

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 334100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 4/10/2025
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NAME OF PROVIDER OR SUPPLIER MEDILODGE OF EAST LANSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1843 N HAGADORN RD EAST LANSING, MI 48823
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F0000 SS=	INITIAL COMMENTS Medilodge of East Lansing was surveyed for an Abbreviated survey on 4/10/25. Intakes: MI00151792, MI00151694, MI00151358, MI00150699, MI00150638, MI00151418, MI00151442, MI00151852 Census=69	F0000		
F0677 SS= E	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: This citation pertains to intake MI00151358, MI00150638 and MI00151852. Based on observation, interview, and record review the facility failed to provide Activities of Daily Living (ADL's), including bathing/showering for four dependent resident (R103, R104, R106, and R110) reviewed of ADL care, resulting in increased worsening of pressure wounds and likelihood of feelings of worthlessness, disrespect and the potential for infection. Findings include: Review of three complaints received by the State Agency alleged the facility failed to assist and/or provide residents with ADL care including showering, oral care and grooming.	F0677	Element 1 Resident 103 no longer resides in the facility. Resident was discharged home on 3/24/2025. Resident 104 no longer resides in the facility. Resident 104 discharged home on 3/27/2025. Resident 106 no longer resides in the facility. Resident 106 discharged to the hospital on 4/1/2025. Resident 110 continues to reside in the facility. Resident was offered a shower and ADL's including oral care was completed by 4/25/2025. Element 2 A one-time audit of the last 3 days of current residents was conducted to verify that they have received or been offered a shower/bed bath. If a shower/bed bath had not been offered at time of audit, it would be immediately offered and given or documented if refused. This was completed by the Director of Nursing/Designee by 4/25/25.	4/25/2025

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

TITLE

(X6) DATE

Electronically Signed

05/02/2025

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

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	<p>Resident #106(R106)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated 2/7/25, reflected R106 was a 39-year-old male admitted to the facility on 8/1/24, with re-admission 3/13/25 related to wound infection with other diagnoses that included traumatic brain dysfunction, cerebral vascular accident, acute respiratory failure with anoxic brain damage with tracheostomy, contracture of left knee and right knee. The MDS reflected R106 was dependent on staff for all care. Continued review reflected R106 had been discharged to hospital 4/1/25.</p> <p>Review of R106 Documentation Survey Report (Task Report), dated 2/1/25 through 3/31/25, reflected R106 had</p> <p>five missed showers, as evidenced by no documentation as completed. Continued review reflected 51 shifts with no oral care provided as evidenced by no documentation or documentation that oral care was not provided. Continued review reflected R106 had task, "Assist/Remind to Turn and Reposition per Care Plan and PRN[as needed]." The Report reflected R106 had 42 eight-hour shifts that R106 was not turned and repositioned, as evidenced by no documentation as completed.</p> <p>Resident #103(R103)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated 3/24/25, reflected R103 was a 86-year-old male admitted to the facility on 3/17/25, with diagnoses that included cerebral vascular infarction, vascular dementia, mild neurocognitive disorder, and depression. The MDS reflected R103 required partial to moderate assist with showering and dressing. Continued review of R103 MDS reflected resident had</p>		<p>A one-time audit of current residents was conducted to ensure residents received ADL care including oral care by 4/25/25. Anyone that had not received ADL care including oral care was immediately completed and documented on by 4/25/25. This was completed by the Director of Nursing/Designee.</p> <p>Element 3</p> <p>The QAPI Committee reviewed the policy, Activities of Daily Living and deemed it appropriate by 4/25/25.</p> <p>The Director of Nursing has re-educated the certified nursing assistants and the licensed nurses on the Activities of Daily Living policy with emphasis to showers and ensuring residents are being offered and given showers on their shower days and completing and documenting ADL care including oral care every shift. This education will be completed by 4/25/25.</p> <p>Element 4</p> <p>The Director of Nursing or Designee will conduct random audits weekly for four weeks and then monthly thereafter until substantial compliance is sustained, to verify that a showers/bed baths and ADL care including oral care is being offered, given and/or documented on if refused.</p> <p>Audits will be reviewed by the QAPI committee monthly for 3 months until substantial compliance is met.</p> <p>The Administrator is responsible to maintain compliance.</p>		

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	<p>dentures and had been discharge from facility 3/24/25.</p> <p>Review of R103 Documentation Survey Report (Task Report), dated 3/17/25 through 3/24/25, reflected R103 had one missed showers, as evidenced by no documentation as completed, with no shower for five days and was present at facility for a total of seven days. Continued review reflected five shifts with no oral care provided as evidenced by no documentation or documentation that oral care was not provided.</p> <p>Review of R103 Care Plan, dated 3/17/25, reflected no mention of R103's dentures including ADL assist for oral care.</p> <p>Resident #104 (R104)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated 3/1/25, reflected R104 was a 58-year-old male admitted to the facility on 2/24/25, with diagnoses that included cerebral vascular infarction with partial paralysis. The MDS reflected R104 required partial to moderate assist with showering and had been discharged from the facility 3/27/25.</p> <p>Review of R104 Documentation Survey Report (Task Report), dated 2/24/25 through 3/27/25, reflected R104 had five missed showers, as evidenced by no documentation as completed.</p> <p>Resident #110 (R110)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated 1/7/25, reflected R110 was a 45-year-old male admitted to the facility on 2/8/22, with diagnoses that included traumatic spinal cord injury with partial paralysis, anxiety and depression. The MDS reflected R110 was dependent on staff for care including with</p>				

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	<p>showering.</p> <p>During an interview on 4/8/25 at 4:19 p.m., R110 was laying in bed and appeared calm and pleasant and able to answer questions without difficulty. R110 reported had missed several showers in past three months and believed it was related to not enough staff to meet residents needs. R110 reported on several evening shifts over past three months there was only three to four Certified Nurse Aid in the entire facility that included ventilator unit. R110 reported had completed several facility grievances related to staffing concerns and missed showers and reported past two weeks have seen slight improvement.</p> <p>Review of R110 Documentation Survey Report (Task Report), dated 1/1/25 through 3/31/25, reflected R110 had nine missed showers, as evidenced by no documentation as completed, including time frame of 20 days without showering or bathing care.</p> <p>Review of facility Grievance Forms, dated 1/1/25 through current, reflected several reported concerns with missed showers, staffing and linen changes.</p> <p>During a telephone interview on 4/9/25 at 8:26 a.m., Ombudsman "L" reported had received several complaints from residents and families related staffing concerns because care needs were not being met.</p> <p>During an interview on 4/9/25 at 11:15 a.m., Registered Nurse Manager (RN) "L" reported had taken over staff scheduling in past two weeks after prior facility scheduler left. RN "L" reported staffing had been difficult for past two months with prior scheduler issues, frequent call in's, terminations, and open shifts. RN "L" reported managers had been picking up shifts to meet</p>				

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	<p>minimum staffing requirements.</p> <p>During a telephone interview on 4/9/25 at 12:26 p.m., Certified Nurse Aid (CNA) "D" reported staffing had been an issue at facility for past two to three months with recent improvements over past two weeks since new scheduler. CNA "D" reported several complaints form residents about missed showers. CNA "D" reported often worked day shift and reported often arrived to shift with at least three residents who required full bed changes related to being saturated in urine at least five days per week for last month. CNA "D" reported often only three CNA staff scheduled on night shift and did not feel resident needs were being met related to not enough staff and reported had reported to management and completed concern form with no changes until last two weeks.</p> <p>During a telephone interview on 4/9/25 at 4:05 p.m., Confidential Staff (CS) "M" reported facility has had staffing issue for past three months. CS "M" reported resident basic needs were not being met including incontinence care, turn/reposition, showers, oral care and range of motion. CS "M" reported over past three months second and third shift had been the worse with only enough time to complete incontinence care and repositioning for dependant residents two times per shift and should be every two hour with minimal assist from nurse staff. CS "M" reported restorative staff pulled to floor for resident care five of five days per week for past couple months.</p> <p>During an interview on 4/10/25 at 2:15 p.m, Unit Manager "G" reported would expect CNA staff follow Kardex including every two hour incontinence care, repositioning and showers as scheduled and document in Tasks and verified should not be holes on Tasks with no documentation.</p>				

