STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	614010	A. BUILDING _____ B. WING _____	3/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE NURSING CENTER	2053 S SHERIDAN DRIVE MUSKEGON, MI 49442

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Christian Care Nursing Center was surveyed for a Recertification survey on 3/27/25. Intakes: MI00150317. Census: 49.	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or	F0550	F550 1. Residents #5, 30, 35 and 40 still currently reside in the facility, the cited residents did not sustain harm from the deficient practice and are at their psychosocial baseline. Weekly Guardian Angel Rounds have been initiated. 2. Current residents have the potential to be affected by the deficient practice. Residents were interviewed by 4/25/2025 during Guardian Angel Rounds to ensure resident rights were being met and any issues/concerns were addressed and reported. A weekly resident council will be held x 4 weeks to ensure the current resident's needs are addressed. 3. Policy on Resident Rights was reviewed and deemed appropriate, all staff were in-serviced by the Admin/designee by 4/25/2025. 4. The QAPI committee has directed the DON/designee to perform random weekly audits of staff providing care to ensure that resident rights are being observed. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	4/25/2025

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

Electronically Signed | 04/18/2025

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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CHRISTIAN CARE NURSING CENTER	**2053 S SHERIDAN DRIVE MUSKEGON, MI 49442**

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	her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide care in a dignified manner for four Residents (R5, R30, R35 and R40) of 15 Residents reviewed. Findings included: R5 Review of R5's face sheet dated 3/27/25 revealed she was admitted on 1/23/24 and had diagnoses that included: Diabetes, stage 4 kidney disease, diverticulosis of intestine, irritable bowel syndrome with diarrhea, and urine retention. She was her own responsible party. R5 was observed in bed on 3/25/25 at 10:58 AM and R5 was very upset with the facility's poor response to her needs for assistance. R5 said she has talked to management about the ineffectiveness of the call light system, but they tell her it would take $80,000 to fix the current call light system. R5 said there is no light in the hall that goes off when she puts her call light on. The staff are supposed to carry "iPads" (as identified by R5) around their neck to know when someone needs assistance. The staff must take the "iPad" off when they provide care as it gets in the way and bumps the residents when they are doing care. R5 said her care may take staff 20 to 30 minutes and when she is getting care they cannot see if other patients need			

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	care. R5 had a metal call bell on her bedside table, and she reports she starts ringing it when they do not respond in 15 minutes to her light. R5 said she does not like to have a bowel movement in her bed, and it is painful and frustrating to hold it more than 15 minutes. R5 said "they keep trying to take my call bell away, but I will not let them." R30 R30 was observed being lifted from her wheelchair to bed with a full body electronic lift on 3/26/25 at 9:42 AM by Certified Nurse Aides ("F" and "G"). CNA "F" and "G" did not talk to R30 during the transfer or care. They did not indicate when they were going to lift her, turn her or remove her brief. R30's eyes were open, and she did not speak during this observation. When R30 was lifted out of her wheelchair she had a wet spot about 3 to 4 inches in diameter in the center of her buttock. R30's wheelchair had a strong urine smell. CNA "F" removed the cushion cover and said she would get a new cover from therapy. After the cover was removed the wheelchair and cushions still had a strong urine smell. R35 Review of R35's face sheet dated 3/27/25 revealed she was a 98-year-old female admitted to the facility on 11/4/22 and had diagnoses that included: Alzheimer's disease, chronic pain, rheumatoid arthritis and generalized anxiety disorder. She was not her own responsible party. Review of R35's Brief Interview for Mental Status (BIMS) dated 2/24/25 revealed she scored 10/15, indicating she has moderate			

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	cognitive impairment. R35 was observed in bed on 3/25/25 at 11:39 AM. R35 was upset about the quality of the incontinence briefs. R35 said "the staff have to put two diapers on me to keep my bed clean." She reported all the staff know about the problem with these briefs, but "no one is doing anything." R35 also complained that the food quality has gotten bad, and no one is doing anything about it. "They don't write down the concerns, they just don't care." R40 Review of R40's face sheet dated 3/27/25 revealed she was an 82-year-old female admitted to the facility on 9/19/23 and had diagnoses that included: Alzheimer's disease, hemiplegia, convulsions, heart disease, cardiomegaly, and psychotic disorder with delusions. She was not her own responsible party. During an interview with R40's responsible party on 3/25/25 at 10:33 AM, he expressed concern about the facility purchasing cheap briefs for R40. He said they leak and cause more laundry issues and more frequent changes. He said the staff all know it and are upset too, "but management does not care about it." On 3/26/25 at 10:30 AM, R40 was in bed and her responsible party was in the room. R40 had her eyes open but did not speak. R40's wheelchair had a fabric seat cushion in it and the wheelchair had a strong urine smell. R40's responsible party said since the facility started buying cheap briefs she frequently has urine soak through to her clothing.			

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	During an interview with the Director of Nursing (DON) on 3/26/25 at 11:30 AM, the DON was asked about concerns related to the quality of the briefs. The DON responded she was aware of the concerns but did not offer any solutions to the concerns. During an interview with the Nursing Home Administrator (NHA) on 3/26/25 at 2:00 PM residents concern about having to use two briefs, increased laundry use and urine soaking through to their clothing, soiled wheelchair cushions, residents' frustration, and lack of dignity related to residents not feeling their concerns were being heard were discussed. The NHA said he was aware of some of the concerns but not the extent of the problem. He said he would start working on trialing different products.			
F0552 SS= D	Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as	F0552	1. Residents #350 still currently resides in the facility, she was educated on and consented to the use of Abilify on 3/28/2025. 2. Like residents are identified as those who are ordered antipsychotic medications, they have the potential to be affected by this deficient practice. A sweep was completed by 4/23/2025 to ensure all like residents have the appropriate education and consent documented and their plan of care updated as needed. 3. Policy on the use of antipsychotic medications was reviewed and deemed appropriate. Licensed nurses and social work staff were in-serviced between by 4/25/2025 on appropriate procedures. 4. The QAPI committee has directed the DON/designee to perform random weekly audits on residents who are ordered Antipsychotic medications to ensure the	4/25/2025

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	evidenced by: Based on interview and record review, the facility failed to inform 1 of 5 residents (R350) reviewed for unnecessary medications of the risks versus benefits and indications for use of a psychotropic medication prior to administering it. Findings include: A review of R350's Admission Record, dated 3/27/25, revealed they were a 76-year-old resident who admitted to the facility on 3/20/25 with multiple diagnoses that included dementia and cerebral infarction (a condition where blood flow to the brain is interrupted causing brain tissue damage). In addition, R350's Admission Record revealed they were their own responsible party. A review of R350's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 3/27/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of "14" which revealed R350 was cognitively intact. A review of R350's March 2025 Medication Administration Record revealed they were being administered aripiprazole (Abilify- an antipsychotic medication) and had been since admission. A review of R350's electronic medical record failed to reveal any documentation that R350 was informed of the reason why they were receiving aripiprazole (indications for use) and/or the risks and benefits of its use. On 3/27/25 at 1:55 PM, the Nursing Home Administrator (NHA) was informed via e-mail		proper procedure is followed. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	

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	(the NHA's verbalized preferred method of receiving document requests) that the surveyor could not locate any documentation that R350 had been informed of the reason why they were receiving aripiprazole and/or the risks and benefits of it's use. The surveyor requested that the NHA provide any documentation that they may have that R350 had received this information prior to them receiving the aripiprazole. During an interview on 3/27/25 at 3:00 PM, the NHA stated he could not locate any documentation that R350 had been informed of the reason why they were receiving aripiprazole and/or the risks and benefits of its use. He stated he contacted the physician (whom he indicated was at the facility) and the physician stated he would immediately talk to R350 about their aripiprazole, including why they were receiving it and the risks and benefits of it. The surveyor requested a copy of the physician's note after he spoke with R350 that would reveal he spoke to R350 about their aripiprazole. The NHA stated that the physician's note would probably not be available until the next day (after the survey team exited the facility) and hinted that the physician may not presently be at the facility but may visit the facility later today or tomorrow and/or they may not dictate their notes until tonight or tomorrow. The surveyor requested any documentation that the physician spoke to R350 about their aripiprazole prior to exit from the facility, if the notes/documentation became available. The NHA verbally acknowledged this request. As of the completion of the survey and exit from the facility, the facility failed to provide this documentation.			
F0585 SS= D	Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances	F0585	F585 1. Residents #10 and #40 still currently reside in the facility, their grievances were immediately documented and addressed	4/25/2025

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	without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance		between by 4/23/2025. 2. Current residents have the potential to be affected by this deficient practice. A resident council meeting will be held on 4/22/2025, to ensure current residents can express their concerns. A weekly resident council will be held x 4 weeks to ensure the current resident's needs are addressed. 3. Resident Council policy was reviewed and revised. Department heads and facility managers were educated by the Admin/designee between by 4/23/2025 on proper procedures. 4. The QAPI committee has directed the DON/designee to perform random weekly audits on 20% of current residents in the facility, to ensure their concerns are being addressed. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	

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	process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence			

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	demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to respond timely to resident grievances for 2 Residents (R10 and R40) of 15 residents sampled. Findings include: R10 Review of R10's face sheet dated 3/27/25 revealed, she a 90-year-old female that was admitted to the facility on 1/13/26 and had diagnoses that included: generalized weakness, unsteady on feet, vascular dementia, kidney disease and major depressive disorder. She was not her own responsible party. During an interview with R10 on 3/26/25 at 11:26 AM, R10 complained of problems with wheelchair comfort. R10 was scooted down in her wheelchair sitting on her low back. R10 was not able to reposition herself in her wheelchair. R10 also complained that the meals have decreased in quality and said she used to be able to get more fresh fruits. R10 was asked if she attended resident council and if the residents were able to address concerns in the meeting. R10 said she was the resident council president and reported they do talk about the concerns but was unaware of any formal written grievance forms. R10 said all they do is talk, "nothing gets done".			

