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	634595	A. BUILDING _____ B. WING _____	3/6/2025

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MAPLE MANOR REHAB CENTER OF NOVI INC	31215 NOVI ROAD NOVI, MI 48377

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F0000 SS=	INITIAL COMMENTS Maple Manor Rehab of Novi INC. was surveyed for a Recertification survey on 3/6/25. Census:47	F0000		
F0604 SS= D	Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate assessments and physician	F0604		

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

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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	orders with medical symptoms were completed for audible position change alarms for two (R6 and R342) of two Residents reviewed for restraints resulting in the potential to restrict body movements due to the fear of sounding the alarm with physical discomfort and psychological distress utilizing a reasonable person concept. Findings include: R6 Record review revealed R6 was recently admitted to the facility on 2/14/25. R6's admission diagnoses included urinary tract infection, peripheral vascular disease, heart disease, diabetes and Alzheimer's disease. Based on the nursing admission assessment dated 2/14/25, R6 was able to make their needs known and they were living at home with their wife prior to this admission. An initial observation was completed on 3/4/25 at approximately 10:45 AM. R6 was observed sitting in their wheelchair (WC) with a position change alarm box in their wheelchair. When queried what it was they were not sure what it was for. When queried what did they do when they needed to get assistance from staff they reported that they would call for help. R6 was able to move around in their wheelchair. A sensor pad for position change alarm for their bed was also observed in R6's bed. A follow up observation was completed later that day at approximately 2 PM. R6 was sitting up in			

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	their WC. R6 had position change alarm pad and box in their bed. Review of R6's Electronic Medical Record (EMR) revealed that an order dated 2/27/25 that read, "Chair alarm monitoring protocol: check placement and function: once per shift. Placement: ensure the chair alarm is properly attached and positioned on the chair. Test the alarm functionality to ensure it is working correctly ...". The order did not indicate the medical symptom and or the diagnosis that warranted the use of chair. There was no order to use an alarm in bed and R6 had an alarm unit on their bed. Nursing progress notes dated 3/1/25, 3/2/25, 3/3/25 and 3/4/25 revealed the use of alarms in bed and in wheelchair. However, the progress notes did not reveal any rationale why a position change alarm was used in the wheelchair and bed. There was no evidence of any documentation in R6's EMR that the facility had attempted any least restrictive approaches prior to use of a position change alarm. There was no documentation that indicated that medical symptom that warranted the use of a position change alarm. Review of R6's assessments did not reveal any nursing and or interdisciplinary assessments that recommended the use of a position change alarm. Review of R6's care plan revealed a care plan for "physical restraints" dated 2/14/24. The care plan did not reveal use of any position change alarms. Review of R6's fall care plan did not reveal			

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	the use of any position change alarms. R342 R342 was admitted to the facility on 2/17/25 after hospitalization. R342's admitting diagnoses included orthostatic hypotension and muscle weakness. R342 was living at home with their family prior to hospitalization and they were admitted to the facility for short-term skilled nursing and rehabilitation care. Review of R342's Brief Interview for Mental Status (BIMS) assessment dated 2/18/25 revealed a score of 15/15, indicative of intact cognition. Review of the nursing admission assessment dated 2/17/25 revealed that R342 was aware of their limitations and able to use to call light and ask for assistance. An initial observation was completed on 3/4/25 at approximately 10:30 AM from the hallway. R342 had a sign on the door that read that they were on contact precautions. A staff member was in R342's room. R342 was observed sitting on their edge of their bed and they had a position change alarm box attached to the side of their bed. During a follow-up observation completed on 3/5/25 at approximately 12:15 PM, R342 was observed sitting in the edge of the bed eating lunch. This Surveyor heard the alarm in the hallway. R342 was trying to reposition themselves in the bed to make the alarm noise stop. The alarm stopped for a few seconds and started to go off again and R342			

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	was trying to readjust themselves in bed trying to stop the alarm and a staff member went in to assist the resident. Later that afternoon at approximately an hour after the observation an interview was completed with the resident. R342 was still sitting on their edge of their bed and the position change alarm box was attached to the side. They were queried about the alarm and they thought they needed the alarm because they might fall. They also added that they knew how to use their call light and ask for assistance. Review of R342's Electronic Medical Record (EMR) did not reveal any order for the use of any position change alarm. Review of progress notes revealed a physician progress note dated 2/18/25 that revealed that R342 had a history of near falls or near misses at home due to their orthostatic hypotension (a condition where blood pressure drops when a person stands up from a sitting or lying position). Further review of R342's nursing progress revealed since admission to the facility multiple notes that read R342 was alert and oriented to and able to make their needs known. A progress note dated 2/21/25 read in part, "received patient alert, lying in bed and oriented x 3 ...needs 1 person assist ADL's (Activities of Daily Living) and toileting .... bed alarm in place working ...". Further review of R342's EMR did not reveal any nursing or interdisciplinary assessments that recommended the use of alarms. There were no orders with any medical symptoms that			

