STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634570	A. BUILDING _____ B. WING _____	6/5/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAHSER HILLS CARE CENTRE	25300 LAHSER RD SOUTHFIELD, MI 48034

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F0000 SS=	INITIAL COMMENTS Lahser Hills Care Centre was surveyed for a Recertification survey on 6/5/25. Intakes: MI00153251 Census: 106	F0000		
F0561 SS= D	Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a working	F0561	F 561 1.) Resident #67 clock was immediately replaced. All residents have the potential to be affected. 2.) A one-time audit was completed to ensure that all clocks were in working order. Nursing and Maintenance department were re-educated to ensure that clocks were working in their rooms when completing any tasks. 3.) System change: maintenance will complete weekly rounds to ensure clocks are within working order. 4.) Administrator/Designee will review 5 rooms weekly x 12 weeks them monthly x 3 months to ensure that clocks are within working order. Any non-adherence will result in 1:1 education. All audits will be submitted to the QA committee for review and further recomendations The administrator will be responsible for ongoing sustained compliance.	6/30/2025

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

Electronically Signed | 06/23/2025

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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	clock for one (R67) of one resident reviewed for choices. Findings include: On 6/3/25 at 9:42 AM, R67 was observed lying in their bed. R67's bed was positioned so that R67 had a clear, direct view of the door. A clock was observed directly above the door. The time on the clock was 1:05, and the second hand was not moving. R67 was asked how long the clock had been broken. R67 explained it had never worked since they had been in that room, someone would put a new battery in the clock and it would work for 45 minutes then stop again. R67 was asked how they knew what time it was. R67 explained they had a cellular phone they could use for the time, but since the clock was above the door, every time they looked at the door they saw the broken clock and it was an annoyance. Review of the clinical record revealed R67 was admitted into the facility on 12/17/22 and readmitted 5/15/23 with diagnoses that included: Parkinson's disease, kidney disease and diabetes. According to the Minimum Data Set (MDS) assessment dated 4/15/25, R67 was cognitively intact. Review of R67's census documentation, R67 had been in their room since 1/1/24. On 6/4/25 at 8:49 AM and on 6/5/25 at 8:40 AM, the clock in R67's room was at the same time of 1:05.			

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	On 5/5/25 at 10:10 AM, the Maintenance Supervisor was interviewed and asked about the clock in R67's room. The Maintenance Supervisor explained he was unaware of any issue with the clock in R67's room, and would check to see if it had been entered into their maintenance system (TELS). On 6/5/25 at 10:15 AM, Licensed Practical Nurse (LPN) "E" was interviewed and asked about the clock in R67's room. LPN "E" explained she remembered putting it into TELS a month or so ago that it needed a battery. LPN "E" was informed R67 had said it only worked for 45 minutes after a new battery was put in. LPN "E" explained it was probably more then 45 minutes, but she would put it into TELS to get R67 a new clock. On 6/5/25 at 11:35 AM, Certified Nursing Assistant (CNA) "F" was interviewed by phone and asked about the clock in R67's room. CNA "F" explained about a month ago, R67 had told her the clock was not working so she had told one of the maintenance men and they put a new battery in it, even though they had put a new one in not too long before that. When asked if she had put it into the TELS system, CNA "F" explained she had just told the maintenance man. On 6/5/25 at approximately 12:00 PM, the Maintenance Supervisor explained there was no ticket in the TELS system about the clock in R67's room.			

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	Review of a facility policy titled, "Resident Rights" revised 10/2009 read in part, "...Residents are entitled to exercise their rights and privileges to the fullest extent possible..."			
F0584 SS= D	Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F0584	F584 1.) Resident #15 & #99 bedside commode was immediately replaced. All residents have the potential to be affected. 2.) A one-time audit was completed to ensure that all bedside commodes were in working order. Nursing, housekeeping, and maintenance departments were re-educated to ensure that bedside commodes were working in their rooms when completing any tasks. 3.) System change: housekeeping will complete weekly rounds to ensure bedside commodes are within working order. 4.) Administrator/Designee will review 5 rooms weekly x 12 weeks then monthly x 3 months to ensure that bedside commodes are within working order. Any non-adherence will result in 1:1 education. All audits will be submitted to the QA committee for review and further recomendations. The Administrator is responsible for ongoing and sustained compliance.	6/30/2025

