

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634586	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 4/9/2025
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NAME OF PROVIDER OR SUPPLIER OPTALIS HEALTH AND REHABILITATION OF TROY	STREET ADDRESS, CITY, STATE, ZIP CODE 925 W SOUTH BLVD TROY, MI 48085
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F0000 SS=	INITIAL COMMENTS Optalis Health and Rehabilitation of Troy was surveyed for an Abbreviated survey on 4/10/25. Intakes: MI00150318, MI00150676 & MI00151683. Census= 105.	F0000		
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 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	F0578	578 Request/Refuse/Discontinue treatment; Formulate Adv Dir It is the practice of the facility to ensure the resident right to request, refuse and/or discontinue treatment, to participate in or refuse to participate in experimental research and to formulate an advance directive. Element 1 Resident 408 remains in the facility and have been unharmed by the deficient practice. The resident's code status order has been corrected to DNR (do not resuscitate). Element 2 Residents residing in the facility who have signed a DNR are at risk. An audit was completed by the DON/designee of all residents with a signed DNR to ensure their physician order and demographics page match. The plan of care has been reviewed and updated by the interdisciplinary team. Element 3 The interdisciplinary team reviewed the advanced directive policy and deemed it appropriate for use as written. The licensed nursing staff and social work staff were educated on the policy. Element 4	5/6/2025

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

TITLE

(X6) DATE

Electronically Signed

05/02/2025

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

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	<p>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:</p> <p>This citation pertains to intake #MI00151683</p> <p>Based on observation, interview and record review, the facility failed to ensure consistent implementation and documentation of a DNR (Do Not Resuscitate) order for one resident (R408) of four residents reviewed for resident rights.</p> <p>Findings include:</p> <p>On 4/9/25 at approximately 9:50 a.m., R408 was observed in their room, laying in their bed. R408 was observed with a wander guard on their right ankle. R408 was observed to be thin and have some confusion when participating in the interview.</p> <p>On 4/9/25 the medical record for R408 was reviewed and revealed the following: R408 was initially admitted to the facility on 12/17/24 and had diagnoses including Dementia and Malignant Neoplasm of Prostate. A review of R408's MDS (minimum data set) with an ARD (assessment reference date) of 3/20/25 revealed R408 needed some</p>		<p>The administrator/designee will audit all new admits/readmits to ensure appropriate advance directives orders and documentation is in place weekly x4 and monthly x3.</p> <p>Element 5 The administrator/designee holds the ultimate responsibility of compliance: date of compliance May 6, 2025</p>	

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	<p>assistance from facility staff with most of their activities of daily living. R408's BIMS score (brief interview for mental status) was 12 indicating moderately impaired cognition.</p> <p>A review of R408's electronic medical record (EMR) demographic page revealed R408 was designated as a "Full code" (Cardiopulmonary resuscitation is to be performed).</p> <p>A DNR order signed by R408 on 12/24/24 and by their Physician on 12/24/24 documented R408 was not be resuscitated.</p> <p>A Social Work note dated 3/18/25 documented in part, the following: "Advanced care planning discussed. His wife is his (inactive) DPOA-HC (durable power of attorney-healthcare). Copy on file. Code status reviewed and he wishes to continue as a DNR. The BIMs assessment was administered with score=12/15 indicating moderate cognitive impairment. He is able to make his needs known..."</p> <p>On 4/9/25 at approximately 10:32 a.m., Nurse "B" was queried what they would do for R408 regarding R408's code status/advanced directive. Nurse "B" was observed reviewing R408's EMR and reported that R408 is a full code and if they went into cardiac arrest they would perform CPR.</p> <p>On 4/9/25 at approximately 11:00 a.m., Social Worker "I" (SW "I") was queried regarding the</p>			

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	<p>process for honoring resident rights and advanced directives such as their chosen code status. SW "I" reported that Nursing does the initial code status documentation and Social Work follows up to confirm it. SW "I" was queried regarding R408's conflicting advanced directives/code status's in the EMR. SW "I" was queried what R408's code status was and they indicated that R408 was a "full code." SW "I" was then observed reviewing R408's DNR order in their record that they had signed and indicated that their status would have to changed to DNR and they did not know how the mistake occurred, but would have it corrected and changed to "DNR" to reflect R408's advanced directive wishes.</p> <p>On 4/10/25 a facility document titled "Advanced Directives-Code Status" was reviewed and revealed the following: "It is the policy of the facility that the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives related to code status are honored in accordance with state law and facility policy. Do Not Resuscitate (DNR) - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, durable power of attorney for health care, patient advocate with power regarding Life-Sustaining Treatment or other legal representative to make health care decisions regarding the resident's code status has directed that no cardiopulmonary resuscitation (CPR) or other</p>			

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	<p>life-sustaining treatments or methods are to be used...In accordance with the Michigan Do-Not-Resuscitate Procedure Act a DNR must be documented on the Do-Not-Resuscitate (DNR) form for the DNR to be valid. Until the form is fully filled out and signed by the resident or the resident's legal representative, two witnesses, and physician, the resident will be a Full Code by default. Full Code - indicates that if a person's heart has stopped beating and/or they have stopped breathing, resuscitation procedures will be provided to keep them alive. This process can include chest compressions and defibrillation and is referred to as CPR. Upon admission, the facility will inquire if the resident has executed a written advance directive related to their code status. If they have not, the facility will provide information in a manner easy to understand to the resident related to their right to formulate advanced directives related to their code status....If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident is legal representative. If the resident becomes able to receive and understand this information later, he or she will be provided with the same materials as described above, even if his or her legal representative has already been given the information. if the resident and/or their legal representative has chosen for the resident's code status to be Do-Not Resuscitate: The facility will accept a Michigan Do-Not-Resuscitate (DNR) form</p>			

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	<p>that has been completed prior to admission to the facility under the following circumstances: The form is fully filled out and includes the resident signature or the resident's legal representative signature, two witness signatures, and physician signature...</p> <p>The facility confirms and documents that the resident and/or resident's legal representative's wishes have not changed since the form was initially completed related to their DNR code status. The attending physician writes an order for the resident's DNR code status. The Michigan Do-Not-Resuscitate form will be uploaded into the resident's electronic health record... under the documents tab. If the resident does not already have a Michigan Do-Not-Resuscitate (DNR) form in place, the facility will assist the resident and/or their legal representative in completing the form. Until the form is fully filled out and signed by the resident or the resident's legal representative, two witnesses, and physician, the resident will be a Full Code by default. Once fully filled out, the Michigan Do-Not-Resuscitate form will be uploaded into the resident's electronic health record in... under the documents tab. The physician's order for DNR will be entered...using the template in the order's tab. From the physician order the resident's DNR code status will auto-populate and be prominently displayed on the resident's chart header...and will also populate to the resident's face sheet. If the resident and/or their legal representative has chosen for the resident's</p>			

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F0600 SS= D	<p>code status to be a Full Code: The physician's order for Full Code status will be entered...using the template in the order's tab. From the physician order the resident's Full Code status will auto-populate and be prominently displayed on the resident's chart header...and will also populate to the resident's face sheet. The resident's code status discussion is documented upon admission in the nursing Admission Readmission Evaluation and the Social Services Assessment, quarterly in the care conference UDA/note, with significant change of condition, and upon resident/resident legal representative request in the resident's medical record..."</p> <p>Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to intake #MI00150318</p> <p>Based on interview and record review, the</p>	F0600	<p>F600 Free from Abuse and Neglect It is the intent of the facility to ensure that all alleged violations are thoroughly investigated to prevent further potential abuse.</p> <p>Element 1 Resident 404 does not reside within the facility. Nurse M is no longer working at the facility. Facility staff were re-educated on Abuse Policy.</p> <p>Element 2 All residents residing in the facility can be affected by the cited practice. Residents with BIMS score of 12 or higher have been interviewed to identify concerns with abuse. Potential allegations identified will be reviewed through the abuse prevention process. Residents with BIMS score of 11 or lower will be assessed for signs and symptoms of abuse. Potential allegations identified will be</p>	5/6/2025

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	<p>facility failed to protect the resident's right to be free from physical abuse by a staff member for one resident (R404) of four residents reviewed for abuse/neglect/mistreatment. Findings include:</p> <p>On 4/9/25 a concern submitted to the State Agency was reviewed which alleged R404 was physically abused by a staff member.</p> <p>On 4/9/25 the medical record for R404 was reviewed and revealed the following: R404 was initially admitted to the facility on 1/28/25 and had diagnoses including Parkinsonism, Dysphagia and Cognitive communication deficit. A review of R404's MDS (minimum data set) with an ARD (assessment reference date) of 2/3/25 revealed R404 needed assistance from facility staff with most of their activities of daily living. R404's BIMS score (brief interview for mental status) was 14 indicating intact cognition.</p> <p>On 4/9/25 a statement from the facility pertaining to the alleged incident on 2/3/25 that was received during an interview from R404 in their room on 2/5/25 was reviewed and revealed the following: "Resident states in early morning of 2/3/25, assigned nurse answered call light and proceeded to start to provide incontinence for resident. While nurse was rolling resident, she states she accidentally kicked nurse as she was afraid, she was falling and moved her legs behind</p>		<p>reviewed through the abuse prevention process.</p> <p>Element 3 The interdisciplinary team reviewed the abuse policy and deemed it appropriate for use as written. The facility staff were educated on the abuse policy; in addition, the facility managers were educated on disciplinary actions and the administrator and DON educated with an emphasis on the reporting within the 2-hour window and what constitutes abuse. The facility staff will be in-serviced on types of abuse at each monthly in-service for the next 3 months to provide additional education.</p> <p>Element 4 The IDT will randomly interview residents and staff regarding allegations of abuse weekly for 4 weeks then monthly for 3 months. Any allegations of abuse will be immediately reported to the administrator for investigation and reporting. The administrator/designee will bring allegations of abuse investigations to the QAPI meeting to ensure compliance.</p> <p>Element 5 The administrator/designee holds the ultimate responsibility of compliance: date of compliance May 6, 2025.</p>	

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	<p>her. Resident states assigned nurse then proceeded to hit her on her left upper arm and told her that she would now have to wait for day shift to finish providing her care. Resident stated that she feels safe at facility and has had no other problems with staff but is requesting that the assigned nurse not be assigned to her in the future..."</p> <p>On 4/9/25 a review of the facility reported incident/investigation was conducted and revealed the following: "Date of Event: 2/3/25...Investigation: Allegation of Mistreatment...Time of Incident: 12:00 AM...Resident stated that in the early morning of 2/3/25, not sure of the time; but she knew it was the midnight nurse. She stated that the assigned nurse answered her call light and proceeded to start to provide incontinence care. While the nurse was rolling her, she stated that she accidentally kicked nurse as she was afraid of falling from the bed her legs was behind her. Resident stated that the nurse hit her in the upper arm and then stated that she would have to wait for the day shift to arrive to finish providing her with care. Assigned nurse [Nurse "M"] has not worked in the building since the alleged incident. [R404] stated that she feels safe in the facility and has had no other problems with her care she likes the facility...The assigned nurse [Nurse "M"] interviewed she stated that the events resident [R404] states that happened never occurred. [Nurse "M"] stated that she did not provide any ADL care to the resident and only interacted with her</p>			

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	<p>when passing medications. Nurse states she did not physically touch the resident during her shift. Nurse stated that the resident is confused. Nurse states that she was not aware of any form of abuse occurring during her shift....The facility feels that the allegation substantiated, and the nurse received disciplinary action and education on dignity and respect. The facility believes in promoting excellent quality of care and take pride in doing so for the residents. All applicable parties notified, Family, Medical Director, Administrator, State of Michigan. All findings will be reviewed in QAPI (quality assurance/performance improvement) for further recommendations..."</p> <p>On 4/9/25 a disciplinary action document for Nurse "M" pertaining to the incident with R404 was reviewed and revealed the following: "Employee Name: [Nurse "M"]...Date 2/5/25...Department: Nursing...Corrective Action: 3rd Final Written Warning. Date 2/3/25. Deficiency 230 (#21, #1, #40)...Work Rule Violation Number: #1 Confirmed verbal, physical or emotional abuse or negligence towards residents...#21. Rudeness/Unprofessional behavior toward a resident...#40. Carelessness/Negligence in the performance of job assignment...Witness to Presentation [Director of Nursing]...Date 2/5/25..."</p> <p>On 4/9/25 at approximately 1:23 p.m., a conversation with the Administrator, Director of Nursing (DON) and Nurse Manager "N"</p>			

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	<p>(NM "N") regarding the incident investigation for R404 and Nurse "M" was conducted. The Administrator was queried how they came to their conclusion that R404's allegation that Nurse "M" had hit them and neglected to finish providing care on 2/3/25 was substantiated and they reported they had believed R404's interview due to R404 never making other false allegations, being cognitively intact and not changing their story. The Administrator was queried regarding their decision to provide Nurse "M" a final warning vs termination after substantiating the allegation and they reported that was the decision at the time. The Administrator was queried regarding the language in Nurse "M's disciplinary action that indicated Nurse "M" and committed "confirmed verbal, physical or emotional abuse or negligence" towards R404 and they indicated that they had not reviewed the disciplinary action thoroughly and looking at that language that Nurse "M" should be terminated and now allowed back to work but that the language was used based off the "work rules" policies the facility had. The Administrator was queried if Nurse "M" was still providing care to residents in the facility and they indicated they were and that they acknowledged the disconnect of the language in the disciplinary action document.</p> <p>On 4/9/25 a facility document titled "Abuse" was reviewed and revealed the following: "POLICY OVERVIEW: Residents have the right to be free from abuse, neglect, exploitation,</p>			

