STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	654010	A. BUILDING _____ B. WING _____	4/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT WEST BRANCH	445 S VALLEY ST WEST BRANCH, MI 48661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS The Villa At West Branch was surveyed for a Combined Recertification/Abbreviated Survey exiting on 04/29/2025. Event ID: 6OKI11 Intake Number: MI00150007 Census: 59	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination,	F0550	F550(D) Resident Rights/Exercise of Rights Residents 4, 108, and 208, all have catheter dignity bags or leaf covered catheter bags and have been verified that they are being used appropriately to maintain residents' rights and dignity. Any resident with a catheter could be affected by this. Residents with catheters have all been reviewed and verified to have dignity bags or leaf covered catheter bags. Any concerns identified were immediately corrected. The Residents Rights guideline was reviewed and deemed appropriate by the NHA and DON. The DON/Designee will educate all staff on the guideline and the need to treat residents with dignity and respect by keeping their catheters covered with a dignity bag or a leaf covered bag. The DON/Designee will audit all catheters 3x/weekly for 4 weeks and until substantial compliance is achieved to verify that all	5/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/22/2025

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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	or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that residents were treated in a dignified manner for three residents (R4, R108, R208) of 16 residents reviewed for dignity, resulting in uncovered urine collection bags and lack of respect for residents individuality. Findings include: Resident #208 (R208): R208 is 73 years old and admitted to the facility on 04/05/2025 with diagnoses that include neuromuscular dysfunction of the bladder, hypertension, anxiety and a history of colon cancer. On 04/27/25 at 10:37 AM, R208 was observed sitting in bed and watching TV. R208 was noted to have an indwelling urinary catheter in place. The urine collection bag was not covered, urine was present in the bag. On 04/28/25 at 08:36 AM, R208 was observed in the dining room eating breakfast, the urine		catheters are covered with appropriate dignity device. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and continued improvement.	

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	collection bag was not covered, and urine was present in it. On 04/28/25 at 01:40 PM, record review of R208's electronic medical record (EMR) revealed a physician's order for the indwelling catheter, an appropriate diagnosis of obstructive uropathy and it was dated 04/07/25. On 04/28/25 at 03:18 PM, an interview was conducted with the director of nursing (DON). The DON was asked if the facility has dignity bags that cover the urine collection bags. The DON replied, yes, we do have dignity bags that the urine collection bags slip into, and we have urine collection bags with built in covers. The DON stated they are available to staff, and they can use them. The DON was asked if the urine collection bags should be covered. The DON replied, yes, they should be covered. Resident #4: Observation and interview an 04/27/25 at 11:08 AM with Resident #4 stated "I got the catheter when I came here to this building, I had a Urinary Tract Infection, and they are giving me some pills for it. I couldn't pee on my own, and I use to do a straight stick catheter". The state surveyor Observed urinary catheter at bedside in privacy bag, with tubing touching/lying on the floor. Observation on 04/28/25 at 12:28 PM of			

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	Resident #4 was seated at edge of bed awaiting her noon meal tray. The state surveyor Observed urinary catheter and tubing laying on the floor outside of the privacy bag. Resident #4 stated that she "did not know what was going on with the catheter bag. The staff/girls take care of the catheter for me". Observation on 04/28/25 at 12:30 PM Activities aide "A" brought in her lunch tray, she did not know anything about the urinary catheter. On 04/28/25 at 12:32 PM the state surveyor went to find Licensed Practical Nurse "B" and returned with the surveyor to Resident #4's room. Both LPN "B" and state surveyor observed urinary catheter on the floor outside the privacy bag. LPN "B" stated "I don't know why the catheter was out of the privacy bag and on the floor, I know that Resident #4 doesn't like to get out of bed. LPN "B" only put on gloves and picked up the catheter from the floor with no enhanced barrier PPE put on. On 04/28/25 12:36 PM Resident #4 stated that she had not been into the bathroom or out of bed. Resident #108: Observation and interview during the initial screen process at the start of the survey on 04/27/25 at 10:41 AM of Resident #108 noted a urinary catheter visible from the doorway hanging at bed side with a volume measure burette (Urometer) on front of bag with yellow solution noted with no privacy			

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	bag in place. Resident #108 stated he has been at the facility a week, but that no one has told him anything and that they need to respond to the buzzer faster, because he waits 30 minutes to 45 minutes. In an observation and interview on 04/29/25 at 08:24 AM of Resident #108 was lying in bed with his breakfast meal. Observation of urinary catheter was noted to have a blue privacy bag in place today. Resident #108 stated "that the girls added that cover bag yesterday afternoon". The Resident #108 did not know why they waited till then after everyone that walked by saw it.			
F0578 SS= D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F0578	F 578(D) Request/ Refuse/ Discontinue Treatment/ Formulate Advanced Directives Resident 8 had their code status reviewed and updated in PCC with the correct responsible party's signature. All residents have the potential to be affected. A full house sweep was completed to ensure proper documentation and signatures were in place for code status elections. Any identified concerns were immediately addressed. The Advanced Directive Guideline was reviewed and deemed appropriate by Director of Nursing and Administrator. The Director of Nursing/Designee will educate the IDT and licensed nurses on proper documentation and signatures for obtaining a code status. The Director of Nursing/Designee will conduct random observations 3x/week for 4 weeks	5/28/2025

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	entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that advance directive forms were completed by a designated responsible party for one resident (Resident #8) of two residents reviewed for advance directives. Findings include: Resident #8: On 4/27/25 at 2:55 PM, Resident #8 was observed in their room sitting in a semi reclined position in a Broda chair. When asked questions, Resident #8 was pleasantly confused and unable to provide answers to questions related to medical conditions and/or care. Record review revealed Resident #8 was originally admitted to the facility on 8/24/24 and readmitted on 10/8/24 with diagnoses which		and until substantial compliance is achieved to ensure proper documentation is in place for resident's code status elections. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and continued improvement.	

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	included dementia, and falls. Review of Minimum Data Set (MDS) assessment dated 1/27/25 revealed the Resident was severely cognitively impaired and required substantial/maximum assistance. Review of Resident #8's Electronic Medical Record (EMR) revealed the Resident was admitted to Hospice Services in January 2025. A "Physician's Evaluation of Resident's Competency To Make Health Care Decisions" Form was present in Resident #8's EMR. The form specified the Resident was incompetent to make medical decisions and was signed by a Physician on 12/27/24 and a Clinical Psychologist on 12/26/24. Further review of Resident #8's EMR revealed the most recent Advance Directive form specifying Code Status was entitled, "MDHHS-5836, Michigan Physician Orders for Scope of Treatment (MI-POST)." The form was dated as "prepared" on 2/5/25. The form detailed the Resident's code status was "DO NOT attempt Resuscitation/CPR (Cardiopulmonary Resuscitation). (No CPR, allow Natural Death) ... Medical Interventions ... Comfort-Focused Treatment ..." The form was signed by Resident #8 (no date), Former Assistant Director of Nursing (ADON) "O" on 2/6/25, and Physician "N" on 2/12/25. Further review of Resident #8's EMR revealed DPOA paperwork with a patient advocate designated. An interview was completed with Social Services Designee (SSD) "P" on 4/28/25 at 1:52 PM. When			

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	queried who signed Resident #8's most recent Advance Directive/DNR order, SSD "P" reviewed Resident #8's EMR and stated, "(Resident #8) did." SSD "P" was then asked if Resident #8 was deemed incompetent and replied, "Yes." When asked why Resident #8 signed the form after she was deemed incompetent to make medical decisions, SSD "P" stated, "It was probably an error on the nurses part." When asked to clarify if they were saying Resident #8 should not have signed the form, SSD "P" confirmed the Resident should not have signed the form due to being incompetent. On 4/29/25 at 11:59 AM, an interview was completed with the Director of Nursing (DON). Resident #8's Advance Directive DNR form from February 2025 and incompetency documentation were reviewed with the DON. When queried why the Resident signed the DNR Advance Directive form, the DON did not provide an explanation. Review of facility policy/procedure entitled, "Advance Directives and Care Planning Guidelines" (Effective 11/28/17) revealed, "It is the practice of the facility to establish, implement and maintain written guidelines for advance directives ... The resident will be evaluated periodically for decision-making ability capacity ..."			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F0677	F677 (D) ADL Care Provided for Dependent Rights Resident 13 was reviewed for ADL care, and it was verified that ADL cares have been completed for him including shaving. All residents could be affected by this. A	5/28/2025