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	Based on observation, interview, and record review, the facility failed to ensure a safe homelike environment for two Residents (R15 and R99) of two residents reviewed for equipment safety, when their toilet durable medical equipment was found in disrepair. Findings include: On 6/03/25 at 1:30 p.m., R99's bathroom was observed in Room 222-1. There was a gray metal toilet safety frame (bedside commode) over their toilet. The left plastic armrest (when seated on the commode) was observed with an opening where the occupant's hand would push from to stand up. The opening was cracked, with sharp, jagged edges, placing R99 and any occupants at risk for skin tears. On 6/03/25 at 1:33 p.m., R99 observed their bathroom, and stated, "Oh, that needs to be fixed, as that could cut people (sitting) on it." On 6/03/25 at 3:03 p.m., R99 was observed dressed, seated in a manual wheelchair. On 6/03/25 at 3:04 p.m., R99 confirmed they used their bathroom for toileting occasionally. Review of R99's most recent skin assessment, dated 5/28/25, showed no skin tears or new skin concerns. Review of the Electronic Medical Record (EMR) revealed R99 scored 15/15 on the Brief			

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	Interview for Mental Status (BIMS) assessment, which showed they scored as cognitively intact. Further review revealed they were their own responsible party. Review of R99's Care Plan, accessed 6/05/25, revealed they required one-person assist for transfers and toileting. On 6/03/25 at 12:28 p.m., R15 was observed in the dining room, seated upright in a high back manual recline wheelchair. R15 was assisted by staff to eat their lunch. On 6/03/25 at 1:32 p.m., R15's adjoining bathroom was observed in Room 224. The same toilet safety frame over the toilet was observed in disrepair. On 6/03/25 at 1:35 p.m., Certified Nurse Aide (CNA) "L" reported they were R15's aide, and had not noticed the open, cracked left arm on R15 and R99's toilet safety frame over their toilet. CNA "L" reported this would place residents who used the commode at risk for a skin tear. On 6/03/25 at 1:44 p.m., the Director of Nursing (DON) reported they had observed the cracked armrest on R99's and R15's toilet safety frame in their adjoining bathroom on 6/03/25. The DON confirmed they were replacing the toilet safety frame. The DON reported they understood the concerns and risk for skin tears or injury from the disrepaired equipment.			

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	Review of a new work order, dated 6/03/25, revealed the raised toilet seat was replaced in room 122. Review of the policy, "Safe, Homelike Environment", revised October 2009, revealed, "Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation Person-Centered Care Characteristics of a Personalized, Homelike Setting Characteristics...1. Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting..."			
F0646 SS= D	MD/ID Significant Change Notification §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the local state mental	F0646	F 646 1.) Resident #60 new 77/78 was completed . All residents have the potential to be affected. 2.) A one time audit was completed on all in-house residents to ensure their PASR screening was up to date. The SW department was re-educated on PASRR screening by the Regional Clinical Nurse Consultant. 3.) System change: the MDS department will meet with SW weekly to ensure that all new admits, significant changes, and quarterly the PASRR have been reviewed and updated as needed. 4.) The Administrator/Designee will review 5	6/30/2025

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	health authority of Preadmission Screening and Resident Review (PASARR) changes for one (R60) of two residents reviewed for PASARR. Findings include: Review of the clinical record revealed R60 was admitted into the facility on 3/3/25 with diagnoses that included schizophrenia, unspecified. According to the survey software, R60 was identified as having no PASARR II with a mental illness diagnosis. (PASARR Level II is a comprehensive evaluation by the appropriate state-designated authority and determines whether the individual has MD (Mental Disorder), ID (Intellectual Disorder) or a related condition, determines the appropriate setting for the individual and recommends what, if any, specialized services and/or rehabilitative services the individual needs.) Further review of the admission Minimum Data Set (MDS) assessment dated 3/10/25 documented R60 scored a 14/15 on the Brief Interview for Mental Status Exam (BIMS) which indicated intact cognition, had a diagnosis of schizophrenia and received antipsychotic medication. However, the MDS section that prompted staff to respond yes or no for "Is the resident currently considered by the state level II PASARR process to have serious mental illness and/or intellectual disability or a related condition?" was		records weekly x 12 weeks then monthly x 3 months to ensure that PASRR screenings are updated. Any non-adherence will result in 1:1 education. All audits will be submitted to the QA committee for review and further recommendations. The Administrator will be responsible for ongoing sustained compliance.	

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	inaccurately marked as "0.No". Review of R60's mental health evaluations since admission included the following two consultations with contracted Psych Physician Assistant/PA 'J' in which neither assessments identified dementia as a primary diagnosis, but did identify the resident's MD. The psych consultation on 3/18/25 documented, in part: "...Facility currently is utilizing the following psychiatric diagnosis for the resident: F20.9 SCHIZOPHRENIA, UNSPECIFIED Psychiatry/psychology are being asked to clarify the following: Pt (Patient) HX (history) and diagnoses; best medical intervention. Patient's daughter, who is her guardian, was reached via telephone and provided extensive past hx as well as past medication hx. Patient has long hx of schizophrenia, which was triggered by a car accident when she was a teenager. Following this; she had multiple episodes of psychosis where she became unintelligible and unable to communicate appropriately. She would improve and resolve and would not need the antipsychotic meds for long stretches and would maintain a normal mood & affect, eating well and doing well overall. Then she would relapse; with repetition of this cycle. Her daughter was raised by other family as the patient was unable to care for her children, and the children would have to help monitor their mother when she became			

