

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 4/30/2025
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NAME OF PROVIDER OR SUPPLIER SKLD WEST BLOOMFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 6950 FARMINGTON RD WEST BLOOMFIELD, MI 48322
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F0000 SS=	INITIAL COMMENTS SKLD West Bloomfield was surveyed for an Abbreviated survey on 4/30/25. Intakes: MI00150568, MI00150793, MI00151843, MI00152154 & MI00152471. Census= 83.	F0000		
F0610 SS= D	Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00152154. Based on observation, interview, and record review the facility failed to thoroughly investigate an allegation of sexual abuse for one resident (R304) of three residents reviewed for abuse, resulting in the potential for unidentified instances of abuse. Findings include: A complaint received by the State Agency alleged	F0610	Element I: Resident #304 continues to reside in the facility and states that she feels safe, she was physically assessed by the charge nurse and provider. Resident #304 is followed by the facility social worker with no effect to mood or routine noted. The allegation of abuse was investigated and not verified. All residents have the potential to be affected by this citation. Element II: An initial "care concern" audit was completed to ensure that there were not any existing or new allegations of abuse. There was nothing remarkable to report. Element III: The Senior Administrator educated the facility administrator on the facility policy titled, "Nursing Administration...Subject: Abuse and Neglect". The Senior Administrator also provided education on the contents of a proper investigation including, but not limited to, reviewing PCC documentation. The facility educated its staff on abuse reporting. Element IV: The Senior Administrator will perform weekly audits on any investigative files should the need arise, to ensure that necessary contents are provided. The findings from those audits will be reviewed by the administrator and submitted to the QAPI committee for review and recommendation. Element V: The Administrator is responsible for achieving and maintaining compliance with	6/2/2025

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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	<p>R304 had been sexually abused.</p> <p>A review of R304's clinical record revealed they admitted to the facility on 8/1/21, went to the emergency room on 4/12/25, and returned to the facility on 4/13/25. A review of R304's progress notes revealed a note entered into the record by Nurse 'D' on 4/11/25 at 8:04 AM that read, "...Patient woke up this morning at 6:30am <sic> confused and thinks there was a man in her room..."</p> <p>A review of a facility provided investigation file for R304 was conducted on 4/30/25 at 9:30 AM. The file included a typed summary that indicated the facility had been made aware by a city police officer that while in the hospital on 4/12/25, R304 alleged they had been raped by a male caregiver. The summary further indicated R304 denied the allegation. The file provided indicated the only other interviews conducted were with R304's responsible party and two male staff members who work on R304's unit. The file did not contain interviews with any other staff such as: their assigned nurse, nurse aide, other staff assigned to the unit at the time of the allegation, Nurse 'D' who documented R304 reporting a man in their room, or any other residents in the facility.</p> <p>A review of the progress note dated 4/11/25 8:04 AM revealed the following: "Patient woke up this morning at 6:30am confused and thinks there was a man in her room. Writer notified Nurse Practitioner..."</p> <p>On 4/30/25 at 11:00 AM, R304 was observed in their bed. An interview regarding an abuse allegation reported to hospital staff was attempted, however R304 did not have any recollection of the incident.</p> <p>On 4/30/25 at 2:30 PM, an interview was</p>		the compliance date being 6/2/2025.		

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F0689 SS= D	<p>conducted via telephone with the facility's Administrator/Abuse Coordinator. They were asked about their investigation and whether they interviewed any other staff other than the two males and they said they did not. They were then asked if they interviewed any other residents and said they did not. When asked if they were aware on 4/11/25 (prior to the allegation on 4/12/25) that R304 reported there was a man in their room and they said they were not aware.</p> <p>A review of a facility provided policy titled, "Nursing Administration...Subject: Abuse and Neglect" updated 3/2024 was conducted and read, "...If abuse/neglect is suspected the facility will:...3. Conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses. 4. Conduct the investigation with clear communication process to ensure all relevant information is reported and recorded..."</p> <p>Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to Intake Number(s): MI00151843.</p> <p>Based on interview and record review, the facility failed to assess a resident timely after a fall, document the fall in a timely manner, and investigate to determine the root cause</p>	F0689	<p>Resident # 303 is currently not in the facility (unrelated to this citation). Resident 303 root cause for the incident was identified post incident, resident was assessed with orders for x-rays of her knee, ankle, hips and back related to pain. No abnormal findings were identified. The resident's care plan was updated to have 2 person assistance with transfers.</p> <p>CNA no longer employed at the facility. Nurse Tyonna Hayes-King was provided 1:1 education on the Fall Management policy, with emphasis on what is considered an incident, timely assessment of a resident post fall with investigation to determine root cause analysis and reporting/documentation of all incident/accidents to the Director of Nursing. All residents have the potential to be affected by the deficient practice.</p> <p>An audit was conducted of all resident</p>	6/2/2025

