral feeding changes during morning meeting to ensure all weights are obtained. Element 4 Unit Manager/Designee will complete random weekly audits X4 weeks of weights to ensure no weekly weights are missed with results of findings submitted to DON who will report findings to QAPI for review and recommendations. Element 5 Director of Nursing is responsible for	

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	living. A review of the medical record revealed the Resident had a change in condition on 3/10/25 and was transferred to the hospital and returned on 3/20/25 with a PEG tube for feeding. A review of Resident #62's hospital discharge records of consult to Nutrition Services revealed, Nutrition Diagnosis: Increased Nutrient Needs (Protein) related to increased demand AEB (as evidence by) current medical condition (brain bleed) ... Intervention/Plan/Goal: Goal tube feeding is Jevity 1.5 bolus 4 cartons daily with 4 packets protein powder. Providing: 1520 kcal, 84 gm protein. A review of Resident weights revealed a weight on 3/9/25 (prior to discharge to hospital) of 131.6 lbs (pounds) and re-admission weight of 118.4 lbs on 3/21/25 and 18 days later 4/8/25 a weight of 114.2 lbs. A review of Resident #62's Nutritional Evaluation, effective date on 3/24/25 revealed the Resident's Tube Feeding Order: Jevity 1.5; 4 cartons daily; Enteral Composition of Calories: Calories 1420, Calories/Kg (kilograms) 26 kcal/kg, Protein 60; Weight Status: Loss, Enter % of weight loss or gain 12.6 (weight loss); Estimated Nutritional Needs: Calorie needs: 1340-1610, Protein needs: 54-65; Additional detail: Patient with dysphagia and need for nutrition support via PEG to meet nutritional needs; Additional comments/information:		maintaining compliance.	

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	...Nutrition/Monitoring Recommendations: Weight per policy-Will monitor weights/PO intake/skin/labs-Monitoring tube feeding tolerance and need to adjust... A review of Resident #62's Nutritional Evaluation, effective date on 4/10/25 revealed the Resident's Tube Feeding Order: Jevity 1.5; 4 cartons daily with Enteral Composition of Calories: 1420 and Protein 60; Weight Status: Loss, Enter % of weight loss or gain 13.6 (weight loss); Estimated Nutritional Needs: Calorie needs: 1554-1813, Protein needs: 67-78; Additional detail: Patient with dysphagia and need for nutrition support via PEG to meet nutritional needs; Additional comments/information: ...Nutrition/Monitoring Recommendations: Weight per policy, Recommend increasing tube feeding to Jevity 1.5; 5 cartons total daily 2/2 (due to) continued weight loss. Provides 1775 kcal, 76 gms protein ... On 4/24/25 at 3:14 PM, an interview was conducted with Dietitian "P" who was the interim Dietician at the time of the survey. A review of Resident #62's weight (wt) loss from 3/9/25 of 131.6 lbs. to 3/21/25 of 118.4 lbs (13.2 lbs wt loss) and on 4/8/24 of a weight of 113.2 (an additional 5.2 lbs wt. loss). When asked when a Resident readmitted with a change in nutritional status of enteral feedings and a 13.2 weight loss upon return would weight monitoring be completed, the Dietitian stated, "For the first 4 weeks typically we do weights weekly." The			

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	Dietitian reported that the Resident should be getting that weight done today. When asked if the Resident got missed with monitoring weights, the Dietician stated, "Yeah that's what it looks like." The Dietician indicated that they did not anticipate further weight loss now that the Resident was increased to 5 cartons of the enteral feeding. A review of the enteral orders revealed the Resident was on 4 cartons from 3/21 to 4/10 and the Dietitian reported that with that weight loss, the Dietitian had increased the tube feeding by another carton, we just did not check her weight after that carton. The Resident's weights were not monitored weekly after the 5th carton was started. On 4/24/25 at 3:32 PM, the Dietitian informed the surveyor that the Resident's weight had gone up to "116 pounds today." On 4/25/25 at 12:42 PM, an interview was conducted with the Director of Nursing (DON) regarding concern of Resident #62 returning from the hospital with weight loss and ordered enteral nutrition, weights not monitored timely, and the Resident had additional weight loss. The DON reported she documents all the weights and that they missed the weekly weights on Resident #62. A review of facility policy titled, "Weight Policy," reviewed 1/25, revealed, "Purpose: Weight changes have significant nutritional implications. The purpose of this policy is to help maintain acceptable parameters of			