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	psychotic. Pt has hx of paranoia, erratic and bizarre behaviors (stripping naked and leaving the house) and she did live with her sister for some time; and her sister (who had dementia) did not believe that the patient needed the medications for schizophrenia. However, with any small changes in the patient's own health or that of her sister (with whom she was residing), the patient would deteriorate mental. Dementia process was noted with cognitive decline starting in 2010/2011. Pt was moved to a facility and was wandering at her other facility. Ultimately she required a wanderguard as she did leave the facility one night for no reason...ASSESSMENT & PLAN Undifferentiated schizophrenia [F20.3] (worsening) Plan: Patient's schizophrenia appears to be undifferentiated, based on HX provided from daughter. She was medicated for many years with good control of psychosis..." The psych consultation on 5/12/2025 documented, in part: "...ORIENTATION-The patient is oriented to time, place, person, and situation (oriented x4). She is able to identify that yesterday was Mother's Day. There is no inconsistency or variability in orientation...Attention and concentration are good...Judgment is intact...Insight is intact, though patient does not believe her hoarding behaviors are problematic, stating she just keeps things she might need in the future...Impulse control is			

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	intact, There are no signs of resistance, impulsiveness, or oppositional behavior...Speech is slow but clear, coherent, and not slurred...Thought processes are organized and remain so with redirection...There are no delusions, paranoia, or hallucinations, The patient denies perceptual disturbances, No delusional or bizarre material is expressed...Immediate, recent, and remote memory are grossly intact without any impairment...The patient demonstrates a good fund of knowledge, There are no signs of impairment...Mood is normal, without signs of depression, anxiety, agitation or psychosis. The patient appears euthymic and reports doing very well at this time...There are no symptoms of delirium present, Patient exhibits hoarding behaviors...Diagnosis: Schizophrenia...Assessment and Plan F20.3 - Undifferentiated schizophrenia Status: Improving / Not at Goal...Patient was in the midst of a psychotic episode upon facility admission but appears more alert and communicative today. Currently on risperidone 25 mg twice daily. Hoarding behaviors are considered a component of her mental illness and dementia. No medication changes indicated; nonpharmacologic interventions have been successful with staff assisting patient in cleaning and organizing her room. Will continue to monitor for psychotic symptoms, though patient currently denies hallucinations and presents with organized thought processes..."			

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	Review of the only available PASARR for R60 revealed a 3877 form dated 9/13/24 completed by Nurse 'K' (former Corporate Nurse) that documented yes for R60 having mental illness and dementia, and routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days. The explanation for any yes responses documented, "Dx (Diagnosis): Dementia, Adjustment disorder with mixed anxiety and depressive mood, Schizophrenia. Medications: Seroquel (an antipsychotic medication). Further review of the clinical record revealed there was no revision to the above 3877 or evidence the facility had submitted a change in condition to the local mental health agency for evaluation. On 6/3/25 at 2:49 PM, an interview was conducted with the Social Service Director (SSD 'A'). When asked about whether R60 had any additional PASARR documentation other than the forms from their previous facility, SSD 'A' reported they would follow-up. On 6/4/25 at 9:16 AM, an interview was conducted with SSD 'A'. When asked about R60's lack of level II evaluation, SSD 'A' confirmed there was none completed and repeated the reason was R60 had come from another facility with a dementia exemption and wouldn't be needed to be submitted again until next year.			

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	When asked why there was no review of the admission PASARR to determine if a change in condition should be considered given the psych evaluations and the facility's BIMS assessment which indicated intact cognition, SSD 'A' offered no further response. On 6/4/25 at 9:37 AM, SSD 'A' returned and further reported R60 did not need a level II evaluation due to the dementia diagnosis. There was no further evidence that a change of condition had been initiated and submitted to the local mental health for consideration of a level II evaluation. On 6/4/25 at 11:15 AM, an interview was conducted with the Administrator. They were informed of the interview with SSD 'A' and concerns with lack of change of condition for level II evaluation for R60 and reported they would follow-up with SSD 'A'. A that time, they were requested to provide a facility policy for PASARR. On 6/4/25 at 4:18 PM, the Administrator reported via email "Policy for: PASARR- We follow regulations on PASARR".			
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the	F0684	F 684 1.) Resident #6 and #13 were re-assessed by the wound nurse and no acute issues noted. All residents have the potential to be affected. 2.) A one-time audit was completed to ensure that all dressing changes were completed as ordered. Licensed nurses were re-educated	6/30/2025