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F0686 SS= G	<p>During an interview on 4/10/25 at 5:50 p.m., Unit Manager "G" reported there was 32 of 69 residents in facility that required two person assist with care.</p> <p>Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to intake number MI00151442 and MI00151852</p> <p>Based on observation, interview, and record review the facility failed to provide for three out of three residents (Resident #105, #106, #111) care and services to prevent and promote healing of pressure ulcers resulting in worsening wounds, osteomyelitis, and hospitalization.</p> <p>Findings Included:</p> <p>Review of the facility Matrix, dated 4/8/25, the facility census was 69 and they had nine current residents with pressure ulcers and three had facility acquired pressure wounds.</p>	F0686	<p>Element 1</p> <p>Resident 105 no longer resides in the facility and was discharged to the hospital on 3/26/25.</p> <p>Resident 106 longer resides in the facility and was discharged to the hospital on 4/1/25.</p> <p>Resident 111 continues to reside in the facility. Her wounds, treatment orders and care plans were reviewed by the Director of Nursing, Wound Nurse, and wound care provider by 4/25/25 and deemed to be appropriate. An unavoidable assessment was completed due to residents wound was expected to decline on admission due to comorbidities and assessment of periwound.</p> <p>Element 2</p> <p>A skin sweep of current residents was completed by the Director of Nursing/Designee by 4/25/25 for any new skin areas. Any new areas noted were assessed, had treatment orders entered and care plans updated for interventions to prevent and promote healing of wounds.</p> <p>A one-time audit of current residents <input type="checkbox"/> with wounds was completed to ensure the wounds have appropriate treatment orders and interventions to prevent and promote healing of wounds. This was completed by the</p>	4/25/2025

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	<p>Review of two complaints received by the State Agency alleged the facility failed to prevent worsening of pressure ulcers for R105 and R106, who was known high risk for skin breakdown.</p> <p>Resident #106(R106)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated 2/7/25, reflected R106 was a 39-year-old male admitted to the facility on 8/1/24, with re-admission 3/13/25 related to wound infection with other diagnoses that included traumatic brain dysfunction, cerebral vascular accident, acute respiratory failure with anoxic brain damage with tracheostomy, contracture of left knee and right knee, The MDS reflected R106 was dependent on staff for all care. Continued review of the MDS reflected R106 had one new stage 4 pressure ulcer(PU) (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed) not present on admission.</p> <p>During a telephone interview on 4/9/25 at 9:43 a.m., R106 Responsible Party (RP) "K" reported R106 was currently in the hospital for several infected worsening facility acquired pressure wounds since 4/1/25. R106 RP "K" facility staff were not turning and repositioning R106 enough and on several occasions appeared to be unkept and unroomed.</p> <p>Review of R106 Physician Progress Note, dated 10/25/24, reflected, "Patient is a 38M[male], medical history of TBI[traumatic brain injury],trach and PEG [percutaneous endoscopic gastrostomy] placement, nonverbal, AOx0[alert and oriented times 0] at baseline, who resides at [named long term care facility]. His brain injury occurred in April 2022 when he was struck by a vehicle on his bicycle. He was admitted to [named hospital] for medical management. He</p>		<p>Director of Nursing/Designee by 4/25/25.</p> <p>A one-time audit of resident's most recent Braden score was completed and anyone with a Braden of 10 or below was placed on the yellow dot program for turning and repositioning.</p> <p>Element 3</p> <p>The QAPI Committee has reviewed the Pressure Ulcer Prevention and Management policy and has deemed it to be appropriate by 4/25/25.</p> <p>The Director of Nursing and/or designee educated the Wound Care Nurse and the licensed nurses on the Pressure Ulcer Prevention and Management policy by 4/25/25 with emphasis on the yellow dot program for turning and repositioning, ensuring wound treatments are being completed and appropriate interventions are in place to prevent and promote healing of wounds.</p> <p>Nurse Aides were educated on the yellow dot program for turning and repositions and checking resident karded to ensure interventions are in place. This was completed by the Staff Development Coordinator/Designee by 4/25/25.</p> <p>Wounds will be reviewed daily in morning clinical M-F to ensure treatments are being completed and weekly in standard of care meeting to ensure appropriate interventions are in place to prevent and promote wound healing.</p> <p>Element 4</p>	

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	<p>required PEG tube and tracheostomy. Ultimately, he was admitted to [named long term care facility] on 8/1/2024. He has required multiple ED[emergency department] visits for PEG tube replacement after being dislodged. Additionally, his most recent hospitalization was due to aspiration PNA [pneumonia]. However, he was recently able to be decannulated and is now doing well on room air ...consulted for rehab needs and evaluation of contracture's and bruxism [grinding of teeth] ..."</p> <p>Review of R106 Provide Note, dated 10/28/24, reflected, "Primary Chief Complaint: Skin: Pressure Wound ...History Present Illness : 38M with hx[history] TBI, chronic resp.[respiratory] failure, nonverbal, total care, developed a new Stage 2 pressure wound on his coccyx ...This is an acute new problem ..."</p> <p>Review of R106 Pertinent Charting Skin Note, dated 2/2/25, reflected, "Location of skin area being documented: Coccyx, bilateral ischial tuberosities Coccyx, wound is white around the edges but improving with the wound bed. Cleaned and dressing applied. Right Ischial tuberosity has a fluid filled blister that is intact. Skin prep applied, let dry, then applied non-adherent pad then comfort foam border. Left: hip is open ..."</p> <p>Review of R106 Pertinent Charting Skin Note, dated 2/14/25, reflected, "Location of skin area being documented: Coccyx, bilateral hips Coccyx wounds still declining, with the rim of wound white, skin prepped the outside of wound before applying dressing. Right hip doing well, still flush with skin, dressing applied. Left hip declining, slightly deeper than last observed by myself with significant amount of drainage ..."</p> <p>Review of R106 Pertinent Charting Skin Note,</p>		<p>The Director of Nursing/designee will audit residents with wounds weekly x4 weeks then monthly thereafter to ensure interventions are in place and treatments are being completed to prevent and promote healing of wounds.</p> <p>The Director of Nursing/designee will audit residents with a Braden of 10 or less weekly x4 weeks then monthly thereafter to ensure they are being turned and repositioned appropriately to prevent and promote healing of wounds.</p> <p>Results will be reviewed monthly by the QAPI Committee until substantial compliance is achieved.</p> <p>The Administrator is responsible to maintain compliance.</p>		

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	<p>dated 2/17/25, reflected, "Location of skin area being documented: Coccyx, Left hip, right hip left outer foot. Coccyx wound no change, but still not doing well, left hip is worse, wound is draining more and has an odor to it. Right hip is almost completely healed. This area looks great. Left outer foot has a blister on it ...risk management started"</p> <p>Review of R106 Wound Notes, dated 10/29/24 through 3/4/25, reflected the following:</p> <p>10/29/24-Coccyx NEW Facility Acquired(FA) Stage 4 pressure ulcer(PU)--1.07 x 0.6 x 0.1 cm</p> <p>Start date 10/28/24.</p> <p>2/4/25--Coccyx FA stage 4 PU-3.6 x 2.3 x 0.3 cm</p> <p>-Left Trochanter(hip) New Facility Acquired-6.7 x 3.3 x 0.2 cm--NEW</p> <p>-Right Trochanter New Facility Acquired blister-4.8 x 3.3 x 0.1 cm-NEW</p> <p>2/18/25-Coccyx FA stage 4 PU-4.2 x 3.3 x 0.4 cm-slough</p> <p>-Right Trochanter FA PU-RESOLVED</p> <p>-Left Trochanter FA blister-3.9 x 5 x 0.2 cm-slough, dark non-granulation</p> <p>-Left lateral foot NEW hematoma-2.4 x 1.3 x 0 cm--NEW</p> <p>3/4/25--Coccyx FA unstageable PU-4.7 x 3.0 x 0.4 cm--slough</p> <p>-Left Trochanter FA unstageable pressure-6.2 x 2.2-slough</p>			

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	<p>-Left lateral foot FA deep tissue injury-2.4 x 1.5 x 0 cm</p> <p>Review of R106 Provider Notes, dated 3/13/25, reflected, "Primary Chief Complaint: Readmission ...Patient was sent to ED on 3/6 sepsis and sacral wound infection. Patient had a sacral decubital and it was debrided, and patient grew out Escherichia coli ESBL and Pseudomonas aeruginosa and staff. Patient was treated with Zyvox. And patient is requiring meropenem 500 mg every 6 hours and levofloxacin 750 every 24 hours for 6 weeks. Patient is being readmitted to the facility ..."</p> <p>Review of R106 Nursing Evaluation Summary Note, dated 3/13/25 at 9:21 p.m., reflected, "Resident arrive via stretcher from [named] hospital after a hospital stay r/t[related to] infection ..."</p> <p>Review of R106 Physician History and Physical Note, dated 3/14/25, reflected, "He is being seen for readmission to the facility after hospitalization at [named]. He was admitted for suspected sepsis with hypotension and tachycardia. Source was felt to be due to a sacral ulcer. He was taken for debridement on 3/8/25 with cultures showing ESBL E. coli and Pseudomonas. ID was consulted and recommended 6 weeks of meropenem and Levaquin ...PICC[peripherally inserted central catheter] was placed on 3/13. Today, he was noted by nursing to have been grinding his teeth more, diaphoretic, and appearing more uncomfortable ..."</p> <p>Review of R106 Pertinent Charting-Infections/Signs Symptoms Note, dated 3/16/25, reflected, " ...Resident has had a difficult night tonight. Has been moaning and groaning, have given PR muscle relaxer and his scheduled medications and they do not appear to help. When</p>			