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	<p>of the fall for one (R303) of two residents reviewed for falls. Findings include:</p> <p>A review of a complaint submitted to the State Agency revealed an allegation that R303 fell in the shower while assisted by a Certified Nursing Assistant (CNA) who transferred the resident by herself. R303's knee was swollen as a result of the fall. According to the complainant, as noted in the intake, the facility staff said R303 "slipped down but didn't fall".</p> <p>On 4/30/25 at 10:03 AM, it was explained by staff that R303 was on leave of absence from the facility for the day. Therefore, R303 was not available for observation or interview. A second attempt to observe or interview R303 was made at approximately 1:30 PM. R303 had not yet returned to the facility.</p> <p>A review of R303's clinical record revealed R303 was admitted into the facility on 1/29/25 and readmitted on 3/27/25 with diagnoses that included: hemiplegia and hemiparesis (paralysis and weakness on one side of the body). A review of a Minimum Data Set (MDS) assessment dated 2/1/25 revealed R303 had severely impaired cognition and required partial/moderate assistance from staff for tub or shower transfers.</p> <p>A review of R303's progress notes revealed a "General Progress Note" written by Licensed Practical Nurse (LPN) 'A' on 3/19/25 at 2:27 AM (midnight shift) that noted, "Resident self reported fall to writer and stated that during her shower this am (morning) on dayshift, CNA attempted to transfer her without any assistance and she fell to floor on her knees and toes. Resident</p>		<p>incident/accidents from the past 90 days to ensure all residents with incident/accidents were assessed, investigation completed to determine root cause analysis and documentation, care plan updated in the resident medical record.</p> <p>The DON/designee spoke with all residents who were able to be interviewed for any incident/accident/falls that have not been reported. None were identified.</p> <p>The DON/designee will review all incident/accidents from the previous day/weekend during daily clinical meeting to ensure residents with incident/accidents have been assessed timely after a fall, investigation is completed to determine root cause analysis. The DON/unit managers will provide focused oversight during daily rounds on the units and provide educational opportunities and reminders to staff who provide care to residents to ensure any incidents that occur while providing care are immediately reported for investigation. This will include random interviews with residents while rounding daily. By 5/21/2025 licensed nurses and certified nursing assistants will be educated on the Best Practice Fall Management policy with emphasis on what is considered a fall (examples of residents being lowered to the floor), head to toe assessments of residents in a timely manner, investigations to determine root cause analysis and reporting of incident/accidents.</p> <p>The DON/designee will audit all risk management reports weekly x 4 weeks and then monthly x 3 months or until substantial compliance has been maintained to ensure that nurses are following the policy for risk management and falls, with emphasis on assessing residents in a timely manner and investigation to determine root cause analysis</p>		

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	<p>c/o (complained of) pain this evening in BLE (bilateral lower extremities) and was given Tylenol PRN (as needed)...Resident stated she was assisted up with CNA and two other people in shower room on unit...new order for STAT (right away) x-ray to BLE, hips, knees, and ankles and lower back..."</p> <p>Further review of R303's progress notes revealed no documentation from day shift on 3/18/25 that noted R303's fall or that she was assessed afterwards.</p> <p>On 4/30/25 at 11:54 AM, Infection Control Nurse (Nurse 'C') who was the designated staff in charge in the absence of the Administrator and Director of Nursing (DON) was asked to provide any incident reports with associated investigations for R303 since 3/1/25. The Administrator and DON were included in the email.</p> <p>On 4/30/25 at 12:17 PM, Nurse 'C' provided one incident report for R303. At that time, Nurse 'C' was asked if there was any documented investigation for the incident. Nurse 'C' reported she would look into it.</p> <p>A review of an incident report for R303 dated 3/19/25 at 12:00 AM, completed by LPN 'A', revealed, "Resident self reported to nurse that during her shower this morning, CNA attempted to transfer resident alone even after she told her she would need help to transfer her. Resident says she then fell to the floor on her knees and toes and CNA went and got help of another two people to help her back up. Later this evening she c/o BLE pain..." In the "notes" section of the incident report, the Director of Nursing (DON) documented, "...Resident stated was lowered to the floor while in the shower room.</p>		<p>for falls.</p> <p>The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions.</p> <p>The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 6/2/2025 and for sustained compliance thereafter.</p>		