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	comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure that wound care was completed according to physician's orders for two residents (R13 and R6) of three reviewed for impaired skin conditions (non pressure related). Findings include: R6 On 6/3/25 at 9:40 AM, R6 was observed in their room sitting in their chair located near the bed. R6 appeared to be dressed and ready for the day. With further observation of R6, there were two kerlex bandages around the resident's ankles that were dirty and unkempt with a date of 5/27 with initials that appeared to be a "CN". R6 was asked if they knew why their legs were wrapped up and how often did the facility change the bandages but R6 could not recall or answer for either question. A review of the record revealed that R6 was admitted to the facility on 2/1/25 with a medical diagnosis of dementia, type two diabetes, and varicose veins. A further review of the record revealed that R6's dressings to the legs were to be changed daily. On 6/4/25 at 12:20 PM, an interview was		on completing dressings as ordered. 3.) System change: the nurse managers during rounds will spot check wound care dressings to ensure they are completed as ordered. 4.) DON/Designee will observe 5 dressing changes weekly x 12 weeks then monthly x 3 months to ensure they are completed as ordered. Any nonadherence will result in 1:1 education. All audits will be brought to the QA committee for review and further recomendations. The Director of Nursing will be responsible for ongoing and sustained compliance.	

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	conducted with the Unit Manager "R" and the Vice President of Clinical Operations (VP "Q"). When asked why did staff members document on a treatment that was not completed and should staff chart off on items that were not completed, the Unit Manager "R" and VP "Q" stated it should not have been charted as completed if it was not and they would have to find out more information as to why and who documented for six days that they were changing the bandages when they were not. R13 On 6/3/25 at 10:45 AM, R13 was observed in the bed resting with left foot propped on a pillow. It was wrapped in kerlex with an ace wrap over it and had a strong odor coming through the bandages. R13 was asked about the wound on the left foot and asked when was the last time the facility changed it (because it was an undated bandaged that was applied). R13 reported the staff had changed it on that Saturday (5/31/25) but it was to be done daily and that they are to use a solution called dakins so it would not stink. A review of the record revealed that R13 was admitted to the facility on 12/20/24 with the diagnosis of venous insufficiency, type two diabetes, and chronic pain due to trauma. R13 had a Brief Interview for Mental Status Score (BIMs) of 15 which indicated no cognitive impairments.			

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	A further review of the record revealed that R13 had a physician's order for daily dressing changes and that staff had signed off that treatments had been completed. However the observed treatment had no date of when it was last changed, had significant odor from the wound site, and the interview with R13 reported the wound dressing had not been changed since Saturday. On 6/4/25 at 12:20 PM, an interview with the Unit Manager "R" and VP "Q" was conducted and they were asked if they required staff to date the treatments when completed. Unit Manager "R" stated yes, staff should date the treatments to assure they are completed. Unit Manager "R" was then asked why the treatments had not been dated for R13 and they reported they would look into it. There was no additional information provided by the exit of the survey.			
F0686 SS= G	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	F0686	F 686 1.) Resident #80 was reassessed by the nurse manager for pressure ulcer prevention to ensure treatments were appropriate and the care plan was updated. All residents have the potential to be affected. 2.) A one- time audit was completed to ensure that all skin alterations were identified and preventative measures were in place. Licensed nurses and cenas were re-educated on preventive skin measures, accuracy of completing skin assessments and documentation. 3.) System change: Nurse managers will withness 5 skin assessments weekly with the	6/30/2025

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	developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent pressure ulcer formation, document accurate skin assessments and implement interventions for one (R80) of three residents reviewed for pressure ulcers resulting in R80 acquiring a Stage 4 (full-thickness skin and tissue loss). Findings include: On 6/3/25 at 9:51 AM, R80 was observed lying in their bed. R80 was asked if they had any wounds or sores. R80 explained they had a couple wounds on their bottom. When asked if they had developed the wound at the facility or if they were present when they were admitted, R80 explained one developed at the facility. Review of the clinical record revealed R80 was admitted into the facility on 1/17/25 and readmitted 2/4/25 with diagnoses that included: paraplegia, hypertension and stroke. According to the Minimum Data Set (MDS) assessment dated 4/22/25, R80 was cognitively intact. The MDS assessment also indicated in section M0300 that R80 had one facility acquired Stage 4 pressure ulcer. Review of R80's skin management care plan revealed an intervention initiated 1/17/25 that read, "CNA's (Certified Nursing		nurse to ensure accuracy. Any new areas identified will be documented in the skin assessment. 4.) DON/Designee will audit 5 charts weekly x 12 weeks then monthly x 3 months to ensure appropriate preventive measures are in place, and will complete 5 random skin assessments to ensure accuracy. Any nonadherence will result in 1:1 education. All audits will be taken to the QA committee for review and further recomendations. The DON is responsible for ongoing and sustained compliance.	