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F0609 SS= D	<p>mistreatment, and misappropriation of resident property. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint that is not required to treat the patient/resident's medical symptoms..."</p> <p>Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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:</p>	F0609	<p>F609 Reporting of Alleged Violations It is the practice of the facility to ensure that all allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in bodily injury to the administrator and to other officials in accordance with state law through established procedures.</p> <p>Element 1 Resident 406 remains in the facility and continues to receive supportive visits for psych services. The plan of care was updated, and she The contracted CNA involved in the incident no longer works at the facility.</p> <p>Element 2 All residents residing in the facility can be affected by this cited practice. Residents with BIMS score of 12 or higher have been interviewed to identify concerns with abuse. Potential allegations identified will be reviewed through the abuse prevention process. Residents with BIMS score of 11 or power will</p>	5/6/2025

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	<p>This citation pertains to intake # MI00150676.</p> <p>Based on interview, and record review, the facility failed to report an allegation of abuse to the State Agency and Administrator (Abuse Coordinator) within the required time frame for one (R406) of four residents reviewed for abuse.</p> <p>Findings include:</p> <p>A review of a Facility Reported Incident (FRI) submitted to the State Agency on 2/19/24 documented R406 sustained an injury of unknown origin which was a fracture of the tibia and fibula while receiving care from an agency CNA (Certified Nursing Assistant) on 2/14/25.</p> <p>On 4/9/25 at 10:40 AM, R406 was observed lying in bed with a trapeze bar positioned above the head of the bed and there was a pillow placed along the resident's right lower extremity. R406 was alert and remembered this surveyor from a previous survey. The resident reported since their initial back injury that brought them to the facility in August 2024, their right leg tended to wander to the right and when it did, they didn't have any control over the leg and the leg can just slide down. They reported they usually have a pillow or wedge to the right side to keep the leg up.</p> <p>They were informed of the investigation into the reported incident from 2/14/25 and was</p>		<p>be assessed for signs and symptoms of abuse. Potential allegations identified will be reviewed through the abuse prevention process.</p> <p>Element 3 The interdisciplinary team reviewed the abuse policy and deemed it appropriate for use as written. The facility staff were educated on the abuse policy; in addition, the administrator and DON educated with an emphasis on the reporting within the 2-hour window and what constitutes abuse. The facility staff will be in-serviced on types of abuse at each monthly in-service for the next 3 months to provide additional education.</p> <p>Element 4 The IDT will randomly interview residents and staff regarding allegations of abuse weekly for 4 weeks then monthly for 3 months. Any allegations of abuse will be immediately reported to the administrator for investigation and reporting. The administrator/designee will bring allegations of abuse investigations to the QAPI meeting to ensure compliance with the abuse process to include timely reporting and investigation.</p> <p>Element 5 The administrator/designee is responsible for compliance: date of compliance May 6, 2025.</p>		

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	<p>asked to recall the events as best they could. R406 reported the aides have a habit of lifting the pad underneath them to turn or move them. The nighttime aide (not sure of their name) did it so fast my right leg came off the mattress. She picked it (leg) up and it happened again so quickly and my foot hit the floor. I know it hit the floor because I felt that cold tile floor. Right after that I tried to call her back to ask the nurse for a pain med but I was afraid so I didn't. I talked to that aide after that and she said she didn't do anything. I talked to the nurse the next day (not able to recall any specific nurse's name). I was afraid to have the aide come back after that.</p> <p>Review of the clinical record revealed R406 was initially admitted into the facility on 8/29/24 with diagnoses that included: acute appearing distal tibia fracture (2/19/25), wedge compression fracture of third lumbar vertebra (8/29/24), and encounter for other orthopedic aftercare (8/29/24).</p> <p>According to the Minimum Data Set (MDS) assessment dated 2/27/25, R406 scored 15/15 on the Brief Interview for Mental Status exam (BIMS) which indicated intact cognition, was frequently incontinent of urine and always incontinent of bowel, had occasional pain and received as needed pain medication, and had no falls since the previous MDS assessment on 12/3/24.</p> <p>According to the Kardex (specific instructions</p>			

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	<p>on the resident's care needs) R406 required two-person assistance with bed mobility, including toileting and the use of a mechanical lift (Hoyer) for transfers (which was the same status prior to this incident and remained unchanged since this incident).</p> <p>Physician orders revealed radiology orders for "STAT XRAY RIGHT FEMUR/KNEE/TIBIA/FIBULA/ANKLE R/T (related to) PAIN" were ordered on 2/18/25 at 3:43 PM. The xray results were not received until 2/19/25 at 12:48 PM.</p> <p>According to facility documentation submitted to the State Agency on 2/19/25, "...It was brought to the attention of the Administrator on 2/19/25 that the resident [R406] had a fracture of the Tibia and Fibula, the incident actually occurred on 2/14/25 which the CNA (Certified Nursing Assistant) that was caring for the resident was from the agency. Investigation initiated immediately to see what occurred on the day in question...</p> <p>Investigation: Injury of unknown origin 2/19/25...Writer was notified on 2/19/25 that resident [R406] had complaint on 2/14/25, she did not notify the nurse due to incident that occurred with the CNA (although R406 reported she had notified the nurse the next morning), resident stated that she did not feel safe to tell the nurse due to CNA reactions. Nurse Manager (the Nurse Manager/NM 'A' was not informed until 2/18/25) ensured safety and the resident</p>			

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	<p>stated that she feels safe living in the facility. On 2/17/25 resident complained of mild pain to right leg, resident asked for pain medication. Medication was administered for pain to the right leg, and it was effective. The next day the resident called the Nurse Manager to her room and stated that she was having increased pain to her right leg, nurse manger informed the Nurse Practitioner and ordered a STAT Xray. Facility received the Xray results back which stated distal tibia fracture. A new order was placed for the [R406] to see PM&R (Physical Medicine & Rehab) and no weight bearing to affected leg. Physician went into access [R406] the resident refused to be transferred to the hospital she stated that she prefers to see the Ortho; Nurse manager made [R406] appointment to see Orthopedic. The CNA involved in this investigation is an agency staff that we interviewed, she stated that she went into the residents room around 1:00AM to answer her call light, resident needed a brief change. She stated the resident was already complaining of right leg pain. CNA stated she pulled the resident towards her to roll resident over to change her, residents leg never hit the floor at all. Nurses that worked with the resident was asked if the resident complained of any pain or were they aware of any incidents with the resident they stated no (there was no documentation included in the investigation documents of this). 2/19/25 The social worker (SW) did wellness visit completed with resident and her daughter via phone. Resident reports that she does not</p>			

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	<p>feel safe in the facility currently...Resident is requesting to transfer facilities and will notify SW when she found a facility to transfer to. Social Services dept (department) will continue to follow up as needed..."</p> <p>The documentation provided for this investigation confirmed R406 reported complaints of leg pain to facility nursing staff as well as the Nurse Manager (NM 'A') prior to the Administrator (Abuse Coordinator) being notified on 2/19/25.</p> <p>On 4/9/25 at 2:06 PM, an interview was conducted with the Administrator. When asked to review the facility's investigation and timeline of events for R406's injuries, the Administrator reported that person involved is an agency staff. When asked to confirm when they were first notified, and by who, the Administrator reported they thought it was NM 'A' on 2/19/25. The Administrator further reported the resident was complaining of pain on 2/14 and at first it was an injury of unknown origin but then confirmed the aide did not follow the plan of care and should've had two people during care.</p> <p>On 4/9/25 at 2:12 PM, the Director of Nursing (DON) joined the interview. When asked to confirm whether they had been notified of any changes in the resident's pain, prior to 2/18/25, the DON reported not that they could recall.</p> <p>On 4/9/25 at 2:17 PM, NM 'A' joined the</p>			

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	<p>interview. When asked about when they were notified of the resident's change in status, NM 'A' reported the resident called me into the room and said she was having pain and confirmed that was on 2/18/25. They further reported they were not notified of any other concerns prior to 2/18/25. They confirmed they did not report to the Administrator until 2/19/25, once the x-ray results came back positive for a fracture.</p> <p>The Administrator, DON and NM 'A' were informed of the concerns that the facility did not identify and report timely to the Abuse Coordinator and State Agency. The Administrator reported NM 'A' should've reported it when they became aware of the concern on 2/18/25. The Administrator was asked also about why other nursing staff had not reported R406's concerns given the resident notified a nurse the next morning, and the Administrator reported they had a lot of training to do and was difficult when they utilized agency staff. When asked if they had any further questions, the Administrator and DON reported they had none.</p> <p>According to the facility's policy titled, "Abuse" dated 4/13/2022:</p> <p>"...The facility will ensure that all allegations involving abuse, neglect, exploitation, mistreatment, injuries of unknown source...are reported immediately to the Administrator and...Reported to the State Survey Agency immediately but not later</p>			

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F0610 SS= D	<p>than two hours after the allegation is made if the allegation involves abuse or results in serious bodily injury..."</p> <p>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:</p> <p>This citation pertains to intake # MI00150676 and MI00150318.</p> <p>Based on interview and record review, the facility failed to complete a thorough investigation into an initial injury of unknown origin and allegation of mistreatment for one resident (R406) and ensure protection/prevention of further access with an employee (alleged perpetrator) with confirmed abuse findings from having continued access to one resident (R404) out of four residents reviewed for abuse.</p>	F0610	<p>F610 Investigate/Prevent/Correct Alleged Violation It is the practice of the facility, in response to allegations of abuse, neglect, exploitation or mistreatment, the facility must have evidence that all alleged violations are thoroughly investigated. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Report the results of all investigations to the administrator and to other officials in accordance with State law, including to the State Survey Agency, within 5 working day of the incident and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Element 1 Resident 406 remains in the facility and continues to receive supportive visits for psych services. The plan of care was updated, and the contracted CNA involved in the incident no longer works at the facility.</p> <p>Element 2 Residents with allegations of abuse have the potential to be affected. Investigation files of those residents with open investigations have been reviewed to validate a thorough investigation was conducted to include implementation of corrective measures to prevent further potential abuse. No additional instances as identified in the citation were identified. Residents with BIMS score of 12 or higher were interviewed to identify concerns with</p>	5/6/2025	

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	<p>Findings include:</p> <p>According to the facility's policy titled, "Abuse" dated 4/13/2022:</p> <p>"...Prevention consists of facility systems designed to detect, identify, correct, and prevent the occurrence of abuse...The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation...If a staff member is the alleged perpetrator, that staff member should be immediately removed from the facility and the schedule pending the outcome of the investigation...Once reported, the center conducts a timely, thorough, and objective investigation of any allegation of abuse...Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations (such as other residents ...Providing complete and thorough documentation of the investigation...RESPONSE...Ensure involved patient/resident's plan of care is reviewed and revised, as appropriate, consistent with the results of the investigation..."</p> <p>R406:</p> <p>A review of a Facility Reported Incident (FRI) submitted to the State Agency on 2/19/24 documented R406 sustained an injury of</p>		<p>abuse. Potential allegations identified will be reviewed through the abuse prevention process.</p> <p>Residents with BIMS score of 11 or lower will be assessed for signs and symptoms of abuse. Potential allegations identified will be reviewed through the abuse prevention process.</p> <p>Element 3 The interdisciplinary team reviewed the abuse policy and deemed it appropriate for use as written. The facility managers were educated on the abuse policy with an emphasis on completing a full and thorough investigation and on corrective actions to prevent further potential abuse. The Quality Assurance Consultant will in-service Unit Manager and Director of Nursing regarding maintaining all evidence of an investigation.</p> <p>Element 4 Audits on allegations of abuse will be completed weekly by the Administrator/designee to validate a full and thorough investigation was completed, corrective actions were taken to prevent further potential abuse and that evidence of the investigation is maintained. Results of the audits and interviews will be submitted to the QAPI committee for further review and recommendations.</p> <p>Element 5 The administrator/designee is responsible for compliance: date of compliance May 6, 2025.</p>	

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	<p>unknown origin which was a fracture of the tibia and fibula while receiving care from an agency CNA (Certified Nursing Assistant) on 2/14/25.</p> <p>On 4/9/25 at 10:40 AM, R406 was observed lying in bed with a trapeze bar positioned above the head of the bed and there was a pillow placed along the resident's right lower extremity. R406 was alert and remembered this surveyor from a previous survey. The resident reported since their initial back injury that brought them to the facility in August 2024, their right leg tended to wander to the right and when it did, they didn't have any control over the leg and the leg can just slide down. They reported they usually have a pillow or wedge to the right side to keep the leg up.</p> <p>They were informed of the investigation into the reported incident from 2/14/25 and was asked to recall the events as best they could. R406 reported the aides have a habit of lifting the pad underneath them to turn or move them. The nighttime aide (not sure of their name) did it so fast my right leg came off the mattress. She picked it (leg) up and it happened again so quickly and my foot hit the floor. I know it hit the floor because I felt that cold tile floor. Right after that I tried to call her back to ask the nurse for a pain med but I was afraid so I didn't. I talked to that aide after that and she said she didn't do anything. I talked to the nurse the next day (not able to recall any specific nurse's name).</p>			