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	During an interview with Occupational Therapist (OT) "U" on 3/27/25 at 10:15 AM, OT said she had worked with R10 on wheelchair seating. OT "U" reviewed her notes and noted she had provided a low back cushion for R10 prior to therapy ending. OT "U" was not able to locate any communication form that would have given nursing instruction for the use of the cushion. OT "U" could not locate any information on R10 Kardex for the use of the cushion. OT "U" had not received any information on R10's having any concerns with wheelchair comfort after therapy ended. During an interview with OT on 3/27/25 at 12:12 PM, OT "U" confirmed R10 had the low back cushion she had provided, but R10 was not positioned well. OT "U" instructed nursing to do frequent wheelchair positioning checks and provided nursing a written communication form for the use of the cushion and frequent positioning today. Review of the February 27th, 2025, Resident Council minutes revealed R10 called the meeting to order. The dietary section revealed, "Residents brought up concerns regarding dessert amounts, type of meat being served and quality of meat served, types of bread served, amount of canned food used, and temperature of food upon service. Concern form filled out and emailed to Adm (Administrator) and Dietary Manager for review. Review of the January 2025 Resident Council minutes revealed R10 called the meeting to order. The dietary section included: "Residents state that they are tired of all white bread, and they would like to be offered a variety, and that white bread is not			

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	healthy. Residents would like butter on the bread/rolls and/or to be served butter packets with their meals. One resident states that they do not received enough fresh fruit and that he was promised offerings of butterscotch pudding and the staff state they do not have any." Review of the December 2024 Resident Council minutes revealed that R10 called the meeting to order. The dietary complaints included requests for more fresh fruit, vegetables and ice cream. Review of a Grievance/Complaint Report dated 2/20/25 revealed, the Nursing Home Administrator (NHA) received this form from the Resident Council revealed, "On behalf of the resident council, it was identified concerns are not completely communicated resolved." The Resolution of grievance//complaint revealed, this will be closed in April and monthly audits are being conducted for 4 months. This was signed by the NHA on 3/27/25 (during the annual survey). R40 Review of R40's face sheet dated 3/27/25 revealed she was an 82-year-old female admitted to the facility on 9/19/23 and had diagnoses that included: Alzheimer's disease, hemiplegia, convulsions, heart disease, cardiomegaly, and psychotic disorder with delusions. She was not her own responsible party. During an interview with R40's responsible party (RP) on 3/25/25 at 10:33 AM he was very concerned about the amount of canned and processed food R40 receives. R40's			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(RP) said he feeds her daily. He reports he tastes the food, and it is all very salty. R40 was very concerned as R40 has multiple medical concerns and has always been told she should be on a low sodium diet. R40's RP said he has attended multiple meetings he expressed frustration that complains are not resolved. He was concerned about her sodium intake due to her multiple medical concerns. During an interview with the Dietary Manager (DM) "R" on 3/26/25 at 10:00 AM he was questioned about assessing and monitoring R40's sodium intake. DM "R" said they do not offer low sodium diets just no added salts. DM confirmed that most of meals come from canned or processed food and he does not calculate the amount of sodium she received daily. During an interview with the Director of Nursing (DON) on 3/26/25 at 12:38 PM, the DON confirmed that R40's responsible party has many concerns. The DON could not recall specifics to the concerns and was not sure if she had completed concern forms. The DON said the food concerns would have been followed up by the Dietary Manager. During an interview with the Nursing Home Administration (NHA) on 3/26/25 at 2:00 PM, he was not completely aware of R40's Responsible Party's concerns and said he had been doing education with the Dietary Manager and Activity Director related to completing grievance forms for concerns.			
F0623 SS= D	Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or	F0623	F623 1. Resident #47 no longer resides in the facility, an investigation of the event was	4/30/2025

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	discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights,		completed and the license nurse involved received education on appropriate assessment, notification and documentation of transfers. 2. Like residents are identified as those who are emergently transferred to the hospital. A sweep of like residents for the last 2 weeks was completed by 4/23/2025 to ensure appropriate documentation of the reason for transfer was in place. A Transfer form was added to the facility's EMR system to guide the licensed nurses in appropriate documentation. 3. Licensed nurses were educated on the use of the new Transfer form in PCC to complete which includes, appropriate assessment, notifications and documentation for all residents who require emergent transfer to a hospital. 4. The QAPI Committee has directed the DON and/or designee to ensure that weekly audits are completed on residents who are transferred out emergently, to ensure the appropriate assessment, notifications and documentation is completed. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	

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	including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).			

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	This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to record the reason for a transfer to the hospital emergency department in the resident's medical record for 1 of 1 resident (R47) reviewed for hospital transfers. Findings include: A review of R47's Admission Record, dated 3/27/25, revealed they were a 72-year-old resident who admitted to the facility on 1/2/25. In addition, R47's Admission Record revealed they had multiple diagnoses that included liver cirrhosis, chronic congestive heart failure, chronic kidney disease, and diabetes. A review of R47's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 1/4/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of "13" which revealed R47 was cognitively intact. A review of R47's Health Status note, dated 1/4/25, revealed, "[Name of R47] requested to go to ED (emergency department) for evaluation. Contacted on call nurse, called on call, [name of healthcare provider] at 1105 (11:05 am) to get order to send out. Called [name of ambulance company] at 1108 (11:08 am) for transport. Left with [name of ambulance company] around 1130 (11:30 am) to ED." A review of R47's electronic medical records failed to reveal any other documentation that would indicate the reason (besides the resident wanted to go) that R47 had been transferred to the hospital emergency department for evaluation on			

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	1/4/25 (e.g., a transfer form, physical assessment, physician communication note, physician note, etc.). During an interview on 03/27/25 at 08:30 a.m., the Nursing Home Administrator (NHA) was notified that the surveyor could not locate any documentation in R47's electronic medical record that would indicate the reason that R47 had been transferred to the hospital emergency department for evaluation on 1/4/25. The NHA stated he would review R47's medical record and see if he could find any documentation. The surveyor requested copies of any documentation that he may be able to locate. During an interview on 03/27/25 at 10:03 a.m., the Director of Nursing (DON) stated they did not do a transfer form for R47. She stated that the transfer form was a "new development" that they added to the assessments tab recently. The DON stated they did do a progress note that stated R47 requested to go to the ER. She stated she did not know why R47 wanted to go to the ER, just that he wanted to go so the facility sent him. The DON stated that because R47 requested to go to the ER, then the facility would not have done an assessment before sending him. She stated she does not expect the nurses to do an assessment on a resident before they go to the ER if the resident requested the transfer since they would send them anyway, even if the transfer was not medically necessary.			
F0625 SS= D	Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The	F0625	1. Resident #47 no longer reside in the facility, an investigation of the event was completed and the admissions diretor received education on appropriate notification and documentation of Bed Hold policy notifications. 1. Like residents are identified as those who have been transferred emergently from the facility. A facility sweep was completed by	4/30/2025

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	duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide to the resident and/or the resident representative written notice which specified the duration of the bed-hold policy during which the resident was permitted to return and resume residence in the nursing facility for 1 of 1 resident (R47) reviewed for hospital transfers. Findings include: A review of R47's Admission Record, dated 3/27/25, revealed they were a 72-year-old resident who admitted to the facility on 1/2/25. In addition, R47's Admission Record revealed they had multiple diagnoses that included liver cirrhosis, chronic congestive heart failure, chronic kidney disease, and diabetes. A review of R47's Minimum Data Set (MDS) (a		4/30/2025 of transferred residents from the last 2 weeks to ensure proper notification of the Bed Hold policy was provided and documentation made in their EMR. 2. Policy for Bed Hold has been reviewed and deemed appropriate. The Business office manager has been educated on appropriate processes on 4/23/2025. 3. The QAPI Committee has directed the NHA and/or designee to ensure that weekly audits are completed on 100% of residents who are transferred out emergently to ensure the proper process is followed. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	

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	tool used for assessing a resident's care needs), dated 1/4/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of "13" which revealed R47 was cognitively intact. A review of R47's Health Status note, dated 1/4/25, revealed, "[Name of R47] requested to go to ED (emergency department) for evaluation. Contacted on call nurse, called on call, [name of healthcare provider] at 1105 (11:05 am) to get order to send out. Called [name of ambulance company] at 1108 (11:08 am) for transport. Left with [name of ambulance company] around 1130 (11:30 am) to ED." A review of R47's electronic medical records failed to reveal any documentation that would indicate the facility had presented, or attempted to present, R47 or their responsible party with the facility's bed hold policy prior to or immediately following their transfer to the hospital on 1/4/25. During an interview with the Nursing Home Administrator on 03/27/25 at 08:30 a.m., the Nursing Home Administrator (NHA) was notified the surveyor could not locate any documentation that would indicate the facility had presented, or attempted to present, R47 or their responsible party with the facility's bed hold policy prior to or immediately following their transfer to the hospital on 1/4/25. The NHA stated he would look for the documentation and provide the surveyor with a copy of it, if it was located. During an interview on 03/27/25 at 10:03 a.m., the Director of Nursing (DON) stated that R47 should have been given the bed hold policy and it should have been explained to him. The DON was informed that the surveyor could not locate any documentation that R47 had been given the bed hold policy and had it explained to him. She			

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	stated she would look into it and give me a copy of anything that she finds. During a second interview on 03/27/25 at 10:59 a.m., the DON stated Admissions Coordinator (AC) "P" went over the bed hold policy with R47 and their family. She stated that AC "P" did not document her discussion with R47 or their family in R47's medical record, but there were e-mails back and forth between AC "P" and R47's family. During a third interview on 03/27/25 at 01:00 PM, the surveyor requested a copy of the e-mails between R47's family and AC "P" that would reveal the facility's bed hold policy was discussed with them. The DON stated, "I might have misspoke." She stated she did not actually know if AC "P" spoke with R47 or their family about the facility's bed hold policy. The DON stated she knew AC "P" went to the hospital to speak with R47 and their family after R47 went to the hospital. She stated the e-mail that she was referring to was the one AC "P" sent to the facility notifying them that R47 had been admitted to hospice, would be discharged to a hospice home when discharged from the hospital, and would not be returning to the facility. She stated that information was entered as an Alert Note, dated 1/4/25. A review of R47's Alert Note, dated 1/4/25, revealed, "[Name of hospital] ER called and resident is on Hospice now and is transferring to [name of hospice house] tomorrow. He will not be returning to this facility." A review of the facility's "Bed Hold Notice Upon Transfer" policy, revised 5/17/2023, revealed, "Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the			