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	Assistants) will check my skin daily with care and report anything unusual they notice to the nurse." Review of R80's "Total Body Skin Assessment" dated 3/25/25 documented "0" in the box for "Enter the # (number) of New Wounds". Review of R80's March 2025 Treatment Administration Record (TAR) revealed an order with a start date of 3/19/25 that read, "Lotrimin AF (anti-fungal) External Cream 1 %... Apply to bilateral gluteal topically two times a day for rash until 04/01/2025 23:59 (11:59 PM) cleanse bilateral gluteal fold apply cream x 2 weeks". The treatment was marked as completed two times a day from 3/19/25 until it was discontinued on 3/25/25. Review of R80's "Wound Evaluation" dated 3/25/24 read in part, "...#3 - Pressure - Unstageable (Slough and/or eschar); Body Location: Location not set; New - Minutes old; acquired: In-House Acquired... Length 3.24 cm (centimeters; Width 1.69 cm; Deepest Point 1.5 cm...Goal of Care: Healable..." Review of R80's Wound Evaluation dated 4/1/25 read in part, "...#3 - Pressure - Stage 4; Body Location: Right Ischium (bony protuberance of the sit bone); Stable - 7 days old; Acquired: In-House Acquired...Length 1.33 cm; Width 0.76 cm; Deepest Point 1.6 cm...Goal of Care: Healable...Progress: Stable..."			

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	Review of R80's Wound Evaluations dated 4/8/25, 4/15/25, 4/22/25, 4/29/25, 4/29/25, 5/6/25, 5/13/25, 5/20/25, 5/27/25 revealed wound #3 on the Right Ischium was documented as "Stable" or "Improving", none documented stalled, deteriorating. On 6/4/25 R80 was out of the facility on outside appointments. Review of a "Skin & Wound Evaluation" dated 6/3/25 read in part, "...Type: Pressure... Stage: Stage 4...Location: Right Ischium...Length 0.8 cm...Width 0.7 cm...Depth 1.0 cm...Undermining 1.9 cm...Goal of Care: Healable...Progress: Stable..." On 6/5/25 at 8:42 AM, R80 was observed sitting up in the bed eating breakfast. R80 was asked about observation of wound care. R80 explained their wounds had already been changed that morning and as it was painful was hesitant to have it done again. R80 was asked if they knew how they acquired the wound. R80 pointed to their motorized wheelchair, that had a reclining seat, and explained they used to be up in their chair all day and now tried to only be in the chair for two hours at a time and felt that contributed to the wound. On 6/5/25 at 10:40 AM, the Director of Nursing (DON) was interviewed and shown the picture of R80's Right Ischium wound on the Wound Evaluation dated 3/25/25. The DON was asked if a wound should ever be			

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	first identified as an Unstageable pressure ulcer. The DON acknowledged the concern. When asked about the Total Body Skin Assessment dated 3/25/25 that documented no new wounds and the Lotrimin Cream documented as applied two times a day, the DON had no answer. The DON was asked if the wound in the picture could have developed that day. The DON acknowledged the wound would had not developed that day. On 6/5/25 at approximately 12:30 PM, the DON provided an undated, unsigned document that read in part, "...On 3/25/25-patient developed stage 4 to right ischium. Seen by wound care on 3/25, documentation of skin breakdown and worsening are unavoidable. Recommend hospice and palliative services... This occurred despite consistent implementation of pressure injury prevention interventions related to limited mobility and paralysis secondary to paraplegia and CVA (stroke). Neuropathy causing diminished sensation, and patient's refusals of hospice or palliative care support..." The DON was asked if the wound could be truly unavoidable since it was continuing to heal and had never deteriorated in the two months since it had been identified. The DON acknowledged the concern. Review of a facility policy titled, "Pressure Ulcers/Skin Breakdown - Clinical Protocol"			

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	revised 10/2010 read in part, "...the nurse shall assess and document/report the following: ...b. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue..."			
F0692 SS= E	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 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 ensure weights were taken appropriately and verified as accurate per professional standards of nutritional practice for one Resident (R21) of two residents reviewed for nutritional status, with multiple facility residents affected who were weighed. Findings include:	F0692		

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	On 6/03/25 at 9:46 a.m., R21 was observed dressed, seated on the edge of their bed. R21 was thin in stature. Their breakfast tray was observed in front of them on a tray table, which included scrambled eggs, biscuits and gravy and two bowls of cereal, with juice, milk, and coffee. R21 showed this Surveyor their meal ticket. It was noted the word "Oatmeal" was scratched out with a black marker. R21 was observed feeding themselves breakfast. The ticket showed R21 was on a regular diet with thin liquids. On 6/03/25 at 9:48 a.m., R21 reported they wanted Oatmeal every day, and their dentures were loose, which they wanted addressed to help them chew food more easily. Review of R21's Electronic Medical Record (EMR) showed their weights until 2/04/24 were documented as follows (in the Vitals section): 1/08/25: 182.0 pounds (in standing). 1/15/25: 183.0 pounds (in sitting). 1/15/25: 183.8 pounds (in sitting). 1/20/25: 183.8 pounds (in sitting). 2/04/25: 144.4 pounds (in sitting). The weight record reflected a 39.4-pound weight change in a two-week period, from 1/20/25 to 2/04/25, which would be atypical. On 6/03/25 at approximately 9:50 a.m., R21 was asked about any significant weight loss during their stay. R21 responded they were			