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	<p>I was afraid to have the aide come back after that.</p> <p>Review of the clinical record revealed R406 was initially admitted into the facility on 8/29/24 with diagnoses that included: acute appearing distal tibia fracture (2/19/25), wedge compression fracture of third lumbar vertebra (8/29/24), and encounter for other orthopedic aftercare (8/29/24).</p> <p>According to the Minimum Data Set (MDS) assessment dated 2/27/25, R406 scored 15/15 on the Brief Interview for Mental Status exam (BIMS) which indicated intact cognition, was frequently incontinent of urine and always incontinent of bowel, had occasional pain and received as needed pain medication, and had no falls since the previous MDS assessment on 12/3/24.</p> <p>According to the Kardex (specific instructions on the resident's care needs) R406 required two-person assistance with bed mobility, including toileting and the use of a mechanical lift (Hoyer) for transfers (which was the same status prior to this incident and remained unchanged since this incident).</p> <p>Review of the documentation submitted to the State Agency on 2/19/25 revealed the same documentation provided by the facility for review on 4/9/25. This documentation revealed there was only one witness statement obtained which was from an Agency Certified Nursing Assistant (CNA 'G')</p>			

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	<p>on 2/18/25 by phone with the Director of Nursing (DON) that read, "Name and title of person conducting interview: [name redacted] DON Date of incident: 2/14/25 Date/Time/Place of interview: 2/18/25</p> <p>STATEMENT: Went in around 1am to answer call light. Resident needed her brief changed. Resident already complaining of pain to right leg. Pulled the bed pad towards me to roll resident over, resident leg did not hit the floor at all. Assisted the resident with 1 PA (Physical Assistance)...VIA PHONE 2/18/25."</p> <p>There were no other interviews from other staff, or residents included in the documentation provided during this survey, or submitted to the State Agency as part of this investigation.</p> <p>Review of the facility's investigation documented, in part:</p> <p>"...It was brought to the attention of the Administrator on 2/19/25 that the resident [R406] had a fracture of the Tibia and Fibula, the incident actually occurred on 2/14/25 which the CNA (Certified Nursing Assistant) that was caring for the resident was from the agency. Investigation initiated immediately to see what occurred on the day in question...Investigation: Injury of unknown origin 2/19/25...Writer was notified on 2/19/25 that resident [R406] had complaint on 2/14/25, she did not notify the nurse due to incident that occurred with the CNA</p>			

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	<p>(although R406 reported she had notified the nurse the next morning), resident stated that she did not feel safe to tell the nurse due to CNA reactions. Nurse Manager (the Nurse Manager/NM 'A' was not informed until 2/18/25) ensured safety and the resident stated that she feels safe living in the facility. On 2/17/25 resident complained of mild pain to right leg, resident asked for pain medication. Medication was administered for pain to the right leg, and it was effective. The next day the resident called the Nurse Manager to her room and stated that she was having increased pain to her right leg, nurse manager informed the Nurse Practitioner and ordered a STAT Xray. Facility received the Xray results back which stated distal tibia fracture. A new order was placed for the [R406] to see PM&R (Physical Medicine & Rehab) and no weight bearing to affected leg. Physician went into access [R406] the resident refused to be transferred to the hospital she stated that she prefers to see the Ortho; Nurse manager made [R406] appointment to see Orthopedic. The CNA involved in this investigation is an agency staff that we interviewed, she stated that she went into the residents room around 1:00AM to answer her call light, resident needed a brief change. She stated the resident was already complaining of right leg pain. CNA stated she pulled the resident towards her to roll resident over to change her, residents leg never hit the floor at all. Nurses that worked with the resident was asked if the resident complained of any pain or were they aware</p>			

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	<p>of any incidents with the resident they stated no (there was no documentation included in the investigation documents of this). 2/19/25 The social worker (SW) did wellness visit completed with resident and her daughter via phone. Resident reports that she does not feel safe in the facility currently...Resident is requesting to transfer facilities and will notify SW when she found a facility to transfer to. Social Services dept will continue to follow up as needed..."</p> <p>On 4/9/25 at 2:06 PM, an interview was conducted with the Administrator. When asked to review the facility's investigation and timeline of events for R406's injuries, the Administrator reported that person involved is an agency staff. When asked to confirm when they were first notified, and by who, the Administrator reported they thought it was NM 'A' on 2/19/25. The Administrator further reported the resident was complaining of pain on 2/14 and at first it was an injury of unknown origin but then confirmed the aide did not follow the plan of care and should've had two people during care. When asked if this was their complete investigation, they reported "Yes".</p> <p>On 4/9/25 at 2:12 PM, the Director of Nursing (DON) joined the interview. When asked to confirm whether they had been notified of any changes in the resident's pain, prior to 2/18/25, the DON reported not that they could recall. When asked if other nurses were interviewed or asked to provide a statement,</p>			

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	<p>the Administrator reported NM 'A' would've done the like residents and the DON would've done the nursing staff interviews. When asked if that had been done, should that be a part of their investigation, the Administrator reported it should.</p> <p>On 4/9/25 at 2:17 PM, NM 'A' joined the interview. When asked about when they were notified of the resident's change in status, NM 'A' reported the resident called me into the room and said she was having pain and confirmed that was on 2/18/25. They further reported they were not notified of any other concerns prior to 2/18/25. They confirmed they did not report to the Administrator until 2/19/25, once the x-ray results came back positive for a fracture. When asked about if they had any other documentation of interviews with like-residents or staff, NM 'A' left the office and returned a short while later and reported they did not have any additional documentation and they had given that to the Administrator.</p> <p>When asked about whether there had been any education or disciplinary actions to any staff, the Administrator reported they didn't see that in their documentation and did not provide any further information or clarification.</p> <p>The Administrator, DON and NM 'A' were informed of the concerns that they did not complete a thorough investigation and the Administrator reported they had a lot of</p>			

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	<p>training to do and was difficult when they utilized agency staff. When asked if they had any further questions, the Administrator and DON reported they had none.</p> <p>On 4/9/25 at 3:00 PM, NM 'A' provided a form that was not filled out and stated these were the questions they asked other residents but confirmed they didn't have the documentation they provided to the Administrator. NM 'A' was informed that without the documentation of which residents were interviewed, that was not able to be verified that had been completed and was asked to follow-up with the Administrator to provide any additional information regarding R406's investigation. (There was no further follow-up provided by the end of the survey.)</p> <p>R404</p> <p>On 4/9/25 a concern submitted to the State Agency was reviewed which alleged R404 was physically abused by a staff member during the midnight shift on 2/3/25.</p> <p>On 4/9/25 the medical record for R404 was reviewed and revealed the following: R404 was initially admitted to the facility on 1/28/25 and had diagnoses including Parkinsonism, Dysphagia and Cognitive communication deficit. A review of R404's MDS (minimum data set) with an ARD (assessment reference date) of 2/3/25 revealed R404 needed assistance from facility</p>			

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	<p>staff with most of their activities of daily living. R404's BIMS score (brief interview for mental status) was 14 indicating intact cognition.</p> <p>On 4/9/25 a statement from the facility pertaining to the alleged incident on 2/3/25 that was received during an interview from R404 in their room on 2/5/25 was reviewed and revealed the following: "Resident states in early morning of 2/3/25, assigned nurse answered call light and proceeded to start to provide incontinence for resident. While nurse was rolling resident, she states she accidentally kicked nurse as she was afraid, she was falling and moved her legs behind her. Resident states assigned nurse then proceeded to hit her on her left upper arm and told her that she would now have to wait for day shift to finish providing her care. Resident stated that she feels safe at facility and has had no other problems with staff but is requesting that the assigned nurse not be assigned to her in the future..."</p> <p>On 4/9/25 a review of the facility reported incident/investigation was conducted and revealed the following: "Date of Event: 2/3/25...Investigation: Allegation of Mistreatment...Time of Incident: 12:00 AM...Resident stated that in the early morning of 2/3/25, not sure of the time; but she knew it was the midnight nurse. She stated that the assigned nurse answered her call light and proceeded to start to provide incontinence care. While the nurse was</p>			

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	<p>rolling her, she stated that she accidentally kicked nurse as she was afraid of falling from the bed her legs was behind her. Resident stated that the nurse hit her in the upper arm and then stated that she would have to wait for the day shift to arrive to finish providing her with care. Assigned nurse [Nurse "M"] has not worked in the building since the alleged incident. [R404] stated that she feels safe in the facility and has had no other problems with her care she likes the facility...The assigned nurse [Nurse "M"] interviewed she stated that the events resident [R404] states that happened never occurred. [Nurse "M"] stated that she did not provide any ADL care to the resident and only interacted with her when passing medications. Nurse states she did not physically touch the resident during her shift. Nurse stated that the resident is confused. Nurse states that she was not aware of any form of abuse occurring during her shift....The facility feels that the allegation substantiated, and the nurse received disciplinary action and education on dignity and respect. The facility believes in promoting excellent quality of care and take pride in doing so for the residents. All applicable parties notified, Family, Medical Director, Administrator, State of Michigan. All findings will be reviewed in QAPI (quality assurance/performance improvement) for further recommendations..."</p> <p>On 4/9/25 a disciplinary action document for Nurse "M" pertaining to the incident with R404 was reviewed and revealed the</p>				

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	<p>following: "Employee Name: [Nurse "M"]...Date 2/5/25...Department: Nursing...Corrective Action: 3rd Final Written Warning. Date 2/3/25. Deficiency 230 (#21, #1, #40)...Work Rule Violation Number: #1 Confirmed verbal, physical or emotional abuse or negligence towards residents...#21. Rudeness/Unprofessional behavior toward a resident...#40. Carelessness/Negligence in the performance of job assignment...Witness to Presentation [Director of Nursing]...Date 2/5/25..."</p> <p>On 4/9/25 at approximately 1:23 p.m., a conversation with the Administrator, Director of Nursing (DON) and Nurse Manager "N" (NM "N") regarding the incident investigation for R404 and Nurse "M" was conducted. The Administrator was queried how they came to their conclusion that R404's allegation that Nurse "M" had hit them and neglected to finish providing care on 2/3/25 was substantiated and they reported the they had believed R404's interview due to R404 never making other false allegations, being cognitively intact and not changing their story. The Administrator was queried regarding their decision to provide Nurse "M" a final warning vs termination after substantiating the allegation and they reported that was the decision at the time. The Administrator was queried regarding the language in Nurse "M's disciplinary action that indicated Nurse "M" and committed "confirmed verbal, physical or emotional abuse or negligence" towards R404 and they</p>			

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	<p>indicated that they had not reviewed the disciplinary action thoroughly and looking at that language that Nurse "M" should be terminated and now allowed back to work but that the language was used based off the "work rules" policies the facility had. The Administrator was queried if Nurse "M" was still providing care to resident in the facility and they indicated they were. The DON reported they had taken Nurse "M" of the assignments of working with R404 and that R404 had reported they did not want Nurse "M" caring for them.</p> <p>On 4/9/25 at approximately 1:30 p.m., R404's medical record was reviewed with the Administrator which revealed Nurse "M" had been assigned to be R404's Nurse after the incident date. Nurse "M" had documented notes in R404's medical record on 2/10/24 and 2/24/24. R404's February 2025 MAR (Medication Administration Record) was reviewed with the Administrator which documented Nurse "M" had administered R404 medication on 2/10, 2/11, 2/12, 2/13, 2/18, 2/21, 2/22 and 2/23. At that time, the Administrator reported Nurse "M" should not have been providing care to R404 and they were unaware Nurse "M" had been assigned as R404 Nurse after being aware of the incident. The Administrator was queried if it was their policy to protect residents and honor their wishes for not having specific caregivers that were involved in allegations provide care to the residents in the facility and they reported it was.</p>			

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	<p>On 4/9/25 a facility document titled "Abuse" was reviewed and revealed the following: "POLICY OVERVIEW: Residents have the right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of resident property. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint that is not required to treat the patient/resident's medical symptoms...Protection: Abuse against residents can be perpetrated by various people within the facility. The facility supports and protects patients, family members, and staff from harm during an investigation of alleged abuse including retribution and retaliation. Protective actions depend upon the people involved. Any allegation of abuse must be immediately reported to the supervisor and the Abuse Prevention Coordinator. The Administrator initiates investigating any allegation of abuse against a patient. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: Immediately removing the resident from contact with the alleged abuser. Evaluation of the physical and psychosocial condition of the resident and providing emotional support to the patient during and after the investigation as needed. Providing a safe and secure environment for all patients. If a staff member is the alleged perpetrator, that staff member should be</p>			

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	<p>immediately removed from the facility and the schedule pending the outcome of the investigation. If a non-staff person (visitor, family member, etc.) is the alleged perpetrator, that non-staff person should be immediately removed from the facility, prevented access to the resident pending the outcome of the investigation, and/or referring the matter to the appropriate authorities as indicated. If a resident is the alleged perpetrator, the facility will ensure other residents are protected as determined by the circumstances, which may include but are not limited to resident room changes, increased supervision, or immediate transfer or discharge, if indicated. Notification to the resident's attending physician and resident representative of the incident or allegation of abuse....Investigation: Key to investigating abuse allegations is an environment that facilitates the reporting of such allegations. Once reported, the center conducts a timely, thorough, and objective investigation of any allegation of abuse. It is the Center's policy to investigate all alleged violations involving Abuse, Neglect, Misappropriation of Resident Property, Exploitation or Mistreatment, including Injuries of Unknown Source to ensure that all individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Report the results of all investigations to the administrator or designee and to the State</p>				