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	resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed... 1. Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies: a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; b. The reserve bed payment policy in the state plan policy, if any. c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed. d. Conditions upon which the resident would return to the facility: " The resident requires the services which the facility provides; "The resident is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services... 5. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file."			
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess, monitor and provide care for one (R30) of one resident	F0684	F684 1. Resident #30 still currently resides in the facility; Ultram has been ordered for her pain and she is being monitored daily for any s/sx of dental infections. Her plan of care has been updated to reflect her status. Resident #30 is scheduled for tooth extraction. 2. Like residents are identified as those requiring dental services outside the facility. The plans of care for all like residents were reviewed by 4/30/2025 and updated to reflect the residents' current needs and treatment. Follow up appointments and responsible party notification were documented by 4/23/2025. 3. Policy on Ancillary Services has been reviewed and revised. Social worker was educated by the DON/designee by 4/23/2025	4/30/2025

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	reviewed for dental care. Findings include: Review of a Face Sheet revealed R30 originally admitted to the facility on 10/7/20 and has pertinent diagnoses of Alzheimer's disease, dementia, and abnormal posture. During an observation on 3/25/25 at approximately 11:00 AM, R30 was observed at a table near the nurses' station clenching her shirt. She was nonverbal had limited movement. In an interview on 3/25/25 at 12:11 PM, R30's husband reported concerns of his wife not being able to get her tooth extracted timely and she is having pain. He reported he can tell she had pain by her behaviors and the clenching of her teeth. Review of a dental consultation dated 1/3/25 for R30 revealed she needed to have diagnostics done and oral surgery to get her tooth extracted while sedated and was given a referral for oral surgery. Review of a Nursing Progress note dated 3/6/25 for R30 revealed she went to a dental appointment the day before with her husband. "No after visit summary, follow up paperwork or appt. (appointment) reminder. Per husband, (R30) had an Xray done, but no dental procedures." No follow up documentation in the EMR indicating the facility followed up on this. Review of a Physician Progress note dated 3/25/25 for R30 revealed no mention of dental concerns or follow up care. "No nonverbal signs or symptoms of pain or discomfort observed. Care plans reviewed and updated to reflect (R30's) strengths, preferences and concerns." Review of the Care Plan for R30 revealed no		on appropriate process. Licensed nurses were educated on identification, notification and treatment of dental pain 4. The QAPI committee has directed the DON/designee to perform random weekly audits of all residents currently in the facility receiving offsite dental services to ensure they are being monitored for their dental issues and their plan of care addresses their needs. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	

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	focus for dental concerns. In an interview on 3/27/25 at 9:44 AM, Social Worker (SW) "X" reported that the local surgeons are not able to meet the physical needs R30 has do a tooth extraction safely with sedation while having contractures and need for a high-backed wheelchair. Some claim the room is too small for her too. The facility is doing their due diligence to seek care for her. SW "X" was asked about R30's pain and reported R30 has anxiety and thinks pain is also contributing more to her anxiety. R30 has contractures and clenches her teeth at a baseline so assessing her pain may be difficult. Review of the March Medication Administration Record (MAR) for R30 revealed she has an order for Tylenol 500 milligrams (mg), 2 tablets, three times day for dental pain ordered 12/24/24. Review of her pain assessment revealed all month her pain was rated as a 0/10 scale. No monitoring for infections ordered/documented. In an interview on 3/27/25 at 10:57 AM, Unit Manager (UM) "K" was questioned about monitoring of pain and infection for R30 when she is not able to express it, and she reported it is hard to tell because she has a history of ticks and clenching her teeth. R30 was on an antibiotic in the beginning and is already getting Tylenol for her arthritis. The Social Worker is working on pursuing an oral surgeon but is not having any success locally per the husband's request. UM "K" was not clear if the physician was aware or updated on the concerns of R30 needing her tooth extracted. In a follow-up interview on 3/27/25 at 2:03 PM, UM "K" was questioned about expectations for monitoring R30 for pain and infection is related to her tooth and UM "K" reported she just put in			

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	an order for nursing to monitor for signs and symptoms of swelling, discharge, or infection and document that into the computer. She then talked to the physician today about R30's care and is waiting for an order for Ultram to be put into the computer.			
F0686 SS= E	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to follow policies and procedures to accurately assess, monitor and treat/improve pressure ulcers for 2 Residents (R1, and R350) of 4 Residents reviewed for pressure ulcers. Findings included: R350 Review of R350's face sheet dated 3/26/25 revealed she was a 76-year-old female admitted to the facility on 3/20/25, her	F0686	1. Resident #350 no longer resides at facility. The nurse was instructed to complete a wound assessment but failed to do so. This nurse was coached by DON. Resident #1 still currently resides in the facility; no negative outcome was identified due to this deficient practice. Her plan of care has been reviewed to reflect her status. She was assessed and is comfortable. Her wound care documentation is up to date. 2. Like residents are identified as those with pressure injuries. The plans of care for all like residents were reviewed by 4/25/2025 and updated to reflect the residents' current needs and treatment. 3. The policy and procedure on skin management, along with dressing change policies have been reviewed and revised. Consultant Nurse educated the DON on assessments and documentation on skin management. Nurses were educated by DON/designee by 4/25/2025 on appropriate management/documentation/care. An admission wound assessment was activated in the EMR. Licensed Nursing staff were educated on completing this assessment on admission. 4. The QAPI committee has directed the DON/designee to perform random weekly audits of all residents currently in the facility with wound injuries to ensure their wounds are properly cared for and documented, and their plan of care/orders addresses their needs. The Administrator is responsible for ensuring that substantial compliance is	4/30/2025

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	diagnoses included: acute kidney failure, chronic kidney disease, dysphagia (difficulty swallowing), osteomyelitis (bone infection), and vascular disease. She was her own responsible party. Review of R350's admission skin assessment dated 3/20/25 and locked on 3/21/25 revealed that R350 had a stage 1 ulcer on her gluteal clef that measured 3.4 x 2 x 0.3. there was no mention of any skin issues on R350 thighs or other areas of her buttock. Review of R350's admission skin assessment dated 3/20/25 at 16:36 (4:36 PM) and locked on 3/27/25 (during the survey) revealed R350 had a stage 3 pressure ulcer on her coccyx that measured 3.7 x 1.3 x .3 and indicated that her right and left thigh (front) were excoriated. No mention of open areas in the excoriated area. R350 was observed on 3/25/25 at 10:10 AM in bed on her back with the head of her bed elevated about 20 degrees. R350 did not respond to calling her name. R350 was observed sleeping on her back in bed on 3/26/25 at 8:20 AM. R350 was observed in bed on her back with the head of the bed elevated about 45 degrees on 2/26/25 at 10:00 AM. R350 was complaining of severe butt pain. R350 was not able to operate the bed controller and reported she was not able to shift her weight or roll in bed. R350 said staff do not roll her in bed. R350 was assisted with her call light to get staff assistance.		attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	

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	R350 was observed in bed on 3/26/25 at 10:45 AM. R350 was still in the same position she was in at 10:00 AM. R350's Physician "B" was in the room. The Surveyor expressed concern over the lack of turning and positioning. Physician "B" said he would follow up with the staff. On 3/26/25 at 11:00 AM, Licensed Practical Nurse (LPN) "D" and Certified Nurse Aide (CNA) "M" changed R350's brief. The brief was soaked and full of loose bowel movement (BM). The BM covered the buttock and no dressing was visible. CNA "M" said there was gauze on R350's buttock, and she wiped it off with the disposable wipe and put it in the trash. R350 cried out in pain with the brief change and clean up. R350 had a wound on her coccyx area that was approximately 1.5 inches by .5 inches and open another open area that was approximately ¼ in diameter on her right upper buttock. R350 had about 10 other open, weeping areas approximately ¼ in diameter on both inner thighs. LPN "D" said she did not see a treatment in the system for these wounds so she would need to see if the treatments are listed on another shift. CNA "M" said she had been assigned to R350 since 6:00 AM this morning. CNA "M" reported that was R350's first brief change and she had not repositioned R350 as she was not on a turning schedule. R350 required assistance of 2 people to turn for the brief change. (5 hours without a brief change or repositioning) On 3/26/25 at 11:19 AM the Director of Nursing (DON) came in the assist LPN "D" and CNA "M" with R350. The Surveyor explained that CNA "M" indicated that she had not repositioned R350 today because			

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	she was not on a turn schedule. The DON responded it was standard of care to reposition residents every 2 hours if they are not able to turn independently. The DON helped LPN "D" reposition R350 on her right side (Assist of 2 people). R350 continued to cry in pain and reported the painful area was her butt. Review of R350's Kardex (nurse aide care information) dated 3/26/25 revealed R350 needed extensive assistance of 2 people for bed mobility, and she required reposition/shift weight to reposition frequently. During an interview with the DON on 3/26/25 at 12:27 PM, R350's nursing admission skin assessment dated locked 3/21/25 was reviewed and it only showed one ulcer on her gluteal clef that measured 3.4 x 2 x 0.3 and it was noted as a stage 1. The DON said she assisted the nurse that did this assessment on the day of admission and the DON said she would have staged the wound in the coccyx area as stage 2 and she saw a total of 6 stage 2 ulcers. The DON could not locate any notes in R350's medical record that matched her memory of the admission assessment for R350. The DON said she had the information somewhere on a note. She looked through her piles of notes and could not locate any written skin assessment for R350 dated 3/20/25. The DON reported she is doing education for accurate skin assessments. I reported that I observed 2 open areas on the buttock and at least 10 open areas on her inner thighs. The Surveyor requested R350's hospital records as they had not been placed into R350's medical record. The DON had access to hospital records on her computer. The DON reviewed			