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	not specifically aware of a significant weight loss but could not be certain. Review of R21's census revealed they were admitted to the facility on 1/06/25. Review of R21's initial dietary assessment, dated 1/07/25, revealed they were on a regular diet with mechanical soft textures, and had upper and lower dentures. The assessment showed their hospital weight was 77.1 kg (169.97 pounds), nearly 170 pounds, and said they were consuming 75% to 100% of meals. The assessment further revealed R21 had no difficulty swallowing and had some difficulties chewing due to loose dentures and they had requested follow-up. The recommendations revealed: "Diet as ordered, obtain weights per protocol, and honor food preferences as feasible." Review of R21's hospital weight records, from the hospital discharge record, printed 1/06/25, dated 12/31/24 to 1/01/25, revealed a weight of 66.9 kg (kilograms = 147.48 pounds), from their most recent admission. Review of R21's (hospital) After Visit Summary, dated 12/26/24 through 1/06/25, printed 1/06/25, revealed R21's height as 6 feet, 2 inches, and a weight of 147 pounds and 7.8 ounces (66.9 kg). Review of R21's Minimum Data Set (MDS) assessment, dated 1/12/25, revealed R21 was admitted to the facility on 1/06/24, with diagnoses including dementia and anxiety. The assessment revealed R21 required set up with eating, moderate assistance with transfers, and supervision with wheelchair mobility. The Brief Interview for Mental Status (BIMS) assessment revealed a score			

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	of 10/15, which showed R21 had moderate cognitive impairment. The nutrition assessment revealed R21 was 72" tall and weighed 184 pounds upon admission. The MDS weight was noted as a significant difference from their hospital weight. Review of R21's Dietary Weight Change note, dated 2/11/25 at 3:27 p.m., revealed R21's current body weight was 144.4 pounds. The note described, " ...(R21's) weight loss may be r/t (related to) weighing errors and/or varying PO (by mouth) intake at/between meals ...Goal is weight stability at this time. Reweight requested ...Obtain weights per protocol ..." On 6/05/25 at 12:59 p.m., RD "M" was asked about R21's wide fluctuation in weight, and significant weight loss per the EMR weight documentation, which showed a considerable weight loss of nearly 40 pounds for R21, from 1/08/25 through 2/04/25. RD "M" explained the facility had scale discrepancies and inconsistencies across staff weighing the facility residents at that time. RD "M" reported the facility completed a Past Non-Compliance (PNC), and said the main deficiency was one of the scales was not calibrated properly. RD "M" explained the facility had since calibrated the scales and had a consistent person taking the residents' weights, to ensure the weights were taken the same way, by the same person, and with the same scale. RD "M" was asked what they did about R21's significant documented weight loss, per their notes and the weights in the EMR. RD "M" reported they notified R21's physician and family member when the significant weight loss (or change) was discovered, which was reflected in their notes, and worked to discover the cause.			

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	On 6/05/25 at approximately 1:10 p.m., RD "M" was asked to review R21's facility admission hospital records with this Surveyor. RD "M" reviewed the hospital discharge weight of 66.9 kg on 12/31/25 to 1/01/25 and agreed this was 147.48 pounds. R21 reported they had "missed this". RD "M" was asked if they typically reviewed the hospital weight when a resident admitted to the facility, and acknowledged this was part of their typical process when completing the initial dietary assessment. RD "M" explained their typical resident weighing process was to obtain weekly weights for residents the first four weeks since their admission, and then monthly after, unless there were any significant changes. RD "M" reported they understood the concerns, and confirmed the facility had corrected the concerns. RD "M" understood the concern about referencing the hospital weight in their documentation accurately. Significant weight loss for R21 was not verified, given their admission weight was about 147 pounds per hospital documentation, with consistent weights obtained after 2/04/25. On 6/05/25 at 2:10 p.m., the concerns related to inaccurate weights and related process concerns for R21, and multiple facility residents were shared with the Nursing Home Administrator (NHA), and the Executive Director, NHA "O", including RD "M" reporting the concerns had been addressed after they were discovered by February 2025 and the hospital and initial weight discrepancy. The NHA asked to follow-up with the Survey team after further review. On 6/05/25 at 2:35 p.m., the Director of			