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	<p>dressing was completed, he did appear to settle down and is at this time quiet."</p> <p>Review of R106 Provider Wound Note, dated 3/18/25, reflected, "Chief Complaint / Nature of Presenting Problem: Sacral and left hip pressure wounds History Of Present Illness:39yr old male requested by facility for evaluation of wounds and follow up related to coccyx, left lateral foot, and left hip pressure wounds ...Coccyx stage 4 pressure Measurements- 5.1 x 3.7 x 1.5cm Tissue type- Pink non-granulation/slough ...Infection-delayed healing/non-viable tissue ...Wound Plan Of Care- Medihoney/lightly fluffed saline gauze/foam BID and prn ...Wound Additional Orders- Caregiver staff to provide frequent turning and repositioning ...Left lateral foot deep tissue injury Measurements- 3 x 1.7 x 0cm Tissue type- discolored epithelial ...Left trochanter unstageable pressure Measurements- 6.6 x 7 x Unable to determine true depth Tissue type- pink non-granulation/slough ...Wound Plan Of Care-Medihoney/lightly fluffed saline gauze/foam BID and prn ..."</p> <p>Review of R106 Provider Wound Note, dated 3/25/25, reflected, "Coccyx stage 4 pressure Measurements- 5 x 3.8 x 1.2cm ...Tissue type- Pink non-granulation/slough Peri Wound- fragile Drainage- Light serosanguineous Pain- none Infection- delayed healing/non-viable tissue Overall Wound Condition- stable Wound Plan Of Care- Medihoney/lightly fluffed saline gauze/foam BID and prn ...Left lateral foot deep tissue injury Measurements- 2.8 x 1.7 x 0cm Tissue type- discolored epithelial Peri Wound-fragile ...Left trochanter unstageable pressure Measurements- 7.7 x 7.6 x Unable to determine true depth Tissue type- pink non-granulation/slough Peri Wound- fragile Drainage-Light serosanguineous Pain- none Infection- non-viable tissue ..."</p>				

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	<p>Review of R106 Wound Provider Note, dated 4/1/25, reflected, "Chief Complaint / Nature of Presenting Problem: Sacral and left hip pressure wounds History Of Present Illness: 39yr old male requested by facility for evaluation of wounds and follow up related to coccyx, left lateral foot, and left hip pressure wounds. Caregiver staff notes recent fevers and odor from buttocks wounds ...Coccyx unstageable pressure Measurements- 5.8 x 5.2 x unable to determine true depth Tissue type- slough/dark avascular tissue Peri Wound- fragile Drainage- Light serosanguineous Pain- none Infection- delayed healing/non-viable tissue Overall Wound Condition- deterioration ...Left lateral foot deep tissue injury Measurements- 2.8 x 2 x 0cm Tissue type- discolored epithelial ...Overall Wound Condition- stalled Wound Plan Of Care- skin prep and OTA daily ...Left trochanter unstageable pressure Measurements- 7.8 x 7 x Unable to determine true depth Tissue type- pink non-granulation/slough Peri Wound- fragile Drainage- Light serosanguineous Pain- none Infection- non-viable tissue ...Right trochanter blister Measurements- 1.5 x 2.5 x 0.1cm Tissue type- dermal Peri Wound- fragile ...Overall Wound Condition- new ...Right Upper arm blister lateral Measurements- 1.3 x 0.9 x 0cm Tissue type- fluid filled epithelial Peri Wound- fragile ...Overall Wound Condition- new ...Right Upper arm blister medial Measurements- 1.8 x 0.5 x 0cm Tissue type- fluid filled epithelial Peri Wound- fragile ...Overall Wound Condition- new ...Reclassified sacral wound as unstageable d/t increase in slough and appearance of avascular tissue. Concern as wound continues to deteriorate despite use of IV meropenem and levaquin. Pt now experiencing blisters in recurrent areas such as his right trochanter. Pt likely requires advanced imaging and diagnostics to assist in identifying underlying reason for sacral wound deterioration. Notified physician and she agreed pt should be transferred to [named] ER for further evaluation</p>				

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	<p>..."</p> <p>Review of R106 Skin Care Plan, dated 8/1/24, reflected interventions that included, "Assist resident with turning and repositioning per facility protocol and PRN. Resident utilizes pillows and wedges to assist with offloading bony prominence ...Preventative treatment(s) per orders ... Provide incontinence care as needed ...Provide incontinence care as needed ..."</p> <p>Review of R106 Treatment Administration Record, dated 2/1/25 through 3/31/25, reflected R106 had 20 missed wound treatments, as evidenced by no documentation as completed, for facility acquired pressure wounds. Continued review of the TAR reflected Provider order for twice daily wound care to R106 Coccyx wound was completed daily (seven missed treatments).</p> <p>Review of R106 facility, "Documentation Survey Report v2(Task Report), dated 2/1/25 through 3/31/25, reflected R106 had task, "Assist/Remind to Turn and Reposition per Care Plan and PRN." The Report reflected R106 had 42 eight-hour shifts that R106 was not turned and repositioned, as evidenced by no documentation as completed.</p> <p>Resident #111(R111)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated 3/25/25, reflected R111 was a 79-year-old female admitted to the facility on 2/26/25, with re-admission 4/5/25 related to wound infection with other diagnoses that included non-traumatic brain dysfunction, heart failure, and seizure disorder. The MDS reflected R111 was dependent on staff for all care. Continued review of the MDS reflected R111 had one unstageable pressure wound related to slough in wound bed and one unstageable pressure wound related to suspected deep tissue injury</p>			

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	<p>both on admission.</p> <p>During an observation on 4/9/25 at 3:15 p.m., Registered Nurse (RN) "C" entered R111 room with dressing supplies to complete wound care treatment. R111 was laying in bed and was nonverbal. CNA staff assisted with positioning. RN "C" removed old dressing dated 4/8/25 that was saturated over sacral area. R111 had large sacral wound the size of small football with about 50 % slough in base of wound. RN "C" cleaned would bed with normal saline and gauze, ointment, then place dry gauze pads loosely under border foam dressing. RN "C" reported R111 admitted with sacral wound and was recently re-admitted to hospital related to osteomyelitis (bone infection).</p> <p>Review of R111 Physician order, dated 4/5/25, reflected, "Monitor sacral wound, if saturated/ missing replace every day and night shift for WOUND CARE related</p> <p>to PRESSURE ULCER OF SACRAL REGION"</p> <p>Review of R111 Provider Note, dated 2/27/25, reflected, "79 year old seen today for new admission. She is currently resting in bed. She was admitted to the hospital secondary to cardiac arrest ...Her neurological status did not improve and neurology was consulted, EEG[brain activity scan] showed no seizure and did show diffuse encephalopathy. MRI[soft tissue scan] brain showed anoxic brain injury pattern. She had trach and peg placed on 2/11. She was also treated for Klebsiella UTI and moraxella and MSSA[type of bacteria] pneumonia and she did complete course of antibiotics. She then continued to have fevers and ID[infectious disease] rec to continue with Cefazolin for 14 days as repeat respiratory culture showed MSSA. She has picc line in place ..."</p>			

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	<p>Review of R111 Nursing Evaluation Summary, dated 2/27/25, reflected, "Skin assessment completed and open areas to coccyx and right gluteal fold noted as well as DTI[deep tissue injury] to right heel, no other skin issues noted. "</p> <p>Review of R111 Wound Notes, dated 2/27/25 through ----, reflected the following:</p> <p>2/27/25-Coccyx-3.69 x 1.48 cm</p> <p>3/4/25--Coccyx unstageable PU-3.6 x 3.7 unable to determine depth related to slough.</p> <p>-Right ischium stage 2 pressure-0.6 x 0.5 x 0.1 cm</p> <p>-Right heel deep tissue injury-1.4 x 1 x 0 cm</p> <p>3/18/25-Coccyx unstageable PU-9.7 x 7.2 x unable to determine related to slough/dark non-granulation. Note, "Caregiver staff to provide frequent turning and repositioning to offload wounds.</p> <p>-Right heel deep tissue injury-1.1 x 1.2 x 0cm</p> <p>3/25/25-Coccyx unstageable PU-11.9 x 8.9 x unable to determine depth related to slough, deterioration.</p> <p>-Right heel-1.1 x 1 x 0</p> <p>Continue review of wound note, dated 3/25/25, reflected, "Ordered 2 V xray of sacral wound d/t continued acute deterioration AEB[as evidenced by] increase in size, significant odor, and delayed healing. Ordered metrogel applied to wound followed by dakins gauze. Later during documentation reviewed xray results showing</p>			