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F0677 SS= D	<p>Agency in accordance with State law. The investigation process includes: Identifying staff responsible for the investigation. Determining the purpose of the investigation and issue(s) to be investigated, whether or not the alleged violation has occurred, the extent, and cause. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations (such as other residents, family members, staff who worked closely with the alleged perpetrator and/or alleged victim). Conducting observations of the alleged victim, including identification of any injuries as appropriate, the location where the alleged situation occurred, interactions and relationships between staff and the alleged victim and/or other residents, and interactions/relationships between resident to other residents as applicable...."</p> <p>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:</p> <p>Based on observation, interview, and record review, the facility failed to promptly respond, provide timely assistance and proper positioning in bed for one (R410) of</p>	F0677	<p>F677 ADL Care Provided for Dependent Residents It is the practice of the facility to ensure that residents that are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>Element 1 Resident 410 remains in the facility and has been assisted with repositioning, ADL care, and call light placement at the time of the survey, the plan of care was reviewed and updated.</p>	5/6/2025	

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	<p>four residents reviewed for quality of care.</p> <p>Findings include:</p> <p>On 4/9/25 at 9:37 AM, upon walking off the elevator onto the second floor, a resident was heard yelling out continuously, very loudly. There were three employees observed seated at the nursing desk which included an CNA (Certified Nurse Assistant), NM (Nurse Manager) 'A', and Unit Clerk 'F'. There was a female resident and male visitor seated just outside the nursing desk (across from the staff) making remarks about the resident yelling. At this time, no staff were observed to respond to the resident's yelling.</p> <p>Continued observations down the hallway around the corner from the yelling resident revealed several other residents in their rooms making remarks about how bad they felt about the resident yelling and hoped they were ok.</p> <p>On 4/9/25 at 9:40 AM, upon entry into R410's room, the resident was observed lying in bed, poorly positioned and leaning down to the left side with their head slightly off the edge of the mattress and their lower extremities almost off the bottom right side of the mattress (positioned diagonally across the mattress). The adaptive call light was observed clipped to the upper left side of the mattress, dangling down (out of reach). R410 immediately stopped yelling upon approach and stated "Need change". When asked if</p>		<p>Element 2 Residents who need staff assistance and/or positioning devices for proper positioning have the potential to be affected by the cited practice. An audit of residents requiring staff assistance and/or positioning devices for proper positioning was completed and their care plans/Kardex were reviewed and updated, if applicable. An audit was completed to ensure call lights were within reach and residents who require staff assistance and/or positioning devices of proper positioning were in place.</p> <p>Element 3 The interdisciplinary team reviewed the "Activities of Daily Living" (ADL's), call light, incontinence care, and repositioning policies and procedures and deemed them appropriate for use as written. The facility licensed nurses and nursing assistants have been educated on the above policies.</p> <p>Element 4 The DON/designee will complete random audits weekly to ensure residents requiring staff assistance and/or positioning devices are properly positioned. The IDT team will complete random audits weekly to ensure call lights are within reach. The IDT team will complete random audits weekly to ensure residents calling out for assistance are responded to. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Any deficient practice will be corrected/updated immediately. The results will also be taken to the QAPI meeting.</p> <p>Element 5 The Administrator is responsible for compliance: date of compliance May 6, 2025.</p>	

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	<p>they were wet, R410 stated "Wet. Change." The resident had no pants or socks on, and their brief was observed to be swollen (as if wet with urine).</p> <p>The resident's call light was activated by this surveyor at 9:41 AM.</p> <p>At 9:49 AM, an unknown therapist entered the room to tack up a restorative therapy program to the board on the wall. They asked if this surveyor was waiting for nurse and they were informed we were and they then asked if they could do anything and were informed we were waiting on nursing staff.</p> <p>At 9:51 AM, Unit Clerk 'F' entered the room and reported they were responding to the call light. They reported they were also a CNA. Upon seeing the resident in the bed, Unit Clerk 'F' stated "Oh you look a little uncomfortable." And proceeded to reposition them in the bed by raising the bed up and down with the remote control.</p> <p>When asked about whether they heard the resident yelling earlier, Unit Clerk 'F' stated "It's kind of a behavior with her." When Unit Clerk 'F' was informed R410 stated they needed to be changed, Unit Clerk 'F' stated "That's also a behavior with her. Sometimes you can hear it (yelling) from downstairs." When asked to confirm whether the resident was wet or not, Unit Clerk 'F' checked the outside front of the disposable brief and stated "This time she's wet.". When asked</p>			

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	<p>how the call light should be positioned, Unit Clerk 'F' confirmed the call light was out of reach and stated, "Should be across her."</p> <p>On 4/9/25 at 10:05 AM, there was no staff observed at the nursing desk and a staff schedule was observed on top of the counter which identified CNA 'C' was assigned to R410.</p> <p>On 4/9/25 at 10:09 AM, an interview was conducted with Unit Manager (UM 'A'). When shown the copy of the nursing schedule that was on top of the counter, UM 'A' grabbed the copy out of this surveyor's hands and started to crumple the form and stated that was wrong and this is new one (pulled binder off desk). UM 'A' was asked to return the form and provide a copy of the current assignment. UM 'A' confirmed CNA 'C' was assigned to R410.</p> <p>When asked about the earlier observation upon entering the second floor of NM 'A' and several other staff seated behind the desk and not responding to R410's yelling, NM 'A' reported that was the resident's behavior and she yells out a lot. When asked if that was the resident's behavior, what intervention should be done in response, NM 'A' reported we should respond. When asked why they didn't respond, they reported they were in the process of doing something for the State and could not answer for the others.</p> <p>On 4/9/25 at 11:29 AM, an interview was</p>			

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	<p>conducted with CNA 'C'. When asked about their assignment today, CNA 'C' reported there were several changes made to the assignment but they had been assigned to R410 from the beginning. They further reported they had assisted R410 with their breakfast meal since they were a "feeder" and changed the resident's brief a little while ago when they got them up in the wheelchair. CNA 'C' confirmed prior to (name of Unit Clerk 'F') changing the resident, they had not provided any incontinence care since they started their shift today.</p> <p>When informed of the concerns with how the resident was left positioned in bed and placement of call light, CNA 'C' reported the resident couldn't use the call light anyways but usually when she yelled out that was when she needed something. She leans over and that's normal for her, I put a pillow in her chair once I got her up. When asked if they were aware of the resident's tendency to lean while in bed, why weren't any positioning devices used, they did not provide any further information.</p> <p>On 4/9/25 at 11:40 AM, an interview was conducted with the DON. They were informed of the observations and interviews for R410. The DON reported staff should be ensuring residents were properly positioned in bed and that routine incontinence care should be completed. Regarding the staff not responding to the resident's yelling, the DON reported that should not have occurred and</p>			

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	<p>all staff were responsible to go and assess the resident and confirmed the resident does have behaviors of yelling out loudly but usually calms down when approached by staff.</p> <p>Review of the clinical record revealed R410 was admitted into the facility on 9/19/24 with diagnoses that included unspecified dementia, unspecified severity, with other behavioral disturbance, dysarthria and anarthria, acute kidney failure, disorder of muscle, psychotic disorder with delusions due to known physiological condition, depression, anxiety disorder, and rhabdomyolysis.</p> <p>According to the Minimum Data Set (MDS) assessment dated 3/18/25, R410 had clear speech, usually able to make self understood, usually able to understand others, had short and long term memory impairment per staff assessment for mental status, was always incontinent of bowel and bladder, and required partial to moderate assistance with most activities of daily living.</p> <p>Review of task documentation for the bladder elimination for the past 30 days revealed the last documented entry was on 4/8/25 at 11:18 PM. There was none documented on 4/9/25.</p> <p>Review of the Kardex and care plans revealed nothing specific about R410's behaviors of yelling out.</p>			

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	<p>The "The resident has impaired cognitive function/dementia or impaired thought processes r/t (related to) Disease Process" care plan initiated 9/23/24 included interventions for:</p> <p>"Communication: Use the resident preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact...The resident understands consistent, simple, directive sentences..." initiated 10/22/24.</p> <p>The "Safety risk due to history of falls" care plan initiated 9/19/24 included interventions for:</p> <p>"Call light within reach" Initiated 9/19/24.</p> <p>The "ALTERATION IN ELIMINATION r/t (related to) cognitive impairment, debility and generalized weakness" care plan initiated 9/20/24 included interventions for:</p> <p>"Assist with toileting and hygiene needs PRN (as needed)." Initiated 9/20/24.</p> <p>"Incontinence care per facility protocol". Initiated 9/20/24.</p> <p>According to the facility's policy titled, "Repositioning" dated 8/9/2023:</p> <p>"...Residents who are immobile and/or dependent upon staff for repositioning should be repositioned at least every two</p>			

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F0684 SS= H	<p>hours...If ineffective, the turning and repositioning frequency will be modified to resident tolerance...Moving up in bed...Roll the resident toward you to place the slide sheet or draw sheet against the resident's back...Roll the resident onto the sheet and spread the sheet out flat under the resident. If needed, have the 2nd staff member roll the resident toward them to spread the sheet out flat under the resident..."</p> <p>Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to intake: MI00151683.</p> <p>Based on interviews and record reviews the facility failed to ensure consistency with the timely identification and reporting in changes in condition, ensuring accurate assessments and monitoring for a resident with an identified change of condition, ensure professional nursing standards of practice were consistently followed for medication administration, failed to ensure the implementation of a physician order for oxygen administration and intravenous therapy was administered, failed to ensure accurate and complete documentation of nursing skilled notes and failed to timely transfer to a higher level of</p>	F0684	<p>F684 – Quality of Care It is the practice of the facility to ensure that quality care is provided following the fundamental principle that applies to all treatment and care provided to the facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive per- centered care-plan, and the residents' choices.</p> <p>Element 1 Resident R402 no longer resides in the facility.</p> <p>Element 2 Residents residing in the facility who have a change in condition have the potential to be affected by the cited practice. The facility has completed audits and reviews of current residents pertaining to any of the cited practices listed below. An audit was conducted to ensure that residents with a change of condition have appropriate evaluation, monitoring, documentation and physician notification. An audit was conducted on residents who</p>	5/6/2025	

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	<p>care, for one R402 of four residents reviewed for a change of condition and resulting in multiple hospitalizations. Findings include:</p> <p>A review of the medical record revealed R402 was admitted to the facility on 11/26/24 with diagnoses that included: Fracture of right pubis, repeated falls, severe protein-calorie malnutrition, dysphagia-oro-pharyngeal phase, and abnormal weight loss.</p> <p>A review of a submitted complaint revealed on 1/7/25 the complainant was instructed by the facility that they had to sign an Against Medical Advice (AMA) for R402 to be transferred to the hospital due to concerns of the family identifying a change of condition with the resident. Further review of the complaint noted the continuous failure of the facility staff to accurately assess, monitor, report and treat identified changes in condition for R402.</p> <p>Review of the progress notes revealed the following:</p> <p>A Therapy note dated 12/31/24 at 10:32 AM, documented in part " ... SLP (Speech Language Pathologist) recently evaluated 12/18/24 ... placed on mechanical soft diet per preference ... Pt ... requested further downgrade to puree to see if it would be easier for him to eat with fewer feelings of gagging. Pt continues to report lack of appetite and the thought of foods making him gag ... Pt reports this happened before and he saw a GI (Gastroenterologist) who placed feeding tube ..."</p> <p>A Doctor of Osteopathic (DO) note dated 1/3/25 at 5:20 PM, documented in part " ... failure to thrive, dysphagia due to previous CVA (stroke) came in after a mechanical fall resulting in a right to pubis fracture ... Patient was observed dry heaving ... Patient reports poor appetite, unable to</p>		<p>have blood pressure medications to ensure their vital signs were obtained and orders followed as written.</p> <p>A full house sweep was conducted of resident rooms for oxygen and IV equipment and was reconciled with resident active orders for oxygen and IV medications.</p> <p>An audit of residents recently transferred to acute care since the date of survey exit (4/10/2025) was conducted to ensure that acute care transfer was completed in a timely manner in accordance with the residents' needs.</p> <p>If any of the above noted areas were found to be out of compliance, they were corrected immediately with all necessary parties notified.</p> <p>Element 3 A QAPI meeting was held by the interdisciplinary team who reviewed the change of condition policy, medication pass policy, physician orders policy, and the resident transfer policy, to which all were deemed appropriate for use. Facility nurses will be reeducated on the policies with a focus on changes in condition and completion of documentation of the change in condition.</p> <p>Element 4 The DON/Designee will audit for resident changes of condition twice a week for 4 weeks, then monthly for 3 months. Audits will include but are not limited to timely identification, accurate assessment, monitoring, and documentation of the resident's change in condition, documentation and implementation of physician orders, and timely transfers to a higher level of care when necessary. Residents will be discussed within the morning IDT meetings Monday-Friday. The results of the audits will be reviewed during the monthly QAPI meeting. Any areas</p>		