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	nutritional status. Procedures: ...2. ...Weekly weights are obtained on those residents within the first 4 weeks of admission and those residents deemed appropriate per the assessment of the dietitian, dietary manager, physician or as determined by IDT (Interdisciplinary Team) ..."			
F0694 SS= D	Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to 1) Monitor a PICC (Peripherally Inserted Central Catheter) line placement for Resident #8; 2) Monitor antibiotic administration and notify the physician of three missed doses for Resident #289; and 3) Document the clinical rationale for an increase in the Vancomycin dose for Resident #84 for three of four residents reviewed for PICC lines. Findings Include: Resident #84: On 4/23/2024 at approximately 3:35 PM, Resident #84 was observed ambulating down the hallway into her room. She stated she	F0694	Element 1 Resident #8 PICC line was discontinued prior to entrance of survey team Resident # 84 Medical record was updated with rationale for the increased Vancomycin Resident # 289 Physician was contacted regarding missed doses due to Resident being out on LOA. Element 2 An audit was completed for Residents who have PICC lines to ensure measurements of the external catheter length is documented in the TAR/MAR or in a progress note. Any concerns identified were corrected. An audit was completed for Residents who have had an increase in dosage of vancomycin to ensure rationale was documented in the medical record. Any concerns identified were corrected. An audit was completed for Residents who leave facility on LOA to ensure dosage of medications were not missed. If any medications are missed due to Resident out of facility, documentation of Physician notification in patients medical record. Element 3 Director of Nursing/Designee completed re-education to Licensed Nurses in measuring PICC line from the insertion site to end of PICC line on admission & weekly with dressing changes. Director of Nursing/Designee completed	5/20/2025

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	developed osteomyelitis and is here for IV antibiotics. On 4/24/2025 at approximately 9:30 AM, a review was conducted of Resident #84's medical records and it indicated she readmitted to the facility on 4/16/2025 with diagnoses that included, Osteomyelitis, Diabetes, Asthma, Heart Disease and Atrial Fibrillation. Resident #84 is her own person and able to make her needs known to staff. Further review of her record yielded the following: Physician Orders: Vancomycin HCl (hydrochloride) Intravenous Solution 1500 MG/400ML (Vancomycin HCl)-Use 1500 mg intravenously one time a day for osteomyelitis. Ordered on 4/17/2025. Vancomycin HCl Intravenous Solution 2000 MG/400ML (Vancomycin HCl)-Use 2000 mg intravenously one time a day for osteomyelitis. Ordered on 4/19/2025. Review was conducted of Resident #84's chart and there was no subsequent documentation of the clinical rationale for the increase in the Vancomycin dosage. On 4/24/2025 at 10:20 AM, Unit Manager "K" was asked about rationale regarding the change in Vancomycin dosage. The Manager stated typically it would be due to lab values as pharmacy doses the Vancomycin for		education to Licensed Nurses in process for when pharmacy adjusts dose of Vancomycin via phone call or fax, the staff will adjust the order & document. Director of Nursing/Designee completed education to Licensed Nurses in any missed dose, the nurse will contact the physician & document in the patients medical record. Any staff members not educated by May 20, 2025 will be educated on their next scheduled shift. Unit Managers/Designee will verify that there are no missing PICC line weekly measurements during morning meeting. Nurse Managers will review medication orders during morning meeting to ensure all increases of Vancomycin dosage has documentation of Physician rationale. Nurse Managers will review medical record for any missed dosage of medications while Residents are out on leave to ensure Physician notification is documented in patients medical record. Element 4 Unit Manager/Designee will complete random weekly audits X4 weeks of PICC line measurements, change in vancomycin dosage rationalization and missed dosage documentation are present with results of findings submitted to DON who will report findings to QAPI for review and recommendations. Element 5 Director of Nursing is responsible for maintaining compliance.	