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	<p>suspicion for osteomyelitis. Discussed results with physician and authorized transfer to sparrow ER for advanced imagining, culturing, abx [antibiotic]selection, and debridement of wound. DON notified. Called facility and notified nursing of findings and requested pt be sent to Sparrow ER along with xray results ..."</p> <p>Review of R111 Provider Progress Note, dated 4/7/25, reflected, "Chief Complaint / Nature of Presenting Problem: Re admission, osteomyelitis History Of Present Illness:79 year old seen today for re admission she was in the hospital secondary to osteomyelitis. There is no discharge summary at this time. Reviewed progress notes in [named EMR] and she was admitted to the hospital with concern for worsening decubitus ulcer, she had CT scan that showed coccygeal soft tissue ulceration ... worrisome for osteomyelitis. She was placed on IV antibiotics and ID was consulted."</p> <p>Review of R111 Hospital Infectious Disease Consult, dated 4/2/25, revealed diagnosis that included osteomyelitis of scrum and coccyx, stage 4 pressure ulcer and sepsis.</p> <p>Review of R111 Treatment Administration Record, dated 3/1/25 through 3/25/25, reflected R111 had 4 missed wound treatments, as evidenced by no documentation as completed, for worsening coccyx pressure wound.</p> <p>Review of R111 facility, "Documentation Survey Report v2(Task Report), dated 3/1/25 through 3/25/25, reflected R111 had task, "Assist/Remind to Turn and Reposition per Care Plan and PRN." The Report reflected R111 had 23 eight-hour shifts that R111 was not turned and repositioned, as evidenced by no documentation as completed.</p> <p>Resident #105(R105)</p>			

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	<p>Review of the Face Sheet and Minimum Data Set (MDS) dated 2/27/25, reflected R105 was a 47-year-old female admitted to the facility on 10/30/24, with diagnoses that included cerebral vascular accident with current comatose state, acute respiratory failure with anoxic brain damage with tracheostomy, Pulmonary embolism, diabetes mellitus, hypertension, and one stage 2 pressure ulcers present on admission and one unstageable pressure ulcer not present on admission. The MDS reflected R105 was dependent on staff for all care. Continued review of the MDS, dated 1/28/25, reflected R105 had one new unstageable pressure wound not present on admission (12/24/24).</p> <p>During a telephone interview on 4/9/25 at 9:32 a.m., R105 family "I" reported R105 admitted to facility 10/30/24 with an open area on coccyx area and on left side. R105 family "I" reported R105 coccyx area was almost healed, and staff stopped repositioning R105 and wound gradually worsened and R105 developed new skin breakdown on right side at the facility. R105 family "I" reported R105 was re-admitted several times to the hospital for repeat wound infections, last time on 3/26/25 and stated, "tired of it, she had been through enough." R105 family reported spoke with management several times with concerns that R105 was not being turned and repositioned every two hours and they hung a turning log on wall over R105 bed that staff were instructed to document every time R105 was turned. R105 family member reported log was incomplete and still in R105 room.</p> <p>During an observation and record review on 3/9/25 at 9:40 a.m., R105 name was posted outside room door and turning log document was hanging on the wall above the head of the bed. The log reflected, "Resident needs to be turned q2 [every two] hours and PRN [as needed]."</p>			

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	<p>Continued review of the log reflected first entry 3/13/25 at 6:40 p.m. with "L" circled that indicated turn direction with a total of six entries including last, dated 3/16/25, for four days. (If R105 was turned every two hours, should be 12 entries each day on log for a total of 156 entries between 3/13/25 and 3/26/25).</p> <p>Review of R105 Electronic Medical Record (EMR), dated 10/30/24 through 3/26/25, reflected R105 admitted to facility 10/30/24 and transferred to hospital 12/10/24 and return 12/24/24. Continued review of the EMR reflected R105 was transferred to the hospital on 1/28/25 and returned to facility 2/21/25. Continued review of the EMR reflected R105 re-admitted back to the hospital on 3/26/25 and had not returned to the facility.</p> <p>Review of R105 Provider Progress Note, dated 10/31/24, reflected, "History Of Present Illness:</p> <p>47 year old seen today for new admission. She is currently resting in bed and her husband is at bedside. She had PEA [pulseless electrical activity] arrest and CT [computed tomography scan] chest which showed PE [pulmonary embolism] with moderate clot burden and multifocal consolidation and groundglass disease. She was seen by IR [interventional radiology] and had thrombectomy. CT showed cerebral ischemia. Per notes brainstem reflexes intact but not definite sign of higher function. She was seen by neurology. She was treated for UTI [urinary tract infection]. Urine culture showed e faecium and respiratory cultures showed pseudomonas. She does have trach in place and peg tube. Her husband tells me before she was hospitalized with her blood clots she was pretty healthy."</p> <p>Review of R105 Pertinent Charting-Skin Progress Note, dated 10/31/24 at 8:31 a.m., reflected,</p>			

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	<p>"Event Date: 10/30/24 Location of skin area being documented: coccyx and left rear thigh Description: pressure ulcers ...Physician notification: Resident admitted to facility with wounds, Provider aware."</p> <p>Review of R105 Social Services Progress Note, dated 11/4/24, reflected, "IDT [interdisciplinary team] met with res and husband for initial CC [care conference] ...Expressed concerns about preventing pressure wounds. Nursing explained res is on a schedule for repositioning ..."</p> <p>Review of R105 Provider Wound Notes, dated 11/5/24 through 12/3/24, reflected the following:</p> <p>11/5/24-Coccyx stage 3 pressure-5.5 x 3.9. 0.2 cm</p> <p>-Left rear thigh stage 2 pressure with no measurements noted. "Wound Additional Orders-Caregiver staff to provide frequent turning and repositioning to offload wounds."</p> <p>11/12/24-Coccyx stage 3 pressure-1.4 x 1.7 x 0.2 cm</p> <p>-Left rear thigh stage 2 pressure-RESOLVED.</p> <p>11/26/24-Coccyx stage 3 pressure-0.6 x 0.4 x 0 cm</p> <p>12/3/24-Coccyx stage 3 pressure-1.11 x 0.94 cm</p> <p>Review of Provider Note, dated 12/10/24, reflected, "This is an acute new problem Condition is guarded 47yo[year old] female with respiratory failure, anoxic brain damage, HTN [hypertension] who has a BP[blood pressure] of 87/53 with a HR[heart rate] of 118 and now desaturating down to 88% on 2L[liters]. She is grey appearing, tachypneic. Orders : Transfer to Emergency Department ..."</p>			

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	<p>Review of R105 Hospital Discharge documentation, dated 12/24/24, reflected R105 had discharge diagnosis that included, severe sepsis, pyelonephritis, pneumonitis, and decubitus ulcers.</p> <p>Review of R105 Provider Progress Note, dated 12/30/24, reflected, "patient with new pressure ulcers on R[right] & L[left] buttocks. L buttocks has areas of blistering, no drainage, R buttocks is an area of redness, no open wound ...Physical Exam - Notes : SKIN stage 1 pressure ulcer R buttocks, stage 2 pressure ulcer L buttocks ...Pressure ulcer of left buttock, stage 1 This is an acute new problem Condition is stable cover with xeroform, change daily wound care consultL89312 - Pressure ulcer of right buttock, stage 2 (Primary) This is an acute new problem Condition is stable cover with xeroform, change daily wound care consult ..."</p> <p>Review of R105 Wound Notes, dated 12/24/24 through 1/28/25, reflected the following:</p> <p>12/24/24-Coccyx stage 3 pressure-6.57 x 7.92 cm (no mention of other wounds)</p> <p>12/30/24-Coccyx stage 3 pressure-9.07 x 5.58 cm (worsened)</p> <p>12/31/24-Coccyx stage 3 pressure-7.9 x 8 x 0.2 cm</p> <p>-Right gluteus blister-4 x 5.9 x 0.1 cm, non-viable dark epithelial (New Facility acquired)</p> <p>1/7/25-Coccyx stage 3 pressure-9.1 x 5.7 x 0.3 cm(Worsened)</p> <p>-Right gluteus blister -4.8 x 3.6 x 0.2 cm (Facility acquired)</p>			