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	<p>tolerate diet as he does not like the food being offered to him. He does report some dry heaving which has been present for the past 2 ½ weeks per his report. Check comprehensive blood work. Add Zofran as needed for 14 days ..."</p> <p>A Nursing note dated 1/4/25 at 12:37 PM, documented in part " ... S/w (spoke with) resident daughter (name) today ... had concerns regarding her father because his girlfriend (name), had advised her that he ws aspirating and had an emesis episode. Writer checked on resident and spoke with him. Resident stated that he did not have an emesis episode and that he swallowed his pop too fast and coughed. (daughter name) wanted to know what the protocol was if she requested that her father is sent to urgent care. (daughter name) advised by the writer that is considered AMA. Writer did advise (daughter name) that resident is showing no signs of aspiration, and he currently calm laying in his bed. (Daughter name) was satisfied with the report that was given from writer and stated she was concerned because of the report that was given to her from resident girlfriend ..."</p> <p>A Nursing note dated 1/5/25 at 12:28 AM, documented in part " ... Resident unstable to standing ..."</p> <p>A Nursing note dated 1/5/25 at 8:52 PM, documented in part " ... resident unstable to stand ..."</p> <p>A Nursing note dated 1/7/25 at 2:05 PM, documented in part " ... Writer spoke with daughter (name). She expressed concerns that she and significant other feel resident has had decline neurologically and wishes resident to be sent to hospital ... Writer assessed resident who was alert, able to make needs known and VS (vital signs) at baseline. Resident observed to be at baseline with</p>		<p>found to be out of compliance will be corrected immediately with physician and family notifications completed as appropriate.</p> <p>Element 5 The director of nursing is responsible for ultimate compliance. Compliance date of May 6 2025.</p>	

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	<p>no obvious symptoms of decline noted. Resident denies pain/discomfort at this time. Notified resident that daughter was requesting transfer, resident stated he was okay with "whatever". Per MD (Medical Doctor), resident is table for continued care in facility and transfer will be AMA ... Daughter uncomfortable with waiting ... prefers resident to transfer to (hospital name) for further evaluation ... resident sent to hospital via EMS (emergency medical services) ..." This note was documented by Unit Manager (UM) "N".</p> <p>Review of the medical record revealed no nursing assessment/evaluation or vitals obtained for the resident for this period of time, despite UM "N" documentation of the resident to have been stable.</p> <p>A review of the hospital records revealed the following:</p> <p>A "Emergency Medicine" consult dated 1/7/25 at 3:57 PM, documented in part " ... present to the Emergency Center (EC) today with a chief complaint of AMS (Altered Mental Status) ... They (EMS) state when he first arrived his blood pressure was in the 50s. They state he was also hypothermic and tried to warm him up in the ambulance with no improvement. The patient states he doesn't know how he got here or who called the ambulance ... Patient is globally weak ... Mucous membranes are dry ... presents with hypotension and decreased p.o. intake. Patient with dry mucous membranes ... with hypotension and unknown cause sepsis initially concern was started on broad-spectrum antibiotics ... Patient had AKI (Acute Kidney Injury) continue IV fluids ... Admission for continue monitoring ..."</p> <p>A "Infectious Disease" consult dated 1/8/25 at 11:03 AM, documented in part " ... presented to EC yesterday from his rehab facility AMS. They reported hypothermia. On arrival rectal temp 35.9</p>				

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	<p>(96.6 F), other labs showed create 2.39, BUN 55 ... he has been started on vanco and zosyn ... Impressions ... Hypotension ... Hypothermia ... Continue IV Zosyn pending further culture data ..."</p> <p>The review of the above initial presentation and assessment obtained by the EMS personnel and ER revealed an identified change of condition that the facility failed to identify and acknowledge. The facility staff failed to complete an assessment and obtain vitals to inform the Physician of an accurate status for R402.</p> <p>Review of a facility policy titled "Changed in Condition policy" dated 10.2022", documented in part " ... It is the policy of this facility that residents will be routinely monitored and evaluated by all staff members to determine the need for additional health services monitoring of ... changes in condition ... Observations or Changes of Condition could indicate the need for additional health services or monitoring ... When a change in condition is identified , the physician team will be called for direction ..."</p> <p>Review of the medical record revealed R402 was re-admitted to the facility on 1/16/25 with the instructions to stop taking losartan 100 mg (milligrams), stop potassium chloride 20 meq (milliequivalent), to change metoprolol succinate and to start dronabinol.</p> <p>A Physical Medicine and Rehabilitation note dated 1/17/25 at 8:01 AM, documented in part " ... in his wheelchair comfortably without complaints except for generalized fatigue and BLE (bilateral lower extremity) weakness. He continues to note the decreased appetite as feeling of gagging while swallowing ..."</p> <p>A Nursing note dated 1/22/25 at 11:22 AM,</p>			

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	<p>documented in part " ... spoke with daughter (name) regarding resident and concerns with oral food intake. Resident requesting peg tube placement ... Daughter okay with peg tube ..."</p> <p>A Nursing note dated 1/25/25 at 5:54 PM, documented in part " ... Pt (patient) is failing to thrive. He isn't eating any of his food. Writer thought patient hasn't been eating due to increased confusion and attempted to feed pt and he vomited. DON (Director of Nursing) notified ..."</p> <p>There was no documentation of the DON's recommendation or documentation of the physician to have been notified.</p> <p>Review of the January 2025 Medication Administration Record (MAR)/Treatment Administration Record (TAR) and recorded vitals revealed the following:</p> <p>On 1/26/25 at 11:23 AM- R402's blood pressure was recorded at 100/63. The morning dose of Metoprolol Tartrate 100 mg was held.</p> <p>The blood pressure was not obtained again before the administration of the resident's 9:00 PM administration of Metoprolol Tartrate for high blood pressure.</p> <p>On 1/27/25 the morning Metoprolol Tartrate was administered without a blood pressure obtained for R402.</p> <p>On 1/27/25 at 7:31 PM, the recorded blood pressure was 80/60.</p> <p>Review of a RT (Respiratory Therapist) note dated 1/27/25 at 10:00 AM, documented in part " ... Resident seen this morning due to hypotensive episode, pulse ox on 2L (liters) NC (nasal</p>			

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	<p>cannula) 100%. Weaned to RA (room air) without incident. No respiratory distress noted by writer at this time.</p> <p>A review of the medical record reveal no documentation on why or when oxygen was applied to R402 (prior to the documentation of this note) and no physician order for the oxygen to be administered.</p> <p>Review of a facility policy titled "Oxygen Administration" dated 5/7/24, documented in part " ... Oxygen shall be administered using a physician's order unless there is an emergent need. In an emergency situation, the order is to e obtained by the physician after the resident is stable ..."</p> <p>A Nurse Practitioner (NP) note dated 1/27/25 at 10:11 AM, documented in part " ... Chief Complaint: Hypoxemia and tachycardia ... Patient reports feeling "yucky". Per nursing staff, his appetite has been very poor for the last few days ... Oxygen in place ... Temperature 96.8 blood pressure 100/63 heart rate 45 respiratory rate 16 02 saturation 90 on oxygen, 70 on room air ..."</p> <p>A Speech therapist "Summary of Daily Skilled Services" dated 1/27/2025 at 3:48 PM, documented in part " ... Pt with increased confusion and low O2 (oxygen) with inability to get BP (blood pressure) via machine. Nursing notified who then informed unit manager, DON, RT, and NP who came to assess ... Pt with increased confusion and difficulty following commands. Nursing notified and addressed ..."</p> <p>A Nursing note dated 1/27/25 at 3:57 PM, documented in part " ... Patient observed with low blood pressure 70/55 heart rate 115. Writer placed patient on 4-5L of O2 (oxygen) via nasal cannula. Patient placed on 1 L 0.9% Normal saline ..."</p>			

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	<p>Patient O2 saturation now at 97% on room air. Patient oxygen began and <sic> desaturated to 89 writer placed patient back on 2L O2 oxygen saturation now at 97%. Orders for stat chest xray and labs <sic> work are in place. Physician present at time of occurrence. Writer will continue to provide care during shift ..."</p> <p>Review of the medical record revealed no order implemented for the administration of supplemental oxygen.</p> <p>A Nursing note dated 1/27/25 at 7:35 PM, documented in part " ... Patient oxygen saturation at 97% on 4L O2 ... Heart rate elevated 112. Writer to inform oncoming nurse ..."</p> <p>Review of the medical record revealed no documentation on why or when R402's oxygen had to be increased from the previous documented 2L to the 4L. Further reviewed revealed no documentation of notification to the Physician regarding the consistent elevated heart rate.</p> <p>Review of the January 2025 MAR/TAR and vitals record revealed the following:</p> <p>On 1/28/25, the morning Metoprolol Tartrate medication was administered without a blood pressure to have been obtained for R402.</p> <p>A speech therapist "Summary of Daily Skilled Services" dated 1/28/25 at 10:30 AM, documented in part " ... Pt with continued lethargy and refusal for solid foods ... Pt with continued increases confusion requiring increase cues and stimulation to participate in tx (treatment) ..."</p> <p>A Medical Doctor (MD) note dated 1/28/25 at 1:06 PM, seen today for hypernatremia. Patient</p>			

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	<p>having decreased p.o. (by mouth) intake ... vitals (blank) ... Oxygen in place ... Hyponatremia- Likely secondary to intravascular volume depletion. Continue with IV fluids. Repeat BMP tomorrow ... Wean O2 as tolerated ... Possible PEG tube soon. Occasionally hypotensive. Continue current plan of care with parameters for administration ... poor appetite and weight loss ... Patient is refusing p.o. intake ..."</p> <p>A review of a physician order dated 1/28/25, noted to provide " ...normal saline x1 liter ..."</p> <p>A review of the medical record revealed the 1 liter of normal saline ordered on 1/28/25 was never administered as ordered by the MD.</p> <p>Review of the blood pressure tab noted a blood pressure obtained on 1/28/25 at 3:27 PM, at 36/33.</p> <p>Review of the medical record revealed no documentation of the Physician to have been notified of the abnormal blood pressure level at that time.</p> <p>A Nursing note dated 1/28/25 at 3:44 PM, documented in part " ... resident being sent out to hospital via (medical director name) orders. Resident vital signs read 37/31, 87, 97.6, 93%... resident is able to respond to voice stimulation, the resident is a/o/x1 (alert and oriented times one) with confusion and competitiveness ..."</p> <p>Review of the physician orders noted in part " ... Complete: Skill Nursing Note Under Assessment Tab every night shift ..." the nurses failed to complete and/or inaccurate assessments for the following dates: 1/25/25 (assessment generated but nothing documented) and 1/27/25 - "no respiratory problems noted"- the resident required supplemental oxygen, which was not needed</p>			

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	<p>previously.</p> <p>A review of the hospital record revealed the following:</p> <p>A "Emergency Medicine" consult dated 1/28/25 at 4:44 PM, " ... presents to the Emergency center today with a chief complain of altered mental status ... patient has been experiencing 1 week of decreased responsiveness and decreased PO intake. Today, they checked his blood pressure and found this to be low in the 70's/60's ... lethargic ... Patient will be admitted to the intensive care unit for close monitoring ..."</p> <p>A "Discharge/Expiration Summary" dated 2/3/25, documented in part " ... saw patient on 2/2/2025, in ICU ...Daughter ... aware of poor prognosis and decided for comfort care only ... Patient expired on 2/3/2025 and was pronounced ... at 4:14 am ..."</p> <p>On 4/10/25 at 11:34 AM, the DON (with the Administrator present) was asked about the change of condition identified by the family of R402 on 1/7/25 that required the resident to be transferred to the hospital, why the facility staff failed to identify and assess the change of condition and inform the family that they would have to sign an AMA for R402 to be transferred to the hospital. The DON was asked about the incomplete and inaccurate skilled nursing notes, why the 1L of Normal Saline was not administered as prescribed by the MD, Why R402 required supplemental oxygen, the date, time, and vitals on the day it was applied. The DON was asked why there was no oxygen order implemented for R402 and the lack of assessment and monitoring of R402 with an identified change of condition. The DON stated they would look into it and follow back up.</p>			

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F0689 SS= G	<p>At 12:04 PM, UM "N" was interviewed and asked about the day R402 was transferred out to the hospital on 1/7/25. UM "N" was asked about their note indicating that R402 was assessed and vitals to have been at baseline. UM "N" replied although they documented the note, they did not assess R402. UM "N" stated they talked to the nurse that was assigned to R402 on 1/7/25 and relied on their assessment. When asked why they informed R402's loved ones that they would have to sign an AMA for R402 to be sent to the hospital for a change of condition they identified and the facility failed to accurately assess, UM "N" stated they did not make that decision alone and that they contacted the Physician. UM "N" asked what Physician was contacted and what details were provided regarding R402's status and UM "N" stated they could not remember. UM "N" was asked the nurses name that completed the assessment and vitals on R402 prior to their transfer to the hospital on 1/7//25 and UM "N" stated they could not recall.</p> <p>On 4/10/25 at 1:57 PM, the DON returned and stated the facility had a standing policy that noted to apply 2L of O2 on any resident under 90%. The DON was reminded that there was no oxygen order ever implemented for R402 and reminded of the documentation of the resident to have required 4-5L of oxygen, the DON acknowledged the concern. The DON then stated they reviewed the blood pressures and medication administrations and two of the nurses no longer work at the facility, however one nurse is a current employee who will be re-educated.</p> <p>No further explanation or documentation was provided by the end of the survey.</p>	F0689	<p>F689 Free of Accident Hazards/Supervision/Devices It is the practice of the facility to ensure that</p>	5/6/2025	