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	residents. Review was completed of Resident #84's chart and there were no other documents located that provided documentation for the increase. The Manager stated she would follow up. On 4/25/2025 at approximately 5:00 PM, Unit Manager "K" explained labs were completed for Resident #86 on 4/17/2025 but her Vancomycin level was not completed. The manager provided a document from pharmacy which was faxed on 4/18/2025 at 2:07 PM. The document stated, " ...Low trough-please call pharmacy ...4/18/25 increase dose to 2g iv qd) ...". The document this information was located on, was the residents lab results from her most recent hospital stay. Manager "K" stated this was the reason the dosage was increased but agreed there should have been documentation in the chart to this fact. It can be noted this document was not accessible in the resident's medical record. On 4/25/2025 at 11:40 AM, the DON (Director of Nursing) stated she was made aware of the concern and spoke to the nurse regarding it. The nurse told her she received something from pharmacy but failed to complete a progress note. The DON expressed understanding of the concern. Resident #289: On 4/24/2025 at approximately 9:30 AM, Resident #289 was observed resting in bed.			

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	He shared he was diagnosed with pneumonia, but it continued to progress in the community, and he ended up in the hospital for an extended stay. He developed a secondary infection in his shoulder as well and is here for his IV antibiotics course. On 4/24/2025 at approximately 10:30 AM, a review was conducted of Resident #289's medical records and it indicated he was admitted to the facility on 4/18/2025 with diagnoses that included Arthritis due to bacteria in right shoulder, Pneumonia, Hypertension, Anxiety and Depression. Resident #289 is his own person and is able to make his needs known to facility staff. Further review yielded the following: Physician Orders: Cefepime HCl Intravenous Solution Reconstituted 2 GM (gram)-Use 2 grams intravenously every 8 hours for septic joint until 5/8/2025 (3 times a day) Vancomycin HCl Intravenous Solution 1250 MG (milligram)/250 ML (milliliters) - use 1250 mg This citation has intravenously two times a day for septic join until 5/8/2025. Progress Notes: 4/20/2025 13:02: "Cefepime HCl Intravenous Solution Reconstituted 2 GM Use 2 gram intravenously every 8 hours for septic joint until 05/08/2025 23:59 LOA."			

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	4/20/2025 21:52: "Note Text: Vancomycin HCl Intravenous Solution 1250 MG/250 ML Use 1250 mg intravenously two times a day for septic joint until 05/08/2025 23:59 Resident out with family and has not returned." 4/20/2025 21:53: "Note Text: Cefepime HCl Intravenous Solution Reconstituted 2 GM Use 2 gram intravenously every 8 hours for septic joint until 05/08/2025 23:59 LOA with family and has not returned at this time." 4/20/2025 21:54: "Note Text: Flush IV line with 5ml NS before and after medication administration. every shift Resident LOA with family and not back at this time." 4/20/2025 21:59: "Note Text: Vitals q shift every shift Resident went LOA and not back as this time." 4/20/2025 22:00: " Resident went out LOA (leave of absence) with family and left approx. 8:00 am. This writer called resident on his cell phone at 9:30 PM to ask what time he will be back. Resident apologized for not being back he had fallen asleep. Resident stated that he would leave 30-45 min to come back to facility. No meds were given this shift." 4/20/2025 22:31: "Patient arrived back to facility via self. Patient is pleasant. Patient is alert and orientated x 4. Vitals obtained and WNL (within normal limits). Will continue to			

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	monitor." On 4/20/2025, Resident #280 missed three antibiotic doses - one Vancomycin dose and two Cefepime doses. There was no documentation of notification to his practitioners or infection preventionist regarding the missed doses and possible next steps. On 4/24/2025 at 2:45 PM, Nurse Manager "K" was asked the process when residents are LOA and miss medications due to their absence. The manager explained upon their return the nurse would contact the doctor to inform them of which medications were missed and wait for instructions and there would be a subsequent progress note. Resident #289's three missed antibiotic doses were discussed by the manager, and she stated she would follow up after further investigation. On 4/24/2025 at approximately 5:00 PM, Nurse Manager "K" reported they were not able to find any documentation that Resident #289's doctor was informed regarding his missed doses. They will be following up regarding this. On 4/25/2025 at 11:45 AM, the DON (Director of Nursing) stated she was aware of the concerns and their Infection Control Nurse contacted the Infectious Disease doctor for further direction.			