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	<p>1/14/25-Coccyx stage 3 pressure-8.6 x 4.5 x 0.3 cm</p> <p>-Right gluteus blister-3.2 x 1.8 x 0.2 cm (Facility acquired)</p> <p>1/21/25-Coccyx stage 3 pressure-7.9 x 4.6 cm, overall wound condition deterioration.</p> <p>-Right gluteus blister-2.7 x 1.2 cm (Facility acquired)</p> <p>1/28/25-Coccyx stage 3 pressure-7.4 x 4.1 cm</p> <p>-Right gluteus blister-3.1 x 1.8 cm (Facility acquired)</p> <p>Review of R105 provider note, dated 1/28/25, reflected, " ...Called husband to request consent for conservative sharps debridement of wounds. Husband requested pt be sent to [named] ER [emergency room] for further evaluation of wounds and debridement in hospital as he is currently unwilling to allow debridement within facility. Facility leadership and nurse notified and pt[patient] transferred to [named] ER ..."</p> <p>Review of R105 Hospital Discharge Summary, dated 2/20/25, reflected, "Patient is a 47-year-old female who presented to [named hospital] with worsening sacral ulcer ...admitted to medicine for sacral ulceration, abdominal abscess ...SURGERY Consulted, S/p Bedside Debridement Sacral ulceration 1/30/2025- RECOMMEND Continue DAILY wound care at Discharge. RECOMMEND Continue frequent repositioning. RECOMMEND CLOSE Follow up SURGERY/Wound Clinic at discharge if Able ..."</p> <p>Review of R105 Nurse Progress Note, dated 2/23/25, reflected, "Resident returned from</p>			

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	<p>Hospital with left upper arm midline /IV ATB therapy(meropenem) for bacterial infection to be continued until 2/28/25."</p> <p>Review of R105 History and Physical, dated 3/1/25, reflected, "She is being seen for readmission to facility after hospitalization at [named]. She presented to the ED with worsening sacral ulcer and fever ...Surgery was performed on bedside debridement of the sacral ulcer on 1/30/25. She will need ongoing daily wound care and follow up with the [named] wound clinic ...Abscess of abdominal cavity ..."</p> <p>Review of R105 Wound Notes, dated 3/4/25 through---, reflected the following:</p> <p>3/4/25-Sacrum pressure-7.1 x 6.4 x unable to determine true depth.</p> <p>-Right gluteus blister-2 x 1 x unable to determine true depth. (Facility acquired)</p> <p>3/11/25-Sacrum pressure-6.7 x 3.8 x unable to determine true depth, Tissue type slough</p> <p>-Right gluteus blister-3 x 1.7, Tissue type slough/crusting (Facility acquired)</p> <p>3/18/25-Sacrum pressure-7.7 x 3.8 x unable to determine true depth, Tissue type: slough.</p> <p>-Right gluteus unstageable pressure-2.8 x 1.2 x unable to determine true depth, slough. (Worsening and Facility acquired)</p> <p>3/25/25-Sacram pressure-6.4 x 5.8 x unable to determine true depth, slough</p> <p>-Right gluteus unstageable pressure-0.6 x 0.5, unable to determine true depth, slough. (Worsening and Facility acquired)</p>			

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	<p>Review of R105 Skin Care Plan, dated 10/30/24, reflected, "Resident has impaired skin integrity as evidenced by:</p> <p>Unstageable pressure wound to sacrum, Unstageable pressure injury to rear right thigh related to immobility, anoxic brain damage, respiratory failure, tube feed status...Revision on: 03/20/2025." Continued review reflected interventions that included, "Administer treatment (s) per orders...Assist resident with turning and repositioning as needed..."</p> <p>Review of R105 Nurse Progress Note, dated 3/26/25, reflected, "Res[resident] was having appt with wound clinic. Doctor sent her to [named] ER d/t[related to] worse than anticipated infection to the wounds ..."</p> <p>Review of R105 Treatment Administration Record, dated 12/1/24 through 3/26/25, reflected R105 had 21 missed wound treatments, as evidenced by no documentation as completed, for coccyx wound and facility acquired right gluteus pressure wound. Continued review of the TAR reflected documentation indicating to see Progress Notes with no evidence of Progress Notes completed on correlating dates.</p> <p>Review of R105 facility, "Documentation Survey Report v2(Task Report), dated 1/1/25 through 3/26/25, reflected R105 had task, "Assist/Remind to Turn and Reposition per Care Plan and PRN." The Report reflected R105 had 37 eight-hour shifts that was not turned and repositioned, as evidenced by no documentation as completed.</p> <p>During an interview on 4/10/25 at 2:15 p.m., Unit Manager (UM) "G" reported wounds were assessed every seven days wound team that included wound nurse and wound provider. UM</p>			

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	<p>"G" reported would expect floor nurses to follow Physician treatment orders and document on Treatment Administration Record (TAR) as completed. UM "G" reported would expect Certified Nurse Aids (CNA) staff to turn and reposition residents every two hours if indicated on the Care Plans and document in the Task documentation (CNA Point of Care Electronic Medical Record). UM "G" reported the TAR and the Task documentation should not have wholes (no documentation as completed). UM "G" reported would follow up. Requested UM "G" for evidence that R106 facility acquired pressure wound was unavoidable.</p> <p>During a telephone interview on 4/10/25 at 4:20 p.m., Wound Nurse (WN) "J" reported R105 had small coccyx wound on admission that worsened and was later documented as Sacrum wound. WN "G" reported R105 developed facility acquired pressure ulcer to right gluteus that started blister and was later reclassified to unstageable because of slough in base of wound. WN "G" reported R105 Coccyx wound was documented as stage 3 pressure wound on admission related to hospital documentation with prior history and verified was small on admission with 0.2 cm depth.</p> <p>During a second interview on 4/10/25 at 4:40 p.m., UM "J" reported it was discovered recently Wound Nurse (WN) "G" was not documenting wound treatments as completed on TAR on Tuesdays. UM "J" verified R105, R106 and R111 had holes on TAR and reported some were documented in progress notes as treatments in place and not on TAR and was unsure why and verified should be documented on TAR as completed with no holes, which reflect missed treatments. UM "G" reported facility has had issue with staffing for past few months and recent improvements in past two weeks. UM "G" reported had worked the floor several times in past 2 months to fill in for call-ins with long</p>			

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F0689 SS= D	<p>shifts. UM "G" reported had also worked as CNA staff to make sure facility has at least three CNA staff in facility.</p> <p>During a second telephone interview on 4/10/25 at 4:58 p.m., WN "G" reported R105 was unable to locate evidence R105, R106 or R111 worsening pressure ulcers and facility acquired pressure ulcers were unavoidable and reported appropriate interventions were on the Care Plans and staff were expected to follow Care Plans and physician orders. WN "G" verified R105, R106 and R111 were all at high risk for skin breakdown. WN "G" reported last week had noticed that wound rounds were not documented as completed on TAR and verified if nurses complete treatment orders should document on TAR as completed. WN "G" reported facility had staffing issues past couple months with recent improvements. WN "G" reported facility had several residents that required every two hour turn and repositioning assistance with times with only three CNA staff in entire facility and reported was not possible turn residents every 2 hours.</p> <p>Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:</p> <p>This citation refers to intake MI00151694 and MI00150699.</p>	F0689	<p>Element 1</p> <p>Resident 102 no longer resides in the facility. Resident was discharged to the hospital on 12/15/25.</p> <p>Element 2</p> <p>A one-time audit of current residents fall interventions to ensure fall interventions are in place and reflect residents current needs. This was completed by the Director of Nursing / Designee by 4/25/25.</p> <p>Element 3</p>	4/25/2025

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	<p>Based on interview and record review, the facility failed to provide adequate supervision for resident with known high risk for falls and implement care planned interventions to prevent fall injuries for 1 residents (R102) out of 3 residents reviewed for falls, resulting in R102 fall with injury requiring emergency room treatment and hospital admission.</p> <p>Findings included:</p> <p>Resident #102(R102)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated 12/15/24, reflected R102 was a 82 year old male admitted to the facility on 12/11/24, with diagnoses that included left hip fracture post fall at home, current post care for left hip surgical revision post fall with fracture and infection requiring intravenous antibiotics via central line catheter, peripheral vascular disease, hypertension (high blood pressure), diabetes mellitus, and anemia. The MDS reflected R102 had a BIM (assessment tool) score of 12 which indicated his ability to make daily decisions was moderately impaired, and he required substantial to maximum assist with transfers.</p> <p>Review of the complaint received by the State Agency alleged the facility failed to prevent an avoidable fall for R102, who was known high risk for fall, that resulted in rib fractures on 12/14/24.</p> <p>Review of R102 Progress Notes dated 12/11/24, reflected, "...Fall precautions per facility policy.</p> <p>Condition is guarded ...History of Present Illness...Patient was admitted to the facility today and is awaiting full H&P[historical and physical] and review by the primary team. The nurse consulted (name of) Health to assess the patient, to review discharge medications and orders and to</p>		<p>The QAPI Committee has reviewed the Falls Clinical Protocol policy and has deemed it to be appropriate by 4/25/25.</p> <p>The Director of Nursing and/or designee educated the Nurses and C.N.As on Falls Clinical Protocol policy with emphasis on ensuring interventions are in place and that the interventions that are in place are noted on the incident reports. This education will be completed by 4/25/25.</p> <p>Element 4</p> <p>The Director of Nursing/designee will audit 10 residents to ensure fall interventions are in place and audit residents with falls to ensure that fall intervention that were in place at the time of the fall were documented on the incident report and care plan is updated with new interventions. These will be done weekly x4 weeks then monthly thereafter.</p> <p>Results will be reviewed monthly by the QAPI Committee until substantial compliance is achieved.</p> <p>The Administrator is responsible to maintain compliance.</p>	