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	<p>§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 # MI00150676.</p> <p>Based on interview, and record review, the facility failed the appropriate level of assistance per plan of care to prevent serious injury (acute appearing distal tibia fracture) for one (R406) of four residents reviewed for quality of care.</p> <p>Findings include:</p> <p>A review of a Facility Reported Incident (FRI) submitted to the State Agency on 2/19/24 documented R406 sustained an injury of unknown origin which was a "fracture of the tibia and fibula" while receiving care from an agency CNA (Certified Nursing Assistant) on 2/14/25.</p> <p>On 4/9/25 at 10:40 AM, R406 was observed lying in bed with a trapeze bar positioned above the head of the bed and there was a pillow placed along the resident's right lower extremity. R406 was alert and remembered this surveyor from a previous survey. The resident reported since their initial back injury that brought them to the facility in August 2024, their right leg tended to wander to the</p>		<p>the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Element 1 Resident 406 remains in the facility and continues to receive supportive visits for psych services. The plan of care was updated.</p> <p>Element 2 Residents residing in the facility requiring two persons assist for bed mobility are at risk. An audit was completed by the DON/designee of all residents requiring 2 persons assist with bed mobility to ensure their Kardex and care plan were appropriate to ensure adequate support to prevent accidents.</p> <p>Element 3 The interdisciplinary team reviewed the ADL policy and deemed it appropriate for use as written. Licensed nurses and nursing assistants (to include agency staff) will be educated on the ADL policy with emphasis on following Kardex/Care plan when providing assistance with bed mobility and ADL care. In-services will be ongoing as needed.</p> <p>Element 4 The administrator/designee will conduct random audits for residents requiring 2 people to assist with bed mobility to ensure the plan of care was followed weekly for 4 weeks then monthly for three months.</p> <p>Element 5 The administrator/designee is responsible for compliance: date of compliance May 6, 2025.</p>	

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	<p>right and when it did, they didn't have any control over the leg and the leg can just slide down. They reported they usually have a pillow or wedge to the right side to keep the leg up.</p> <p>They were informed of the investigation into the reported incident from 2/14/25 and was asked to recall the events as best they could. R406 reported the aides have a habit of lifting the pad underneath them to turn or move them. The nighttime aide (not sure of their name) did it so fast my right leg came off the mattress. She picked it (leg) up and it happened again so quickly and my foot hit the floor. I know it hit the floor because I felt that cold tile floor. Right after that I tried to call her back to ask the nurse for a pain med but I was afraid so I didn't. I talked to that aide after that and she said she didn't do anything. I talked to the nurse the next day (not able to recall any specific nurse's name). I was afraid to have the aide come back after that.</p> <p>Review of the clinical record revealed R406 was initially admitted into the facility on 8/29/24 with diagnoses that included: acute appearing distal tibia fracture (2/19/25), wedge compression fracture of third lumbar vertebra (8/29/24), and encounter for other orthopedic aftercare (8/29/24).</p> <p>According to the Minimum Data Set (MDS) assessment dated 2/27/25, R406 scored 15/15 on the Brief Interview for Mental Status</p>			

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	<p>exam (BIMS) which indicated intact cognition, was frequently incontinent of urine and always incontinent of bowel, had occasional pain and received as needed pain medication, and had no falls since the previous MDS assessment on 12/3/24.</p> <p>According to the Kardex (specific instructions on the resident's care needs) R406 required two-person assistance with bed mobility, including toileting and the use of a mechanical lift (Hoyer) for transfers (which was the same status prior to this incident and remained unchanged since this incident).</p> <p>Review of the progress notes included a Physical Medicine and Rehabilitation entry on 2/20/25 at 3:34 PM which read, "...Based on the view of the films...recommend NWB (Non-Weight Bearing) right LE (Lower Extremity) and ER (Emergency Room) Ortho evaluation of new acute appearing distal tibia fracture...[Physician 'H'] is aware that patient may need casting or splinting but needs to be determined by Ortho...The patient was not examined at this time but stated that she noted new pain on Friday when being changed when her right leg hit the floor..."</p> <p>Review of the documentation submitted to the State Agency on 2/19/25 revealed the same documentation provided by the facility for review on 4/9/25. This documentation revealed there was only one witness statement obtained which was from an Agency Certified Nursing Assistant (CNA 'G')</p>			

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	<p>on 2/18/25 by phone with the Director of Nursing (DON) that read, "Name and title of person conducting interview: [name redacted] DON Date of incident: 2/14/25 Date/Time/Place of interview: 2/18/25</p> <p>STATEMENT: Went in around 1am to answer call light. Resident needed her brief changed. Resident already complaining of pain to right leg. Pulled the bed pad towards me to roll resident over, resident leg did not hit the floor at all. Assisted the resident with 1 PA (Physical Assistance)...VIA PHONE 2/18/25."</p> <p>There were no other interviews from other staff, or residents included in the documentation provided during this survey, or submitted to the State Agency as part of this investigation. There was no documentation of any education that the facility implemented following this incident to ensure all staff were informed of the need to provide care per plan of care.</p> <p>Review of the facility's investigation documented, in part:</p> <p>"...It was brought to the attention of the Administrator on 2/19/25 that the resident [R406] had a fracture of the Tibia and Fibula, the incident actually occurred on 2/14/25 which the CNA (Certified Nursing Assistant) that was caring for the resident was from the agency...Investigation initiated immediately to see what occurred on the day in question...Investigation: Injury of unknown</p>			

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	<p>origin 2/19/25...Writer was notified on 2/19/25 that resident [R406] had complaint on 2/14/25, she did not notify the nurse due to incident that occurred with the CNA (although R406 reported she had notified the nurse the next morning), resident stated that she did not feel safe to tell the nurse due to CNA reactions. Nurse Manager (the Nurse Manager/NM 'A' was not informed until 2/18/25) ensured safety and the resident stated that she feels safe living in the facility. On 2/17/25 resident complained of mild pain to right leg, resident asked for pain medication. Medication was administered for pain to the right leg, and it was effective. The next day the resident called the Nurse Manager to her room and stated that she was having increased pain to her right leg, nurse manager informed the Nurse Practitioner and ordered a STAT Xray. Facility received the Xray results back which stated distal tibia fracture. A new order was placed for the [R406] to see PM&R (Physical Medicine & Rehab) and no weight bearing to affected leg. Physician went into access [R406] the resident refused to be transferred to the hospital she stated that she prefers to see the Ortho; Nurse manager made [R406] appointment to see Orthopedic. The CNA involved in this investigation is an agency staff that we interviewed, she stated that she went into the residents room around 1:00AM to answer her call light, resident needed a brief change. She stated the resident was already complaining of right leg pain. CNA stated she pulled the resident towards her to</p>				

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	<p>roll resident over to change her, residents leg never hit the floor at all. Nurses that worked with the resident was asked if the resident complained of any pain or were they aware of any incidents with the resident they stated no (there was no documentation included in the investigation documents of this). 2/19/25 The social worker (SW) did wellness visit completed with resident and her daughter via phone. Resident reports that she does not feel safe in the facility currently...Resident is requesting to transfer facilities and will notify SW when she found a facility to transfer to. Social Services dept will continue to follow up as needed..."</p> <p>On 4/9/25 at 2:06 PM, an interview was conducted with the Administrator. When asked to review the facility's investigation and timeline of events for R406's injuries, the Administrator reported that person involved is an agency staff. The Administrator further reported the resident was complaining of pain on 2/14 and at first it was an injury of unknown origin but then confirmed the aide did not follow the plan of care and should've had two people during care. When asked if this was their complete investigation, they reported "Yes".</p> <p>On 4/9/25 at 2:12 PM, the Director of Nursing (DON) joined the interview. The DON confirmed the events as documented on the facility's investigation. When asked if staff had been offered any education in regard to staff not providing care per their assessed</p>			

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	<p>needs, the DON reported they did not. The DON and Administrator were informed of the concerns that care had not been provided per plan of care. When asked if the resident's plan of care which required two-person assist with bed mobility, incontinence care, and transfers had changed following this incident, or if they required that level prior, both the DON and Administrator reported nothing had changed, R406 required that level at the time of the incident. The Administrator further reported for safety, she's always been a two person assist.</p> <p>On 4/9/25 at 5:21 PM, a phone interview was conducted with Agency Certified Nursing Assistant (CNA 'G'). When asked to recall the events from the time they provided care to R406 on 2/14/25, CNA 'G' reported:</p> <p>"I had her and when I was trying to turn her, she's a very healthy lady and don't mean to be disrespectful, but I pulled her and I proceeded to change her brief three to four times because she had the runs. Recall the resident saying my leg was about to fall off the bed but it didn't fall and I was able to get it back on."</p> <p>When asked to clarify what they meant by they were able to get the leg back on if it didn't fall down, CNA 'G' reported she didn't fall or anything.</p> <p>When asked if they were aware the resident's plan of care required the resident required</p>			

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F0692 SS= H	<p>two people to assist with incontinence care, CNA 'G' reported that was their first time working at the facility and wasn't told that in report."</p> <p>According to the facility's policy titled, "Repositioning" dated 8/9/2023:</p> <p>"...Residents who are immobile and/or dependent upon staff for repositioning should be repositioned at least every two hours...If ineffective, the turning and repositioning frequency will be modified to resident tolerance...Moving up in bed...Roll the resident toward you to place the slide sheet or draw sheet against the resident's back...Roll the resident onto the sheet and spread the sheet out flat under the resident. If needed, have the 2nd staff member roll the resident toward them to spread the sheet out flat under the resident..."</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 preferences indicate otherwise; §483.25(g) (2) Is offered sufficient fluid intake to</p>	F0692	<p>F692 Nutrition/Hydration Status Maintenance It is the practice of the facility to ensure that resident maintains acceptable parameters of nutritional status such as usual body weight or desirable body weight range and electrolyte balance, unless the residents clinical condition demonstrates that this is not possible or resident preferences indicate otherwise.</p> <p>Element 1 Resident 402 no longer resides in the facility.</p> <p>Element 2 Residents who live in the facility can be affected by the deficient practice. An audit</p>	5/6/2025

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	<p>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: MI00151683.</p> <p>Based on interview and record reviews several failures were identified regarding the facility's nutritional management and oversight that included- a delayed gastroenterology referral/follow up, delayed nutritional assessment/lack of oversight/monitoring, untimely implementation of nutritional interventions and a communication break down with the facility's Interdisciplinary team to ensure a collaborative approach for one R402 of four residents reviewed for Nutrition and Hydration, resulting in a severe weight loss of 13.27% within two months, hospitalization and the contribution to R402's death. Findings include:</p> <p>A review of a complaint submitted to the State Agency (SA) documented concerns regarding the facility staff failed to timely follow up with a Gastroenterology appointment for a Percutaneous Endoscopic Gastrostomy tube placement and concerns of the facility staff to timely assess, monitor and evaluate the nutritional status of R402.</p> <p>A review of the medical record revealed R402 was admitted to the facility on 11/26/24 with diagnoses that included: Fracture of right pubis, repeated falls, severe protein-calorie malnutrition, dysphagia-orpharyngeal phase, and abnormal weight loss.</p>		<p>was conducted for residents with recommendations for Gastrointestinal referrals to ensure that they have a physician order for the consult and documentation that an appointment for the consult was scheduled with the Gastrointestinal specialist. Current residents in the facility had their weights reviewed to be sure that the most recent and accurate weights were reported to the Dietitian. An audit was completed by the Dietitian of residents with significant weight loss to ensure physician notification was documented and interventions are in place to address weight loss. Current residents admitted within the last 30 days will be reviewed to ensure admission weights were obtained and recorded in their medical records. Any resident admitted within the last 30 days who does not have a weight recorded in the medical record will be weighed and documented in the medical record. Newly admitted residents will be reviewed by the dietitian to ensure weekly weights are completed and documented for 4 weeks and then as directed by the dietician. The IDT Team will have a nutritional at risk meeting weekly to review residents at nutritional risk, residents with significant weight loss, and residents with gastrointestinal referrals, to ensure physician notification has been completed and documented, and appropriate nutritional interventions are in place.</p> <p>Element 3 The interdisciplinary team reviewed the Consultations policy and deemed it appropriate. The facility unit clerks and nurse managers were educated on the Consultations policy. The interdisciplinary team reviewed the weight policy and deemed it appropriate for use. The</p>		