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	warranted the use of position change alarms. There was no evidence of any documentation that other least restrictive measures were attempted prior to use of position change alarms. R342's care plan did not reveal the use of any position change alarms. Review of a Minimum Data Set (MDS) assessment dated 2/23/25 did not reveal use of any position change alarm. An interview Certified Nursing Assistant (CNA) "O" was completed on 3/5/25 at approximately 12 PM. They were working on the unit where R342 and R6 were residing. CNA "F" was queried about the use of position change alarms and why they were used. They reported that they were used to let the staff know when residents attempted to get out of bed/wheelchair. They added they used alarm for residents if they were a fall risk. When queried if R342's was able to ask for staff assistance they reported that they were able to ask for assistance. When queried further about the process and who made the determination they reported that they were not sure. An interview with CNA "F" was completed on 3/5/25 at approximately 12:15 PM. CNA "F' was also assigned on the unit where R6, and R342 were residing. CNA "F" reported that they had been at facility for approximately 5 years and they had regularly worked that unit. They were queried about the use of position change alarms. CNA "F" reported that the facility used alarms for residents if			

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	they were a fall risk. They added alarms were used to alert the staff members if residents attempted to stand or transfer on their own. When they queried about the process and who made the determination, CNA "F" reported that usually nurses made the decision, sometimes therapy staff. They added that at times if the CNAs felt that residents were at risk for fall they would let the nurses know and put an alarm for the resident. When queried what other interventions they would attempt before attaching an alarm they were not sure. An initial interview with Director of Nursing (DON) was completed on 3/5/25 at approximately 12:30 PM. They were queried about the facility process for use of position change alarms. The DON reported that the facility completed a nursing and or interdisciplinary assessment upon admission and throughout the resident stay as needed if resident's condition warranted use of any such devices. When queried further about the process, they added if residents had a fall or if they had history of falls then interdisciplinary team recommended the use of alarms. They were queried about the interdisciplinary assessments and other interventions attempted etc. for R6 and R342. They were queried about if the expect their staff to have assessments, orders and care plan etc. for the use of position change alarms including other measures that were attempted prior to use of alarms and they reported "yes". The DON reviewed the EMR			

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	and reported that there was no documentation in the EMR for R6 and R342 and reported that they understood the concern. They added they would check for any internal documents they might have and would report back. A follow up interview was completed with the DON on 3/6/24 at approximately 10 AM. The DON reported that they did not have any additional documents and they understood the concerns for use of position change alarms for R6 and R342. They added both residents were at risk and they had added orders and care plans. When queried about the assessment they added that they would follow up. A facility provided document titled "Resident Alarms" with a revision date of 01/25 read in part, "It is the policy of the facility to use resident alarms in limited circumstances in accordance with the resident's needs, goals, and preferences, so the resident will be able to attain or maintain his or her highest practicable level of physical, mental, and psychosocial well-being. Definition: An 'alarm' is any physical or electronic device that monitors resident movement when alerts the staff, by either audible or inaudible means, when movement is detected. Policy Explanation and Compliance			

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	Guidelines: 1. The use of alarms does not eliminate the need for adequate supervision of threshold. Types of alarms include: a. Bed alarms ... b. Chair alarms ... c. Floor mat alarms ... d. Motion sensor alarms ... e. Wander/elopement alarms ... f. Other ... 2. Identification of risk a. Each resident shall be assessed for fall and elopement risk upon admission and periodically thereafter as part of the comprehensive assessment process. b. Medical symptoms shall be identified and documented in the medical record. This information may come from the resident's medical history, physical exam, or individual observation. 3. Evaluation and analysis of risk a. The interdisciplinary team shall analyze each resident's unique risks and medical symptoms to determine the root cause of			

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	each risk. b. The interdisciplinary team shall consider the severity of risks slash symptoms, the immediacy of risks, and trends such as time of the day, location, or stated reasons for the behavior/ fall. 4. Implementation of interventions a. Resident directed approaches shall be implemented in accordance with the resident's needs, goals, and preferences. b. Alarms shall be initiated only to address a specific medical symptom or unique risk, when the benefit of the alarm outweighs the risk associated with its use. c. Interventions shall be communicated to all relevant staff, including frequency/timeframes and responsibility ....".			
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 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	F0688		

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	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, interviews, and record review, the facility failed to ensure a positioning device (hand splints) were implemented for one (R16) of one resident reviewed for positioning and range of motion services resulting in the potential for contracture progression (hardening of the muscles, tendons, and other soft tissues) with further decline in range of motion and compromise with skin integrity. Findings include: R16 R16 was a long-term resident originally admitted to the facility on 7/2/19. R16's admitting diagnoses included traumatic brain injury from motor vehicle accident, quadriplegia (paralysis of both arms and both legs) and seizures. R16 had a tracheostomy (An opening surgically created through the neck into the trachea/windpipe to allow air to fill the lungs) and they were breathing with the assistance of a ventilator (breathing machine). R16 was non-verbal and were totally dependent on staff assistance with all their needs. An initial observation was completed on 3/4/25 at approximately 9:35 AM. R16 was			