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	Based on observation, interview and record review, the facility failed to implement procedures to ensure Activity of Daily Living (ADL) care per preference was provided to one resident (Resident #13) of two residents reviewed for ADL care. Findings include: Resident #13: On 4/27/25 at 11:59 AM, Resident #13 was observed in their room. The Resident was in bed, positioned on their back, wearing a hospital style gown. The Resident had an unkept appearance and their face was unshaven. An interview was completed at this time. When asked if they liked their facial hair or if they preferred to be shaved, Resident #13 replied, "I like to be shaved." When asked why they weren't shaven when they like to be, Resident #13 stated, "Only do when go to the shower room." On 4/28/25 at 12:21 PM, Resident #13 was observed in their room. The Resident was in bed, positioned on their back. The Resident's face remained unshaved. On 4/28/25 at 4:00 PM, an interview was completed with Certified Nursing Assistant (CNA) "Q". When queried regarding the frequency in which male resident's faces are shaved, CNA "Q" replied, "Shaving is done when showered." When asked about Resident #13 stating they preferred to be shaved and saying they were only shaved when they received showers, CNA "Q" confirmed that is the usual facility procedure.		whole house sweep was conducted to ensure that all residents have appropriate ADL cares completed daily. Any concerns identified were immediately corrected. The Activities of Daily Living Guideline was reviewed by the NHA and DON and was deemed appropriate. The DON/Designee will educate all staff on the guideline and the need to complete ADL cares on all residents daily. The DON/Designee will complete audits 3x/week for 4 weeks and until substantial compliance is achieved on ADLs for all residents to verify that they are being completed to maintain good nutrition, grooming, and personal and oral hygiene. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and continued improvement.	

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	Record review revealed Resident #13 was originally admitted to the facility on 8/29/18 and most recently readmitted on 3/13/25 with diagnoses which included heart disease, Alzheimer's disease, and cerebral infarctions (strokes) with resulting left and right sided paralysis and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment dated 2/7/25 revealed the Resident was severely cognitively impaired, had one sided upper and lower impaired Range of Motion (ROM) and required moderate assistance to complete personal hygiene and maximum assistance with toileting and transfers. Review of Resident #13''s Electronic Medical Record (EMR) revealed a care plan entitled, "The resident has actual ADL self-care performance deficit r/t (related to) Activity Intolerance, confusion, R and Left sided paralysis as a result of CVA (Cerebral Vascular Accident - stroke). Res often refuses to get out of bed throughout the day ... prefers to stay in bed. Muscle weakness ..." (Initiated: 3/14/25). The care plan included the interventions: - "Bathing: 1 person Physical Assist Tuesday, Saturday and PRN (as needed)" (Initiated: 3/14/25) - "Dressing: 1 person Physical Assist" (Initiated: 3/14/25) - "Transfers: Resident requires 2 person physical assistance" (Initiated: 3/14/25) At 9:13 AM on 4/29/25, an interview was completed with the Director of Nursing (DON).			

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	When queried regarding observations of Resident #13 being unshaven and the Resident stating they are only shaved on shower days but like to be clean shaven and shaved more frequently than only on shower days, the DON stated, "(Resident #13) is alert. They can ask" if they want to be shaved." No further explanation was provided related to the Resident's impaired cognition. Resident #13's complete "Documentation Survey Report" for January to March 2025 were requested at this time. Review of provided January to March 2025 "Documentation Survey Report" for Resident #13 revealed the "Task Only" report was provided. The report specified Resident #13 was scheduled to receive showers on Tuesday and Saturdays. The documentation report did not delineate shaving from other areas of hygiene provided.			
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow physician's orders for administration of oxygen, update care plans for oxygen administration and	F0695	F695 (D) Respiratory/ Tracheostomy Care and Suctioning Residents 16, 23, and 211 had their care plans, orders, and sanitary storage measures reviewed and updated. All residents that require respiratory order have the potential to be affected. A whole house sweep was conducted to ensure that all residents have appropriate care plans, orders per physician, and proper storage of respiratory equipment. Any concerns identified were immediately corrected. The Oxygen Administration Guideline was reviewed by the NHA and DON and was deemed appropriate. The DON/Designee will educate all clinical staff on the Oxygen Administration guideline on proper respiratory	5/28/2025

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	maintain oxygen supplies in a sanitary manner for three residents (R16, R23 and R211) of four residents reviewed for respiratory care, resulting in inaccurate care plans, inaccurate and missing oxygen administration orders and improper storage of nebulizers and oxygen tubing. Findings include: **Resident #23** R23 is 78 years old and admitted to the facility on 01/12/2022 with diagnoses that include chronic obstructive pulmonary disease (COPD), dysphagia, muscle weakness and dementia. On 04/27/25 at 11:31AM, R23 was observed lying in bed and they had just completed a nebulized breathing treatment, the nebulizer was still running and R23 wanted it turned off. R23 stated they do the treatments themself. R23 was asked if the staff helps get her setup with the treatment. R23 stated, yes, nursing staff get me set up and then I shut it off when I am done. The nebulizer machine was observed out of reach for R23. This surveyor located the floor nurse and informed them R23 was done with their treatment. Registered Nurse (RN) "D" was observed entering the room, shutting off the nebulizer, placing the mask and tubing in a plastic bag with medication residue still in the chamber of the medication cup on the mask. RN "D" then exited the room. These findings		care plans, orders, and storage of respiratory equipment. The DON/Designee will complete audits 3x/week for 4 weeks and until substantial compliance is achieved on respiratory care plans, orders and storage of respiratory equipment for all residents. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and continued improvement.	

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	were verified with the Director of Nursing (DON) and RN "D". On 04/28/25 at 03:20PM, an interview was conducted with the DON. The DON was asked what the nurse should have done in that situation when the nebulizer treatment was completed. The DON stated, I educated RN "D" immediately and RN "D" is aware of what to do going forward. The DON stated that RN "D" should've made sure the nebulizer was completely separated, cleaned and dried before putting it away. **Resident #211** R211 is 80 years old and admitted to the facility on 04/24/2025 with diagnoses that include COPD, chronic respiratory failure, asthma and failure to thrive. On 04/27/25 at 11:40AM, R211 was observed sitting on the side of the bed, nasal cannula in place and the oxygen concentrator was set to 3LPM of Oxygen for administration. On 04/27/25 at 11:55AM, review of the electronic medical record (EMR) for R211 revealed a physician's order for continuous O2 via nasal cannula at 4LPM for a diagnosis of COPD. The DON was informed of this finding and the discrepancy between the order and the concentrator settings in the room. On 04/28/25 at 03:34PM, an interview was			

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	conducted with the DON. The DON was asked about the discrepancy from the day before. The DON stated we entered a new order for R211's oxygen administration for 2LPM-4LPM depending on her needs and we verified the concentrator was now administering the correct rate. The DON was asked who is responsible for making sure the physician's order is matching what rate of oxygen is being administered. The DON stated that the nurse on the floor is responsible for making sure the orders match what is being administered. On 04/29/25 at 09:15AM, review of the oxygen therapy care plan revealed an intervention: Oxygen Settings: O2 via nasal prongs at 4LPM continuous. The physician's order was updated to be 2LPM-4LPM of oxygen administration, the care plan and Kardex still states to be at 4LPM continuous. Record review of the policy titled, "Oxygen Administration" revealed: Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. Resident #16:			

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	An interview was completed with Resident #16 in their room on 4/27/25 at 12:16 PM. Resident #16 was in bed, positioned on their back with the head of their bed elevated at approximately a 25-degree angle. Audible wheezing was heard with the Resident's respirations. An oxygen concentrator was observed in the Resident's room. Nasal Cannula (NC) oxygen tubing was connected to the concentrator. The tubing was not dated and laying on the top of the concentrator and not contained in a bag. When asked if they typically use supplemental oxygen, Resident #16 stated, "I have the past couple days." When asked why, Resident #16 revealed they had been coughing and feeling short of breath. On 4/28/25 at 12:27 PM, an observation of Resident #16 and their room revealed the oxygen concentrator with the undated and uncontained NC tubing remained in the place in the room. Record review revealed Resident #16 was admitted to the facility on 4/23/24 with diagnoses which included Congestive Heart Failure (CHF), diabetes mellitus, lymphedema, anxiety, and depression. Review of the Minimum Data Set (MDS) assessment dated 1/31/25 revealed the Resident was cognitively intact and required set-up to total assistance to complete Activities of Daily Living (ADLs). Review of Resident #16's Electronic Medical Record (EMR) revealed the Resident did not have a care plan nor intervention for supplemental oxygen administration. Review of Resident #16's Health Care Provider (HCP) order in place for supplemental oxygen.			