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	the hospital records for R350 and the hospital had documentation reporting R350's pressure ulcer on her coccyx was a stage 3 and they did not document any other open areas on the buttock or thighs. On 3/27/25 at 9:30 AM, Physician "B" saw the Surveyor in the hall and asked if R350 was being positioned off her butt today. The Surveyor reported that when she saw R350 today, she was still on her butt and the assessments completed last night did not reflect the observations made yesterday. Physician "B" went to his office and called Nurse Practitioner (NP) "A" after he reviewed her documentation from 3/24/25. Physician "B" said NP "A" would be in today to assess R350 and order her wound care. Physician "B" said he and NP "A" just need to hit send on her notes, and they go to the printer in the administration office. We went to the printer, and Physician "B" handed me his note. The Nursing Home Administrator (NHA) was at the printer. The NHA confirmed that they were not having any problems with getting the NP "A's" notes or Physician "B's" notes. The Surveyor informed the NHA that R350 NP "A" notes were still not in her medical records. During an interview with the DON on 3/27/25 at 10:44 AM, the DON said she located an order for R350's coccyx wound dated 3/25/25 (5 days after admission). The DON reviewed the surveyors screen for orders in R350's electronic medical records (EMR) and confirmed that the surveyor did not have that information. The DON could not locate wound treatments for R350's coccyx pressure ulcer prior to 3/25/25. The DON reported that all other open area's on R350's buttock and thighs were excoriation. The			

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	DON said they do not count, or size open weeping areas that are excoriated. The DON was not able to explain how they are able to determine if the excoriated area was improving or declining if they did not document any description or indicate the skin was open. The DON did not have any response. During an interview with NP "A" on 3/27/25 at 11:45 AM, NP "A" said she had assessed R350 on 3/24/25 and R350 only had the stage 3 ulcer on her buttock area. NP "A" said all the other open areas were a rash and they were not present on 3/24/25. NP "A" said she ordered a new treatment for the rash. The NP said the rash was most likely due to R350 having loose stools and she was also started on bowel medication today. Review of R350's Treatment Administration Record (TAR) dated March 2025 revealed, Multiple Wounds: All stage 2 Posteriorly - BL (bilateral thigh fold, Left inner buttock 3/24/25. Anteriorly - BL (bilateral) upper thigh fold near groin. Cleanse with normal saline, pat dry and apply hydrocolloid dressings to each wound. Change every 3 days, sooner if soiled. Started 3/21/25 and discontinued on 3/24/25. It was only marked as completed on 3/21/25. This same order was noted on the March TAR as starting and ending on 3/25/25 and marked as completed on 3/25/25. No wound care order was found on the March 2025 TAR for R350's coccyx stage 3 pressure ulcer. Resident #1 (R1) Review of a Face Sheet revealed R1 originally admitted to the facility on 12/4/23 with pertinent diagnoses of Wedge compression fracture of first			

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	lumbar vertebra, morbid obesity and a stage III sacral pressure ulcer. Review of the Minimum Data Set (MDS) dated 1/11/25 for R1 revealed she is at risk for pressure ulcers and had one stage III pressure ulcer. She has limited range of motion (LROM) with impairment to bilateral lower extremities and dependent on staff for toileting, transfers, and mobility. Review of the Facility Matrix provided 3/25/25 at the beginning of this survey revealed R1 had a Stage III Pressure Ulcer. Review of a Braden Scale for Predicting Pressure Sore Risk dated 2/7/25 for R1 revealed she is a high risk. During an observation and an interview on 3/25/25 at 10:28 AM, R1 was in bed with a wedge under her left side. She reported she had the pressure ulcer on her backside prior to admission and thinks it is getting better. During an observation 3/26/25 at approximately 8:00 AM, R1 was observed in her specialty Broda wheelchair. During an observation and an interview on 3/26/25 at 11:23 AM, Licensed Practical Nurse (LPN) "T" had R1 transferred to bed for a pressure ulcer dressing change and placed the wound dressing supplies on a table beside the bed with no barrier and did not clean the table. R1's brief was saturated with urine and not cleaned up prior to dressing change. The nurse removed the old dressing from R1's sacrum which was packed with gauze. The wound was approximately a golf ball size round and deep. LPN "T" used the same gloves to remove the old dressing and packed wound that was saturated with serosanguinous			

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	drainage to clean and apply the new dressing which consisted of packing the wound with gauze soaked with Dakins solution and packed in the wound with her soiled glove via her finger. An antifungal cream mixed with a zinc-based cream was applied to the surrounding area of the wound, then an ABD (abdominal pad) was applied over the packed wound and adhered with hypafix tape. LPN "T" then changed her gloves post wound care to assist with peri care and transferred R1 back to her wheelchair. When she was done with wound care supplies, she took them out of the room to the wound cart and placed them in the drawer. In an interview on 3/26/25 at 11:57 AM, LPN "T" reported R1 should be offloading while up in her wheelchair and could not confirm that it was being done. When asked about hand hygiene and changing gloves during a dressing change after removing old dressing and applying a new one, LPN "T" said "What about it? I don't know, but I am guessing you think I should have changed my gloves?" When asked about packing the wound with her soiled gloves with her finger, she reported there is no undermining so packing the wound with her finger verses a cotton swab was appropriate. LPN "T" reported wound care rounds are done weekly on Mondays with the wound care nurse and did not know why there was no documentation in the EMR to reflect R1's wound care visit. When asked about the unused wound care supplies being place outside the room in the wound care cart, LPN "T" reported she could not leave them in the room. In an interview on 3/26/25 at 12:01 PM, Certified Nursing Assistant (CNA) "F" reported R1 normally lays back down after breakfast but this day she stayed up to get her hair done but the hairdresser canceled her appointment, so R1 stayed up in her wheelchair.			

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	During an observation on 3/26/25 at 1:49 PM, R1 was transferred to her bed. Review of a "Skin integrity" Care Plan for R1 initiated 12/20/24 revealed: "is at risk for skin breakdown [related to] admitting with pressure Ulcers on her coccyx 12/4/23. No meaningful interventions or revisions for a stage III or a stage IV pressure ulcer on the care plan. No frequent repositioning or offloading is on the Care Plan. Review of the Activities of Daily Living (ADL) Care Plan for R1 revealed: "BED MOBILITY: The resident is totally dependent on (2) staff for repositioning and turning in bed, initiated 12/20/24. Review of a Wound Care Note for R1 dated 2/3/25 revealed: "Sacral wound is 5.8 x 3.5 x 4 cm. ..." (Stage IV pressure ulcer.) Review of a Wound Care Note for R1 dated 3/17/25 revealed: "Incontinent of urine with removal of the old dressing. ... The sacral wound is 6 x 4 x 3.8 cm (centimeters and is 100% granulation without any maceration/erythema around. ... Moderate amount of serosanguineous drainage on the old dressing. ... Assessment/Plan: coccyx/sacrum wound stage IV pressure ulcer after sharp debridement by [Physician] on 4/29/24. ... Continue with turning from side-to-side and she was on her left side today. Wound is slowly improving. Review of a Skin Assessment dated 3/17/25 for R1 revealed she has a Stage III pressure ulcer on her coccyx measuring 6.0 x 4.0 x 3.8 (cm) with no drainage and 100% granulation. (Wound Care notes reflect a stage IV pressure ulcer.) Review of the Electronic Medical Records (EMR) on 3/26/25 for R1 revealed no skin assessments or			

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	wound care documentation for 3/24/25. In an interview on 3/26/25 at 2:03 PM, the Director of Nursing (DON) reported the Wound Care Nurse was here on Monday (3/24/25) and was not sure where the progress notes of R1's pressure ulcers were or why there was no skin assessment documented in the EMR. She reported the Wound Care Nurse will dictate the notes and the facility will then upload them into their computer. When queried about changing gloves and performing hand hygiene after removing old soiled wound dressings, the DON reported it would depend on if the gloves are visibly soiled. When it comes to packing wounds, the DON reported whether she used the same glove using her finger or a cotton swab would depend on the wound, but she usually uses a cotton swab. When given the observed scenario of LPN "T's" dressing change on R1, the DON did expect a barrier or a cleaned table prior to setting wound care supplies down. Regarding the changing of gloves during a dressing change, the DON reported R1's dressing change is not sterile and "her germs are hers," but she would personally have changed her gloves. When asked about the wound care supplies that have been in the residents' room and taken outside the room to the wound care cart, the DON reported the supplies should be resident specific and left in the room or prepped before going into the room so no supplies would be left over. In an interview on 3/26/25 at 2:22 PM, Registered Nurse (RN)/Infection Control Nurse "K" reported that for wound care, a cleaned table or a barrier for supplies should be set up and hand hygiene and new gloves should be used after removing old dressing. A wound can be packed with a gloved finger for shallow wounds but deeper wounds or tunneling should use a cotton swab. Left over wound care supplies should not be taken to the cart.			