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	observed laying on their bed and a staff member was in the room. R16 had bilateral hand contractures, the fingers in both of their hands were bent in a clawed position. Some fingertips were close to the palm of hands. R16 did not have any type of splint/device on their hands. Two follow up observations were completed later that day at approximately 11:30 AM and 1:20 PM. R16's hands were observed in the same position. There were no hands splints or braces in R16's room. On 3/5/25 at approximately 10:15 AM, a follow up observation was completed the next day. R16 was observed in their bed. R16's hands were in the clawed position as yesterday. R16 did not have splints/devices on their hands. Review of R16's Electronic Medical Record (EMR) revealed a care plan that "I require splint on bilateral hands at night ..." that was initiated on 9/25/20 and goal for 4/19/25 read "Resident's bilateral hands will be free from injury, skin break down, edema, atrophy and contractures." An interview with Licensed Practical Nurse (LPN) "L" who was assigned to care for R16 was completed on 3/5/25 at approximately 10:35 AM. LPN "L" reported that they had been working at the facility for about 3 years and they regularly worked the unit where R16 was residing and they were very familiar with			

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	them. They were queried about R16's hand contractures and if any interventions were in place. LPN "L" reported that some staff members used rolled washcloths but they were not sure why it was not on. When queried further about R16's hand splints LPN "L" reported that they had never seen any splints for the resident and they confirmed that R16 did not have any hand splints in their room. An interview with Certified Nursing Assistant (CNA) "N" who was assigned to care for R16 was completed on 3/5/24 at approximately 11:45 AM. CNA "N" reported that they had been at the facility for about 8 years and they had regularly worked the unit where R16 was residing. CNA "N" was queried how they had obtained their information to care for their residents and they reported that they obtained information from the CNA care card that was kept in the resident's room, from the computer and also from their charge nurses. CNA "N" brought the document from R16's room was titled "Resident Care Guide". CNA "N" brought 3 different sheets. They were no dates on the documents and they were not able to identify the most current document. The document did not specify use of any splints. CNA "N" logged on to the computer and showed the CNA care plan for R16 upon request. One care plan read "I require splint on bilateral hands ...". When queried if R16 was using any splints, CNA "N" reported that R16 did not have any splints. They added that some staff members used rolled wash cloths			

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	and added that it was not consistent and was dependent on the staff member who were assigned to work with the resident. An interview with the Director of Rehab (DOR) "M" was completed on 3/5/25 at approximately 10:45 AM. They were queried about R16's hand contractures and if they had any splints in place as stated on their care plan. DOR "M" reported that they were not aware if R16 had any splints but they remembered R16 having some type of device such as a carrot and they would look into it. When queried further they reported that staff might have missed the splints after R16's readmission from the hospital; they would look into system to ensure that orders were reinstated and would initiate some audit. When queried about R16's contractures and their high-risk for worsening contractures, DOR "M" reported that they understood and agreed the rationale for the concern and they would follow up with their team. An interview with the Director of Nursing (DON) was completed on 3/5/25 at approximately 12:40 PM. The DON was queried about R16's splint and how the CNAs documented and who was providing oversight to ensure that CNAs were following the plan of care. The DON reported that CNAs were supposed to follow the plan of care and document; and nurses were providing the oversight. They were notified on the concern regarding R16's contracture and their risk with no plan in place to			

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	maintain their range of motion. They reported that they understood the concern and they would follow up with their team. A facility provided document titled "Prevention of Decline in Range of Motion" with a revision date of January 2025, read in part, "Resident who enter facility without a range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable. Policy Explanation and compliance guidelines: 1. The facility in collaboration with the medical director, director of nurses and as appropriate, physical slash occupational consultant shall establish and utilize a systematic approach for prevention of decline in range of motion, including the assessment appropriate care planning and preventive care. 2. Assessment for range of motion: a. The facility will assess the residence range of motion (such as current extent of movement of his slash her joints and identification of limitations) on admission readmission, regularly and upon significant change period the facility will communicate with therapy regarding any range of motion limitations noted, as necessary.			

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	634595	A. BUILDING _____ B. WING _____	3/6/2025

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	b. Nursing assistants will report any significant changes in range of motion, as noted during daily care activities, to the resident's nurse when any change is noted. c. The assessment should include identified risks which could impact residents' range of motion including but not limited to: i. Immobilization ii. neurological conditions causing functional limitations iii. any condition where movement may result in pain, spasms, or loss of movement iv. clinical conditions such as immobilized limbs or digits because of injury, fractures or surgical procedures including amputations 3. Appropriate care planning: a. Based on the comprehensive assessment, the facility will provide interventions, exercises and or therapy to maintain or improve range of motion. b. The facility will provide treatment and care in accordance with professional standards of practice. This includes but not limited to: i. Appropriate services (specialized rehabilitation, restorative, maintenance). ii. Appropriate Equipment (braces or splints).			