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	Review of progress note documentation in Resident #16's EMR revealed the most recent documentation of supplemental oxygen administration was on 11/24/24. An interview was completed with Unit Manager Licensed Practical Nurse (LPN) "E" on 4/28/25 at 3:44 PM. When queried if Resident #16 is supposed to have supplemental oxygen, LPN "E" reviewed the Resident's EMR and stated, "I'm not seeing any orders." A tour of Resident #16's room was completed with LPN "E" at this time. LPN "E" confirmed the oxygen concentrator was in the Resident's room. A closer observation of the oxygen tubing at this time revealed the nasal cannula prongs were bent as when used. When queried regarding the oxygen tubing, LPN "E" verbalized open tubing should be dated and contained in a bag. LPN "E" removed the oxygen concentrator and tubing from the room. An interview was conducted with the Director of Nursing (DON) on 4/28/25 at 4:05 PM. When queried if Resident #16 had a Health Care Provider order for oxygen, the DON reviewed the Resident's EMR and verbalized they did not. The DON was informed that Resident #16 had an oxygen concentrator with connected, undated and uncontained tubing in the room. The DON reviewed the EMR and verbalized there was no documentation of oxygen administration in the Resident's EMR. When asked why the concentrator and tubing were in the room and why Resident #16 stated they had used it when there was no order and no documentation, the DON did not provide an explanation. An interview was completed with Therapy Staff			

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	"R" and Therapy Director "S" on 4/29/25 at 8:56 AM. When queried if Resident #16 had supplement oxygen in place during therapy sessions, Staff "R" stated, "(Resident #16) was complaining of shortness of breath and I told the nurse. They (nurse) told me to put oxygen on them and I reported back to her (nurse)." When queried what the nurses name was, Staff "R" revealed they did not remember. Therapy documentation for Resident #16 was reviewed at this time a revealed the following: - 4/21/25: "Physical Therapy Treatment Encounter Note (s) ... Tolerates fair, SOB (Shortness of Breath) in which nursing notified and O2 (oxygen) put on 2L (2 liters/minute). Patient sat with O2 being monitored ... felt better after O2 applied ..."			
F0700 SS= D	Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by:	F0700	F700 (D) Bedrails Resident 47 had their bedrail care plans, orders and evaluations updated. All residents that require bedrails have the potential to be affected. A whole house sweep was conducted to ensure that all residents have appropriate orders, evaluations, and assessment/monitoring in place, concerns identified were immediately corrected. The Bedrail Guideline was reviewed by the NHA and DON and was deemed appropriate. The DON/Designee will educate all staff on the guideline and on appropriate orders, evaluations, and assessments/monitoring and of risk factors for entrapment and other safety hazards related to bedrails. The DON/Designee will complete audits	5/28/2025

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	Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures for bed rail use for one resident (#47) of four residents reviewed for accidents/hazards resulting in a lack of health care provider orders and assessment/monitoring. Findings include: Resident #47: On 4/28/25 at 8:30 AM and 12:58 PM, Resident #47 was observed in their room in bed with their eyes closed. One side of their bed was positioned against the wall and side rails were present on the bed. Record review revealed Resident #47 was admitted to the facility on 11/17/24 with diagnoses which included left lower limb monoplegia (paralysis), Schizophrenia, depression, and Traumatic Brain Injury (TBI). Review of the Minimum Data Set (MDS) assessment dated 2/20/25 revealed the Resident was cognitively intact and required set-up to substantial assistance to complete Activities of Daily Living (ADLs). Review of Resident #47's Electronic Medical Record (EMR) revealed a care plan entitled "The resident has had an actual fall with no injury due to Poor Balance" (Initiated: 2/28/25). The care plan included the intervention, "Date and description of other interventions put in place after a fall: 2.27.25 - Education on use of half rails and utilizing call lights prior to transfers for safety" (Initiated: 2/28/25).		3x/week for 4 weeks and until substantial compliance is achieved to ensure that residents have appropriate orders, evaluations, and assessment/monitoring in place for bedrails The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and continued improvement	

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	Resident #47 did not have another care plan in place, current and/or discontinued, related to bed rail use. Review of documentation in Resident #47's EMR revealed the following: - 2/28/25 at 2:52 PM: "IDT (Interdisciplinary Team Note ... reviewed fall from 2/27/25 ... resident stated fell out of bed while trying to get up ... no injuries were noted. Resident educated on importance of using side rails to help with bed mobility and to utilize call light prior to attempting to transfer ... CP (care plan) reviewed and updated. An assessment, informed consent, and/or evaluation for side rail use was not noted in Resident #47's EMR. A review of Resident #47's health care provider orders revealed the Resident did not have an order for side rails on their bed. A review of Resident #47's Incident and Accident (I and A) form related to their fall on 2/27/25 revealed, "Incident ... resident was observed kneeling on knees facing the bed with hands on the bed. Resident was ask what happened. resident stated to the nurse ...rolled out of bed. Resident was asked if was sleeping or awake and resident stated awake. Resident has no harm done... Resident was put back into bed ... Other Info: Education on the use of the safety bars on bed and use of call light when needed ..." An interview was conducted with the Director of Nursing (DON) and Clinical Registered Nurse (RN)			

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	"J" on 4/29/25 at 9:55 AM. When queried regarding the facility policy/procedure related to side rail use, the DON revealed a physician order is required for use and initial and ongoing assessments are completed. When queried regarding the location of Resident #47's consent, assessments, and physician order for side rail use, the DON reviewed the Resident's EMR and confirmed the Resident did not have an order and/or documentation is place related to side rail use/assessment. Resident #47's I and A form from their fall on 2/27/25 was reviewed with the DON and RN "J" at this time. When asked if the I and A intervention meant the side rails were already in place at that time, the DON and RN "J" confirmed. When queried when the side rails were placed on the Resident's bed, the DON revealed they did not know. Review of facility policy/procedure entitled, "Bed Rail Device Guideline" (Effective 11/28/17) revealed, "It is the practice of this facility to identify and reduce safety risks and hazards commonly associated with bed rail use. A duo-faceted approach will be used to achieve sustainable quality outcomes, including 1) regular bed maintenance and 2) individual bed rail evaluations ... The facility will also ensure individual resident bed rail evaluations are performed on a regular basis. Individual bed rail evaluations will include data collection analysis and determination of potential alternatives to bed rail use. When bed rail(s) are deemed necessary and appropriate, the facility will provide education to resident or resident's representative pertaining to the risk and benefits of bed rail use. The facility's priority is to ensure safe and appropriate bed rail use ... BED RAIL USE GUIDELINE: It is the practice of this facility to			

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	prevent entrapment and other safety hazards associated with bed rail use. The facility's leadership will be responsible for 1) completing individual bed rail evaluation on a regular basis, and 2) providing employees appropriate information, education, and training pertaining to general risks and benefits of side rail use, and 3) education pertaining to resident-specific risks and care needs associated with bed rail use ... b. Upon admission, readmission or change of condition, residents will be screened to determine: 1) Level of independence with bed mobility, 2) Bed comfort level 3) If the bed meets manufacturers' recommendations and specifications pertaining to resident height and weight 4) Assess the need for special equipment or accessories (e.g. side rails) c. Evaluate the resident to identify appropriate alternative prior to installing bed rails d. Evaluate the resident for risk of entrapment from bed rails prior to installation e. Bed rails will not be used when used for convenience or discipline. f. The facility will document ongoing need for the use of a bed rail and the least restrictive alternative. g. Review the risk and benefits with resident and resident representative h. Obtain informed consent. i. Obtain physician order for medical symptom evaluated and need for bed rail use. j. Resident care plan will include use of bed rails as evaluated. Based upon the individualized comprehensive evaluation if it is determined that bed rails will be indicated to assist resident in maintaining or improving functional ability and do not constitute a restriction as defined as a restraint, bed rails may be utilized and care planned with consent of the resident/resident representative to meet the individualized need ..."			

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F0758 SS= D	Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F0758	F 758 (D) Unnecessary Psychotropic Meds Residents 43's chart was reviewed, and all consents pertaining to psychotropic medications were obtained immediately. All residents that require the use of psychoactive medications have the potential to be affected. A whole house sweep was conducted to ensure that all residents have consents related to psychoactive medications, any concerns identified were immediately addressed. The Use of Anti-Psychotic Medications Guideline was reviewed and deemed appropriate by the Director of Nursing and Administrator. The Director of Nursing/ Designee will educate clinical staff and IDT on the Use of Anti-Psychotic Medications guideline and on proper collection of informed consents. The DON/Designee will conduct random observations 3x/week for 4 weeks and until substantial compliance is achieved to ensure residents with psychoactive medications have proper consents. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and continued improvement	5/28/2025

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	Based on observation, interview and record review, the facility failed to obtain informed consents for psychotropic medications for one resident (Resident #43) of 5 residents reviewed for unnecessary medications, resulting in a lack of informed consent prior to initiation and administration of psychoactive medications. Findings include: Record review of the facility 'Behavior and Psychotropic Medication Management Meeting Guideline' policy/procedure dated 11/28/2017 revealed the purpose was to assure appropriate team interaction to provide timely, resident-specific interventions. Process #2. Review list of residents for team meeting ahead of time with nursing unit staff: Initiate and/or review the behavior and psychotropic medication evaluation.... Record review of the facility 'Mood and Behavior Guideline' policy dated 11/28/2017 revealed the objectives of the Mood and Behavior Guideline is to provide a plan of care that is individualized to the residents needs based upon the comprehensive assessment by the interdisciplinary team. This plan of care will include medically related social services to address mood and behavioral health services to attain or maintain the highest practicable well-being.			