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	In an interview on 3/27/25 at approximately 9:00 AM, the DON walked down the hall and told this surveyor she will "eat crow" because gloves and hand hygiene should be done after removing a soiled dressing. Review of a Wound Care note dated 3/24/25 for R1 which was provided by the end of this survey on 3/27/25 revealed: "patient turned on her right side with 2 assist. Old dressing was removed. Incontinent of urine during the removal of the old dressing. Sacral wound is 6 x 4 x 3.8 cm, 100% granulation ..." Review of a policy titled "Pressure Injury Prevention and Management" last revised 12/2022 revealed: "The facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injures. ... 3. Assessment of Pressure Injury Risk: b. Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. c. Assessments of pressure injuries will be performed by a licensed nurse and documented on the Weekly Skin Assessment form. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS. d. After completing a thorough assessment/evaluation, the interdisciplinary team should develop a relevant care plan that includes measurable goals for prevention and management of pressure ulcers/pressure injuries with appropriate interventions. 4. Interventions for Prevention and to Promote Healing:			

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	a. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment ... b. Evidenced-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Pressure prevention interventions could include but are not limited to: Redistribute pressure ... Minimize exposure to moisture with use of incontinence management ... use of up down schedule. ... 5. Monitoring: a. The Unit Manager or designee will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of findings in the medical record. Change in care plan interventions will be completed. Review of a policy titled Non-Sterile Dressing Change last revised 5/2019 revealed: "Designated staff members will use non-sterile dressing techniques for all dressing changes unless otherwise indicated by physician or manufacturer guidelines. Clean aseptic technique should be used. In the event of multiple wounds, each wound is considered a separate treatment. ... 4. Prepare a clean, dry work area at bedside. Use disinfectant solution to prepare work surface. Optional: Cover work surface with clean dry paper or cloth towel, to prevent contamination of supplies. ... 10. Remove soiled dressing, place it in trash bag. ... 11. Remove gloves, wash hands, apply new gloves. ..."			
F0688 SS= D	Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does	F0688	F688 1. Resident #3 still currently resides in the facility; His care plan was reviewed, and orders were entered in order for staff can	4/25/2025

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	not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to provide the care of contractures for one (R3) of one resident reviewed for contractures. Findings include: Review of a Face Sheet revealed R3 originally admitted to the facility on 6/8/2005 and has pertinent diagnoses of contractures, spastic hemiplegia (one sided weakness) affecting left nondominant side, and brain injury. Review of the Minimal Data Set (MDS) dated 3/17/25 revealed R3 is moderately cognitively impaired and has limited range of motion in bilateral upper and lower extremities and is dependent on staff for mobility. During an observation on 3/25/25 at 10:39 AM, R3 was observed in the hallway with contractures in bilateral upper extremities at both wrist and hands. No devices in place on his right or left hands.		document the application and removal of his splint. 2. Like residents are identified as those with limited contractures. The plans of care for all like residents were reviewed by 4/25/2025 and updated to reflect the residents' current needs and treatment. Therapy referrals have been made if indicated, and documentation verification entered for any residents using a positioning device. 3. Policies for ROM and applying splints have been reviewed and revised. Nursing staff and therapy staff were educated by the DON/designee by 4/25/2025 on appropriate process related to this policy. 4. The QAPI committee has directed the DON/designee to perform random weekly audits of residents currently in the facility receiving care for contractures. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	

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	During an observation and an interview on 3/26/25 at 9:18 AM, R3 was in his room eating breakfast in bed. He reported he did not know where his hand splints were, and staff have not put them on his hand in a while. R3 reported staff do not ask him if he wants to wear them either. One hand splint was observed across the room on top of a container. In an interview on 3/26/25 at 9:12 AM, Physical Therapy Assistant/Manager (PTA) "V" reported R3 was just picked up yesterday (the first day of this survey) for an evaluation because he was having trouble eating and was to provide the last Occupational Therapy (OT) notes regarding his contractures. Review of a Care Plan for R3 related to his "decreased functional mobility and ADL's (activities of daily living) related to deficits secondary left sided hemiparesis with contractures ..." revealed an intervention: "Right hand splint: Encourage (R3) to wear up to 4 hrs (hours) during the night as tolerated: monitor skin integrity on removal," last revised 3/26/24. Review of the electronic medical records (EMR) for R3 revealed a task list for staff to chart daily cares and did not have a task to chart applying splints. In an interview on 3/27/25 at 10:31 AM, Occupational Therapist (OT) "W" reported they picked R3 up for therapy this week for feeding and positioning in his chair. His left arm is extremely contracted and has some spastic tone and no function in his left hand. His right is contracted but he still has some use in it. OT "W" reported he does have one hand splint for his right hand but is not sure if he is wearing it at night per his care plan or if it even fits his hand. He used to have a splint for his left hand. The rationale for			

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	him to wear a splint at night for his right hand was so he can use his right hand more for things such as eating. Review of an OT Discharge Summary dated 9/9/2022 for R3 revealed that he was wearing his right-hand splint per the established schedule up to 4 hours a day. "Pt (patient) has splint wear schedule n place with third shift nursing." Review of an OT Discharge Summary dated 3/14/24 for R3 revealed: "pt (patient) has R (right) hand splint to wear per previously established schedule." Review of an OT Evaluation & Plan of Treatment for certification period of 3/25/25 to 6/22/25 for R3 revealed his right upper extremity (RUE) (ROM) range of motion is impaired at his wrist with a flexion contracture and his LUE (left upper extremity) ROM is impaired with arom (active range of motion) to 45 degrees, passive to 90 at shoulder flexion, he has extensor tone at his elbow, flexor tone in hand, and has flexion contractures at his right wrist and digits. In an interview on 3/27/25 at 10:55 AM, Unit Manager (UM) "K" reported there is no documentation in the task list to show splints for R3 were being placed on him at night and reported she just fixed it so staff can document it is being done.			
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as	F0689	1. Resident #17 still currently resides in the facility. Her plan of care has been reviewed and she has not had any additional falls. 2. Like residents are identified as those who have experienced a fall within the last two weeks. The plans of care for all like residents were reviewed by 4/30/2025 and updated to reflect the residents' current needs and treatment.	4/30/2025

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	evidenced by: Based on observations, interviews and record review, the facility failed to prevent a fall for 1 Resident (R17), of 1 Resident reviewed for falls. Finding included: Review of R17's face sheet dated 3/27/25 revealed she was 101 years old, admitted to the facility on 8/10/20 and diagnoses included: unsteady on feet and vascular dementia. She was not her own responsible party. Review of R17's incident and accident report dated 3/16/25 at 16:00 (4:00 PM) revealed R17 had an unwitnessed fall in her room. Predisposing physiological factors included confused, incontinent and impaired memory. The statement section listed staff, see paper statements. No paper statements were provided. The statement at the end of the report revealed," 3/26/25: Root cause: after assessing the situation, it was noted that her anti-rollbacks were not functioning appropriately. The anti-rollbacks were fixed by maintenance. R17 has many fall interventions in place that were all implemented at the time of the fall. There were no care plan violations. She was sent to ED (emergency department) for evaluation with no identified fracture. She remains at risk for falls, she is self-determined at times." (there was no indication of any care or the resident condition prior to the fall). Review of R17's Emergency Department note dated 3/16/25 at 4:54 PM revealed, "Patient is 101, year old female with a history		3. The Policy regarding fall management has been reviewed and deemed appropriate. The NHA and DON were educated on fall investigations, documentation and follow-up by the Nurse Consultant Licensed nursing staff were educated by the DON/designee by 4/25/2025 on fall management. 4. The QAPI committee has directed the DON/designee to perform random weekly audits of all residents that experienced a fall in the facility to ensure their intervention was appropriate and the plan of care addresses their needs. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	

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	of dementia, presenting from (name of nursing home) after an unwitnessed fall. Reportedly, patient had normal Innes (sic) fall, found lying on her right side, and per staff was complaining of pain in her right hip. When EMS arrived, she was able to stand and pivot onto the ED (emergency department) gurney without difficulty, denying any pain for them. On arrival, she was unable to recall the events of the fall or how she ended up on the ground. Denying any pain anywhere at this time." X-ray of the pelvis and right femur were done and negative for any fractures. Review of R17's physician orders revealed R17 was admitted to hospice on 3/26/25. Review of R17's fall care plan dated revision on 4/30/24 revealed, 'R17 is at increased risk for fall or injury related to increased confusion and disorientation secondary to advancing dementia, increased risk for pain and decreased ROM (range of motion) secondary to osteoarthritis and fall contributing to medications. She exercises her right to self-determination without realizing movements exceed her functional ability. She may be more confused and restless in the evening and choose to stay up quite late. She has a history of self-removing grippy socks which places her at greater risk for falls. She likes to be busy and helpful and may attempt activities that put her at risk for falls." Interventions included "offer to sit in comfy stationary chair when observed in Lounge Area." R17 was observed to be eating on the unit in the dining room on 3/27/25 at 9:14 AM, Certified Nurse Aides (CNA's) "H", "I", "J" and "N" were all present. They all reported they			

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	have provided care for R17 prior to her fall 3/16/25 and since. They did not know anything about the fall. They were asked how they would know if anti-rollbacks were not functioning. They said it is obvious as the chair locks up when the resident is not sitting in it. They would not put a resident in a chair if it was not working correctly. They were also concerned that she was unattended in her room as they all know she used to attempt to self-transfer. They reported their shift ends at 2:30 PM and they always put her in a comfortable chair by the television. They reported R17 no longer attempts to self-transfer. R17 was observed on 3/25/25 at 10:26 AM on the nursing unit sitting in a comfortable chair in the television area. She was holding a baby doll and covered with a blanket. She did not respond to questions. R17 was observed in the unit dining room on 3/26/25 at 8:18 AM sitting in a wheelchair with anti-rollback (brake system). She was waiting for breakfast with 10 other residents. On 3/26/25 at 8:38 AM the surveyor asked the Director of Nursing (DON) for all facility fall policy's and all of R17's incident and accident reports for the last 6 months and the full investigation of all falls. On 3/26/25 at 3:18 PM the surveyor asked the DON for R17's full investigation for her fall on 3/16/25 as the report she had provided did not indicate any staff interviews or staff involved. There was no information on care or supervision prior to the fall. During an interview with Environmental Services Worker (EVS) "O" on 3/27/25 at			