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	iii. Assistance as needed (active assisted, passive, supervision) ...".			
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record reviews the facility failed to ensure oxygen therapy was consistently administered as ordered by the Physician for one (R14) of two residents reviewed for respiratory care. Findings include: On 2/4/25 at 9:22 AM, R14 was observed lying on their back in bed. Oxygen tubing was observed on the bed, disconnected from the oxygen concentrator. At this time Licensed Practical Nurse (LPN) "C" asked to reconnect and apply R14's oxygen. LPN "C" stated R14 always takes out their oxygen tubing on their own. LPN "C" proceeded to reconnect the tubing to the concentrator and apply the nasal cannula to R14. A review of the medical record revealed R14	F0695		

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	was admitted to the facility on 2/6/25 with diagnoses that included: sepsis and delirium. R14 required assistance from staff for all Activities of Daily Living (ADLs). Review of a Physician order documented the following: Oxygen via nasal cannula at 2 LPM (Liters Per Minute) Maintain SPO2 (oxygen saturation) = (equal) or > (greater than) 90%. Review of the care plans revealed no care plan implemented for non-compliance regarding their oxygen therapy. Further review of the medical record revealed no interventions implemented regarding noncompliance of oxygen therapy. On 3/5/25 at 11:07 AM, R14 was observed sleeping in their bed, with the oxygen nasal cannula observed on the top of their upper lip. At this time Registered Nurse (RN) "D" was informed of R14's nasal cannula placement. RN "D" entered the room and woke R14 up from their sleep and informed them that they had to keep their oxygen on. RN "D" was observed reapplying the oxygen cannula. A review of a facility policy titled " ... Oxygen Administration" revised January 2025, documented in part " ... Oxygen is administered to residents who need it, consistent with professional standards of			

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	practice, the comprehensive person-centered care plans, and the resident's goals and preferences ... Oxygen is administered under orders of a physician ... The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment ... Monitoring for complications associated with the use of oxygen ... Staff shall notify the physician of any changed in the resident's condition ... or evidence of complications associated with the use of oxygen ..." On 3/6/25 at 9:05 AM, the Director of Nursing (DON) was interviewed and informed of the observed incidents with R14's oxygen administration and the DON stated they were not aware of R14 being noncompliant with their oxygen therapy. The DON stated that R14's non compliance could have started over the weekend, however had they known they could have implemented interventions for the concern. No further explanation or documentation was provided by the end of the survey.			
F0757 SS= D	Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-§483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F0757		

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	§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record reviews the facility failed to ensure physician ordered medications had an indication for use and failed to transcribe physician orders per the facility policy for two (R's 5 and 7) of two residents reviewed for unnecessary medications. Findings include: R5 On 3/4/25 at 9:55 AM, R5 was observed lying back in their bed. Oxygen was observed being administered via nasal cannula and an interview was conducted with the resident at that time. A review of the medical record revealed R5 was readmitted to the facility on 2/13/25 with diagnoses that included: fracture of lower end of the left femur. Review of the Physician orders revealed the following: Bupropion sustained release 150 mg (milligram) twice a day. For the diagnosis section on the order, staff documented "N/A"			

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	(not applicable). Trazodone 150 mg once daily. For the diagnosis section on the order, staff documented "N/A". Xanax 1 mg twice a day PRN (as needed). For the diagnosis section on the order, staff documented "N/A". A review of a facility policy titled " ... Medication Orders" revised January 2025, documented in part " ... This facility shall use uniform guidelines for the ordering of medication ... Elements of the Medication Order ... Diagnosis or indication for use ..." The facility staff failed to document the indication for use for each medication as required by the facility policy. R7 On 3/4/25 at 12:54 PM, R7 was observed in their room. A brief interview was conducted with the resident at that time. A review of the medical record revealed R7 was readmitted to the facility on 2/7/25 with diagnoses that included atrial flutter and heart failure. Review of the Physician orders revealed the following: Eliquis 5 mg every 12 hours. For the diagnosis			

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	634595	A. BUILDING _____ B. WING _____	3/6/2025

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	section on the order, staff documented "N/A". Hydrocodone-acetaminophen 5-325 mg every four hours PRN. For the diagnosis section on the order, staff documented "N/A". On 3/5/25 at 10:58 AM, the Director of Nursing (DON) was interviewed and asked why R' 5 & 7 had no indication documented for the medications prescribed to them and the DON stated the indications are usually put in by the Physician and are usually in the Physician's progress notes. The DON was asked why the indications were not documented when the medication orders are transcribed and the DON stated they will try to implement a process moving forward so the indication section is completed. No further explanation or documentation was provided by the end of the survey.			
F0758 SS= D	Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as	F0758		

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	diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that there was a stop/end date for PRN (as needed) psychotropic medication and failed to ensure that resident specific non-pharmacologic interventions were attempted prior to the administration of PRN psychotropic medication (anxiolytic) for two (R5 and R12) of five residents reviewed for unnecessary medications with potential for adverse side effects and decreased quality of life. Findings			