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	(6.) Psychotropic Medications: Residents with orders for psychotropic medications will follow the guidelines as outlined in the facility 'Psychotropic Medication' use. Resident #43: Observation and interview on 04/27/25 at 11:46 AM of Resident #43 was lying in bed and did respond to the state surveyors' questions. Resident #42 Seem to have a delay in response. Observation on 04/28/25 at 08:56 AM of Resident #43's peg tube medication administration with Licensed Practical Nurse (LPN) "B" and Certified Nurse Assistant (CNA) "H" revealed that medications of liquid Risperidone 0.5mg antipsychotic medication was administered. Record review of Resident #43's March 2025 Medication Administration Record (MAR) revealed on 3/3/2025 psychotropic medications of Quetiapine Fumarate (Seroquel) 50mg via peg tube at bedtime (HS) daily for mood disorder and Risperidone 0.5mg via peg tube one time daily for anxiety and Risperidone 1mg via peg tube at bedtime (HS) were initiated and administered daily. Record review of Resident #43's April 2025 Medication Administration Record (MAR) revealed psychotropic medications of Quetiapine Fumarate (Seroquel) 50mg via			

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	peg tube at bedtime (HS) daily for mood disorder and Risperidone 0.5mg via peg tube one time daily for anxiety and Risperidone 1mg via peg tube at bedtime (HS) were initiated and administered daily. In an interview on 04/29/25 at 02:17 PM with the Nursing Home Administrator (NHA) was asked to find informed and signed consents for the use of psychotropic medications prior to the administration of the medication for Resident #43. The surveyor was referred to the nurse consultant. In an interview and record review of Resident #43's medical record on 04/29/25 at 02:23 PM with Registered Nurse Consultant "J" revealed that there were no consents for psychotropic medications Risperidone, Seroquel or anxiolytic Xanax. Record review of the facility 'Use of Anti-psychotic Medications' form dated 4/2017 revealed key points to consider: Did the resident and/or family/surrogate decision-maker give informed consent for the use of antipsychotic medication.			
F0759 SS= E	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F0759	F 759 (E) Free of Medication Error Rates Residents #36 and #37 continue to reside in the facility with no negative outcomes. All residents have the potential to be affected. A one-time observation of all licensed nurses during medication administration was completed to ensure medication passes free	5/28/2025

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	Based on observation, interview and record review, the facility failed to ensure that the medication error rate was less than 5% when three medication errors were observed from a total of 25 opportunities for two residents (#36, #37) of five residents reviewed. This deficient practice resulted in a medication error rate of 8% and the potential for the risk of adverse medication effects and decreased medication efficacy. Findings include: Resident #37: Observation on 04/27/25 at 10:47 AM of Resident #37's resident room revealed there to be an intravenous (IV) bag of Meropenem 1gm/100ml solution antibiotic mixed and hanging in room dated 4/27/25. Both Residents that resided in the room were noted to be awake and able to answer questions. In an observation and interview on 04/27/25 at 10:51 AM with the Licensed Practical Nurse (LPN) "K" and state surveyor walked into Resident #37's room and observed the hanging medication on the pole. LPN "K" stated that she mixed the IV around 6:00 AM-6:30 AM and was going to start it but the resident was sleeping and just left it in the room. In an interview on 04/27/25 at 11:37 AM with Licensed Practical Nurse (LPN) "E" Unit		of medication errors. The Medication Administration Guideline was reviewed by the Director of Nursing and Administrator and deemed appropriate. The Director of Nursing/ Designee will educate all licensed nursing staff on the guideline and on proper procedure and administration technique during medication administration. The DON/Designee will conduct random observations 3x per week for 4 weeks and until substantial compliance is achieved to ensure proper administration of medications. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and continued improvement.	

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	manager for D-E halls was on call. LPN "E" stated "I was called in because of a staff call-in, or a no-show. I don't usually work the medication carts so I am not very fast at it". Observation and interview on 04/27/25 at 11:53 AM with Licensed Practical Nurse (LPN) "E" stated "it (intravenous medication) was already hung, but not given, its scheduled for 6:00 AM but I administered that bag after 11:00 AM, it is a late dose, and I let the physician know. It was mixed and left on the pole in the resident room, so I gave it to the resident". Observation and interview on 04/27/25 at 11:56 AM with Licensed Practical Nurse (LPN) "E" were observed to discontinued the Meropenem IV that was administered at 11:15 AM for Resident #37 and stated "I am taking it down and flushing the left arm Peripheral Inserted Central Catheter (PICC) line. That medication was due at 6:00 AM". Record review of Resident #37's April Medication Administration Record revealed that Licensed Practical Nurse (LPN) "K" had signed out the Meropenem IV antibiotic as administered at 6:00 AM. Resident #36: Observation on 4/28/2025 at 8:08 AM of Resident #36's medication administration by Licensed Practical Nurse (LPN) "F". Medications of levothyroxine (Synthroid)			

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	were administered long with loratadine, Norvasc, Probiotic, cyclobenzaprine, gabapentin, guaifenesin. Resident #36 stated that She was waiting for her breakfast tray to come. Observation of Resident #36 bedside table revealed medication cups with 3 white tablets and a light green tablet in them. Resident #36 stated that the night nurse left those 3 tablets for her last night at bedside. Record review of Resident #36's physician orders with LPN "F" revealed that there were no orders for Tums antacid as a standing order. Observation and interview on 04/28/25 at 08:10 AM with Licensed Practical Nurse (LPN) "F" during medication pass of Resident #36 revealed 3 white large tables noted in a medication cup on the bedside table and Resident #36 stated "the night nurse last night gave me those to moisturize my mouth and the tums also". The state surveyor and Licensed Practical Nurse (LPN) "F" observed three white large tablets in the med cup at bedside, and a green tums tablet in another cup at bedside. LPN "F" removed the 3 tablets and tum's left at the bedside. Record review of the medication computer on medication cart D-E revealed Resident #36 was ordered Xyilomelts one tablet at bedtime. Breakfast tray was delivered to the resident's room. In an interview on 04/28/25 at 08:39 AM with Resident #36 revealed she did already have her breakfast tray, stating "they just took it			

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	out, breakfast was good this morning". Record review of the 'Nursing 2017 Drug Handbook' page 875, noted levothyroxine medication should be given at the same time each day on an empty stomach, preferably ½ to 1 hour before breakfast. In an interview and record review on 04/29/25 at 10:12 AM with the Director of Nursing related to the Medication administration policy- and the medication errors observed. (1.) Meropenem Intravenous antibiotic Mixed by night shift Licensed Practical Nurse (LPN) "K" at 6 AM, then left hanging in resident room until administered after 11:00 AM by LPN "E" Unit manager, it was the same medication that was mixed by another nurse. The DON stated that "No, never leave a medication for someone else to pass". (2.) Tablets left at bed side by night nurse- The DON stated "there should not be any medications left at the bedside. Staff did tell me about that yesterday and I am aware. The nurse was asked about it and educated". Tums given with no orders- the DON stated, "that's not the usual practice of that night nurse". (3.) Levothyroxine given at 8:08 AM with breakfast and other medications- The DON stated "that will make the levothyroxine in effective. Yes, we could educate the resident			

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	on the effects of levothyroxine and document it". Record review of the facility 'Preparation and General Guidelines Medication Administration' policy dated 5/2022, revealed medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally to do so. Administration: (7.) the person who prepares the dose for administration is the person who administers the dose. (12.) Medications are administered with in 60 minutes of scheduled time, except before, with or after meal orders, which are administered. Unless other wise specified by the prescriber, routine medications are administered according to established medication administration schedule for the facility. (16.) ...medication cart is kept closed and locked when out of sight of the medication nurse...			
F0761 SS= F	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide	F0761	F761 (F) Label/ Store Drugs and Biologicals All medication carts, and medication rooms were reviewed to ensure that they were locked appropriately, and that multi-dose medications were labeled and dated appropriately after opening. A one-time review of medication storage carts and rooms occurred to ensure proper labeling and storage of all medications. The Medication Storage Guideline was reviewed by the Director of Nursing and Administrator and deemed appropriate. The	5/28/2025

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	separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store medications, medical supplies, labeling and storage in 3 of 4 medication carts and 1 of 2 medication rooms, resulting in a medication cart being left unlocked and unattended, a lack of dating of multi-dose medications after opening, and the potential for residents to receive medications with altered efficiency. Findings include: Record review of the facility 'Medication Storage' policy dated 4/2018, revealed (C.) Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmic, nitroglycerin tables, blood sugar testing solutions and strips, once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency. (D.) When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. (1.) The nurse shall place a 'Date opened" sticker on the medication and		Director of Nursing/ Designee will educate licensed nursing staff on proper procedure of labeling/storing all medications in med carts including multi dose medications, med room medications and OTC medications. The DON/Designee will conduct random observations 3x per week for 4 weeks and until substantial compliance is achieved to ensure proper storage/labeling of all medications. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and continued improvement.	