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	9:20 AM, EVS "O" was asked if he fixed R17's anti- rollbacks after 3/16/25. EVS "O" said he did not think he did. EVS "O" said they do not keep any records of repairs and no indication if the facility inspected all wheelchair for function after 3/16/25 when the facility had determined R17's wheelchair was not functioning properly. Records were requested and no records were provided prior to exit. During an interview with the Director of Nursing (DON) on 3/27/25 at 9:28 AM in her office the Surveyor asked for R17's full investigation and Emergency Room report for the fall on 3/16/25. The surveyor asked for information on R17's wheelchair repair and for any information on inspection of the facility wheelchairs as R17's incident and accident report determined the anti-rollbacks may have caused the fall. The DON said she had statements for the investigation somewhere and she would get them. No staff statements were provided prior exit. On 3/27/25 at 3:13 PM the DON provided a hospital emergency (ER) room report to the surveyor and reported R17 did not have a fracture she was only sent to the ER to rule out a fracture. The DON said the NHA would send the full investigation. Upon exit the facility failed to provide a full investigation of R17's fall on 3/16/25, including witness/ staff statements, wheelchair repair documentation, and/or documentation that resident and facility wheelchairs were assessed for proper functioning.			
F0732 SS= E	Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the	F0732	1. No residents were negatively impacted by this deficient practice. 2. Clear wall paper holders were purchased	4/30/2025

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	following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to: 1) post daily nurse staffing data in a prominent place readily accessible to residents and visitors and 2) list the facility census and actual hours worked by category of licensed and unlicensed nursing staff (i.e., Registered Nurse, Licensed Practical Nurse, Nursing Assistant) directly responsible for resident care per shift on the historic daily nurse staffing data sheets.		and mounted in a location on the unit consistent with this requirement and visibility. 3. The Staffing Coordinator was educated on Posted Nurse Staffing Information by the NHA and its requirements including posting the total number of hours worked in real time. The Staffing Coordinator was educated on posting staffing sheets with documented census and updating hours worked upon shift change by the NHA. 4. The QAPI committee has directed the DON/designee to perform random weekly audits of posting nurse staff information including the number of actual hours worked. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	

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	Findings include: During an observation on 03/27/25 at 08:35 AM, the daily Faith's Terrace Staffing data sheet was observed on a bulletin board next to nurse's station facing nurse's station. The staffing data was not visible to residents and/or visitors in hallway or walking by the nurse's station. The Faith's Terrace Staffing data sheet was posted next to other staff only schedules/postings (i.e., On Call Manager Schedule for March 2025, On Call Maintenance person, a thank-you card). The Faith's Terrace Staffing data sheet had the facility census, names of nursing staff members scheduled per shift, and schedule nurse staffing hours listed by category (i.e., Registered Nurse (RN), Licensed Practical Nurse (LPN), Nursing Assistant (CNA), and nursing staff orientees). During an observation on 03/27/25 at 08:45 AM, the daily Love's Garden Staffing data sheet was observed on a bulletin board next to nurse's station facing nurse's station. The staffing data was not visible to residents and/or visitors in hallway or walking by the nurse's station. The Love's Garden Staffing data sheet was posted next to other staff only schedules/postings (i.e., On Call Manager Schedule for March 2025, On Call Maintenance person, a thank-you card). The Love's Garden Staffing data sheet had the facility census, names of nursing staff members scheduled per shift, and schedule nurse staffing hours listed by category (i.e., RN, LPN, CNA, and nursing staff orientees). During an interview on 03/27/25 at 08:50 AM, CNA "Q" stated the daily nurse staffing data sheets are only for nurse and nurse aide use and reference. She stated the nurse staffing sheets are only posted where staff can see them and not residents. CNA "Q" verified that the current location of the Love's Garden Staffing data sheet			

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	was in an area where residents and/or visitors could not see or read it. A review of the historic daily nurse staffing data sheets, dated 2/25/25 to 3/24/25, revealed the daily resident census was not entered on the data sheets and the actual hours worked by nursing staff were inaccurately recorded on and/or not recorded on the staffing data sheets (e.g., all nurse hours actually worked were entered under the "RN" category and none were entered under "LPN" category, even though the majority of the nurses scheduled were LPN's). During an interview on 03/27/25 at 09:00 AM, the Nursing Home Administrator (NHA) stated the daily census numbers are not always recorded on the daily nurse staffing data sheets. The NHA stated they also do not always record the actual working hours of licensed and unlicensed personnel on the daily nurse staffing data sheets. He stated they only list the nursing staff and their scheduled hours and he keeps track of the actual hours worked himself.			
F0755 SS= D	Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the	F0755	1. Resident #4 still currently resides in the facility. Her pain levels for the dates in question were reviewed and her pain levels were 0. She is comfortable and denies pain on her assessment. Her patch is in place and signed out appropriately. 2. Like residents are identified as those requiring controlled substance patches. The orders, and documentation of application and removal was reviewed for those like residents. 3. The revised and approved the Destruction of Narcotics policy and procedure. This policy identifies fully used narcotic vs. a narcotic that still has use. This policy further outlines destruction protocols for both. Licensed nurses were educated by the DON/designee	4/30/2025

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	services of a licensed pharmacist who-§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow policies and procedures to maintain a sensical system of accountability for controlled substances for 1 Resident (R4), of one resident reviewed for narcotic administration. Findings include: Review of a policy titled "Controlled Substance Administration & Accountability last revised 12/29/24 revealed: "It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. f. All controlled substances (Schedule II, III, IV, V) are accounted for in one of the following ways: ... ii. All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided. g. In all cases the dose noted on the usage form or		by 4/25/2025 on appropriate process 4. The QAPI committee has directed the DON/designee to perform random weekly audits of all residents currently in the facility receiving controlled pain patches to ensure they are in place and documented appropriately. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	

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	entered into the automated dispensing system must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form and placed into the patient's medical record. h. The Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient administration. 4. Obtaining/Removing/Destroying Medications: a. The entire amount of controlled substances obtained or dispensed is accounted for. ... d. Two licensed staff must witness any disposal or destruction of a controlled substance and document same (sic) on the Drug Disposition Record, Controlled Drug Record, or via the automated dispensing system. 5. Disposal of Controlled Drug Patches: a. All controlled drug patches removed from patients are disposed of in such a manner as to prevent diversion, fold in half and dispose of patch." Resident #4 (R4) Review of a Medication Administration Record (MAR) revealed R4 had an order started on 5/16/24 for a 25 mcg/hr (microgram/hour) fentanyl (a schedule II opioid) transdermal patch to be applied in the afternoon every 3 days for chronic pain. Review of a "Controlled Drug Record: Topical Patches" proof of use sheet revealed: "Controlled Drug Record - Chart each dose administered. USED PATCH DESTRUCTION: When patch is removed, it must be immediately destroyed and witnessed with two nurse signatures." Review of a "Controlled Drug Record: Topical Patches" proof of use sheet for R4 revealed on			

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	1/20/25, five of ten fentanyl patches were dispensed, no documentation of the quantity received, and five patches are documented on the sheet as follows: (no accountability of the first five patches) 2/4/25- placed on the left chest and old one removed and verified by two nurses for destruction. 2/7/25- placed on the right chest and the old one was removed with only one nurse signature for destruction. 2/10/25- placed on the left chest and two nurses verified destruction of the old one. 2/13/25- placed on the right chest and only one nurse signed it was verified for destruction. 2/16/25- placed on the left chest and two nurses verified destruction of the old one and there were zero remaining patches documented. Review of a "Controlled Drug Record: Topical Patches" proof of use sheet for R4 revealed on 2/12/25, five fentanyl patches were dispensed, five patches received, and five of them are documented on the sheet as follows: 2/19/25- placed on the right chest and two nurses verified destruction of the old one. 2/22/25- placed on the left chest and only one nurse verified the destruction of the old one. 2/25/25- placed on the right chest and two nurses verified the destruction of the old one. 2/25/25 (same date entered)- placed on the left chest and two nurses verified the destruction of the old one with a 2/28/25 date for removal.			

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	(undated entry)- placed on the right chest and only one nurse verified the removal and destruction of the old one on 3/3/25. There were 5 remaining patches documented but no accountability for them. Review of a "Controlled Drug Record: Topical Patches" proof of use sheet for R4 revealed on 2/26/25, four of nine fentanyl patches were dispensed, no documentation on the quantity received, and four of them are documented on the sheet as follows: 3/6/25- placed on the left chest and two nurses verified the destruction of the old one. 3/9/25- placed on the right chest and one nurse verified the destruction of the old one. 3/12/25- placed on the left chest and two nurses verified the destruction of the old one. 3/15/24- placed on the right chest and two nurses verified the destruction of the old one. One patch is documented as remaining but no accountability for it. Review of an untitled document with R4's name on it and "Fentanyl Pat 25 mcg/hr (C=11) revealed a record of placement verification starting on 2/23/25 as follows: 2/23/25- the first shift nurse is the same nurse who signed as the oncoming and off going nurse and circled yes for the patch being in place on the left chest. 2/23/25- the second shift nurse is the same nurse who signed as the oncoming and off going nurse and did not document the patch in place but wrote			

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	in left chest for location. 2/24/25- (third shift for 2/23/25), two different nurses documented the patch was in place on the left chest. 2/24/25 (third shift, second entry)- the oncoming nurse signature is blank and a different nurse than the previous entry signed the location was the left chest but not that it was in place. 2/25/25- The first shift nurse did not sign as the oncoming nurse and the off going nurse documented the location is the left chest. 2/25/25- the second shift oncoming nurse signed but did not document the patch was in place or the location. There is no off going nurse signature. 2/25/25- the third shift is documented with different signatures for the ongoing and off going nurses and verified the patch was in place on the right chest. The document continues to 3/10/25, first shift with many discrepancies/incomplete documentation and accountability. In an interview on 3/27/25 at 1:40 PM, the Director of Nursing (DON) was made aware of concerns for the proof of use documentation of the fentanyl patches for R4. Only one nurse signed for the removal of the patch on 2/22/25 and on 2/25/25 it was signed out twice on the same day. The next entry on 2/25/25 is not dated with only one nurse to witness the removal on 3/3/25. The DON could not explain why the documentation presented the way it did and was to look into it and provide more information. Shortly after, the DON tried to explain why the nurses documented on the form wrong, but the			