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	inlude: R12 R12 was admitted to facility on 2/5/25 after hospitalization. R12's admitting diagnoses included: stroke, diabetic neuropathy, history of falls, heart failure, kidney failure, generalized anxiety disorder, restlessness and agitation. Based on the Minimum Data Set (MDS) assessment dated 2/11/25, R12 had Brief Interview for Mental Status (BIMS) score of 13/15, indicative of intact cognition. Review of R12's physician orders revealed an order for alprazolam (anti-anxiety medication). The order read "alprazolam - schedule IV tablet 0.5 milligram oral twice a day PRN (as needed)" started in 2/5/25 with no end date. Review of R12's Medication Administration Record (MAR) from 2/5/25 through 3/5/25 revealed R12 received the PRN alprazolam on the following dates: 2/5/25 (1 dose); 2/6/25 (2- doses); 2/7/25 (1 dose); 2/9/25 (2-doses); 2/10/25 (1-dose); 2/11/25 (2-doses); 2/12/25 (2-doses); 2/13/25 (1-dose); 2/19/25 (1-dose); 2/21/25 (2-doses); 2/23/25 (1-dose); 2/28/25 (1-dose); 3/4/25 (1 -dose), and 3/5/25 (1 -dose). PRN medication administration reasons under MAR included: "Behavior issues, other and pain". Review of R12's nursing progress notes revealed multiple notes that revealed "yelling for assistance" and staff were redirecting R12 to use call light for assistance. There was non			

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	evidence on R12's EMR about R12's target behaviors monitoring and use of resident specific non-pharmacological interventions prior to administration of PRN psychotropic medication. Review of R12's Electronic Medical Record (EMR) revealed a care plan for "mood state" dated 2/7/25. The care plan read, "I have signs and symptoms of mood distress, related to diagnoses of generalized anxiety disorder, delirium, insomnia, restlessness and agitation ....". One of the approaches read "offer non-pharmacological interventions to improve mood and lessen anxiety depending on patient's preference like attending social activities, deep breathing exercises, massage, listening to music". An interview with Director of Nursing (DON) was completed on 3/6/25 at approximately9:45 AM. DON was queried about the R12's order for PRN psychotropic medication with no end date and the facility process on non-pharmacological interventions prior to administering PRN psychotropic medication. DON reviewed the EMR and reported that they would contact the physician regarding the end date. They also added that staff should administer non-pharmacological interventions prior to administration of PRN medication and should document in progress notes. They were notified of the concerns and they reported that they understood the concern.			

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	Review of facility provided document titled "Use of Psychotropic Medications" with a revision date of January 2025 read in part, "It is the intent of this policy to ensure that residents only receive psychotropic medications when other non-pharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. Policy Explanation and Compliance Guidelines: 1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. 2. Psychotropic medications are to be used only when a practitioner determines that the medication is appropriate to treat residents specific diagnosed and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. 3. Other medications not classified as antipsychotic, antidepressant, anti-anxiety are hypnotic medications but can affect brain activity should not be used as a substitution			

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	for another psychotropic medication unless prescribed with the documented clinical indication for use consistent with accepted clinical standards of practice. 4. When a medication is used that can affect brain activity example antihistamines anticholinergic medications and central nervous system agents for use in conditions such as seizures, mood disorders, pseudobulbar effect and muscle spasms are stiffness and the documented use appears to be a substitution for another psychotropic medication rather than the original or approved indication, then the medication is subject to the requirements pertaining to psychotropic medications. 5. The indications for initiating, maintaining, or discontinuing medications as well as the use of non-pharmacological approaches, will be determined by evaluating the residence physical, behavioral, mental, and psychological science and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and preferences and goals for treatment. 6. Nonpharmacological approaches must be attempted unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications. 7. The resident's medical record shall include			

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	documentation of this evaluation and the rationale for chosen treatment options. This includes any indicated documentation of rationale for prescribing multiple psychotropic medications or switching from one type of psychotropic medication, specifically an anti-psychotic medication to another category psychotropic medication .... 16. Psychotropic medications used on a PRN basis must have a diagnosed specific condition and indication for the use of for the PRN OK use documented in the residence medical record and is subject to the limitations as noted: a. PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond 14 days. The medical record should include documentation from the physician our prescriber for the rationale for the extended time period and indicate a specific duration. b. PRN antipsychotic medication only, shall be limited to 14 days with no exceptions. If the attending physician or the prescribing practitioner believes it is appropriate to write a new order for the PPRN antipsychotic, they must first evaluate the resident to determine if the new order for the PCR and antipsychotic is appropriate ...". R5			