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	enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both an "open date" and "expiration" notation line). The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. Observation on 04/27/25 at 10:07 AM with Registered Nurse "D" of the A-B hall medication cart: Resident medications were reviewed for the following residents: Resident #211 had medications of Cirpofloxin sol 0.3% eye drop multi-dose bottle, opened 4/24/2025 with no expiration date. Multi-dose bottle of Fluticasone 50mcg/act nasal spray open date 4/25/2025 with no expiration dates. Resident #210 had a multi-dose bottle of Fluticasone 50mcg nasal spray opened and 4/26/2025 with no expiration. Resident #2 had a multi-dose bottle of Fluticasone 50 mcg/act open date 3/26/2025 with a second bottle of Fluticasone 50 mcg/act open date 4/20/2025 and neither bottle had an expiration date. Resident #209 had a multi-dose LISPRO insulin pen with open date with no expiration date noted on pen or package and a Lantus insulin pen Opened with no open or expiration dates on pen or package.			

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	Resident #6 had a multi-dose Novolog insulin pen opened 4/13/2025 with no expiration date. Resident #12 had two Lantus insulin pens, one open dated 4/15/25 and one open dated 4/23/25, and an Aspart insulin pen open dated 4/9/25, there were no expiration dates on the pens. Resident #31 had two Novolog insulin pens with open dates of 4/1/25 and 4/11/25, with no expiration dates. Observation of the medication carts Second drawer noted loose tablets of large white tablet and a peach oval small tablet. Observations on 04/27/25 at 10:23 AM with Licensed Practical Nurse (LPN) "K" of the C-hall Cart1 revealed: Resident medications were reviewed for the following residents: Resident #22 had Ofloxacin 0.3% eye drops with no lid on dropper bottle. No expiration dates or open date on bottle or package. Atropine sulfate 1% Ophthalmic ointment open date with no Expiration date. Erythromycin 5mg/ml Ophthalmic ointment open dated with no expiration date. Timolol 0.5% solution/drops Polymyxin trimethp 1000/0.1% eye drop open date of 4/14/25 with no expiration date.			

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	Resident #7 had multi-dose Lantus insulin open date 4/26/2025 with no expiration date. Resident #108 had multi-dose NovoLog insulin pen open dated 4/23/2025 with no expiration date. Resident #25 had multi-dose Liraglutide 18mg/3ml injection pen opened 4/25/25 with no expiration date. Resident #37 had multi-dose Liraglutide 18mg/3ml pen open dated 4/14/25 with no expiration date. Resident #3 had multi-dose Humalog insulin pen opened dated 4/10/2025 with no expiration date. Resident #9 had Ipratropium 3ml multi-doses ampules not in foil packet and not dated 30 pack with 4 loose ampules in the cart. Resident #21 had an Arnuity Ellipta 200mcg aerosol device open dated 4/19/2025 with no expiration date noted on device or baggie. Observation on 04/28/25 at 08:04 AM of the D-E Hall medication cart with Licensed Practical Nurse (LPN) "F" revealed that Ipratropium Bromide solution inhalation ampules a 30-foil packet with ampules missing one loose ampule noted out of the baggie. Observation on 04/27/25 at 12:17 PM with			

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	Licensed Practical Nurse (LPN) "E" of C-hall Medication cart was left unlocked with computer open to screen, of medical information of Resident #3 . In an interview on 04/29/25 at 10:12 AM with the Director of Nursing related to the Medication administration and storage concerns, the DON stated that Licensed Practical Nurse (LPN) "E" did let the DON know that the medication cart was noted to be unlocked in the hallway. Record review of the facility 'Preparation and General Guidelines Medication Administration' policy dated 5/2022, revealed (16.) ...medication cart is kept closed and locked when out of sight of the medication nurse... On 04/28/25 at 07:52 AM, observation of the Side 1 medication room revealed: -Three bottles of expired povidone iodine, expired 2/25. -One bottle of Microdot bleach wipes expired 1/15/25. These findings were verified with Unit Manager (UM) "E" and Licensed Practical Nurse (LPN) "C"			
F0803 SS= D	Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must-	F0803	F803 (D) Menus Meet Resident Needs/ Preferences in Advance/ Followed	5/28/2025

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	§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, intervention and record review, the facility failed to ensure that meal items were provided per the menu and failed to ensure residents were notified of menu changes for all facility residents who eat in the kitchen including one resident (# 16) of four residents reviewed and a confidential group of residents resulting in verbalization of feelings of frustration and discontent with food and meals. Findings include: A tour of the facility kitchen was completed on 4/27/25 at 10:00 AM. Kitchen Staff "U" was observed preparing food for the resident's lunch. When asked what they were serving the Resident's for lunch as the main entrée, Staff "U" replied, "Hot dogs." Resident #16:		Resident 16's food preferences were reviewed and agreed to by the resident, any changes in the resident's preferences were updated. The menu was reviewed to ensure accuracy. All residents have the potential to be affected. A whole house sweep was conducted to ensure that all residents' food preferences are up to date and accurate, and any concerns identified were immediately addressed. Food Preference check will occur Quarterly during care plans and Dietary council in congruence with Resident Council. If the menu must have substitution resident will initial for agreement with substitution. The Cynthia Chow Guideline was reviewed by the Director of Nursing, Dietary Director and Administrator and deemed appropriate. The Administrator/ Designee will educate all Dietary staff on the guideline and proper procedures for ensuring resident food preferences are met. The Admin/Designee will conduct random observations 3x per week for 4 weeks and until substantial compliance is achieved to ensure that proper food preferences are in place, being followed and that the menu is up to date, accurate and that any changes to it are agreed upon by the residents. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and continued improvement.	

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	An interview was completed with Resident #16 in their room on 4/27/25 at 12:16 PM. Resident #16 was in bed, positioned on their back with the head of their bed elevated at approximately a 25-degree angle. At 12:33 PM, Certified Nursing Assistant (CNA) "T" brought Resident #16's lunch tray into their room. CNA "T" uncovered the tray and hot dogs were observed. Resident #16 said to CNA "T", "Are those hot dogs? It's supposed to be brats." CNA "T" replied, "They didn't have any brats." After CNA "T" exited the room Resident #16 revealed they frequently do not receive what is on the menu. Resident #16 became visibly upset and distraught. Resident #16 verbalized how disappointing it is to look forward to eating something specific only to not get it when the meal is served. Review of Facility Provided Menu for 4/27/25 revealed the food for lunch included Bratwurst on bun. Hot dogs were not listed on the menu. During a confidential resident council meeting on 4/28/25 at 9:53 AM, six out of six residents confirmed planned food on menu is often replaced with a different food item without informing residents of substitutions beforehand.			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to	F0812	F812 (F) Food Procurement/ Storage/ Preparation/ Serve/ Sanitary Conditions The Facility immediately removed all undated/ expired food and beverages from all areas, validated check list for sanitation and cleaning of kitchen and food prep areas are in place, cleaned and sanitized kitchen area, ensured hair nets were being worn properly, and proper hand hygiene is taking place.	5/28/2025

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	compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement and operationalize procedures to ensure proper sanitization and food handling processes in the kitchen for 57 of 57 Residents who eat food prepared in the kitchen, resulting in the potential for contamination, consumption of expired food items, and food borne illness, Findings include: A tour of the facility kitchen was completed on 4/27/25 at 10:00 AM. An entrance to the kitchen was located in the main resident dining room. The door was locked and was opened by Dietary Staff "V" after knocking. There were no hairnets present outside or directly inside of the entrance door. When queried regarding hairnet location, Staff "V" indicated they were located at the other entrance, located off the employee hallway and proceeded to obtain and provide a hairnet. Upon entering the kitchen, a handwashing sink was not seen. When queried where staff wash their hands upon entering the kitchen, Staff "V" directed this Surveyor to a sink located in the dishwashing area of the kitchen. Staff "W" was observed in the dishwashing area of the kitchen, doing dishes, and not wearing a hairnet. Staff "W"		-All personal Items of staff were removed from the Kitchen. - All Dishware was removed from shelving, rewashed and fully dried before being put back on the shelving. -Sanitizer solution was replaced with fresh solution and tested to ensure correct levels. -All Food containers were wiped down and sanitized. - All prep and cooking area were wiped down and sanitized. -Thermometer was placed in freezer and proper temp validated as reading for appropriate ranges. - One gallon of Peppermill Honey Dijon Mustard was disposed. -Package of expired Ham was disposed. - Container of expired Sour Cream was Disposed. - Expired Canola Oil was disposed. - Expired Diced Chicken was disposed. - Freezer Burnt Pork roast was disposed. - Freezer Burnt beef roast was disposed. - Label on Eggs was corrected. -All Thawing meat was moved to bottom shelf of walk in and fruit was disposed of. - All Boxes were removed from the floor.	