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	<p>Corrective action: Transfer status changed to 2 person with transfers...Need more support with transfers..."</p> <p>On 4/30/25 at approximately 1:30 PM, Nurse 'C' reported she spoke with the DON and confirmed there was no additional documented investigation related to R303's fall on 3/18/25.</p> <p>A review of a "Post Fall Assessment" for R303, opened on 3/20/25, revealed it was not completed. The assessment was blank and not completed or locked.</p> <p>On 4/30/25 at 3:15 PM, an interview was conducted with the DON via the telephone. When queried about the facility's protocol after a resident had a fall, the DON reported the nurse assessed the resident, notified the DON, resident's responsible party, and the physician, an incident report was completed, and then it was investigated. When queried about when she was notified of R303's fall, the DON reported Nurse 'A' notified her on the midnight shift that R303 said she fell. The DON said she talked to the CNAs and R303 was "lowered to the floor" but that was still considered a fall. When queried about who the CNA was who transferred R303, the DON could not remember. When queried about who the other staff were that assisted getting R303 off the floor, the DON could not remember. The DON confirmed there was no documented investigation to determine the root cause of the fall. When queried about when R303 should have been assessed and when the fall should have been documented and management, physician, and responsible party notified, the DON reported at the time of the fall. When queried about whether the CNA should have continued with</p>			

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F0692 SS= E	<p>the transfer if the resident "told her that she would need help to transfer her", the DON reported the CNA should have gotten additional assistance.</p> <p>A review of a facility policy titled, "Best Practice Fall Management" dated 2/13/20, revealed, in part, the following, "...Post Fall Procedure: Licensed Nurse will complete following: Head to toe assessment...Obtain vital signs...Ensure resident safety...Notify physician...resident responsible party...Documentation: Licensed Nurse will complete following in (electronic medical record) Risk Management: Details...Injuries...Factors...Witnesses...Licensed nurse will conduct and document interview with witness(s) that directly observed and/or heard occurrence...Licensed Nurse will document the following in Progress Note with type of Event Note: Vital signs...Neuro Assessment...ROM (range of motion)...Pain...Skin alterations...or any other injury...New intervention(s)...Notification of physician...Notification of responsible party..."</p> <p>Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident</p>	F0692	<p>Element I- Resident #305 was identified and no longer resides at the center. All residents who reside at the center have the potential to be affected by the deficient practice.</p> <p>Element II- The facility completed an initial audit that consisted of pulling a PCC report for all residents the triggered for significant weight loss in the past 90 days. The facility reviewed the residents on report to ensure adequate interventions are in place to further weight loss.</p> <p>Element III- During morning clinical meetings, the facility IDT will review the EMR clinical dashboard for any resident who triggers for</p>	6/2/2025

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	<p>preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to intake: MI00152471.</p> <p>Based on interview and record review the facility failed to consistently assess, monitor, and review the nutritional needs and ensure adequate interventions were consistently implemented and/or modified to prevent further weight loss for one (R305) of three residents reviewed for nutrition, resulting in a severe weight loss of - 15.05 lbs (pounds) within four weeks of admission. Findings include:</p> <p>A review of a complaint submitted to the State Agency (SA) documented the following in part, "... On 03/19/2025, (R305's name) was discharged from (hospital name) to (facility name) On 04/20/2025... admitted to (hospital name) ... (R305's name) has lost roughly around 20 pounds since he was admitted to (facility name)...."</p> <p>A review of the hospital documents provided to the facility upon R305's admission documented the following:</p> <p>A "Nutrition" consult dated 3/17/25 at 3:45 PM, "... Weight: 68 kg (kilogram) (149 lb (pounds) 14.6 oz (ounces) ... 03/14/25 ... Problem: Malnutrition acute disease or injury related (Severe - active) ... Etiology: Inadequate energy intake ... Report of pt (patient) with no appetite,</p>		<p>less than 50% of meal consumption and/or significant weight loss. The IDT will immediately assess the nutritional needs of those residents to ensure adequate interventions are consistently implemented and/or modified to prevent further weight loss. The facility will conduct weekly risk management meetings to complete follow-up on all residents who identified having weight loss and/or poor appetite. The facility will educate the RD/Designee, and members of the IDT which includes the DON, MDS, Unit Managers and the Certified Dietary Manager on the Nutrition Monitoring and Management policy to promptly identify risk and address any concerns regarding weight loss or poor appetite.</p> <p>Element IV- The Registered Dietician/Designee will audit the medical records of 5 residents with triggered weight loss, times four-weeks, then monthly for three-months to ensure the facility is assessing, monitoring and reviewing nutritional needs and intervention to prevent further weight loss of its residents. The audit results will be given to the administrator who will provide them to the QAPI committee for review and recommendations.</p> <p>Element V- The Administrator is responsible for achieving and maintaining compliance, the compliance date is 6/2/2025</p>		