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	On 3/4/25 at 9:55 AM, R5 was observed lying back in their bed. Oxygen was observed being administered via nasal cannula and an interview was conducted with the resident at that time. A review of the medical record revealed R5 was readmitted to the facility on 2/13/25 with diagnoses that included: fracture of lower end of the left femur. A review of the physician orders revealed the following: Start date: 2/15/25- Xanax 1 mg twice a day PRN (as needed). The "End Date" was noted as "Open Ended". The order did not have a stop date. A review of a facility policy titled "Use of Psychotropic Medication(s)" revised January 2025, documented in part " ... PRN orders for psychotropic medications ... shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescribing for the rationale for the extended time period and indicate a specific duration ..." Further review of the medical record contained no documentation by the			

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	prescribing practitioner on why the Xanax order was extended beyond the 14 days. A review of the March 2025 Medication Administration Record (MAR) documented the Xanax as administered on the following dates: 1st at 8:51 AM and 9:12 PM. 3rd at 8:45 PM. Further review of the medical record revealed no documentation of non-pharmacological interventions utilized before the administration of the Xanax PRN medication. On 3/5/25 at 10:58 AM, the Director of Nursing (DON) was interviewed and asked about R5's Xanax order extending beyond 14 days and asked about the requirements of utilizing and documenting non-pharmacological interventions prior to the administration of the PRN psychotropic medication and the DON acknowledged the order should have a stop date and staff should be documenting interventions prior to administration. No further explanation or documentation was provided by the end of the survey.			
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,	F0880		

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	634595	A. BUILDING _____ B. WING _____	3/6/2025

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	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 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.			

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	§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: Based on observation, interview, and record reviews the facility failed to ensure infection control standards and practices were consistently implemented by the facility staff and failed to implement an effective infection control surveillance program for 47 or 47 (including Resident R14, R19, R5, R35, R2,R342 ad R24) residents residing at the facility during the time of the survey. Findings include: On 3/4/25 at approximately 8:35 AM, upon entrance into the facility. The receptionist informed the survey team that the facility was currently experiencing an Influenza outbreak and a surgical mask would have to be worn by all surveyors. On 3/4/25 at 9:18 AM, upon entry onto the second floor, a contained unit was observed. Two doors interlocked to the unit. Observed on the door was a signage informing all of "Droplet Precautions". The signage informed staff and providers to wear a surgical mask and eye protection. The signage also noted			

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	for all visitors to speak with a nurse. On 3/4/25 at 9:20 AM, Licensed Practical Nurse (LPN) "C" was observed at a medication cart. LPN "C" was asked what information or required Personal Protective Equipment (PPE) was required for the facility visitors. LPN "C" replied visitors must wear the surgical mask and they recommend hand hygiene. On 3/4/25 at 9:22 AM, upon entry into R14's room, the same "Droplet Signage" observed on the unit double doors was observed on R14's room. Observations were made of R14 and their environment. On 3/4/25 at 9:30 AM, upon entry into R19's room, a sign for Enhance Barrier Precautions was observed by the door. Observed outside of the room was a PPE cart that contained gowns, gloves and hand sanitizer. The signage documented for all providers and staff to complete hand hygiene and to wear gloves and a gown for high contact resident care activities. The Signage noted for everyone to clean their hands before entering and when leaving the room. Upon entrance in the room, Certified Nursing Assistant (CNA) "I" was observed providing care and dressing the resident. CNA "I" was observed with gloves on but no gown. After exiting R19's room, LPN "C" stated they forgot to mention that visitors should wear a shield when entering into Droplet Precaution			

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	rooms. LPN "C" was asked what the staff and providers were expected to wear when going into Droplet Precaution rooms and LPN "C" stated the surgical mask and shield as well. A walk through observation was conducted and multiple rooms had the Droplet signage observed posted outside of their rooms, with multiple residents heard coughing from the hallway. On 3/4/25 at 9:54 AM, observed on R5's door was a Droplet Precaution sign. R5 was observed in bed. A brief interview was conducted at that time. A review of R5's medical record revealed R5 had recently been diagnosed with Influenza A. A Physician's order documented the following: Droplet Precautions Indication: For infections transmitted through respiratory droplets from coughing, sneezing, or talking. Precaution of Diagnosis: Specify: flu ... Special Instructions: Hand Hygiene: Perform before and after patient contact and after removing PPE. Patient Placement: Private room; door can remain open. PPE: Surgical mask, gloves, gown, eye protection. On 3/4/25 at 9:38 AM, an interview was conducted with the facility's Infection Control Preventionist (ICP) "B" to inquire about the correct PPE usage for the facility's droplet			

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	rooms for staff and visitors. Initially, ICP "B" stated that visitors had to complete hand hygiene, wear a surgical mask and shield, but then ICP "B" stated the staff had to complete hand hygiene, surgical mask, shield and a gown. ICP "B" was shown the multiple staff members in the contained hallway that was observed entering into the Droplet Precaution rooms with no gown. ICP "B" then stated that the Medical Director stated the gowns were not needed, however they (ICP "B") recommended it to their staff. ICP "B" was shown their signage of Droplet Precautions that does not guide the facility staff to don on gowns and ICP "B" stated they were in talks with the medical director regarding the correct protocol moving forward. A review of the facility policy titled " ... Transmission-Based (Isolation) Precautions" revised January 2025, documented in part " ... It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission ... 'Droplet precautions' refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions ... Healthcare personnel will wear a facemask for close contact with an infectious resident ... if there is a risk of exposure of mucous membranes or substantial spraying of respiratory sections is anticipated, gloves and gown as well as goggles (or face shield)			