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THE VILLA AT WEST BRANCH	445 S VALLEY ST WEST BRANCH, MI 48661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	exited the kitchen. A shelf was present near the hallway entrance doors with multiple uncovered and opened beverages, including open cans, sitting on the top shelf. When queried regarding the beverages, Staff "V" stated, "They are ours." Staff "V" was asked to clarify if they were saying the open beverages were the kitchen staffs, and confirmed they were. When queried if they are supposed to have opened beverages there, Staff "V" responded that is where they were told to put them. When queried who was in charge of the Kitchen at this time, Staff "V" indicated Staff "U". Staff "U" was observed sitting in the kitchen office. At 10:05 AM, Staff "W" was observed reentering the kitchen. Staff "W" did not wash their hands prior to entering the food preparation area and touching food items. Stacked bowls and plates were noted in the kitchen on a shelving unit. Moisture and liquid were observed and felt in the stacked bowls. When asked, Staff "U" confirmed the bowls were not dry and stacked together. When asked if the bowls should be stacked when they are not completely dry, Staff "U" verbalized dishes should be completely dry before being stacked. Small plates were stacked next to the bowls. Moisture was felt on the stacked plates when touched. Staff "U" was asked about the plates and confirmed they felt damp. A container of "Whipped Spread" (Expiration Date 4/25) was sitting on the food preparation table. When asked if the whipped spread was supposed to be sitting out, Staff "U" stated, "Should have been put away." The food preparation table was observed to be dirty with		-The Freezer condenser was de- iced and icicles removed. All residents have the potential to be affected by this. An initial Audit of the kitchen and nutrition room was conducted to identify that all food and beverages were labeled and dated, and that cleaning/ sanitation checklists were available for staff and being completed. The Cynthia Chow Guideline was reviewed by the Director of Nursing, Dietary Director and Administrator and deemed appropriate. The Administrator will provide 1:1 education to the Dietary Manager on the Cynthia Chow Guideline. The Administrator/Designee will provide education to all dietary staff on the Cynthia Chow Guideline and on proper food safety and handling. The dietary manager will ensure all food and beverages are labeled and dated and that cleaning/ sanitation checklist are available for staff and being completed The Administrator/Designee will conduct audits randomly 4x a week for 4 weeks and until substantial compliance is achieved on all shifts to ensure proper sanitization and food handling process in the kitchen. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for improvement in overall quality for our residents.	

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	significant amounts of unknown food substances and crumbs on it. A cleaning/sanitizer bucket was not observed. When asked where the cleaning/sanitixing bucket was, Staff "U" revealed it was kept in the dishwashing area and pointed out where the bucket was. When asked how staff confirm the level of sanitizer in the bucket, Staff "U" obtained chemical testing strips. Upon request, Staff "U" testing the level of sanitizer present in the bucket. The sanitizer level was zero parts per million (ppm). When asked what the level of sanitizer is supposed to be, Staff "U" replied, "Supposed to be at 400 (ppm)." The following items were present in the reach-in refrigerator: - One gallon container of Peppermill Honey Dijon Mustard Dressing, Open and Undated - Package of ham, Labeled as expired on 4/26/25 - Five-pound container of Sour Cream, Labeled as expired 4/21/25 Within the dry food storage area, two 48-ounce bottles of canola oil were expired. When queried, Staff "U" removed the items from service. The following items were observed in the upright freezer in the dry storage area: - The individual serve ice cream cups were not frozen solid to touch. When queried regarding the individual cups feeling squishy and soft, Staff "U" confirmed the cups did not feel frozen solid to touch. - A package of diced chicken. Labeled as expired			

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	4/21/25. - A package of pork roast was in a plastic bag, covered in ice, and freezer burnt. - A package of beef roast was in a plastic bag, covered in ice, and freezer burnt. Staff "U" was asked about the diced chicken and confirmed it was expired and should have been removed from the freezer. When queried regarding the port and beef roasts. Staff "U" verified both were covered in ice and freezer burnt. When asked if there had been any problems with the freezer, Staff "U" replied, "Not that I know of." A thermometer was not observed inside of the freezer. When queried how staff monitor the temperature, Staff "U" verbalized the temperature reading on freezer door is documented. The following items were noted in the walk-in refrigerator: - A white colored, greasy textured substance was present on the tops of the one-gallon containers of Whipped Topping. - A box of 15 dozen grade A eggs was sitting on the floor on the right side of the door. Open "4/22 (2025)" and Use By "5/22 (2025)" was written on the side of the box with a sharpie style marker. The manufacturer label on the box specified the expiration date for the eggs was 5/3/25. - A package of thawing ham was sitting on top of			

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	a box on the bottom shelf of the refrigerator. The door to the walk-in freezer was in the walk-in refrigerator. Upon entering the walk-in freezer, there were multiple boxes of frozen food sitting directly on the floor of the freezer. The freezer condenser was covered in ice and had leaked onto the shelving unit below. Large icicles were present on the shelving unit below the condenser. The boxes of food on the floor prohibited movement and entry into the freezer. A tour of the walk-in refrigerator and freezer was then completed with Staff "U". When queried regarding the substance on the Whipped Topping containers, Staff "U" checked the containers and revealed they believed it was whipped topping. When asked if one of the containers had leaked, Staff "U" stated they were making lunch and "will check" when they are done. When asked about the ham on the top of the box of produce, Staff "U" confirmed the meat was thawing. When asked if it is the normal procedure to place thawing meat on top of a box, Staff "U" replied, "It depends on the space situation." When asked if thawing meat should be on top of something else, Staff "U" replied, "No." Staff "U" was then asked what the expiration date was of the box of 15 dozen eggs and stated, "May 22nd." When queried regarding the manufacture expiration date of the eggs, Staff "U" reviewed the label and stated, "May 3rd". When queried regarding the date written on the box, Staff "U" explained staff write a use by date on the box. Staff "U" was asked when the eggs should be used by and indicated 5/3/25. Staff "U" stated manufacturer expiration date "trumps." When queried regarding the items on the floor in the freezer, Staff "U" stated the food was delivered on			

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	"Friday" and it had not been put away yet. When queried regarding the ice build up in the freezer, Staff "U" revealed Maintenance staff defrost the freezer, and they were unaware of the schedule. At 10:50 AM on 4/27/25, the facility Administrator entered the kitchen. The Administrator was observed donning a hairnet inside the dishwashing area of the kitchen, near the dishwasher where the clean dishes were left to air dry after going through the dishwasher. The Administrator was asked about the open and uncovered employee beverages sitting on the shelf in the dishwasher area of the kitchen and responded that is "where supposed to put them." A tour of the kitchen was completed with the Administrator at this time. The food preparation table remained visibility soiled with the same food materials as previously observed. Staff "V" was preparing items for resident lunches on the table. The food substances were pointed out to the Administrator, and they were informed of prior observation. When asked, the Administrator verbalized the table should have been cleaned and asked Staff "U" to clean the table. When queried regarding the wet stacked bowls, the Administrator did not provide an explanation. The Administrator was then taken to the upright freezer and informed of individual ice cream cups not feeling frozen solid as well as expired and freezer burnt food items. When queried if a second thermometer should be present inside the freezer to confirm temperature, the Administrator replied there should be and opened the freezer to look for a thermometer. The Administrator was unable to locate a thermometer in the freezer. The Administrator			

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	was then shown the walk-in refrigerator and freezer. When queried regarding the ham on top of the produce box, the substance on the whipped topping containers, and the date on the eggs, the Administrator did not provide an explanation. When asked about the food items on the floor in the freezer as well as the icicles and ice build, an explanation was not provided by the Administrator. Upon preparing to exit the kitchen, the Administrator removed their hairnet and threw it away in the garbage located by the handwashing sink on the clean dishes side of the dishwashing area and then proceeded to walk past the clean dishes towards the exit door. When queried if hairnets are required to be worn upon entering the kitchen, the Administrator responded that hairnets do not need to be worn until going into the food preparation and cooking area of the kitchen and were not required in the dishwashing area of the kitchen. An interview was conducted with the Director of Nursing (DON) and Infection Control (IC) Licensed Practical Nurse (LPN) "M" on 4/29/25 at 12:41 PM. When queried if hairnets should be worn in the dishwasher area of the kitchen, the DON asked if staff were not wearing a hairnet. Observations and interviews of staff in the kitchen were relayed to IC LPN "M" and the DON at this time. The DON responded, "Should wear a hairnet" and revealed they thought there was a line in the kitchen, at the entry door to signify where hairnets had to be worn after crossing. When queried regarding observations of staff open and uncovered beverages on the shelf in the dishwashing area of the kitchen, the DON verbalized staff should not have personal beverages there.			