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	<p>ensure safe transition of care. Review of available paperwork and consultation with patient/nurse was completed to identify and manage high risk conditions and medications while awaiting evaluation by primary team. Per discharge docs: discharge dx L [diagnosis left] hip fracture. Patient is an 82-year-old male who presents as a level 3 trauma after a unwitnessed fall. Patient had just got out of [named] when he fell. During his last hospital admission he was found to have bacteremia and he was started on IV [intravenous] ampicillin. He was discharged was given oral antibiotics and then presented to our emergency department. Patient was found to have postoperative changes the left total hip arthroplasty with commuted displaced periprosthetic fracture of the proximal femur with suspicion for infected periprosthetic joint in the left hip, he was also found to have L5[lumbar5] vertebral body stature loss and on initial evaluation was retaining urine. Orthopedics was consulted for the left hip periprosthetic fracture. They repaired the fracture and replaced with a new periprosthetic. Infectious disease was consulted due to bacteremia on last hospital visit and concern for infected periprosthetic they recommended IV ampicillin and was found to actually have positive cultures from the OR that were positive for MRSA [Methicillin-resistant Staphylococcus aureus]. He was then placed on daptomycin IV while in the hospital. Infectious disease recommends oral antibiotic...</p> <p>Neurosurgery was consulted for L 5 vertebral body stature loss/fracture they recommended LSO when out of bed and activity. If able to tolerate PT/OT [physical therapy/occupational therapy] with brace will follow-up outpatient with neurosurgery. Urology was consulted due to concern for possible bladder outlet obstruction. They recommended maintaining Foley for 5 to 7 days after ambulatory and continuing Flomax. and to follow-up outpatient. Patient was taken to the operating room for irrigation and excisional</p>			

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	<p>debridement of left anterior hip wound with revision of left hip hemiarthroplasty prosthesis to a new prosthesis and ORIF [open reduction and internal fixation] of left periprosthetic proximal femur fracture. Patient required preoperative blood transfusions due to low hemoglobin. Patient tolerated the procedure well and was tolerating diet, was urinating and adequately with Foley, and worked with physical therapy. Physical therapy recommended PA CR [medical professionals]..."</p> <p>Review of R102 Progress Note, dated 12/14/24 at 7:31 a.m., reflected,</p> <p>"Date of Service: 12/14/2024 6:08 AM CT</p> <p>Details: Nurse Name: [named Registered Nurse (RN) "C"]</p> <p>Patient Name: [named R102]</p> <p>Primary Chief Complaint: Fall With Injury</p> <p>History Present Illness: patient has a recent left hip surgery. He had unwitnessed fall. Currently complains of left hip pain and his leg is externally rotated. On prophylactic heparin ...Diagnosis, Assessment/Plan: M25552 - Pain in left hip (Primary) rule out fracture Condition is stable</p> <p>Orders: obtain x-ray left hip</p> <p>Assess pain per protocol</p> <p>Fall precautions per facility protocol</p> <p>Monitor with neurochecks per facility protocol</p> <p>Notify a clinician of any change in condition</p>			

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	<p>Disposition: Stay at Facility ... Signed Date: 12/14/2024 6:15 AM"</p> <p>Review of R102 Nurse Progress Note, dated 12/14/25 at 7:38 a.m., reflected, "Found on the floor sitting, surgical incision bleeding but incision intact, left leg shorter then right and slightly inward, Dr on call [named provider] notified and stat x-ray 4 views ordered, ordered via [named mobile Xray company]"</p> <p>Review of R102 Physician Communication Progress note, dated 12/14/24 11:07 a.m., reflected RN "C" reported R102 had pulled out PICC line in place for antibiotics for osteomyelitis (infection of the bone).</p> <p>Review of R102 Nurse Progress Note, dated 12/14/24 at 3:35 p.m., reflected, "CNA [certified nurse aid] reported that res[resident] is sitting on the floor. He was having his both legs underneath him, arms next to him facing door. Per CNA night CNA was telling her how he was restless and not slept last night, he was sitting on the edge of the bed and she placed him to lay in bed shortly before 6am. Res stated he was trying to get to his phone (he doesn't have one). No increased pain to left hip, neuro's WNL [within normal limits]. While laying in bed left leg was looking shorter and slightly inward, not able to move to the side, incision to surgical side intact but bleeding observed to abd pads in place. Stat x-ray 2 views ordered, labs from yesterday evaluated by on call and no n.o[new orders] at this time, our provider to eval on Monday. Later res pull his PICC line and order received to reinsert it to cont IV ABX [antibiotics]. On call, DON [director of nursing] and family notified. New intervention with perimeter matrasse in place"</p> <p>Review of R102 Progress Note, dated 12/15/24 at</p>			

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	<p>2:01 a.m., reflected, "Primary Chief Complaint: Radiology review: abnormal results and/or requiring provider assessment ... Summary: Nurse reports pt fell yesterday at 0600 c/o pain xray completed, she is reporting results. Xray revealed-intact left hip arthroplasty with ORIF transfixing proximal femur new since 12/3/2024, w/ periprosthetic fracture at base of greater trochanter with modest displacement new since 12/3/24. Please correlate clinically, and f/u is recommended. Nurse states she gave acetaminophen 650mg about 30 minutes ago. Will review imaging further, in the mean time nurse to give acetaminophen and apply ice to the affected area, can call radiology for clarification, pcp f/u on Monday if decide to keep in place Orders : Give an additional acetaminophen 325mg po once now Can apply ice pack to the affected area x15minutes prn as tolerated Contact radiology in the morning for clarification of results Monitor and call for change in condition Add to PCP list for review of imaging on Monday Disposition : Stay at Facility ...Signed Date: 12/15/2024 7:23 AM. Addendum Details: *of note regarding initial consult- other than increased restlessness pt was reportedly otherwise stable per nurse assessment. After further review of results recommend transfer to hospital to assess stability of recent left hip arthroplasty. Audio call at 0818, spoke w/ [named nurse], states she is day nurse for pt, gave order regarding ED transfer, she verbalized understanding Orders: Transfer to ED for further evaluation and treatment ...Addendum Created Date:2024-12-15 08:32:50"</p> <p>Review of R102 Nurse Progress Notes, dated 12/15/24 at 3:40 a.m., reflected, "notified on call [named provider] at 3:06am of x-ray results. Placed information in physician communication book for follow-up."</p> <p>Review of R102 Interdisciplinary Team (IDT)- Interdisciplinary Progress Note, dated 12/17/24,</p>			

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	<p>reflected, "Late Entry: Note Text: IDT reviewed. Resident admitted to our facility after a fx [fracture] of the hip x2[two times]. His second fx requiring surgical intervention was while hospitalized. Prior to the fall, we initiated wedges and updated the CP in an attempt to prevent a fall. We had also posted signage in the room encouraging the resident to utilize his call light with the permission of his wife. He was on frequent turning per facility protocol. We reached out to our admissions team who obtained an XR [Xray] report from 12/15. This report impression showed no signs of a fracture. The CNA caring for this resident received education on the importance of following the care plan in place. We will continue to educate all staff and residents."</p> <p>Review of R102 Care Plan, dated 12/12/24, reflected R102 was at risk for fall/injury and had interventions that included, "low bed...Mat to floor next to bed...Non-skid footwear to reduce the risk of slipping as the resident allows. Date Initiated: 12/13/2024...Ensure placement of wedges (2) at the R shoulder and R knee when resting in bed. Date Initiated: 12/13/2024...Non-skid footwear to reduce the risk of slipping as the resident allows.</p> <p>Date Initiated: 12/13/2024..."</p> <p>Review of R102 Fall Incident Report, dated 12/14/24 at 6:25 a.m., reflected R102 had an unwitnessed fall and was found on floor next to bed confused with injury to top of scalp. The report reflected notes that included, "wedges ordered to be in place to right site of hip and shoulder were sitting on the night stand of res discovered sitting on the floor." The Report reflected no mention of care planned fall prevention intervention in place at the time of the fall including level of bed, footwear, or floor mat.</p>			