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	<p>consuming 50% or less of energy needs for 5 days or more. Weight loss trend noted; minimally moderate fat loss and muscle depletion ... Intervention ... Regular diet - assist with feeding, encourage intake ... Pt prefers chocolate ensure plus HP(high protein) w (with)/ all meals (no magic cups, gelatine <sic>, or Glucerna at this time) ... Weekly wt (weight) for insight ... Consider adding daily MVI (multivitamin), thiamine and folic acid given hx (history) poor intake ... Continue Marinol, per medical ..."</p> <p>A review of the medical record revealed R305 was admitted to the facility on 3/19/25 with diagnoses that included: Orthopedic aftercare following surgical amputation, dysphagia (difficulty swallowing), and unspecified severe protein-calorie malnutrition.</p> <p>Further review of the medical record revealed the following:</p> <p>A "Nursing Admission Screening ..." dated 3/19/25 at 11:32 PM, documented in part " ... Weight: 134.2 (lbs) Date: 3/19/2025 23:45 (11:45 PM) ..."</p> <p>A "Dietary Evaluation" dated 3/20/25 at 11:15 AM, documented in part " ... Most Recent Weight ... 134.2 (Lbs) ... Loss of 5% or more in the last month or loss of 10% or more in last 6 months - No or unknown ... Loss of 7.5% in the last 3 months- No or unknown ..."</p> <p>A Physician order dated 3/21/25 noted "Weekly weights" to be obtained.</p> <p>The facility staff failed to obtain a weight for the following week in March (3/23-3/29) as ordered by the Physician.</p> <p>On 4/4/25 the facility staff recorded a weight of</p>			

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	<p>122.8 lbs.</p> <p>This indicated a -8.49 weight loss from the admission weight, within a little over two weeks.</p> <p>A "Dietary" note dated 4/4/25 at 2:22 PM, documented in part " ... Weight accuracy of admission wt (weight) not verified. Patient had swelling and recent BKA (below knee amputation), left gangrene which may also cause wt variation. However patient is often triggering for PO (by mouth) intake less than 25% per food acceptance record. Patient request staff to feed him although able to feed self per therapy. He is on Red Napkin program and gets chocolate milk at all meals include 2 at BF (breakfast) per his preference. He mostly drinks fluids. He was started w (with) Prostat AWC 30 ml (milliliters) for wound healing and MedPass BID (twice a day). Current food intake is insufficient to meet his nutritional needs for wt (weight) stability and wound healing will recommend increasing Medpass 4oz TID (three times daily) for additional 240 kcal and 10 gm protein ... Plan: weekly weight, MedPass 4oz increase to TID ..."</p> <p>On 4/17/25 the facility staff recorded a weight of 114.0 lbs.</p> <p>This indicated a -15.05 weight loss from admission within four weeks.</p> <p>A "Dietary Evaluation" dated 4/17/25 at 7:30 PM, was noted to be incomplete and contained no documentation of the identified weight loss or interventions implemented to prevent further weight loss.</p> <p>A review of a facility policy titled "Nutrition Monitoring & Management Program" dated 7/11/18, documented in part " ... It is the policy of this facility to ensure that all residents maintain</p>			