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	<p>Review of the hospital preadmission documents provided to the facility upon R402's admission documented the following in part, " ... After Visit Summary ... 11/22/2024-11/26/2024 ... Wt (Weight) 196 lb (pounds) 3.4 oz (ounces) ... Most recent update 11/22/2024 at 4:59 PM ..."</p> <p>Review of a Nursing "Admission Evaluation" at the facility dated 11/26/24 at 4:42 PM, documented in part " ... Most Recent Weight ... Weight: 196.0 (Lbs) Date: 11/26/24 21:47 (9:47 PM) ... Scale: Wheelchair ..."</p> <p>Review of a "Nutrition Admission Assessment" note dated 11/27/24 at 5:00 PM, documented the following " ... Pt (patient) is unsure of UBW (usual body weight), he reports that he has lost -30# over the past 3 months, question admission weight given same as hospital weight ... reporting normal/baseline appetite and intake recently, he denies recent changes to his intake. Pt does note that he has lost -30# over the past 3 months, states he is unsure why. Pt appears well-nourished at bedside ... Pt is at risk for inadequate oral intake ... Continue current interventions. Weekly weights ..." This assessment was completed by Registered Dietician (RD) "P".</p> <p>Review of R402's weights noted the following: On 12/3/24 at 11:43 AM- 187.6 lbs</p> <p>This indicated a -4.29 weight loss within one week after admission.</p> <p>A review of the medical record revealed no identification of the weight loss by the facility staff.</p> <p>Further review of the medical record revealed no implementation of interventions to prevent further weight loss, until more than two weeks later.</p>		<p>nursing staff and Dieticians were educated on the policy. The interdisciplinary team reviewed the Monitoring Adequate Nutrition and Hydration Status policy and deemed it appropriate for use. The dietitians were educated on the policy.</p> <p>Element 4 The director of nursing/designee will audit residents with recommendations for gastrointestinal referrals to ensure physician orders and appointments are in place weekly for 4 weeks and then monthly for 3 months. The dietitian will audit newly admitted residents to ensure weights are obtained upon admission and weekly for 3 additional weeks and that current resident's ordered weights/reweights are completed and documented. The administrator/designee will audit residents with significant weight loss to ensure physician notification and nutritional interventions were implemented weekly for 4 weeks then monthly for 3 months. The results will be reviewed monthly in QAPI for 3 months and then PRN if no trends are noted.</p> <p>Element 5 The administrator/designee holds the ultimate responsibility of compliance: date of compliance May 6, 2025.</p>		

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	<p>A review of a Nursing note dated 12/21/24 at 6:46 PM, documented in part " ... Resident c/o (complaints of) ganging <sic> when he eats. Writer called and notified physician. Oder <sic> to be evaluated by speech was put in at this time ... Resident is already on mechanical soft diet no other orders at this time. Writer also logged it in physicians book."</p> <p>Review of a Nurse Practitioner (NP) note dated 12/23/24 at 9:15 AM, documented in part " ... Chief Complaint: Diarrhea, weight loss ... Patient has poor appetite since admission to facility stating he does not "like the food". He does report some recurrent nausea especially in the presence of food ... Patient reports poor appetite, unable to tolerate diet as he does not like the food being offered to him. He does report some dry heaving which has been present for the past 2 ½ weeks per his report ... Add Zofran as needed ... Add low-dose Remeron ... With poor appetite and weight loss Add Remeron 7.5 mg at bedtime ... Patient is experiencing poor appetite, dry heaving Add Pepcid twice a day, continue for 14 days, monitor response ..."</p> <p>This is the first documentation of an intervention implemented for R402's weight loss and nutritional concerns.</p> <p>Review of a documented conversation submitted by the complainant with the facility's Nurse Manager (NM) "N" dated 12/24/24 at 12:17 PM, documented in part " ... I spoke with (NM "N" name) ... she stated that (R402) mentioned wanting a PEG tube, and she explained to him that it's not something he can simply have. I asked what needs to happen for him to get one, and she told me he would need a GI referral. I requested that one be added for the doctor to approve, and she agreed to add it to his file ..."</p>			

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	<p>Review of the medical record revealed no documentation of the NM "N" to have noted in the residents file any follow up of the GI referral for the PEG tube placement and/or notification to the Physician regarding the concern, until the end of January 2025- almost a month later.</p> <p>A Doctor of Osteopathic Medicine (DO) "O" note dated 12/29/24 at 8:41 PM, documented in part " ... Chief Complaint: Nausea, anorexia ... dysphagia (difficulty swallowing) due to previous CVA (cerebrovascular accident- stroke) ... Reporting nausea with current food regimen ... dry oral mucosa ... patient reporting increased nausea with fluid intake. Potentially due to worsening reflux. May require additional management with Tums ..."</p> <p>A review of a (late entry) Therapy note dated 12/31/24 at 10:32 AM, documented in part " ... SLP (Speech Language Pathologist) recently evaluated 12/18/24 with no s/s (signs/symptoms) of aspiration at the time patient placed on mechanical soft diet per preference. Pt later seen by PRN (as needed) SLP and requested further downgrade to puree to see if it would be easier for him to eat with few feelings of gagging. Pt continues to report lack of appetite and the thought of foods making him gag ... Referral for GI (Gastroenterology) may be warranted at this time for further assessment at other possible causes. Pt reports this happened before and he saw a GI who placed feeding tube."</p> <p>A note dated 1/3/25 at 5:20 PM, by DO "O" documented in part " ... Abnormal weight loss ... Patient reports poor appetite, unable to tolerate diet as he does not like the food being offered to him. He does report some dry heaving which has been present for the past 2 ½ weeks per his report. Check comprehensive blood work. Add Zofran as needed for 14 days, maintain on low-dose</p>				

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	<p>Remeron nighttime ..."</p> <p>The medical record revealed R402 was transferred to the hospital on 1/7/25 due to the family's concern of a change in condition.</p> <p>Review of the hospital records revealed the following:</p> <p>An "Emergency Medicine" consult dated 1/7/25 at 3:57 PM, documented in part " ... Patient is globally weak ... Mucous membranes are dry ... presents with hypotension and decreased p.o. (by mouth) intake. Patient with dry mucous membranes decreased p.o. intake. Has a history of severe anxiety significant other requiring G tube ... Patient had AKI (acute kidney injury) continue IV (intravenous) fluids ... Question whether symptoms are just secondary to decreased intake and deconditioning since his pelvic fractures last year. Admission for continued monitoring ..."</p> <p>A "Gastroenterology and Hepatology Consultation" dated 1/8/25 at 10:52 AM, documented in part " ... has had difficulty swallowing. Patient reports that he has been able to tolerate some liquid green, otherwise gags with all other consistencies. He reports some intermittent nausea without vomiting ... AKI noted ... Patient was given fluid boluses and started on antibiotics ... Laboratory Data (1/7/25) BUN- 55 ... Bicarbonate- 17 ... Could consider Corpak (feeding tube) for nutrition ... Will consider PEG placement further work up of dysphagia ..."</p> <p>A "Discharge Summary" filed 1/16/25, documented the following " ... Principle Problem: AKI ... dysphagia ... Protein-calorie malnutrition, severe ... Dysphagia, history of PEG tube placement in the past due to poor p.o. intake. Seen in consultation by speech pathology, case</p>			

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	<p>discussed ... Patient was gagging during evaluation by speech pathology without having anything in his mouth, however consume thin liquids and purees with ease ... Outpatient follow-up recommended ... will need to be readmitted to subacute rehab ..."</p> <p>Review of the facility's medical record revealed the following progress notes:</p> <p>On 1/16/25 at 2:31 PM, a Nursing note documented in part " ... Patient discharged from (hospital name) ... diet order in place placed on pureed diet until evaluated by speech therapy ..."</p> <p>Review of the hospital documents provided to the facility upon admission documented the following:</p> <p>" ... dronabinol 2.5 mg (milligram) capsule, Take 1 capsule by mouth daily for 3 days ... You are started on appetite stimulant. Please address with PCP (primary care provider) within a week whether it's successful, and if your nutrition is adequate. Might need to be evaluated for PEG again ..."</p> <p>Review of a Nursing readmission assessment dated 1/16/25 at 1:58 PM, documented in part " ... Most Recent Weight ... 187.2 (lbs) Date: 1/7/25 ..."</p> <p>The facility staff failed to obtain a new weight for R402 upon re-admission.</p> <p>The next weight recorded in the medical record was dated 1/21/25 at 187.2 lbs.</p> <p>A Nurse Practitioner (NP) note dated 1/20/25 at 4:21 PM, documented in part " ... Dietitian following ... results of CMP (comprehensive metabolic panel) from 1/17/2025 reviewed: Total</p>			

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	<p>protein 4.9 albumin 2.7 Continue supplementations, low-dose Remeron and dronabinol. Monitor diet intake and weight per facility protocol ..."</p> <p>Review of the medical record revealed no dietary re-evaluation since readmission on 1/16/25. Further review of the record revealed no dietary "supplementations" ordered for R402.</p> <p>A Nursing note dated 1/22/25 at 11:22 AM, documented in part "Writer spoke with daughter (name) regarding resident and concerns with oral food intake. Resident requesting peg tube placement ... Daughter okay with peg tube if MD (medical doctor)/dietician feel it is warranted. Concern logged for MD. Dietician aware of decreased consumption ..."</p> <p>A "Late Entry" Dietary note dated 1/23/25 at 11:40 PM, documented in part " ... suffering from dysphagia and nausea also for the last couple of days, worsening ability to tolerate po intake ... Current diet is regular, minced moist, nectar thick. PO intake per FAR (food intake documentation) is poor to variable 0-75%. Pt reports poor appetite & PO intake ... RD recommends health shakes TID ... CBW (current body weight) 1/28- 180 ... reports unintentional wt. loss since x3-6 months r/t (related to) poor PO intake & appetite. Weekly wt. in place for monitoring changes ... 13% wt. loss per pt/clinical records ... Continue current interventions ..." This late entry had a created date of 1/29/25 by PRN (as needed) Registered Dietician (PRN-RD) "Q".</p> <p>Note the above late entry note back dated to 1/23/25, noted a weight from 1/28/25 of 180 that had not been obtained at the time of the supposed 1/23/25 entry date.</p> <p>Further review of the record revealed two</p>			

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	<p>supplement orders with a created date of 1/29/25 and back dated to 1/18/25 as the start dates. The "House Supplement" was ordered for three times a day and the "House Med Pass Supplement" was ordered for twice a day.</p> <p>Review of the January 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed neither the house supplement nor house med pass supplement documented as administered to R402. This reflected the created date of 1/29/25 for both orders to be confirmed as the actual date both orders were implemented.</p> <p>A review of the DO "O" note dated 1/25/25 at 11:12 AM, documented in part " ... Chief Complaint: Generalized weakness, exertional fatigue ... Tolerating full p.o. intake (not accurate). Still reporting some generalized weakness ... Patient is not progressing significantly, still reporting significant fatigue ... Dietitian following ... Continue supplementations, low-dose Remeron and dronabinol. Monitor diet intake and weight per facility protocol. Patient is not having adequate improvement currently ... Poor appetite and weight loss ..."</p> <p>A Nursing note dated 1/25/25 at 5:54 PM, documented in part " ... Pt is failing to thrive. He isn't eating any of his food. Writer thought patient hasn't been eating due to increased confusion and attempted to feed pt and he vomited. DON (Director of Nursing) notified ..."</p> <p>A NP note dated 1/27/25 at 10:11 AM, documented in part " ...Patient had been having trouble with dysphagia and nausea also for the last couple of days. Was having worsening ability to tolerate p.o. intake ... appears very fatigued ... reports feeling "yucky". Per nursing staff, his appetite has been very poor for the last few days</p>			

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	<p>... Patient's daughter (name) was contacted ... During last hospitalization, she was told that father had requested to have a PEG tube placed due to poor appetite but was declined and staff recommended follow-up with GI outpatient. Nurse manager at this facility has been trying to obtain a follow-up appointment with GI specialist outpatient for the past week ... Start patient IV hydration ... Obtain stat blood work, Continue to monitor closely ... Continue supplementations, low-dose Remeron and dronabinol. Monitor diet intake and weight per facility protocol. Patient is still experiencing significant anorexia. Nurse management still working on securing a GI consult. Patient has requested placement of a PEG tube in the past ... Check BMP (basic metabolic panel) today ..."</p> <p>Review of a care plan titled " ... inadequate PO intake r/t (related to) dysphagia ... unintentional 13% weight loss ..." included the following interventions " ... Alert dietician if consumption is poor for more than 48 hours ... Give resident supplements as ordered ..."</p> <p>A review of the meal intake documentation for January 2025 revealed multiple documentation of R402's poor meal consumption.</p> <p>The facility staff failed to continuously comply with the resident's plan of care.</p> <p>A Nursing note dated 1/28/25 at 3:44 PM, noted the resident was transferred to the hospital for a change in condition.</p> <p>Note the late entry dietary evaluation and the late implemented supplements (house supplement and house med pass supplement) dated 1/29/25, was implemented and documented after R402 was transferred to the hospital on 1/28/25 and was no longer in the facility.</p>			