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	Review was completed of the facility policy entitled, "Therapeutic Durg Monitoring (TDM) Policy for skilled Nursing Facility, reviewed 5/24. The policy stated, " ...All TDM results, recommendations and adjustments in therapy should be documented in the residents medical record ..." Resident #8: A review of Resident #8's medical record revealed an admission into the facility on 8/2/224 and readmission on 3/24/25 with diagnoses that included cervical spinal stenosis, diabetes, and methicillin susceptible staphylococcus aureus infection. A review of the Minimum Data Set assessment revealed the Resident had intact cognition and was dependent on a helper for toileting hygiene, bathing, lower body dressing, mobility and transfer. The Resident was sent to the hospital on 3/3/25 and returned to the facility on 3/24/25 with diagnosis of bacteremia, urinary tract infection and had a PICC line in the upper right arm for IV antibiotics. The PICC line was discontinued after conclusion of IV antibiotic regimen on 4/16/25. A review of Resident #8's orders for PICC line dressing, dated 3/25/25, revealed, "PICC/Midline: change dressing q (every) 7 days, every night shift, every Mon (Monday)." A review of Resident #8's Treatment Administration Record (TAR)/Medication Administration Record (MAR) for			

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	documented dressing changes, revealed a dressing change completed on 3/31/25, 4/7/25 and 4/14/25. There were no documented measurements of the external catheter length in the TAR /MAR or the progress notes. On 4/24/25 at 2:38 PM, an interview was conducted with the Director of Nursing (DON) and Unit Manager, Nurse "G" regarding Resident #8's PICC line monitoring while the Resident had been receiving IV antibiotics. The Unit Manager was unsure about facility policy of monitoring the external catheter with dressing changes but indicated that the arm circumference was to be done on admission. The DON indicated she would look up the policy. A review of the medical record with the Unit Manager revealed a lack of measurements of the arm circumference and no documentation on the TAR, progress notes, care plan or admission assessment of the assessment of the external catheter. On 4/24/25 at 3:00 PM, an interview was conducted with the DON and Infection Control Preventionist, Nurse "Q" regarding the PICC line policy. A review of the policy revealed a lack of directive for the PICC line measurements of the external catheter. The DON indicated that an order populates to do the arm circumference on admission and that the measurement for the circumference was a one-time measurement on admission to the facility. The order for the arm circumference			

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	had not been triggered on admission for Resident #8. The DON was asked for the standards of practice for PICC line dressing changes and monitoring/assessment of the PICC line. A review of the facility document received for PICC line care, titled, "Central Vascular Access Device (CVAD)/Midline Care and Maintenance Standard Operating Procedure," revised 3/30/24, revealed, "Introduction: The purpose of this standard operating procedure is to access and maintain a Central Vascular Access Device (CVAD) and midline for administration of medications, and blood draws safely and aseptically. This standard operating procedure is in support of the following policy (s): ... ISO3 - PICC Insertion and Maintenance Policy ... Standard Operating Procedure-Dressing Changes ... 2. Complications: ...d. Measure the external CVAD length at each dressing change or when catheter dislodgement is suspected and compare to the external CVAD length documented at insertion ..."			
F0732 SS= E	Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under	F0732	Element 1 Posted Nurse Staffing document was updated with the corrected day of the week during survey. Element 2 Audit completed of Nurse Staffing binder to identify any missing postings. Element 3 Education completed with Staffing Coordinator to assure daily Nurse Staffing postings are completed accurately and	5/20/2025

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	State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that the clinical staff posting was completed and available for review for multiple days from October 2024- April 2025, resulting in the inability of residents and visitors to know what clinical staff were working on those days. Findings Include: FACILITY Sufficient and Competent Nurse Staffing On 4/24/2025 at 9:17 AM, the Administrator		available for review. The Administrator/Designee will verify daily, Monday thru Friday, that Nurse Staffing is posted accurately. Weekend receptionist will verify, Saturday and Sunday, that Nurse Staffing is posted accurately and immediately notify the Administrator if not posted. Element 4 Administrator/Designee will complete random weekly audits X4 weeks of Nurse staffing posting to assure document is posted accurately with findings submitted to QAPI for review and recommendations. Element 5 Staffing Coordinator is responsible for maintaining compliance.	