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	<p>acceptable parameters of nutritional status, such as body weight and protein levels; unless the resident's clinical condition demonstrates that this is not possible ... Significant weight loss ... should be addressed in the care plan ... Ongoing interventions are evaluated and modified as needed ... Each resident's nutritional status is assessed by the Registered Dietician ... following a change in condition ..."</p> <p>A review of the "Amount of meal consumed" documentation from 4/1/25 to 4/18/25, noted mostly 0% to 25% of meals consumed.</p> <p>Review of a care plan titled "Resident has nutritional problem related too(rt) mechanically altered diet and per patient inability to feed himself, rt BKA (below knee amputation) and active wound/gangrene ... able to feed self per therapy, however don't want to, possible weight loss ..." this care plan was implemented on 3/20/25 and noted the following interventions " Pureed, nectar thick liquids ... per OT (occupational therapy) eval (evaluation) as needed ... Provide and ensure resident has at each meal and/or snack ... Monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Report to nurse and/or MD (medical doctor) and adjust plan of care as indicated ... Provide and serve supplements as ordered. Refer to current physician orders for specifics. Notify nurse and/or RD (Registered Dietician) of changes in consumption, adherence with intake ... RED NAPKIN protocol ... NEEDS FEEDING ASSISTANCE ..."</p> <p>A "Nursing" note dated 4/18/25 at 4:49 AM, documented in part " ... Patient is having a</p>			

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	<p>difficult time swallowing thin fluids., and chewing food per afternoon shift. Dietitian may need to change diet."</p> <p>A "Dietary" note dated 4/18/25 at 12:55 PM, documented in part " ... Per nursing communication to RD (Registered Dietician) and SLP (Speech Language Pathologist) therapy patient asked for water yesterday however started coughing may need eval for thicken liquids-SLP plan to f/u (follow up). Patient do no <sic> eat much, wt loss, on Red Napkin program mostly prefers to drink chocolate milk."</p> <p>A "Dietary" note dated 4/18/25 at 1:00 PM, documented " ... Per SLP communication diet downgraded to pureed nectar thick liquids ..."</p> <p>A "Nursing" note dated 4/20/25 at 12:33 PM, documented in part " ... pt displaying extreme weakness, lethargic, refusing medication and food/fluids. Dr (doctor) notified and orders given to send pt out (to the hospital) ..."</p> <p>A "Dietary" note dated 4/21/25 at 8:56 AM, documented " ... WEIGHT WARNING ... 114.0 ... 15.1%... Patient refusing food and fluids, diet downgraded to pureed, nectar thick liquids r/t (related to) difficulty swallowing coughing w/fluids. Supplements were continued. Pt sent to hospital at this time. Plan: f/u (follow up) after pt returns.</p> <p>As indicated, the Dietician did not identify the weight loss until the day after the resident was sent to the hospital. At the time of this survey, the resident had not returned to the facility.</p> <p>On 5/2/25 at 2:27 PM, the facility's Registered Dietician (RD) "B" was interviewed and asked what the facility's "Red Napkin Protocol" was. RD "B" stated that any resident that needed some</p>			

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F0772 SS= D	<p>type of assistance is put on the Red Napkin program. RD "B" stated they were told this upon being hired. RD "B" was asked to provide the facility's protocol on the Red Napkin program. RD "B" was asked how they are informed of the residents with significant/severe weight loss, RD "B" replied the weight discrepancies are usually discussed with the Interdisciplinary team at their daily meeting or identified by the weekly/monthly list. RD "B" was then asked about the hospital weight compared to the initial facility's weight obtained and the discrepancy. RD "B" was asked about the weekly weight order for R305 and the missed weight in March. RD "B" was then asked about the weight loss of - 15.05% on 4/17/25, that was not identified, reviewed or evaluated until after the resident was transferred to the hospital on 4/20/25. RD "B" was also asked about the incomplete Dietary assessment dated 4/17/25. RD "B" stated they would look into the concerns and follow back up.</p> <p>At 2:50 PM, RD "B" returned and stated the Red Napkin program had been terminated and was no longer in effect. RD "B" stated they remembered talking about this resident at the clinical meetings but was unable to recall what was exactly discussed. RD "B" stated they did not find additional documentation besides what was noted in the record but will continue to look.</p> <p>No further explanation or documentation was provided by the end of the survey.</p> <p>Lab Services Not Provided On-Site §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory</p>	F0772	<p>Resident #305 no longer resides in the facility. All residents have the potential to be affected by this citation. Nurse Mary Bryant was given 1:1 education related to timely execution and ordering of labs by the provider and follow up. On 5/21/2025an audit was completed on all residents from the past 90 days for any labs</p>	6/2/2025