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	According to the 2022 US Food and Drug Administration Food Code (January 18, 2023 Version), "Food employees shall wear hair restrains ... that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, clean equipment, utensils, and linens; and unwrapped single-service and single-use articles ..." Review of facility policy/procedure entitled, "Hair Restraints/Jewelry/Nail Polish" (Revised 2017) revealed, "Policy: Food and nutrition serves employees shall wear hair restraints and bear beards .... Procedure: Hairnets will be worn at all times in the kitchen ..." Review of facility policy/procedure entitled, "Food Safety Requirements Guideline" (Revised: 2/7/25) revealed, "It is the practice of this facility to provide safe and sanitary storage, handling and consumption of all foods ... Safety Precautions ... Use proper hand hygiene before and after serving food ... Refrigeration ... Freezers must keep frozen foods frozen solid. The following are methods to determine the proper working order of the refrigerators and freezers: Document the temperature of external and internal refrigerator gauges ... Freezers must be cold enough to keep foods frozen solid to touch ... Check for situation where potential for cross-contamination is high (e.g. raw meat stored over ready to eat items). Check the firmness of frozen food and inspect the wrapper to determine if it is intact enough to protect the food ..."			
F0847 SS= E	Entering into Binding Arbitration Agreements §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement	F0847	F 847(E) Entering into Binding Arbitration Agreements Resident 9, 35, and 213 arbitration	5/28/2025

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	for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by:		agreements were reviewed and agreed to by the residents, with a new agreement signed. All residents have the potential to be affected. A whole house sweep was conducted to ensure that all residents are aware of and understand our arbitration agreements and have a new arbitration agreement signed if they so choose to enter into the binding arbitration agreement. The Grievance Guideline was reviewed by the Director of Nursing , Admission's Director and Administrator and deemed appropriate. The Administrator/ Designee will educate all IDT staff on the guideline and our Arbitration agreements and who to contact if a resident has any questions about arbitration. The Administrator/Designee will conduct random observations 3x per week for 4 weeks and until substantial compliance is achieved to ensure residents are aware of what an arbitration agreement is and who to contact if they have any question about arbitration agreements The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and continued improvement.	

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	Based on interview and record review the facility failed to ensure that arbitration agreements were explained in a manner that can be understood for three residents (R9, R35, R213) and 6 of 6 residents in resident council reviewed for arbitration agreements, resulting in residents being unsure of what they signed and agreed to. Findings include: On 04/27/25 at 10:06 AM, an interview was conducted with the nursing home administrator (NHA). The NHA was asked if the facility offers binding arbitration agreements to the residents. The NHA stated they do offer them, and they believe that most of the residents in the facility have signed and agreed to them. A list of residents who had signed the agreement was requested. On 04/28/25 at 08:13 AM, an interview was conducted with Admissions Director "G". Admissions Director "G" was asked to explain the process that they go through to explain the arbitration agreements. Admissions Director "G" stated, I go through the admissions agreement step by step and explain everything. I explain the arbitration agreement to the residents but let them know that it is not necessary to agree just to get admitted. Most of the time they agree to the arbitration agreement, but we do have			

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	residents that don't sign. I tell residents you have 30 days from the day you signed to make changes to the arbitration agreement. Admissions Director "G" was asked if they retain copies of the signed agreements. Admissions Director "G" stated yes, I let every resident or responsible party know that they can have a copy of the arbitration agreement or the admission packet if they want one. If the resident is not alert, I go over the agreement with the responsible party or guardian. If the resident does not have a guardian and is not alert, then I have to wait to get things signed. On 04/28/25 a list was provided of all the residents in house who have signed an arbitration agreement. Three cognitively intact residents were chosen from the list Resident # 9 On 04/28/25 an interview was conducted with R9. R9 admitted to the facility on 04/02/25 and has a brief interview for mental status (BIMS) of 13, indicating they are cognitively intact. R9 was asked if they knew what the arbitration agreement was that they signed when they came to the facility. R9 was unable to give an answer and was generally not aware of what the arbitration agreement was. Resident # 35 On 04/28/25 an interview was conducted			

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	with R35. R35 admitted to the facility on 09/05/24 and has a BIMS of 15, indicating they are cognitively intact. R35 was asked if they understood the arbitration agreement they signed when they admitted to the facility. R35 couldn't give an answer on what they thought it was. R35 seemed confused about what she signed. Resident # 213 On 04/28/25 an interview was conducted with R213. R213 admitted to the facility on 04/02/25 and has a BIMS of 13, indicating they are cognitively intact. R235 was asked if they understood what the arbitration agreement was that they signed on admission. R235 stated they were not aware of what they signed. R235 was asked if the arbitration agreement was explained to her. R235 said it was not explained to her. On 04/28/25 at 02:45 PM, an interview was conducted with the NHA. The NHA was asked about the process for explaining arbitration agreements with incoming residents. The NHA stated, "I have watched the admissions director do admission paperwork. She takes her time and is very thorough with everything she does. If anything could be adjusted, maybe the arbitration agreements could come up sooner in the admission packet. Maybe it would be in our best interest to bring this up in resident council or QA." Resident Council:			

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	In an interview and record request on 04/28/25 at 09:53 AM with the Activity director "L" the state surveyor requested 6 months of Resident Council meeting minutes to review prior to the scheduled meeting. Activity Director "L" revealed that the council meet in the main dining room. Resident Council meeting on 04/28/25 at 10:03 AM noted 6 Residents attended the confidential meeting with the state survey agency. During the resident council meeting the residents in attendance were asked about Arbitration agreements. One confidential resident responded that it was a trust issue for them and that the facility give a new admission/arbitration agreement so much information the first week that the resident does not remember what was signed. Another confidential resident stated that they did not know what arbitration was or what it means. The State surveyor inquired if any of the six confidential residents attending the meeting knew what the arbitration agreement was? and 6 of 6 residents did not understand the arbitration process or what it meant.			
F0880 SS= F	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention	F0880	F880- (F) Infection Control/Surveillance A system has immediately been put in place for Infection Preventionist to prevent, identify, report, investigate and control infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing services under a contractual	5/28/2025

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	and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must		arrangement. Resident 4's catheter drainage bag was reviewed to ensure proper storage preventing the potential spread of microorganisms and illnesses. All residents have the potential to be affected for infection control/surveillance. A one-time review of the infection control surveillance process was completed, facility wide audits were initiated, and all residents with catheters were reviewed to ensure proper storage of drainage bags. Any concerns identified were immediately addressed. The Infection Control and Surveillance Guideline was reviewed by the Director of Nursing and Administrator and deemed appropriate. The Director of Nursing/ Designee will educate the Infection Preventionist on proper surveillance, analysis, and tracking of infections and symptoms. The DON/ Designee will educate all staff on proper infection control practices and on proper storage of catheter drainage bags. The DON/Designee will conduct random observations 3x/week for 4 weeks and until substantial compliance is achieved to ensure proper completion of the infection control line listing, completion of facility wide audits, and analysis of monthly data. The DON/Designee will also conduct random observations 4x weekly for 4 weeks and until substantial compliance is achieved to ensure all catheter drainage bags are stored properly. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and continued improvement.	