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	was asked where the posted nurse staffing was located. She said the document was on the wall near the entry to the facility. Upon review of the posted document it said "Tuesday, 4/24/2025". The Administrator, viewed the document; discussed with her the dated was correct but the day was wrong. It was not Tuesday; It was Thursday. She said the staff member "N" responsible for completing the document would correct it. The Administrator said the posted staffing documents were to be posted daily. Requested to review the prior year's posted staffing. The Administrator said Staff "N" would provide the binder with the documents. The posted nurse staffing binder was reviewed. The posted staffing document was used to identify how many RN's (Registered Nurses), LPN's (Licensed Practical Nurses) and CNA's (Certified Nursing Assistants) were staffed each day on each shift. The document identified how many hours were worked for an RN, LPN and CNA and listed "Total Hours per shift) and included the "Date" and "Resident Census" (number of residents in the building on that day). The document was required to show how many residents were in the facility on a particular day and how many qualified nursing staff were present to care for them; any visitors or residents would then be able to see it after it was posted. During the review, it was identified there were approximately 60 days of posted staffing sheets that were missing from October 2024			

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	- April 2025. On 4/25/2025 at 9:45 AM, the Administrator was interviewed about the posted staffing documents and said Staff "N" who was completing the daily posted staffing documents was no longer responsible for ensuring their completion.			
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 record. §483.45(c)(5) The facility must develop and maintain policies and	F0756	Element 1 Resident #18 order for Diltiazem 60mg was discontinued, Physician was notified of medication error during survey. Element 2 An audit of Pharmacy Medication Reviews were completed for the last 30 days to ensure reviews were completed by Physician and had documented response from the Physician in Residents medical record. Any concerns were corrected. Element 3 Physicians were reeducated on reviewing and completing documentation of Pharmacy Medication Reviews in the Residents medical record. Element 4 Unit Manager/Designee will complete random monthly audits of Pharmacy Medication Reviews to ensure all reviews have been documented with findings submitted to DON who will report findings to QAPI for review and recommendations. Element 5 Director of Nursing is responsible for maintaining compliance.	5/20/2025

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	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 1) Identify a medication order discrepancy and 2) Address the pharmacy monthly medication regimen review timely for one resident (Resident #18) of five residents reviewed for medication regimen review, resulting in a medication ordered with the previous order not discontinued. Findings include: Resident #18: A review of Resident #18's medical record revealed an admission into the facility on 6/11/24 with diagnoses that included hypertension (high blood pressure) atherosclerotic heart disease, atrial fibrillation and presence of coronary angioplasty implant and graft. A review of the Minimum Data Set assessment revealed the Resident had intact cognition and needed partial/moderate assistance with eating, oral hygiene, dependent on a helper for other activities of daily living, mobility and transfers.			

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	A review of Resident #18's medication orders revealed an order dated 6/11/24, Diltiazem 60 mg (milligrams), take 1 tablet by mouth four times daily. A review of Resident #18's Physician/Practitioner Progress Note dated 2/1/25 at 6:15 AM, revealed, " ... Patient currently on diltiazem 60 mg 4 times a day will switch to Cardizem CD 240 mg once a day ..." A review of Resident #18's medication orders revealed an order dated 2/2/25, Cardizem LA oral tablet Extended Release 24 Hour 240 mg (Diltiazem HCl), Give 1 tablet by mouth one time a day for HTN (hypertension), with a start date on 2/3/25. The order for the Diltiazem 60 mg, four times daily was not discontinued. A review of Resident #18's Medication Administration Record (MAR) revealed that Cardizem LA 240 MG (Diltiazem HCl) was scheduled/administered at 9:00 AM and the Diltiazem HCl 60 MG was scheduled/administered at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM. A review of Resident #18's medication regimen review (MRR) on 3/3/25 revealed a February MRR performed, but the double order for the Diltiazem 60 mg four times a daily that was not discontinued and the Cardizem CD 240 mg once a day that was started on 2/3/25 was not addressed. On			