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	should be worn ... Droplet- Gloves, Gown- As per standard precautions. Mask- Don a mask upon entry into the patient room or cubicle ..." The facility staff failed to consistently follow the physician order for Droplet Precautions and failed to follow the facility's policy. Infection Surveillance Program Review of the facility's infection control surveillance program revealed no documentation for the facility's February 2025 infection surveillance and No mapping of the facility's infections from May 2024 to current (March 2025). On 3/5/25 at 2:17 PM, the facility's Infection Control Preventionist (ICP) "B" was interviewed and asked about the missing documents and stated they had them. When asked why it was not provided when the Infection Control Surveillance Program was requested, ICP "B" stated they take it home to work on it because they cover two buildings. At 2:22 PM, ICP "B" provided the missing documents. Review of Infection Surveillance Program revealed the following: March 2025 - No data, despite the facility having a current outbreak. February 2025 surveillance- No mapping			

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	completed and the line listing of infections were incomplete. The line list for "Outbreaks" revealed a staff member was identified to be positive for the Flu on 2/21/25. The first resident identified to be positive with the Flu was noted to be transferred to the hospital on 2/21/25 for a fever and reported to be positive for the Flu on 2/22/25. The line listing revealed two more residents became positive with the Flu before ICP "B" contacted the local health department on 2/25/25. Further review of the outbreak line listing revealed 10 additional residents and five additional staff members were diagnosed to be positive for Influenza A and/or symptomatic in the month of February 2025. Review of the Local health department "Recommendation For Prevention And Control Of Influenza Outbreaks In Long Term Care Facilities" documented in part, " ... Early recognition and testing of suspected influenza cases ... Long term care facilities are required to report all suspected and confirmed outbreaks to local public health per Michigan Public Health Code ... LTCF's (Long Term Care Facilities) are required to report the following ... A sudden increase in acute febrile respiratory illness over the normal background rate ... two (2) or more cases of acute respiratory illness occurring within 72hours of each other ... Any resident who tests positive for influenza ... Acute febrile respiratory illness is defined as fever >			

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	100 F AND one or more respiratory symptoms (runny nose, sore throat, laryngitis, or cough). However please note that elderly patients with influenza may not develop a fever. Testing for influenza should occur when any resident has signs and symptoms that could be due to influenza ..." Review of the facility transfers to the hospital identified R35 who exhibited signs and symptoms that could have been due to influenza and not identified on the facility's line listing. Review of R35's progress notes revealed the following: On 2/25/25 at 6:25 PM, " ... had a fever of 100.1 ... has a cough ..." On 2/25/25 at 11:43 PM, " ... patient has been coughing constantly. She is wheezing ... short of breath ... patient is very anxious, coughing and wheezing ..." On 3/6/25 at 11:02 AM, a meeting was held with ICP "B" to review the facility's Infection Control Surveillance Program. February surveillance was reviewed and the concern of February mapping not being completed, the infection surveillance line listing to not be fully completed and the failure to implement a system to timely identify, report, investigate, intervene and control the facility's outbreak. ICP "B" stated they had gotten really busy and had a lot going on			

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	and was unable to complete February's surveillance in real time. ICP "B" stated normally they would review the Infection Control data weekly and complete the line listing and report at the end of the month. ICP "B" was informed of the concern of their review of the infection control data to not be in real time (daily) especially considering the facility currently being in the middle of an Influenza outbreak. ICP "B" was asked why they delayed in reporting to their local health department the facility's outbreak, considering the first resident was identified positive with Influenza A on 2/22/25, the second resident confirmed positive on 2/24/25 and the third resident on 2/25/25. ICP "B" stated they did not consider to count the first resident who was sent out to the hospital for being symptomatic on 2/21/25 and diagnosed positive on 2/22/25, which was then reported to the facility. ICP "B" was then asked about R35 and why the facility did not test the resident for Influenza and ICP "B" stated the facility stopped testing residents since one resident was confirmed positive and told to consider everyone that was symptomatic positive. The guidance provided by the health department was reviewed with ICP "B" that noted to continue testing for resident with signs and symptoms of Influenza. The observations made of the facility staff not following proper infection standards and protocols was reviewed with ICP "B" as well and ICP "B" stated the facility had just in-serviced all staff on the infection protocols.			