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	654010	A. BUILDING _____ B. WING _____	4/29/2025

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	handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement and operationalize a comprehensive Infection Control (IC) program, encompassing outcome and process surveillance including surveillance resulting in lack of accurate and comprehensive infection tracking, surveillance and data monitoring/analysis and failed to ensure a urinary catheter drainage bag was maintained off the floor for one resident (Resident #4) of two residents reviewed resulting in the potential for infection and the likelihood for spread of microorganisms and illness to all 58 facility residents. F indings include: An interview was and review of facility IC data was completed with IC Licensed Practical Nurse (LPN) "M" and the Director of Nursing (DON) on 4/29/25 at 12:41 PM. When queried, IC LPN "M" revealed they had been working at the facility for less than a month and had never worked in IC prior to taking their current position. IC LPN "M" revealed the only IC data they had worked on and were familiar with was for April 2025. The facility IC data provided for April 2025 included a "Monthly Infection Control Log (Line List)" and an infection mapping tool. The data			

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	was reviewed with IC LPN "M" and the DON at this time. Review of the Mapping tool revealed 21 infections listed comprised of seven "UTI (Urinary Tract Infection)", nine "URI (Upper Respiratory Infection)", three "skin" infections, and two "other" infections. Review of the "Monthly Infection Control Log (Line List)" for April 2025 detailed 28 infections which all received antimicrobial treatment for 26 Residents. When queried regarding the discrepancy in the number of infections, IC LPN "M" replied, "Some residents were discharged." When asked if they have a system in place to distinguish/identify if a resident is discharged and/or if they have a room change on the line list and/or mapping tool, IC LPN "M" revealed they did not. When queried how they would identify potential concerns related to environmental contamination and spread of infection without including the information in their surveillance, IC LPN "M" verbalized understanding and indicated they would incorporate the information in their surveillance. When asked again about the discrepancy in the number of infections between the line listing and the mapping tool, IC LPN "M" responded that some residents had multiple infections but only one infection was included on the mapping tool. Review of the line list revealed two residents were listed as having multiple infections. Resident #9 had pneumonia, a UTI, and a yeast infection and Resident #211 had a respiratory infection and conjunctivitis (pink eye). The mapping tool did not designate each of the infections for both residents. IC LPN "M" was			

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	queried further as discrepancy in the number of infections remained, after the residents with multiple infections were excluded and indicated they did not include the residents with prophylactic antibiotics on the mapping tool. Review of the line listing revealed four residents were listed as receiving prophylactic antibiotics. Two out of four residents receiving prophylactic antibiotics were included on the mapping tool. IC LPN "M" reiterated they were new and must have missed something. IC LPN "M" also stated they were not done with the IC data for the month. IC LPN "M" preferred to review April 2025 when asked as it was the only month they had worked with the data. The "Monthly Infection Control Log (Line List)" for April 2025 did not include any carryover infections from the prior month. When asked if they had any carry over infections, IC LPN "M" and the DON revealed they were not sure. A review of the "Monthly Infection Control Log (Line List)" for March 2025 revealed there were seven carryover infections which included respiratory/pneumonia, skin, and UTI. When asked about surveillance and mitigation of potential spread, IC LPN "M" and the DON verbalized understanding. The "Monthly Infection Control Log (Line List)" for April 2025 did not include any infections and/or potential infections which were not treated with an antimicrobial medication. When queried regarding surveillance for potential infections, IC LPN "M" revealed they were not tracking any infection and/or potential infection which was not treated with an antimicrobial medication.			

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	The infection mapping tool April 2025 revealed five Residents were marked with the color designated for URI's in one hall of the facility. When asked if they had any concerns when they identified multiple residents in the same area of the facility with the same infection, IC LPN "M" replied, "If I saw a trend I would educate." Comparison of the URI's with the information on the "Monthly Infection Control Log (Line List)" revealed one resident was listed as having a "respiratory" infection, two were listed as "pneumonia" and the resident in room 125 had a UTI and not a URI. When queried regarding the colored dots on the map not correlating with the infection type listed on the "Monthly Infection Control Log (Line List)", IC LPN "M" reiterated they were new, had not finished for the month, and indicated they made a mistake. The "Monthly Infection Control Log (Line List)" included headings for name, admit date, room, infection type and date of onset, culture date, organism, and antibiotic resistance, antibiotic and date of onset, and if the infection met criteria. Clinical Registered Nurse (RN) "J" entered the room at this time. Review of the line listing detailed Resident #14 revealed the Resident was treated with Macrobid (antibiotic) for a UTI. The line listing specified that the Resident began to have symptoms on 4/12/25 and a Urinalysis (UA) was sent on 4/12/25. An organism was not included on the line listing. Upon request for a copy of the UA culture and sensitivity (C&S), IC LPN "M" indicated they did not have a copy. The DON reviewed the Resident's EMR and stated, "No C&S. It was never done." When queried why an			

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	antibiotic was started without a C&S, IC LPN "M" responded that the doctor ordered it. When queried regarding best practice for antibiotic use and treatment, RN "J" stated, "Best practice is to wait for a C&S." When queried regarding antibiotic stewardship, no further explanation was provided. When queried what criteria is used, IC LPN "M" replied, "McGeer". When asked if a risk vs benefit was completed for antibiotic use without a C&S, the DON and IC LPN "M" revealed there was not. Resident #43 was listed as having a "respiratory" infection on the line listing. The line listing detailed the Resident began having symptoms on 4/3/25 and a culture was obtained on 4/4/25 which was negative for infection. Per the line listing, the infection met McGeer Criteria, and the Resident received Azithromycin (antibiotic). The line listing did not include signs/symptoms of infection. When queried regarding the Resident's signs and symptoms of infection, IC LPN "M" stated, "Cough and runny nose. They did not meet criteria." The DON then stated, "Has a risk vs. benefit note." When queried why an antibiotic was administered for signs and symptoms of a common cold, the staff reiterated that was what the physician ordered. Resident #41 was listed as having facility acquired pneumonia. When queried, the DON verbalized the Resident had came to the facility from the hospital with pneumonia on 3/14/25 and they did not think the Resident fully recovered from it. When queried if a culture was obtained at the hospital, the DON revealed the facility has a difficult time obtaining cultures and results from the hospital.			

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	The line list further detailed Resident # 46 was treated for a UTI. Per the line listing, the Resident's symptoms began on 4/14/24, a UA was completed that day, but a C&S was "not indicated." The Resident was treated with Keflex (antibiotic) starting on 4/14/25. Review of Resident #46's UA revealed "Microscopic (C&S) indicated." When queried why the line listing specified a C&S was not indicated when the UA specified it was, the DON revealed the Resident's medical record and stated, "The order does not say to do a C&S if indicated. The order says just collect UA not to do a C&S." The DON revealed the wrong order was entered. When asked why facility staff did not follow up to ensure the C&S was completed and that the appropriate antibiotic was being utilized, an explanation was not provided. When queried regarding process surveillance, IC LPN "M" indicated they were unsure what that was. When asked if they were completing audits, IC LPN "M" revealed they had not completed any yet but verbalized they had a "hand hygiene" audit to complete for the month. When queried regarding concerns and processes identified, Clinical RN "J" verbalized they were aware of the need for improvement in the IC program and were working with IC LPN "M" and the DON to implement changes and improve the program. Review of facility policy/procedure entitled, "Infection Prevention and Control Program" (Dated 2017) revealed, "The primary mission is to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to			

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	help prevent the development and transmission of communicable diseases and infections ... The Infection Prevention and Control Program includes: 1. A system for preventing, identifying, reporting, investigation, and controlling infections and communicable diseases ... 3. An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use ..." Resident #4: Observation and interview an 04/27/25 at 11:08 AM with Resident #4 stated "I got the catheter when I came here to this building, I had a Urinary Tract Infection, and they are giving me some pills for it. I couldn't pee on my own, and I use to do a straight stick catheter". The state surveyor Observed urinary catheter at bedside in privacy bag, with tubing touching/lying on the floor. Observation on 04/28/25 at 12:28 PM of Resident #4 was seated at edge of bed awaiting her noon meal tray. The state surveyor Observed urinary catheter and tubing laying on the floor outside of the privacy bag. Resident #4 stated that she "did not know what was going on with the catheter bag. The staff /girls take care of the catheter for me". Observation on 04/28/25 at 12:30 PM Activities aide "A" brought in her lunch tray, she did not know anything about the urinary catheter. On 04/28/25 at 12:32 PM the state surveyor went to find Licensed Practical Nurse "B" and			

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	returned with the surveyor to Resident #4's room. Both LPN "B" and state surveyor Observed urinary catheter on the floor outside the privacy bag. LPN "B" stated "I don't know why the catheter was out of the privacy bag and on the floor, I know that Resident #4 doesn't like to get out of bed. LPN "B" put on gloves and picked up the catheter from the floor with no enhanced barrier PPE put on. ON 04/28/25 12:36 PM Resident #4 stated that she had not been into the bathroom or out of bed.			