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	3/30/25, Pharmacy Consultant note revealed a March MRR was completed. The facility document titled, "Pharmacist Recommendations (DON/Medical Director Copy)" dated 3/31/25 revealed, " ...Resident prescribed the following medications: 1. Cardizem LA oral tablet Extended Release 24 Hour 240 MG (Diltiazem HCl)-Give 1 tablet by mouth one time a day for HTN. 2.dilTIAZem HCl Oral Tablet 60 MG (Diltiazem HCl)-Give 1 tablet by mouth four times a day for HTN. PLEASE VERIFY THAT THIS DRUG REGIMEN IS REQUIRED. If not, adjust therapy as necessary ..." The document did not have a response or was signed by the physician. On 4/25/25 at 2:05 PM, an interview was conducted with the Director of Nursing regarding Resident #18's Medication Regimen Reviews and the Resident receiving both the Cardizem LA 240 mg daily and the Diltiazem 60 mg four times a day. The DON reported that the Doctor had not addressed the pharmacy recommendations but that he had them with him. The order for the Diltiazem 60 mg four times a day had not been discontinued. The DON stated, "That is a med error." A concern that the MRR was dated for 3/31/25 and today's date was 4/25/25 and the recommendations had not been addressed. A review of facility policy titled, "Medication Regimen Reviews," revealed, " ...policy Interpretation and Implementation ... 4. The goal of the MRR is to promote positive			

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	outcomes while minimizing adverse consequences and potential risks associated with medication. 5. The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication-related problems, medication errors and other irregularities, for example: a. medications ordered in excessive doses or without clinical indication; ...c. duplicative therapies or omissions of ordered medications; ... h. other medication errors, including those related to documentation ... 10. If the identified irregularity represents a risk to a person's life, health, or safety, the consultant pharmacist contacts the physician immediately (within one hour) to report the information to the physician verbally, and documents the notification. 11. If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director or (if the medical director is the physician of record) the administrator ..."			
F0757 SS= D	Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-§483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose	F0757	Element 1 Resident #52 was not on an Antipsychotic medication at the time of the survey. Consent was obtained for Antidepressant Fluoxetine. Resident #18 order for Diltiazem 60mg was discontinued, Physician was notified of medication error during survey. Element 2 An audit of Antidepressant medication orders was completed to ensure consents were present for all Antidepressant medications. Any concerns were corrected.	5/20/2025

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	should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to 1) Obtain a signed consent for treatment with antipsychotic medications for Resident #52 and 2) Prevent the duplication of medications administered to Resident #18. Findings Include: Resident #52: Unnecessary Meds, Psychotropic Meds, and Med Regimen Review A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #52 was admitted to the facility on 1/26/2023 and readmitted on 5/18/2023 with diagnoses: Dementia, depression, anxiety, diabetes, chronic kidney disease, arthritis, blindness right eye and hypothyroidism. The MDS assessment dated 1/16/2025 revealed the resident had moderate cognitive loss with a Brief Interview for Mental Status/BIMS score of 10/15 and the resident was independent with most care but needed some assistance and oversight with bathing/showering. A review of the physician orders for Resident #52 revealed the resident received Fluoxetine/Prozac for depression, start date 11/15/2024. A review of the medical record did not identify a consent form for treatment with Fluoxetine.		An audit of Pharmacy Medication Reviews were completed for the last 30 days to ensure reviews were completed by Physician and had documented response from the Physician in Residents medical record. Any concerns were corrected. Element 3 Director of Nurses/Designee completed re-education to Licensed nurses on documentation of obtaining consents for Antidepressant medications and discontinuing orders per Physician order. Any licensed nurse not educated by May 20, 2025 will be educated on their next scheduled shift. Licensed Nurses will verify that there is a consent signed for any new Antidepressant Medications as part of the report during shift change. Nurse managers will review during morning meeting to ensure medication orders were discontinued per Physician changes of medications and all consent have been obtained for Antidepressant medications. Element 4 Unit Manager/Designee will complete random weekly audits X4 weeks of medication changes to ensure orders were discontinued and any resident with new Antidepressant medications has a signed consent. Results of findings submitted to DON who will report findings to QAPI for review and recommendations. Element 5 Director of Nursing is responsible for maintaining compliance.	

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	A review of the Care Plans for Resident #52 identified the following: "At risk for falls due to impaired balance/poor coordination, potential medication side effects ..." date initiated 5/18/2023 and revised 2/4/2025. "At risk for changes in mood related to depression, cognitive impairment ..." date initiated 5/18/2023 and revised 10/23/2023. There was no mention of medication for depression. On 4/25/2025 at 2:06 PM, during an interview with the Director of Nursing/ DON about the consent to treat form for Resident #52's Fluoxetine, the DON said she could not find one. A review of the facility policy titled, "Medication Regimen Reviews," dated reviewed 11/2024 provided, " ... The medication regimen and associated treatment goals involve collaboration with the resident (or representative), family members, and the interdisciplinary team (IDT). As such, the MRR includes a review of the resident's (or representatives) stated preferences, the comprehensive care plans and information provided about the risks and benefits of the medication regimen ..." Resident #18: A review of Resident #18's medical record revealed an admission into the facility on 6/11/24 with diagnoses that included hypertension (high blood pressure) atherosclerotic heart disease, atrial fibrillation			