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	<p>A review of the hospital record revealed the following:</p> <p>A "Emergency Medicine" consult dated 1/28/25 at 4:44 PM, " ... presents to the Emergency center today with a chief complain of altered mental status ... patient has been experiencing 1 week of decreased responsiveness and decreased PO intake. Today, they checked his blood pressure and found this to be low in the 70's/60's ... lethargic ... Patient will be admitted to the intensive care unit for close monitoring ..."</p> <p>A Nutritional Assessment dated 1/30/25, documented in part " ... Pt meets criteria for Unspecified severe protein calorie malnutrition and is at refeeding risk with electrolyte fluctuations ... Once corpak placement verified and able to start TF (tube feeding) ... Pt familiar to service from previous admission earlier this month ... Swallowing difficulty. Pt now with continued wt loss 13% since 11/22/2024. Pt with dysphagia and gagging with po intake. Plan at this time is for corpak placement ... Significant wt loss noted ... 01/08/25 86 kg (kilograms, converted to lbs. is 189.6 lbs) 01/30/25 77.2 kg (170.2 lbs) ... Patient meets criteria for unspecified severe protein-calorie malnutrition chronic disease ..."</p> <p>A "Discharge/Expiration Summary" dated 2/3/25, documented in part " ... saw patient on 2/2/2025, in ICU ...Daughter ... aware of poor prognosis and decided for comfort care only ... Patient expired on 2/3/2025 and was pronounced ... at 4:14 am ..."</p> <p>Review of a "Certificate of Death" included "Severe Calorie Malnutrition" with a noted approximate interval between onset and death of "Weeks" as a cause of death.</p>			

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	<p>The last recorded weight in R402's medical record at the facility was dated 1/28/25 (the day the resident was transferred to the hospital) and recorded at 180 lbs. This is a 7.2 lbs weight loss from the 1/7/25 recorded weight. The weight noted at the hospital on 1/30/25 was recorded at 170. 2 lbs, this confirmed a total weight loss of 10.05 % within three weeks and a total of 13.27 % loss from the admission weight obtained two months prior.</p> <p>On 4/10/25 at 9:45 AM, Registered Dietician (RD) "P" was interviewed and asked what interventions were implemented for R402 regarding the initial weight loss on 12/3/24 after only a few days of being at the facility. RD "P" stated normally the nurses would notify them of any weight loss or the facility's electronic system would flag it for their review. RD "P" reviewed the medical record of R402 via their laptop and stated they remembered the resident and believed the facility's initial weight was inaccurate and believed the facility staff duplicated the hospital's recorded weight. RD "P" was asked if they had addressed that with the Administration, DON and Nursing staff and RD "P" stated they believed they did. RD "P" was asked to provide documentation of them to have noted R402's initial weight to be inaccurate and was addressed with the facility staff and RD "P" stated they didn't believe they had maintained documentation of the concern. RD "P" was asked again what interventions were implemented to prevent further weight loss for R402 and RD "P" stated they would look into it and follow back up. RD "P" was asked why none of their documentation identified or addressed R402's nutritional concerns and possible PEG tube placement and RD "P" replied they were unaware of the resident to have requested a PEG tube and unaware of any discussion with the facility's Interdisciplinary team of a PEG tube placement. RD "P" was asked how the facility closely monitored high risk</p>				

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	<p>nutritional residents and if there was additional documentation to provide regarding the overview of R402's nutritional concerns and status. RD "P" stated they check on the resident's monthly but there was no additional meetings or discussions for residents that are high risk for nutritional concerns and/or decline.</p> <p>No further explanation or documentation was provided by RD "P" by the end of the survey.</p> <p>On 4/10/25 at 10:42 AM, the PRN (as needed) Registered Dietician (PRN-RD) "Q" was interviewed (with RD "P" present) and asked about the late entry evaluation that was dated for 1/23/25, however noted as the created date of 1/29/25 when the resident was no longer in the facility. PRN-RD "Q" stated they had consulted with R402 on 1/23/25, however did not lock their assessment until 1/29/25. PRN-RD "Q" was asked if that was the case, why was the supplements for "House Supplement" ordered for three times a day and the "House Med Pass Supplement" ordered for twice a day both have the created dates of 1/29/25 and was observed with no documented administrations on the January 2025 MAR and TAR by the nurses and PRN-RD "Q" did not have a response. PRN-RD "Q" stated they would usually put the orders in right away. PRN-RD "Q" was asked their involvement in monitoring the nutritional status and the possibility of a PEG tube placement for R402 and PRN-RD "Q" stated no one had talked to them regarding PEG tube placement for R402. PRN-RD "Q" and RD "P" both were asked who was monitoring the effectiveness of the Remeron and Dronabinol therapy with R402 and neither provided an answer. The hospitalization discharge (1/16/25) paperwork was read to PRN-RD "Q" and RD "P" regarding if the Dronabinol was ineffective to follow up with GI outpatient for PEG tube placement and both denied being aware of the hospital discharge note. PRN-RD "Q" and</p>			

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	<p>RD "P" were both requested to provide all documentation regarding the nutritional care for R402 that would help to possibly fill in the concern areas regarding the lack of dietary and/or nutritional oversight for R402.</p> <p>No further explanation or documentation was provided by the end of the survey.</p> <p>On 4/10/25 at 11:34 AM, the Administrator and DON was interviewed together and the nutritional concerns noted above was reviewed. The Administrator and DON stated they were unaware of the Registered Dietician concerns of the staff not obtaining accurate weights and documenting hospital weights. The DON stated the RD had never brought that concern to their attention. The DON stated the Administration team meets every morning to discuss any issues or concerns with the residents. When asked if R402 was discussed at any of the morning meetings and if they could provide documentation of the concerns for R402, both stated they were not aware of any discussion for R402. The Administrator and DON stated they were unaware of the reviewed nutritional concerns for R402. The Administrator and DON stated they had already started immediate education with the facility staff.</p> <p>On 4/10/25 at 12:04 PM, Unit Manager (UM) "N" was asked about the discussion with R402's family member on 12/24/24, regarding the PEG tube - GI consultation and why it was never followed up on timely. UM "N" stated they had a hard time trying to find a GI doctor that would take the resident. UM "N" was asked if they informed the attending physician/Medical Director of the facility to help facilitate an appointment for R402 and UM "N" stated they had not. UM "N" stated eventually they found a GI doctor that would see R402, however they were unable to provide documentation of a</p>			

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F0745 SS= D	<p>scheduled appointment and could not provide the GI's doctor name or phone number.</p> <p>Review of a facility policy titled "Monitoring Adequate Nutrition and Hydration Status" dated 4/7/25, documented in part " ... The RD or nutritional professional will screen each resident upon admission, readmission and begin the comprehensive assessment to evaluate nutritional needs of each resident ... The RD or nutritional professional will determine residents "at risk" and communicate to the IDT any information that impacts care. A systematic approach can help staff's efforts to optimize a resident's nutritional status. This process includes identifying and assessing each resident's nutritional status and risk factors, evaluating/analyzing the assessment information, developing and consistently implementing pertinent approaches, and monitoring the effectiveness of interventions and revising them as necessary ..."</p> <p>Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to intake: MI00151683.</p> <p>Based on interview and record reviews the facility staff failed to follow the facility policy on capacity decision making for one (R402) of four residents reviewed for the accuracy of medical records. Findings include:</p> <p>Review of a complaint submitted to the State Agency (SA) documented concerns of the</p>	F0745	<p>F 745 Provision of Medically Related Social Services It is the practice of the facility to ensure that all residents receive medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility failed to follow the policy on capacity decision making for 1 of 4 residents.</p> <p>Element 1 R402 no longer resides at the facility.</p> <p>Element 2 Residents that require a capacity evaluation have the potential to be affected by the cited practice. An audit was completed for residents that have had a capacity evaluation completed to ensure the policy was followed and all appropriate paperwork and</p>	5/6/2025

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	<p>facility's failure to timely assess R402's capacity for decision making, a concern regarding the accuracy of the capacity document once it was completed and the ethics of the Physician that signed off on the capacity report.</p> <p>A review of the medical record revealed R402 was admitted to the facility on 11/26/24 with diagnoses that included: Fracture of right pubis, repeated falls, severe protein-calorie malnutrition, dysphagia-orpharyngeal phase, and abnormal weight loss.</p> <p>Review of a call log submitted to the SA documented a conversation on 1/3/25 at 10:50 AM, between the Daughter of R402 and the facility's Social Work Director (SWD) "J". The conversation noted discussions regarding concern with R402's cognition. Further documentation of the conversation documented that R402 will be added to the list to have a competency evaluation which would possibly activate R402's Durable Power Of Attorney (DPOA) making R402's daughter the decision maker for R402's health and financial matters.</p> <p>A review of SWD "J" progress note dated 1/3/25 at 1:48 PM, revealed no documentation of the capacity and DPOA discussion with R402's daughter noted.</p> <p>Review of a consultation request document dated 1/3/25, documented a referral for a "Psychiatric and Psychological ... Mental Status issues/change ... capacity evaluation ..." request.</p> <p>A review of the medical record revealed the Psychiatric consult to determine capacity was not completed until 1/28/25 by Physician "K" from the facility's contracted behavioral group.</p> <p>Review of a facility form titled "Physician</p>		<p>documentation is in place. Any deficiencies noted in the audit were immediately corrected.</p> <p>Element 3 The Interdisciplinary Team reviewed the Decision-Making Capacity Policy and deemed it appropriate. All social service staff and the attending physicians have been educated on the policy and procedure with emphasis on ensuring capacity evaluations are being completed timely and with appropriate documentation.</p> <p>Element 4 The Social Service Director, or designee, will complete random audits on residents with a request for a capacity evaluation weekly x 4 weeks then monthly x3.</p> <p>Element 5 The administrator is responsible for compliance with a compliance date of May 6th, 2025.</p>		

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	<p>Statement of Capacity for Medical Treatment and Decisions" for R402 was noted to be signed by Physician "K" on 1/28/25. Physician "K" noted R402 lacks the capacity to make reasoned medical decisions and/or provide informed consent for their medical affairs. The specific cause and/or contributing diagnosis to support the decision was noted as "Delirium, encephalopathy ..."</p> <p>This form was not located in the medical record for R402 and could not be found or provided by the facility staff and Administration when asked to provide the original copy for review. A copy of R402's "Physician Statement of Capacity for Medical Treatment and Decisions" facility form was provided to the SA by the complainant.</p> <p>The section that Physician "K" signed for was noted in part " ... As second examining physician, or licensed psychologist, I agree with the determination that this resident lacks capacity to make reasoned medication decisions ... Physician/Licensed Psychologist ..."</p> <p>Although Physician "K" signed as the second examining physician, Physician "K" was actually the first examining Physician to evaluate R402 for capacity.</p> <p>Review of Physician "K" evaluation dated 1/28/25, documented in part " ... Evaluation of cognitive capacity to participate in medical decision-making ... Delirium was observed when he was approached lying in bed. There was no communication and no observed ability to follow instructions. He was restless and agitated ... Cognitive communication deficit confirmed ... Unable to follow instructions ... He remains in need of assistance globally ..."</p> <p>The "Attending Physician" section of the capacity</p>			

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	<p>form noted the signature of Physician "L", dated 1/29/25.</p> <p>Review of the medical record revealed R402 was not in the facility on the date of 1/29/25. It was documented that R402 was transferred to the hospital on 1/28/25 at 3:44 PM for a change in condition.</p> <p>This indicated the resident was not in the facility on the date of 1/29/25, when Physician "L" signed the capacity document.</p> <p>Review of the medical record revealed no documentation from Physician "L" or any of the other attending Physicians to have documented that an evaluation of capacity was completed for R402.</p> <p>Further review of the medical record revealed no documentation from any of the attending Physicians and/or Nurse Practitioners to have evaluated R402 and deemed R402 as lacking the capacity to make their own decisions.</p> <p>Review of a facility policy titled "Decision Making Capacity" with a review date of 1/15/25, documented in part " ... A resident is legally considered their own responsible party until deemed incapacitated by two physicians ... The attending physician must complete a thorough examination on the resident prior to making a determination of a resident's decision-making capacity ... The social worker may ask the attending physician to order a psychiatric consult for the second required determination of decision-making capacity ... The social worker will upload the completed Physician Certification Form, letter, and/or completed documentation into the resident's medical record ..."</p> <p>Review of a Social Services note by Social</p>			

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	<p>Worker (SW) "I" dated 1/29/25 at 12:29 PM, noted in part " ... SW spoke with daughter and notified her that resident was deemed incapable of making his own medical and financial decisions. Copy placed on file ..."</p> <p>A copy of the document was not placed in R402's file.</p> <p>On 4/11/25 at 12:49 PM, a telephone interview was conducted with SW "I". When asked about the capacity document for R402, SW "I" replied they could not remember who R402 was. When asked where they kept the capacity documents they have completed, SW "I" stated they load them into the resident charts. When SW "I" was informed that R402's form could not be found, SW "I" apologized and stated they could not recall the resident.</p> <p>On 4/11/25 at 3:07 PM, a telephone interview was conducted with Physician "L". The attending physician signature section of the capacity form was texted to Physician "L" to confirm their signature. Physician "L" confirmed it was their signature on the form. Physician "L" was asked if it was normal practice in the facility for them to sign a document regarding a resident not to have capacity for decision making when a current face to face examination had not been completed, due to R402 to not have been in the building on 1/29/25. Physician "L" stated it was not the normal procedure per say, however they reviewed the other clinicians notes and R402's record and made the decision that R402 was not improving. Physician "L" stated they had not consulted with R402 for a few days prior to them being transferred to the hospital on 1/28/25 and they did not find documentation of them evaluating R402 for capacity.</p> <p>No further explanation or documentation was</p>			

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	provided by the end of the survey.				