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	<p>During an interview on 4/9/25 at 10:29 a.m., RN "C" reported had just arrived for day shift on 12/14/24 around 6:00 a.m. when R102 fell out of bed and was unable to recall if R102 floor mat was in place or where bed was position at time of the fall. RN "C" reported the positioning wedges were NOT in place and should have been. RN "C" reported R102 did not complain of pain initially and Hoyer was used to place R102 back in bed and then complained of left hip pain. RN "C" reported notified required staff and family and reported R102 wife remained at the bedside through day and night related to R102 confusion and concerns for safety. RN "C" reported was not able to provide R102 one on one care as needed related to increased confusion. RN "C" reported spend additional time with family and R102 for safety concerns and still have other residents needs that needed to be met on highly skilled ventilator unit.</p> <p>During a telephone interview on 4/10/25 at 12:26 p.m., Certified Nurse Aid (CNA) "D" reported worked 12/14/24 day shift when R102 had fall out of bed. CNA "D" reported was rounding at start of shift and saw R102 on the floor next to bed and called, "code purple." CNA "D" reported R102 laying directly on the floor with no mat in place with pool of blood on floor located by R102 left hip. CNA "D" reported R102 was very confused and stated was attempting to reach phone because he was in the barn, but did not have a phone. CNA "D" reported bed was at knee level but not at lowest position and positioning wedges were sitting in chair, not in use at time of fall. CNA "D" reported was upset because wedges should have been in place in bed to help prevent R102 fall out of bed per the Kardex and were not. CNA "C" wanted to send R102 to the hospital, but provider ordered Xray.</p> <p>During an interview on 4/9/25 at 3:00 p.m.,</p>				

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	<p>Assistant Director of Nursing (ADON) "E" reported would expect staff to follow Care Plans and Kardex including interventions to prevent falls.</p> <p>During an interview on 4/10/25 at 12:18 p.m., Nurse Manager Infection Control (NM) "F" reported would expect staff to follow Care Plans and have interventions in place including prior to R102 that had high risk for falls. NM "F" verified R102 Xray completed on 12/14/24 changes since 12/3/24.</p> <p>During an interview on 4/10/25 at 3:06 p.m. R102 family "H" reported R102 originally fell at home and fractured left hip that required surgical repair 11/17/24, then had an unwitnessed fall with re-fracture of left hip at another facility on 12/3/24 that required surgical repair on 12/6/24. R102 family "H" reported discussed at length with facility R102 concern about safety and high risk for falls on admission and care meetings prior to R102 fall with rib fractures on 12/14/24 and hospital admission on 12/15/24. R102 family "H" reported R102 was determined to have new rib fractures and pelvic fractures after additional radiology studies completed at the hospital and additional surgery related to left hip hematoma. R102 family "H" reported R102 was currently on hospice services and reported was upset and stated, "this should not have happened." R102 family "H" reported after facility notified her that R102 had fallen on 12/14/24 went to facility and remained at bedside because was told staff could not be with R102 all the time and was worried about his safety because of increased confusion and repeat attempts to get up.</p> <p>Review of R102 Hospital CT(computed tomography) of the chest/abdomen/pelvic, dated 12/15/24, reflected, "...FINDINGS...Nondisplaced fracture of the right</p>			

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F0725 SS= E	<p>third anterior rib, and possibly fourth rib especially identified..."</p> <p>Review of R102 prior Hospital Records, dated 12/4/24 through 12/11/24, revealed no mention of rib fractures including CT of chest/abdomen/pelvis performed.</p> <p>Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to intakes: MI00151418, MI00151694, MI00151358, MI00150699, MI00150638, MI00151442, and MI00151852.</p>	F0725	<p>Element 1</p> <p>The facility Assessment has been updated by 4/25/25 and reviewed by the QAPI Committee to ensure staffing levels are appropriate to meet the current resident population needs.</p> <p>Current Residents with a BIMS of 9 or above and responsible parties for residents with a BIMS of 8 or below were interviewed for any negative outcomes related to delay in call light response time by the Director of Nursing/Designee by 4/25/25 and did not have any negative outcomes. Residents' concerns were placed on a Quality Assurance form and ran through the Quality Assurance process by 4/25/25.</p> <p>Element 2</p> <p>Current Residents and/or responsible parties have been interviewed to ensure that their needs are being met by the Director of Nursing and/or designee by 4/25/25. Any concerns identified have been addressed immediately.</p> <p>Element 3</p> <p>The QAPI Committee reviewed the policy, Nursing Services and Sufficient Staff and deemed it appropriate by 4/25/25.</p>	4/25/2025

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	<p>Based on observation, interview and record review, the facility failed to ensure sufficient levels of nursing staff to meet resident needs and supervision for seven residents (Resident R102, R103, R104, R105, R106, R110 and R111) and per resident council with the potential for unmet care needs and facility residents to not attain or maintain the highest practicable physical, mental, and psychosocial well-being.</p> <p>Finding include:</p> <p>During an interview on 4/8/25 at 10:55 a.m., Admission Staff "N" reported facility census was 69 and Director of Nursing "B" and Nursing Home Administrator "A" were not currently in the facility.</p> <p>Review of seven complaints received by the State Agency alleged the facility failed to maintain sufficient staff levels to meet resident needs including prevent worsening of pressure ulcers and prevent avoidable fall with injury.</p> <p>Review of the Centers for Medicare and Medicaid Services PBJ Staffing Report for first quarter reflected the facility triggered for excessively low weekend staffing.</p> <p>Resident #102(R102)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated 12/15/24, reflected R102 was a 82 year old male admitted to the facility on 12/11/24, with diagnoses that included left hip fracture post fall at home, current post care for left hip surgical revision post fall with fracture and infection requiring intravenous antibiotics via central line catheter, peripheral vascular disease, hypertension (high blood pressure), diabetes mellitus, and anemia. The MDS reflected R102 had a BIM (assessment tool) score of 12 which indicated his</p>		<p>The Regional Director of Operations has re-educated the Administrator, Director of Nursing and the Scheduler on the Nursing Services and Sufficient Staff Policy, including staffing to meet resident needs. This education will be completed by 4/25/25.</p> <p>During the morning stand up meeting and as needed, staffing will be reviewed to ensure supervision Adjustments will be made as needed.</p> <p>Element 4</p> <p>A weekly audit of 10 of residents will be conducted by the Administrator and/or designee to ensure needs are being met timely for 4 weeks and then monthly thereafter until substantial compliance is sustained.</p> <p>Audits will be reviewed by the QAPI committee monthly for 3 months until substantial compliance is met.</p> <p>The Administrator is responsible to maintain compliance.</p>	

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	<p>ability to make daily decisions was moderately impaired, and he required substantial to maximum assist with transfers.</p> <p>Review of the complaint received by the State Agency alleged the facility failed to prevent an avoidable fall for R102, who was known high risk for fall, that resulted in rib fractures on 12/14/24.</p> <p>During an interview on 4/9/25 at 10:29 a.m., RN "C" reported had just arrived for day shift on 12/14/24 around 6:00 a.m. when R102 fell out of bed and was unable to recall if R102 floor mat was in place or where bed was position at time of the fall. RN "C" reported the positioning wedges were NOT in place and should have been. RN "C" reported R102 did not complain of pain initially and Hoyer was used to place R102 back in bed and then complained of left hip pain. RN "C" reported notified required staff and family and reported R102 wife remained at the bedside through day and night related to R102 confusion and concerns for safety. RN "C" reported was not able to provide R102 one on one care as needed related to increased confusion. RN "C" reported spend additional time with family and R102 for safety concerns and still have other residents needs that needed to be met on highly skilled ventilator unit.</p> <p>Review of R102 Hospital CT(computed tomography) of the chest/abdomen/pelvic, dated 12/15/24, reflected, "...FINDINGS...Nondisplaced fracture of the right third anterior rib, and possibly fourth rib especially identified..."</p> <p>Resident #105(R105)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated 2/27/25, reflected R105 was a 47-year-old female admitted to the facility on</p>			