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	and presence of coronary angioplasty implant and graft. A review of the Minimum Data Set (MDS) assessment revealed the Resident had intact cognition and needed partial/moderate assistance with eating, oral hygiene, dependent on a helper for other activities of daily living, mobility and transfers. A review of Resident #18's medication orders revealed an order dated 6/11/24, Diltiazem 60 mg (milligrams), take 1 tablet by mouth four times daily. A review of Resident #18's Physician/Practitioner Progress Note dated 2/1/25 at 6:15 AM, revealed, " ... Patient currently on diltiazem 60 mg 4 times a day will switch to Cardizem CD 240 mg once a day ..." A review of Resident #18's medication orders revealed an order dated 2/2/25, Cardizem LA oral tablet Extended Release 24 Hour 240 mg (Diltiazem HCl), Give 1 tablet by mouth one time a day for HTN (hypertension), with a start date on 2/3/25. The order for the Diltiazem 60 mg, four times daily was not discontinued. A review of Resident #18's Medication Administration Record (MAR) revealed that Cardizem LA 240 MG (Diltiazem HCl) was scheduled/administered at 9:00 AM and the Diltiazem HCl 60 MG was scheduled/administered at 9:00 AM, 1:00 PM,			

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	5:00 PM, and 9:00 PM. Resident #18 had been receiving both the Cardizem LA 240 MG daily and the Diltiazem 60 MG four times from when the Cardizem LA had been started on 2/3/25 with one Cardizem LA dose not given on 2/12/25. On 4/25/25 at 2:05 PM, an interview was conducted with the Director of Nursing regarding Resident #18's Medication Regimen Reviews and the Resident receiving both the Cardizem LA 240 mg daily and the Diltiazem 60 mg four times a day. The order for the Diltiazem 60 mg four times a day had not been discontinued, the practitioner's progress note was that the medication was to be switched to the Cardizem LA. The DON stated, "That is a med error." A review of facility policy titled, "Adverse Consequences and Medication Errors," revealed, "Policy Statement: The interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects ... 2. The staff and practitioner strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication; ...(2) Is not taking other medications ... that would be incompatible with the prescribed medication ... Medication Errors 1. A "medication error" is defined as the preparation or administration of drugs or			

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	biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional (s) providing services ... 3. A "significant medication-related error" is defined as: a. Requiring medication discontinuation or dose modification ..."			
F0761 SS= D	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that 3	F0761	Element 1 Medication carts on 300, 400 and 500 halls were cleaned during survey. Element 2 Audit of medication carts were completed to ensure all medication carts are clean and sanitized, free of crushed pills, pieces of loose papers and dust in the drawers. Any identified areas were addressed. Element 3 Director of Nursing/Designee reeducated Licensed Nurses on cleaning of medication carts which included making sure cart drawers are free of dust, paper particles and crushed pill residue. Any Licensed Nurses not educated by May 20, 2025 will be educated on their next scheduled shift. Nurse managers/designee will complete random weekly audits of medication carts to ensure medications carts are clean and sanitized. Element 4 Unit Manager/Designee will complete random weekly audits X4 weeks of medication carts to ensure carts are clean and sanitized and query Nurses if they are able to verbalize the appropriate way to clean medication carts with results reported to the Director of Nursing who will be present to QAPI for further follow up and recommendations.	5/20/2025

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	medication carts (Halls 300, 400 and 500) of 4 medication carts observed were maintained clean and sanitized, free of crushed pills, pieces of loose papers and dust in the drawers. Findings Include: Observation of facility medication carts done on 4/23/25 starting at 10:55 a.m., revealed the following: 500 Hall Med Cart: Observation was done on 4/23/25 at approximately 10:40 a.m., accompanied by Nurse, RN "B" revealed the following: -The second and third drawer's had pieces of crushed medications/meds and paper on the bottom back. During an interview done on 4/23/25 at 10:45 a.m., Nurse "B" stated "Third shift cleans it, but we can all clean it." During an interview done on 4/23/25 at approximately 10:55 a.m., Nurse, LPN "C" was asked by this surveyor if the drawers of the med cart could have been cleaned better and she stated "ya, a bit; third shift cleans it and anyone can clean it." 400 Hall Med Cart: Observation was done on 4/23/25 at 11:09		Element 5 Director of Nursing will be responsible for maintaining compliance.	