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	Nursing (DON) shared with the survey team the inaccurate residents' weights were related to significant discrepancies from two of their standard scales, which maintenance verified. The DON reported they reweighed all the residents once this was discovered and ensured all facility residents had an accurate weight. This Surveyor shared there was a concern reported regarding how one staff member was weighing residents inaccurately. The DON clarified the scale inaccuracy was the root cause of the inaccurate weights. This Surveyor shared concerns about the hospital weight not being reflected accurately upon R21's admission by RD "M", which may have helped the weight discrepancies for R21 to be discovered sooner. The DON shared sometimes hospital weights were not accurate, and they were not aware of this concern. The DON confirmed there was a Past Non-Compliance (PNC) which the facility had completed to address the concern, and they would have this loaded into the State Electronic Data share system. On 6/05/25 at 3:05 p.m., the DON shared with the survey team the scales were only off by three to five pounds, and there was a staff member who was weighing residents inaccurately, which had been addressed. The DON reported the staff member was reassigned to another department and they were not weighing facility residents since 2/04/25. The DON reported R21's denture concerns had been addressed, per recommendations of the dentist during the 4/2025 visit, and R21 declined diet modification and implants. A copy of the PNC document was received in the State Electronic data share system on			

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	6/05/25 by 3:07 p.m. Review of the policy, "Weight and Height Measurement", revised 2/10/24, revealed, "Purpose: 1. To obtain a baseline weight and height for each resident upon admission. 2. To maintain constant control of weight changes. 3. To assess nutrition and hydration status of resident. 4. To identity significant changes in condition. Note: Residents are weighed on admission and weekly x (times) 4 weeks. Then monthly unless otherwise requested by nursing. The registered dietician or the attending physician to monitor the resident's condition. Resident's height is measured on admission and annually ..." There was no mention in the policy regarding obtaining the initial weight from the hospital, the calibration of scales, consistency regarding how to weigh residents, or documentation triggers when weight inconsistencies were noted. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: The identification of residents' weight inconsistencies and errors, given significant weight fluctuations for multiple facility residents discovered by facility staff. Registered Dietician (RD) "M" observed weight fluctuations ranging from 30 to 70 pounds on multiple residents over a short period of time. The root cause of the inaccurate weights was determined to be from staff error, per the PNC. Reeducation was provided to involved staff, and a consistent staff member was trained to take the residents' weights in the facility, per the facility weight policy. A one-time audit was			

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	634570	A. BUILDING _____ B. WING _____	6/5/2025

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	completed on 2/04/25 to identify residents requiring a reweigh to ensure accuracy of prior weight changes, when noted. Ongoing audits were completed by the Registered Dietician and or designee for 12 weeks to ensure compliance, with reeducation and disciplinary action as warranted. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.			
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 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 ensure freedom from unnecessary antibiotic therapy for three (R40, R85, and R86) of three residents reviewed for unnecessary antibiotic (ABT) use, resulting in the potential for the development of antimicrobial resistance. Findings include:	F0757	F 757 1.) Resident #40, #85, and #86 were assessed by the nurse manager and no acute issues noted. 2.) A one-time audit was completed on ABT within the last 14 days to ensure they meet mcgreers criteria or have a risk versus benefits completed. The licensed nurses and providers were re-educated on mcgreers criteria. 3.) System change: Mon-Friday during the clinical meeting the ICP/Designee will review ABT to ensure they are meeting McGreer's criteria. 4.) DON/Designee will review 5 ABT weekly x 12 weeks then monthly x 3 months to ensure McGreer's criteria is met. Any non-adherence will result in 1:1 education. All audits will be brought to the QA committee for review and further recommendations. The Director of Nursing will be responsible for ongoing sustained compliance	6/30/2025

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	On 6/4/25 at 3:00 PM, review of the facility's infection control program with Infection Control Preventionist (ICP) "C" revealed the following: R40 was documented in March 2025 as having a facility acquired infection listed as "Urinary", the signs and symptoms were "Fever-Low grade, Altered mental status", the comments included "Criteria Not Met...No culture results...". R40's March 2025 Medication Administration Record (MAR) included an order for "Cipro Oral Tablet 500 MG (milligrams)...Give 1 tablet by mouth two times a day for UTI (urinary tract infection) for 3 Days", and documented as given from 3/24/25-3/26/25. ICP "C" was asked if R40 had a culture and sensitivity (C&S) done to see if there was an infection and what was the low grade fever. ICP "C" explained no C&S was ordered, and she had found in a progress note on 3/14/25 a temperature of 100.1. ICP "C" was asked how a one time slightly elevated temperature 10 days before antibiotics were prescribed was documented as a sign or symptom. ICP "C" had no answer. When asked how was it determined which antibiotic to use when the organism was not identified by a C&S, ICP "C" explained she did not know. R85 was documented in April 2025 as having a facility acquired infection listed as "Urinary", the signs and symptoms were "Altered mental status", the comments included			