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	<p>10/30/24, with diagnoses that included cerebral vascular accident with current comatose state, acute respiratory failure with anoxic brain damage with tracheostomy, Pulmonary embolism, diabetes mellitus, hypertension, and one stage 2 pressure ulcers present on admission and one unstageable pressure ulcer not present on admission. The MDS reflected R105 was dependent on staff for all care. Continued review of the MDS, dated 1/28/25, reflected R105 had one new unstageable pressure wound not present on admission (12/24/24).</p> <p>During a telephone interview on 4/9/25 at 9:32 a.m., R105 family "I" reported R105 admitted to facility 10/30/24 with an open area on coccyx area and on left side. R105 family "I" reported R105 coccyx area was almost healed, and staff stopped repositioning R105 and wound gradually worsened and R105 developed new skin breakdown on right side at the facility. R105 family "I" reported R105 was re-admitted several times to the hospital for repeat wound infections, last time on 3/26/25 and stated, "tired of it, she had been through enough." R105 family reported spoke with management several times with concerns that R105 was not being turned and repositioned every two hours and they hung a turning log on wall over R105 bed that staff were instructed to document every time R105 was turned. R105 family member reported log was incomplete and still in R105 room.</p> <p>Review of R105 Treatment Administration Record, dated 12/1/24 through 3/26/25, reflected R105 had 21 missed wound treatments, as evidenced by no documentation as completed, for coccyx wound and facility acquired right gluteus pressure wound. Continued review of the TAR reflected documentation indicating to see Progress Notes with no evidence of Progress Notes completed on correlating dates.</p>				

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	<p>Review of R105 facility, "Documentation Survey Report v2(Task Report), dated 1/1/25 through 3/26/25, reflected R105 had task, "Assist/Remind to Turn and Reposition per Care Plan and PRN." The Report reflected R105 had 37 eight-hour shifts that was not turned and repositioned, as evidenced by no documentation as completed.</p> <p>Resident #106(R106)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated 2/7/25, reflected R106 was a 39-year-old male admitted to the facility on 8/1/24, with re-admission 3/13/25 related to wound infection with other diagnoses that included traumatic brain dysfunction, cerebral vascular accident, acute respiratory failure with anoxic brain damage with tracheostomy, contracture of left knee and right knee. The MDS reflected R106 was dependent on staff for all care. Continued review reflected R106 had been discharged to hospital 4/1/25.</p> <p>Review of R106 Electronic Medical Record, dated 10/1/24 through 4/1/25, reflected R106 had three facility acquired pressure wounds that worsened including stage 4 pressure ulcer(full thickness tissue loss with exposed bone and/or tendon).</p> <p>Review of R106 Documentation Survey Report (Task Report), dated 2/1/25 through 3/31/25, reflected R106 had</p> <p>five missed showers, evidenced by no documentation as completed. Continued review reflected 51 shifts with no oral care provided as evidenced by no documentation or documentation that oral care was not provided. Continued review reflected R106 had task, "Assist/Remind to Turn and Reposition per Care Plan and PRN." The Report reflected R106 had 42 eight-hour shifts</p>			

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	<p>that R106 was not turned and repositioned, as evidenced by no documentation as completed.</p> <p>Resident #111(R111)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated 3/25/25, reflected R111 was a 79-year-old female admitted to the facility on 2/26/25, with re-admission 4/5/25 related to wound infection with other diagnoses that included non-traumatic brain dysfunction, heart failure, and seizure disorder. The MDS reflected R111 was dependent on staff for all care. Continued review of the MDS reflected R111 had one unstageable pressure wound related to slough in wound bed and one unstageable pressure wound related to suspected deep tissue injury both on admission.</p> <p>Review of R111 EMR, dated 2/26/25 through 4/10/25, reflected R111 was admitted with unstageable pressure ulcer that worsened to stage 4 pressure wound that required hospitalization and surgical intervention for osteomyelitis.</p> <p>Review of R111 Hospital Infectious Disease Consult, dated 4/2/25, revealed diagnosis that included osteomyelitis of scrum and coccyx, stage 4 pressure ulcer and sepsis.</p> <p>Review of R111 Treatment Administration Record, dated 3/1/25 through 3/25/25, reflected R111 had 4 missed wound treatments, as evidenced by no documentation as completed, for worsening coccyx pressure wound.</p> <p>Review of R111 facility, "Documentation Survey Report v2(Task Report), dated 3/1/25 through 3/25/25, reflected R111 had task, "Assist/Remind to Turn and Reposition per Care Plan and PRN." The Report reflected R111 had 23 eight-hour shifts that R111 was not turned and repositioned,</p>			

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	<p>as evidenced by no documentation as completed.</p> <p>Resident #103(R103)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated 3/24/25, reflected R103 was a 86-year-old male admitted to the facility on 3/17/25, with diagnoses that included cerebral vascular infarction, vascular dementia, mild neurocognitive disorder, and depression. The MDS reflected R103 required partial to moderate assist with showering and dressing. Continued review of R103 MDS reflected resident had dentures and had been discharge from facility 3/24/25.</p> <p>Review of R103 Documentation Survey Report (Task Report), dated 3/17/25 through 3/24/25, reflected R103 had one missed showers, as evidenced by no documentation as completed, with no shower for five days and was present at facility for a total of seven days. Continued review reflected five shifts with no oral care provided as evidenced by no documentation or documentation that oral care was not provided.</p> <p>Review of R103 Care Plan, dated 3/17/25, reflected no mention of R103's dentures including ADL assist for oral care.</p> <p>Resident #104(R104)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated 3/1/25, reflected R104 was a 58-year-old male admitted to the facility on 2/24/25, with diagnoses that included cerebral vascular infarction with partial paralysis. The MDS reflected R104 required partial to moderate assist with showering and had been discharged from the facility 3/27/25.</p> <p>Review of R104 Documentation Survey Report</p>			

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	<p>(Task Report), dated 2/24/25 through 3/27/25, reflected R104 had five missed showers, as evidenced by no documentation as completed.</p> <p>Resident #110(R110)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated 1/7/25, reflected R110 was a 45-year-old male admitted to the facility on 2/8/22, with diagnoses that included traumatic spinal cord injury with partial paralysis, anxiety and depression. The MDS reflected R110 was dependent on staff for care including with showering.</p> <p>During an interview on 4/8/25 at 4:19 p.m., R110 was laying in bed and appeared calm and pleasant and able to answer questions without difficulty. R110 reported had missed several showers in past three months and believed it was related to not enough staff to meet residents needs. R110 reported on several evening shifts over past three months there was only three to four Certified Nurse Aid in the entire facility that included ventilator unit. R110 reported had completed several facility grievances related to staffing concerns and missed showers and reported past two weeks have seen slight improvement.</p> <p>Review of R110 Documentation Survey Report (Task Report), dated 1/1/25 through 3/31/25, reflected R110 had nine missed showers, as evidenced by no documentation as completed, including time frame of 20 days without showering or bathing care.</p> <p>Review of facility Grievance Forms and Resident Council, dated 1/1/25 through 4/8/25, reflected several reported concerns with missed showers and staffing concerns.</p> <p>Review of the facility staffing working schedules</p>			

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	<p>for past three months reflected several with three to four CNA staff on second and third shift. According to facility assessment the average facility census was 64 with ventilator unit. The facility assessment reflected 41% of residents were dependant on staff for care.</p> <p>During a telephone interview on 4/9/25 at 8:26 a.m., Ombudsman "L" reported had received several complaints from residents and families related to staffing concerns because care needs were not being met.</p> <p>During an interview on 4/9/25 at 11:15 a.m., Registered Nurse Manager (RN) "L" reported had taken over staff scheduling in past two weeks after prior facility scheduler left. RN "L" reported staffing had been difficult for past two months with prior scheduler issues, frequent call in's, terminations, and open shifts. RN "L" reported managers had been picking up shifts to meet minimum staffing requirements.</p> <p>During a telephone interview on 4/9/25 at 12:26 p.m., Certified Nurse Aid (CNA) "D" reported staffing had been an issue at facility for past two to three months with recent improvements over past two weeks since new scheduler. CNA "D" reported several complaints form residents about missed showers. CNA "D" reported often worked day shift and reported often arrived to shift with at least three residents who required full bed changes related to being saturated in urine at least five days per week for last month. CNA "D" reported often only three CNA staff scheduled on night shift and did not feel resident needs were being met related to not enough staff and reported had reported to management and completed concern form with no changes until last two weeks.</p> <p>During a telephone interview on 4/9/25 at 4:05</p>			

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	<p>p.m., Confidential Staff (CS) "M" reported facility has had staffing issue for past three months. CS "M" reported resident basic needs were not being met including incontinence care, turn/reposition, showers, oral care and range of motion. CS "M" reported over past three months second and third shift had been the worse with only enough time to complete incontinence care and repositioning for dependant residents two times per shift and should be every two hour with minimal assist from nurse staff. CS "M" reported restorative staff pulled to floor for resident care five of five days per week for past couple months.</p> <p>During an interview on 4/10/25 at 2:15 p.m., Unit Manager "G" reported would expect CNA staff follow Kardex including every two hour incontinence care, repositioning and showers as scheduled and document in Tasks and verified should not be holes on Tasks with no documentation.</p> <p>During an interview on 4/10/25 at 5:50 p.m., Unit Manager "G" reported there was 32 of 69 residents in facility that required two person assist with care.</p>			