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	<p>that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to intake: MI00152471.</p> <p>Based on interview and record reviews, the facility failed to obtain STAT (immediate) labs ordered by the physician for a resident identified with a change of condition for one (R305) of one resident reviewed for lab services. Findings include:</p> <p>A review of the medical record revealed R305 was admitted to the facility on 3/19/25, with diagnoses that included: encounter for orthopedic aftercare following surgical amputation, severe protein-calorie malnutrition, peripheral vascular disease and acute kidney failure.</p> <p>Further review of the medical record revealed the following:</p> <p>On 4/18/25 at 12:55 PM, a "Dietary" note documented in part " ... Per nursing communication to RD (Registered Dietitian) and SLP (Speech Language Pathologist) Therapy patient asked for water yesterday however started coughing may need eval (evaluation) for thicken liquids- SLP plan to f/u (follow up). Patient does not eat much, wt (weight) loss ..."</p> <p>On 4/18/25 at 1:08 PM, a "Nursing" note documented in part " ... spoke with physician regarding resident not eating and drinking, participating very little in therapy. New orders received for 0.9% NS (normal saline) at 60 cc/hr (centimeters cubed per hour) x 2 liters, repeat labs CMP (comprehensive metabolic panel), CBCD (complete blood count with differential) , Chest</p>		<p>ordered by the physician/provider that were not obtained/documented. Any lab noted to be ordered that was not obtained, the physician was notified, and labs were re-ordered per the physician. Any labs verified as being drawn, with no evidence of documentation in the resident's medical record was followed up with the provider for review and input into the resident's medical record.</p> <p>The DON/unit managers/designee will review the EMR orders portal daily for labs pending confirmation to ensure that labs ordered by the provider are confirmed and ordered by the charge nurse prior to them being cleared. The DON/unit managers/designee will check the lab portal daily for timely results of ordered labs. lab results will be communicated to the physician for follow up and documentation. By 5/21/2025, licensed nurses will be educated on the policy of laboratory services, specifically ensuring that resident labs ordered by the provider are carried out when ordered and stat labs ordered and follow up as ordered. Education will include the notification of the provider upon receipt of lab results and documentation in the resident's medical record.</p> <p>The DON/designee will conduct random audits on 5 residents medical record weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that residents labs are carried out when ordered with follow up by the physician and documentation in the resident's medical record.</p> <p>The results of the audits will be presented to the QAA committee for review and consideration of further corrective actions.</p> <p>The DON will be responsible for assuring substantial compliance is attained through this</p>		

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	<p>X-ray, AP/Lat (anterior posterior/lateral) ... Orders transcribed. Charge Nurse made aware ..."</p> <p>Review of the Physician orders documented, " ... 4/18/25 ... CMP, CBCD STAT ..."</p> <p>Review of the medical record revealed no results of the STAT CMP & CBC with differential to have been completed.</p> <p>A "Nursing" note dated 4/20/25 at 12:33 PM, documented " ... pt (patient) displaying extreme weakness, lethargic, refusing medications and food/fluids. Dr. (doctor) notified and orders given to send pt out ..."</p> <p>On 4/30/25 at 1:32 PM, the Infection Control Nurse (ICN) "C" who served as the replacement for the Director of Nursing (DON) for this survey was interviewed and asked to provide the STAT labs ordered for R305 on 4/18/25. ICN "C" stated they would look into it and follow back up. At 2:18 PM, ICN "C" returned and stated the facility does not do STAT labs and that their lab company had already came that Friday. ICN "C" stated the labs were not done and would have gotten done the following week. When asked to clarify about the facility not offering STAT lab services, ICN "C" stated the facility's contracted lab does not perform STAT lab services. ICN "C" was asked how the facility handles STAT lab orders ordered by the Physician for residents with an identified change of condition and ICN "C" stated the labs would have to wait to get done on Monday or they would have to transfer the resident to the hospital. ICN "C" was asked to provide the facility's lab contract for review.</p> <p>Review of the facility's laboratory services contract documented a mutual agreement effective 1/10/24. The "Exhibit A" page noted the following, " ... shall provide clinical laboratory</p>		plan of correction by 6/2/2025 and for sustained compliance thereafter.	

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	<p>testing more specifically described as...STAT service- \$25/stat ..."</p> <p>On 4/30/25 at 3:21 PM, via a telephone interview with the Director of Nursing (DON) was notified of the STAT lab concerns for R305 and stated their staff had been keeping them updated with the survey findings and acknowledged the concern.</p> <p>No further explanation or documentation was provided by the end of the survey.</p>				