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	"Criteria Not Met...Culture Results Pending...ABT (antibiotic therapy) started prior to culture...". R85's April 2025 MAR included an order for "Cipro Oral Tablet 500 MG...Give 1 tablet by mouth every morning and at bedtime for UTI for 5 Days", and documented as given 4/1/25-4/6/25. ICP "C" was asked what the C&S results were. ICP "C" explained there was a progress note dated 3/31/25 that read, "...URINE COLLECTED ON 3/28 DROPED [sic] OFF ON 3.29 TO TOLD TO RUN...UA reordered." ICP "C" also explained a C&S was not reordered for R85. ICP "C" was asked if an altered mental status indicated a UTI. ICP "C" explained it did not. Review of R85's progress notes revealed a Nursing Note created 3/29/25 at 11:24 AM by the Director of Nursing (DON) that read, "Urine sample pending collection. Per antibiotic stewardship guidelines, the resident is not having any signs or urinary symptoms. Abt will not be initiated without positive symptoms and culture as the risk outweighs the benefits at the current moment. Behaviors will continue to be monitored and nursing will continue to attempt retrieving urine sample. Provider agreeable to current plan." ICP "C" was asked why there was a progress note by the DON on 3/29/25 saying no antibiotics and then antibiotics were started on 4/1/25 without a C&S or additional signs			

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	or symptoms. ICP "C" had no answer. R86 was documented in April 2025 as having a facility acquired infection listed as "Urinary", the signs and symptoms were "Altered mental status", the comments included "Criteria Not Met...Culture Result Pending, ABT started from abnormal UA...". R86's April 2025 MAR included an order for "Cipro Oral Tablet 500 MG...Give 1 tablet by mouth two times a day for UTI for 5 Days", and documented as given 4/24/25-4/29/25. ICP "C" was asked about the C&S results. ICP "C" explained the C&S came back negative for infection on 4/26/25. ICP "C" was asked if the C&S was negative on 4/26/25, why did R86 continue to get the antibiotic for the full five days until 4/29/25. ICP "C" agreed the antibiotics should have been stopped when the C&S came back negative and had not answer as to why they had not been stopped. On 6/5/25 at approximately 12:30 PM, the DON provided "Risk Vs. (versus) Benefit for Antibiotic Use" documents for R40, R85 and R86. The DON was asked how there was a benefit for R86 to receive an antibiotic when the C&S confirmed there was no infection. The DON acknowledged the concern. When asked about the benefit of antibiotics for R40 and R85 when the only symptom was altered mental status, the DON acknowledged the concern. Antibiotic Stewardship Program §483.80(a)	F0881	F 881	6/30/2025

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F0881 SS= E	Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to consistently maintain a system that consistently met criteria for antibiotic use, this had the ability to affect any resident prescribed an antibiotic of the 107 residents that resided in the facility. Findings include: Review of the facility's Infection Surveillance books revealed multiple incidents of antibiotics prescribed that did not meet antibiotic use criteria, including residents treated for Urinary Tract Infections (UTI's) with no signs and symptoms of infection and no lab results to confirm an infection. On 6/4/25 at 3:00 PM, the facility's Infection Control Preventionist (ICP) "C" was interviewed and asked what criteria was used for antibiotic use. ICP "C" confirmed the facility used McGeer's Criteria. ICP "C" was asked about antibiotics prescribed for UTI's with no culture and sensitivity (C&S - to indicate if an infection was actually present and what antibiotic the bacteria was sensitive		1.) All Residents have the potential to be affected. 2.) A one-time audit was completed on ABT within the last 14 days to ensure they meet mcgreers criteria or have a risk versus benefits completed. The licensed nurses and providers were re-educated on mcgreers criteria. 3.) System change: Mon-Friday during the clinical meeting the ICP/Designee will review ABT to ensure they are meeting McGreer's criteria. 4.) DON/Designee will review 5 ABT weekly x 12 weeks then monthly x 3 months to ensure McGreer's criteria is met or risk verse benefit is obtained. Any non-adherence will result in 1:1 education. All audits will be brought to QA committee for review and further recommendations. The Director of Nursing is responsible for ongoing sustained compliance.	

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	to). ICP "C" explained she was trying to educate the nurses' to ask for a C&S when calling the doctor, and to not just get a Urinalysis (UA). When asked if only a UA was ordered, how was it determined what antibiotic to use if there was no C&S. ICP "C" had no answer. Review of a facility policy titled, "Infection Prevention and Control Program" revised 11/2019 read in part, "...Protocols to review clinical signs and symptoms and laboratory reports to determine if the antibiotic is indicated or if adjustments to therapy should be made..."			