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	a.m., accompanied by Nurse, LPN "D" revealed the following: -The second and third drawer's had an excessive amount of crushed pills and pieces of paper on the bottom in back and 1/4 of a white pill was found. 300 Hall med Cart: Observation was done on 4/23/25 at 12:28 p.m., accompanied by Nurse, LPN "F" revealed the following: -The second and third drawers had crushed meds and small pieces of paper on the bottom in the back. During an interview done on 4/23/25 at 12:28 p.m., Nurse "F" stated "Third shift cleans it (facility med carts)." 300 Hall med Cart: Observation was done on 4/23/25 at 12:28 p.m., accompanied by Nurse, RN "E" revealed the following: -The second and third drawer's had med pieces and dust on the bottom in the back; the third drawer had an excessive amount of crushed meds and one whole round yellow pill was found loose. During an interview done on 4/23/25 at 12:35 p.m., Nurse "E" said the med cart "could have			

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	been wiped down for sure." During an interview done on 4/23/25 at 12:31 p.m., the Director of Nursing confirmed third shift nursing staff were assigned to clean the medication carts. Review of the facility Medication Storage policy (un-dated) revealed nurses are responsible to clean the medication carts.			
F0812 SS= D	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 maintain food preparation and kitchen equipment in a sanitary and good working condition, resulting in an increased likelihood for food borne illnesses with hospitalization, and cross	F0812	Element 1 Plate covers and coffee cups that were on the rack with water were re-washed and dried properly before returning to the rack for use. Can opener, meat slicer, mixer and knife were cleaned during survey. Element 2 Audit completed of kitchen to assure equipment cleanliness as well as plate covers and coffee cups are completely dry on the clean rack. Element 3 Education completed with Dietary staff to assure kitchen equipment cleanliness, plate covers and coffee cups are completely dry before putting away on the clean rack. ‘ Any staff not educated by May 20, 2025 will be educated on their next scheduled shift. Dietary Manger/Designee will complete weekly kitchen audits to ensure appropriate processes are being followed. Element 4 Dietary Manger/Designee will complete random weekly audits X4 weeks of kitchen to assure kitchen cleanliness and all items dried and stored properly with findings submitted to QAPI for review and recommendations. Element 5 Dietary Manager is responsible for	5/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	254200	A. BUILDING _____ B. WING _____	4/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD NURSING AND REHAB	3011 N CENTER RD FLINT, MI 48506

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	contamination affecting 82 residents who consumed oral nutrition from the facility kitchen and ice machine of a total census of 84 residents. Findings include: Review of the Public Health Service 2009 Food Code, adopted by the Michigan Food Law, effective October 1, 2012, Chapter 4-501.14 directs that equipment cleaning frequency is to be "throughout the day at frequency necessary to prevent recontamination of equipment and utensils." On 4/23/25 at 10:15 a.m., a kitchen tour was done accompanied by Dietary Manger "A". The following concerns were identified during the walk-through: -At 10:15 a.m., the large can opener was observed to have a dark colored sticky substance directly behind the blade. -At 10:18 a.m., the large counter mixer that was clean and ready for use had dried batter-like substance on the attachment directly over the mixing bowl. During an interview done on 4/23/25 at 10:18 a.m., Dietary Director "A" stated "I see it, needs to be cleaned." -At 10:20 a.m., a carving knife and a bread large knife that were clean and ready for use		maintaining compliance.	

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	sitting on the bottom shelf of the food prep table, had dried-on food on the blades. -At 10:22 a.m., on the clean and ready for use meat slicer, the blade was observed to have an oily substance on it, and a small amount of dried food. -At 10: 40 a.m., 6 clean and ready for use plate covers were found stacked inside one another and had water inside (increases bacterial growth). -At 10:43 a.m., 3 clean and ready for use coffee cups were found on a tray ready for serving they had water still inside. Review of the facility Dietary Manager Job Description dated 2/22/23, stated "Provides training, direction and guidance for the dietary staff."			