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	patches were still accounted for. Unfortunately, the explanation still did not make sense. The DON then reported that they were going to do away with this current system and do something else.			
F0761 SS= D	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to appropriately maintain medication storage for one medication room of two medication rooms. Findings include:	F0761	F761 1. The Love unit med room refrigerator was immediately audited, all non-medications were removed and medications/vaccines that were not dated were removed and discarded. 2. A sweep of all med room refrigerators was performed by 4/25/2025 to ensure they are used only for medications and/or vaccines and all vaccines are labeled appropriately. 3. The policy on Medication labeling and storage was reviewed and deemed appropriate. Licensed nurses were educated on proper procedure by 4/25/2025 by the DON/designee. 4. The QAPI committee has directed the DON/designee to perform random weekly audits to ensure medications are stored appropriately and expired medication are discarded. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	4/25/2025

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	During an observation and an interview on 3/27/25 at 8:35 AM, the Love Unit Medication Room had a refrigerator with an opened multidose tuberculin vial that was not dated when it was opened. Licensed Practical Nurse (LPN) "T" reported she did not know when it was opened and should be dated when it was opened. Inside the refrigerator was also a urine sample for a newly admitted resident. LPN "T" reported that this refrigerator is to only have medications in it, and this was not to be stored in this room. Review of a policy from the pharmacy titled "Medication Storage in the Facility" last revised 1/2018 revealed: "G. Potentially harmful substances such as urine test reagent tablets, household poisons ... are clearly identified and stored in a locked area separately from medications. H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal and reordered from the pharmacy if a current order exists. ... Expiration Dating (Beyond-use dating) ... C. Certain medications or package types, such as IV solutions, multiple dose injectable vials ... once opened, require an expiration date shorter than the manufacturer's expiration date to insure (sic) medication purity and potency.			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or	F0812	1. No residents were negatively impacted by this deficient practice. 2. The CDM has re-implemented a food cooling log in accordance with 2022 FDA Food Code section 3-501.15 cooling methods. The facility has repaired the quat sanitizer dispenser to ensure proper concentration of 200-400 ppm. The CDM has implemented a	4/30/2025

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	regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: During the initial tour of the kitchen, at 9:40 AM on 3/25/25, and interview with Certified Dietary Manager (CDM) "R" found that the facility rarely cools down food from service or makes large meals in advance that require a cooling and reheating step before being served. Observation of the walk-in cooler, at 9:42 AM on 3/25/25, found a six inch deep quarter pan of gravy dated 3/24/25. At this time, a temperature of the gravy was found to be 42F. Further observation of the walk-in cooler found two ambient air thermometers that read 35F and digital thermometer of the unit also read 35F. A product temperature of a container of mushrooms was found to be 35F. At this time, it was asked if the facility maintains a cooling log, CDM "R" provided a log entitled "HACCP Cooling Log" which had two of four cooling entries completed.		quat sanitizer log to ensure proper concentration under the Code by 4/25/2025. The clean pots and pans under the preparation table were recleaned. The juice gun was recleaned, including removing and disassembling the spout and wiping out the inside. The meat slicer was removed from operation. The mixer was thoroughly cleaned. The top gasket on the refrigerator in the Love Kitchenette was cleaned. The soy sauce identified as half opened was discarded from use. 3. The CDM was educated by the NHA on the Food Safety Requirements Policy and Procedure. All dietary staff were educated on the Food Safety Requirements Policy and Procedure including proper food cooling, proper testing of quat sanitizer, clean food prep surfaces, proper juice gun cleaning, non-food surface cleaning, and proper food refrigeration after opening. These items were added to the daily cleaning log. 4. The QAPI Committee has directed the CDM to perform random weekly audits of proper refrigeration of food items, food cooling temperatures, and cleanliness of food/nonfood contact surface. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	

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	The first completed entry was a Roast Beef logged on 1/7. The log stated that the item was 131F at 5:00 PM and was 79F at 7:00 PM. The second completed entry was Turkey on 2/15. The log stated the Turkey was 132F at 5:30 PM and was measured at 88F at 7:30 PM. A review of the logs instructions found that staff should "Record corrective actions taken, if applicable. The supervisor of food operation will verify proper cooling procedures by routinely monitoring work activity and reviewing this log. Cooling Guidelines - Cooked time/temperature control for safety foods will be cooled: (a) From 135F to 70F within 2 hours." When asked if any of the improperly cooled food was served to residents, CDM "R" was unsure. According to the 2022 FDA Food Code section 3-501.14 Cooling. "(A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57ºC (135ºF) to 21ºC (70°F); and (2) Within a total of 6 hours from 57ºC (135ºF) to 5ºC (41°F) or less ..." According to the 2022 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under § 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if			

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	protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD. During a tour of the preparation area, at 9:49 AM on 3/25/25, a sanitizer bucket of quaternary ammonium was tested and found to be well over the 200-400 parts per million (ppm) that is required for its concentration. When asked what the concentration usually is, CDM "R" stated they normally find it around 300 ppm. At this time the bucket was dumped and a new sanitizer bucket from the three-compartment sink was dispensed. Once tested, with the facility provided QT-40 test strips, it was found that the concentration was over the 500 ppm maximum on the test strip. When asked if they had anyone out working on the chemical dispenser, CDM "R" stated they had not. According to the 2022 FDA Food Code section 7-204.11 Sanitizers, Criteria. Chemical SANITIZERS, including chemical sanitizing solutions generated on-site, and other chemical antimicrobials applied to FOOD-CONTACT SURFACEs shall: "(A) Meet the requirements specified in 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (Food-contact surface sanitizing solutions)P, or (B) Meet the requirements as specified in 40 CFR 180.2020 Pesticide Chemicals Not Requiring a Tolerance or Exemption from Tolerance-Non-food determinations." An interview with CDM "R", at 9:53 AM on 3/25/25, found that clean pans are stored under the preparation table, it was observed that one shallow half pan was found stacked and stored with stuck on food debris.			

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	Observation of the juice gun, at 9:57 AM on 3/25/25, found increased accumulation of debris on the spout once the cap was taken off. An interview with CDM "R" found that staff clean the juice gun nightly and soak it. When asked if they ever take the spout off and wipe away the inside, CDM "R" was unsure. An interview with CDM "R", at 10:03 AM on 3/25/25, found that staff don't use the meat slicer much anymore, but the mixer gets used three or four times a week. At this time, observation of the meat slicer found dried meat shavings at the top backside of the blade and the underside of the mixer was found with increase accumulation of dried cake debris and splatter. During an observation of the Love kitchenette, at 10:33 AM on 3/25/25, it was observed that the top gasket on the refrigeration unit was found with an increased amount of black spotted accumulation. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." During a tour of the dry storage room, at 10:18 AM on 3/25/25, it was observed that a open half full container of soy sauce was found stored on the bottom shelf of the dry storage room. A review of the manufacturer's directions found the container states "Refrigerate After Opening".			

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	According to the 2022 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. "(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11 (B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54C (130F) or above; or (2) At 5C (41F) or less."			
F0880 SS= F	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F0880	1. Resident #1, #4, and #25 continues to reside at the facility and no negative outcomes were identified to the deficient practice. DPS B A digital testing unit was purchased, and levels remain at acceptable levels by 4/25/2025. 2. All residents may be impacted by this deficient practice. The facility completed infection screening evaluation was completed on all residents as of 4/30/2025. Any resident identified with an additional wound or signs/symptoms of an infection will be treated accordingly and their care plans updated. DPS B Current residents can be impacted by legionella. Water levels will continue to be monitored as required. 3. The facility has reviewed the facility Infection Control Plan; This policy is deemed appropriate. The facility's Regional Nurse Consultant educated the DON on proper infection control policies including hand	4/30/2025

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	persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: This citation has two Deficient Practice Statements DPS A Based on observations, interviews and record review, the facility failed to meet standards of care for infection control related to tracking and trending employee/resident		hygiene. Clinical staff were provided with education on the Infection Control Plan by the DON/designee after DON educated, including proper hand hygiene, clean work environment, and employee illness management. The ICP has been appropriately educated on infection tracking and trending. DPS B The facility has incorporated the Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings. The facility Water Management Plan has been updated using the CDC Toolkit including establishing core members. The Director of Plant Operations educated the members of the WMP on understanding what Legionella is and understanding the facility's water system by 4/30/2025. 4. The QAPI Committee has directed the DON/Designee to perform random weekly audits of proper infection control procedures and tracking and trending. The QAPI Committee has directed the Director of Plant Operations to perform random weekly test for Legionella. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	

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CHRISTIAN CARE NURSING CENTER	2053 S SHERIDAN DRIVE MUSKEGON, MI 49442

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	illnesses, maintaining up to date infection control policies and procedures, practicing appropriate hand hygiene for 3 residents (R1, R4 and R25) of 3 residents reviewed for care, and medication storage in 1 of 2 medication storage rooms. Findings included: During the infection control task interview with Infection Preventionist (IP) "K" on 3/27/25 at IP "K" she does not track or do anything with employee illnesses. IP said they had a COVID outbreak in September 2024, and she did not have any data on employee sick calls for absences in September 2024. IP "K" verified she did not have a way to track all sources of outbreaks without monitoring employee illness. Review of the facility "September 2024 Facility Infection Tracking Report" revealed that they had 3 Residents positive for COVID. Review of the facility "Infection Surveillance" Policy dated reviewed/revised 1/1/2024 (over one year since review) revealed, "Infection surveillance" refers to an ongoing systematic collection, analysis, interpretation and dissemination of infection-related data. ..6. The facility will collect data to properly identify possible communicable diseases or infections among residents and staff before they spread by identifying: a. Data to be collected, including how often and the type of data to be documented, including ...ii Observations of staff including the identification of ineffective practice, if any;..10. Employee, volunteer, and contract employee infections will be tracked, as appropriate such as influenza or gastrointestinal infections outbreaks.			

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	Review of the facility "Influenza Education and Immunization" Policy was dated devised: 5/2/2010. Review of the facility "Pneumococcal Vaccinations" Policy was dated 7/28/2016. During an interview with the Nursing Home Administrator (NHA) on 3/27/25 at 2:18 PM, the NHA was informed that the infection control policies that were provided were all more than a year old and some were several years old. The NHA said he would look into it. Upon exit no new infection control policies were provided. Hand Hygiene and Used Supplies Storage Resident #1 (R1) Review of a policy titled Non-Sterile Dressing Change last revised 5/2019 revealed: "Designated staff members will use non-sterile dressing techniques for all dressing changes unless otherwise indicated by physician or manufacturer guidelines. Clean aseptic technique should be used. In the event of multiple wounds, each wound is considered a separate treatment. ... 4. Prepare a clean, dry work area at bedside. Use disinfectant solution to prepare work surface. Optional: Cover work surface with clean dry paper or cloth towel, to prevent contamination of supplies. ... 10. Remove soiled dressing, place it in trash bag. ... 11. Remove gloves, wash hands, apply new gloves. ..." During an observation and an interview on 3/26/25 at 11:23 AM, Licensed Practical Nurse (LPN) "T" had R1 transferred to bed for a pressure ulcer dressing change and placed the wound dressing supplies on a table beside the bed			

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	with no barrier and did not clean the table. R1's brief was saturated with urine and soaked through her brief with an extra liner, her pants, the transfer sling, and her cushioned wheelchair. Peri care was provided after the pressure ulcer dressing change. The nurse removed the old dressing from R1's sacrum which was packed with gauze. LPN "T" used the same gloves to remove the old dressing and the gauze from her packed wound which was saturated with serosanguinous drainage. With the same gloves that removed the old dressing, LPN "T" cleansed the wound and packed it with gauze soaked in Dakins solution with her soiled glove via her finger. An antifungal cream mixed with a zinc-based cream was applied to the surrounding area of the wound, then an ABD (abdominal pad) was applied over the packed wound and adhered with hypafix tape. LPN "T" then changed her gloves post wound care to assist with peri care. At this point Certified Nursing Assistant (CNA) "F" provided peri care for R1 and used the same gloves that touched a urine-soaked brief, soaked clothing, a soaked transfer sling, then provided pericare to then apply a clean brief and clothing, and placing a new transfer sling under the resident. Then CNA "F" removed her gloves and lifted her Enhanced Barrier Precautions gown to reach in her pocket for new gloves. No hand hygiene was performed until after the resident was transferred back to her chair via Hoyer lift. In an interview on 3/26/25 at 11:57 AM, LPN "T" was questioned about hand hygiene and changing gloves during wound care. LPN "T" then replied, "I don't know but I am guessing you think I should have changed my gloves?" In an interview on 3/26/25 at 12:01 PM, CNA "F" reported that she is aware that if her gloves are wet or soiled, she should have changed her gloves and agreed that the urine saturated brief is dirty, and she should have changed her gloves.			

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	In an interview on 3/26/25 at 2:03 PM, the Director of Nursing (DON) reported that changing gloves and performing hand hygiene during wound care after removing the old dressing would depend on if the gloves are visibly soiled. The DON then reported R1's dressing is not a sterile one and R1's germs are her own germs, and did not see the concern of using the same gloves throughout. The DON would expect wound care supplies to be placed on a cleaned table or a table with a clean barrier. When queried about changing gloves and hand hygiene during pericare with a urine saturated brief, the DON reported she never heard of that before and would expect staff to change gloves if they were visibly soiled. When asked if urine is dirty, she reiterated that unless hands/gloves are visibly soiled, there is no need to change gloves. In an interview on 3/26/25 at 2:22 PM, Registered Nurse (RN)/Infection Control Nurse "K" reported that for wound care, a cleaned table or a barrier for supplies should be set up and hand hygiene should be done. New gloves and hand hygiene should be done after removing old dressing. Left over wound care supplies in the residents' room should not be taken to the cart. When asked about changing gloves during peri care when moving from dirty to clean surfaces, RN "K" reported she "never heard of that" and gloves should only be changed if visibly soiled with stool and since urine is clear, there was no need to change gloves and perform hand hygiene during care. RN "K" reported she follows the Centers for Disease Control (CDC) information and guidance. In an interview on 3/27/25 at approximately 9:00 AM, the DON walked down the hall and told this surveyor she will "eat crow" because gloves and hand hygiene should be done after removing a soiled dressing. When asked about during peri care, the DON reported that unless hands are			

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	visibly soiled there is no need to change gloves during care. Resident #4 (R4) During an observation on 3/26/25 at 10:46 AM, LPN "T" gathered wound care dressing supplies out of the wound cart and took them to R4's room and placed them on the uncleaned bedside table with no barrier. Old dressing was removed from the wound on R4's toes and the new treatment/dressing applies with the same gloves and no hand hygiene. When LPN "T" completed care, she took the left-over supplies that included mupirocin, calcium alginate in the opened wrapper, and opened gauze back to the wound care cart. Resident # 25 (R25) During an observation and an interview on 3/26/25 at 11:11 AM, LPN "T" gathered wound care supplies and took them to R25's room and placed them on an uncleaned table with no barrier. After LPN "T" provided wound care, the scissors she used fell into the trash can and she pulled them out and took the scissors, along with other opened left-over supplies out of the room and placed them into the wound care cart. When questioned about the supplies LPN "T" reported the supplies are not resident specific and are multi use for all residents. When asked about the scissors, LPN "T" reported she forgot to clean them and pulled them back out of the drawer and cleaned them with sanitizing wipes. Review of a policy titled "Hand Hygiene" last revised 1/1/24 revealed: "All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. ... 1. Staff will perform hand hygiene when indicated, using proper technique consistent			

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	with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. ... Hand Hygiene Table: Condition: Hands are visibly dirty, hands are visibly soiled with blood or other bodily fluids, ... After handline contaminated objects, ... Before applying and after removing personal protective equipment (PPE), including gloves, ... Before and after handling clean or soiled dressings, linens, ect. ... Before performing resident care procedures, After handling items potentially contaminated with blood, body fluids, secretions, or excretions, When, during resident care, moving from a contaminated body site to a clean body site, After assistance with personal body functions (e.g., elimination ...)" Review of the "Clinical Safety: Hand Hygiene for Healthcare Workers." Clean Hands, Centers for Disease Control, 27 Feb. 2024, www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, accessed 27, Mar. 2025 revealed: "KEY POINTS: Protect yourself and your patients from deadly germs by cleaning your hands. All healthcare personnel should understand how to care for and clean their hands. Why it matters: Hand hygiene protects both healthcare personnel and patients. ... Recommendations: Know when to clean your hands: Immediately before touching a patient. Before performing an aseptic task ... Before moving from work on a soiled body site to clean a body site on the same patient. After touching a patient or patient's surroundings. After contact with blood, bodily fluids, or contaminated surfaces. Immediately after glove removal." Review of a policy titled Non-Sterile Dressing Change last revised 5/2019 revealed: "Designated			

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	staff members will use non-sterile dressing techniques for all dressing changes unless otherwise indicated by physician or manufacturer guidelines. Clean aseptic technique should be used. In the event of multiple wounds, each wound is considered a separate treatment. ... 4. Prepare a clean, dry work area at bedside. Use disinfectant solution to prepare work surface. Optional: Cover work surface with clean dry paper or cloth towel, to prevent contamination of supplies. ... 10. Remove soiled dressing, place it in trash bag. ... 11. Remove gloves, wash hands, apply new gloves. ..." Medication Storage Room During an observation and an interview on 3/27/25 at 8:35 AM, the medication storage room on the Love Unit had a refrigerator with medications stored in it along with a urine sample that belonged to a newly admitted resident at the facility. Licensed Practical Nurse (LPN) "T" reported the urine sample should not have been stored in the medication refrigerator for infection control purposes. Review of a policy from the pharmacy titled "Medication Storage in the Facility" last revised 1/2018 revealed: "G. Potentially harmful substances such as urine test reagent tablets, household poisons ... are clearly identified and stored in a locked area separately from medications." DPS B Based on interview and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in water borne pathogens to			

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	exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility. Findings include: During an interview with Maintenance Director "S" regarding the facilities Water Management Plan (WMP), at 1:40 PM on 3/25/25, it was found that no annual review had been completed on the plan. When asked when the last time members of the Water Management Team met to discuss the plan, MD "S" was unsure, When asked who was a part of the WMP team, MD "S" stated he was unsure and that he is the one that carries out the tasks for the plan which includes taking free chlorine samples, flushing stagnant lines, and having dead end lines removed (over the last year). When asked if there was a control limit for free chorine in the water supply, MD "S" was unsure. A review of the facilities WMP binder, found no completed CDC toolkit. A record review of the facility document entitled "Water Management Program", copyright 2017, under the headline "Water Management Team" it was found that "The water management team is an interdisciplinary team composed of dedicated professionals who represent multiple facets of resident care at Christian Care Nursing Center. The team is charged to facilitate a program focused on the safety of the building water systems and devices across the care continuum by providing vision and direction for water systems management within the facility. The water Management Team will work collaboratively to identify and implement strategies for improving the management and efficiency of the facility's water systems. This committee will be empowered to address all aspects of water systems at Christian Care Nursing Center, including: detecting, monitoring process			

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	improvement, quality, Legionella prevention and staff education, as well as control measures and corrective actions.". The policy goes on to state that "The primary focus of the Water Management Team is to ensure that residents have the safest and sanitary environment based on best practice processes throughout their continuum of care....Establishment of a Water Management Team. The Team will meet routinely on a quarterly basis. The meetings to assess aspects of the water management such as implantation of engineering controls as needed, water quality testing as needed, water pressure, scald control, any results from water testing for Legionella, whether any engineering controls were not within specified limits and why that may have occurred, whether any corrective actions were taken on engineering controls and whether there have been any cases of Legionella diagnosed at or potentially associated with the facility...Conducting an annual review of water management program and updating as necessary."			