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	No further explanation or documentation was provided by the end of the survey. Review of a facility policy titled " ... Infection Prevention and Control Program" revised February 2024, documented in part " ... the designated Infection Preventionist is responsible for oversight of the program and serves ... infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases ... responsible for ... A system of surveillance ... utilized for prevention, identifying, reporting, investigation, and controlling infections and communicable diseases ... All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE ..." R342 On 3/4/25 at 12:03 PM, R342's room was observed to have signage on the door that read, "CONTACT PRECAUTIONS...EVERYONE Clean hands prior to entering...NECESSARY PPE (Personal Protective Equipment) Gown and gloves..." At that time, Certified Nursing Assistant (CNA 'E') was observed retrieving a lunch meal tray from a cart in the hallway and entered into R342's room without cleaning hands, or			

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	donning any personal protective equipment. While in the room, CNA 'E' was observed leaning on the resident's walker next to their bed, touching their face mask, and moving items around the bed. On 3/4/25 at 12:10 PM, CNA 'E' was observed to have their face mask down around their chin and then proceeded to touch their face mask several times, while holding several drink cups and enter into room 248. They immediately exited the room and was not observed using any hand hygiene. Review of the clinical record revealed R342 was admitted into the facility on 2/17/25 with diagnoses that included: shingles (as of 2/26/25). Review of the care plans included: Start Date: 3/3/25 "I need to be in isolation related to herpes zoster". Interventions included: "Follow facility's Infection Control policies/procedures when cleaning/disinfecting room, handling soiled and/or contaminated linen, disinfecting equipment, etc." "Use principles of infection control and universal/standard precautions."			

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	Review of the physician orders included: "Contact Precautions Indication: To prevent the spread of infections transmitted through direct contact with patient skin, bodily fluids, or contaminated surfaces/equipment. Precaution/Route of Diagnosis: Specify: shingles ...Special Instructions: Hand Hygiene: Wash hands with soap and water before and after patient contact. PPE: Gloves and gown required." This order started on 2/26/25. On 3/4/25 12:15 PM, an interview was conducted with CNA 'E'. They reported they worked for a staffing agency and this was their second time at the facility. When asked if they were aware R342's room had contact precautions and to explain what they should do, CNA 'E' reported that resident had the flu (which was not correct) and they didn't come into contact with the resident. They were asked to clarify if they were sure the resident was on those precautions for flu and not something else, CNA 'E' reported they were told by another CNA it was the flu. When informed of the observations of them touching the resident's environment and signage that indicated they were to don/doff PPE and clean hands prior to entering the room, CNA 'E' offered no further response. When asked about the observations of them pulling their face mask down and touching their face mask several times, CNA 'E' reported they had really bad sinus issues and			

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	didn't know the remedy to that with also having to wear a mask. CNA 'E' further reported if they touched their mask, they should be sanitizing their hands after and acknowledged they did not. R24 On 3/4/25 at 9:23 AM, observation of R24's room revealed there was a PPE cart in the hallway just outside their room. Signage on the door documented "STOP Droplet Precautions" VISITORS: Please speak with nurse prior to entering room. PROVIDERS & STAFF Clean hands Prior To Entering And Upon Leaving; PROVIDERS & STAFF Wear A Surgical Mask; PROVIDERS & STAFF Wear Eye Protection; PROVIDERS & STAFF Use Dedicated or Disposable Equipment". The door to the room was closed. Review of the clinical record revealed R24 was admitted into the facility on 3/31/21 and readmitted on 10/7/24 with diagnoses that included: influenza due to unidentified influenza virus with other respiratory manifestations (as of 2/28/25). On 3/4/25 at 9:30 AM, CNA 'F' was asked about why R24 was on droplet precautions and they reported they thought it was for the flu. On 3/4/25 at 9:31 AM, the Infection Preventionist (IP 'B') was asked about the reason for R24 being on droplet precautions			

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	and they reported the resident was on droplet precautions for influenza A and further reported the staff only had to wear surgical mask, face shield, and gown. When asked why the signage only indicated staff were to don/doff face shield and surgical mask, they reported if they wanted to they could wear a gown. On 3/4/25 at 9:53 AM, Physical Therapy Assistant (PTA 'J') was observed donning a gown, gloves, surgical mask, was already wearing glasses and entered the room. At 10:05 AM, PTA 'J' was observed exiting the room and while doing so, brought a blood pressure/vital machine on wheels out of the room and down to the center alcove in the hallway to plug into an outlet. PTA 'J' was not observed cleaning the machine. On 3/4/25 at 10:08 AM, an interview was conducted with PTA 'J'. When asked about the observation of them bringing the vital sign machine out of R24's room, PTA 'J' reported they needed to check their vitals as the resident had a change while participating in a bedside therapy session. When asked about the cleaning of the vital sign machine, PTA 'J' reported they used the can (sanitizer wipes) to wipe down the finger area of the machine which they did in the room. When asked to confirm if the rest of the unit was sanitized, they reported only the finger area. When asked about the signage that indicated staff were to use dedicated equipment, PTA 'J' reported there was no dedicated			

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	equipment for the vital signs for this side of the building and they made sure to clean it as best they could. When asked what they had been educated on about donning/doffing PPE for residents on droplet precautions, PTA 'J' reported they were told it's just glasses, mask and gloves. At first we were told to wear gowns, but that was dropped. R2 On 3/4/25 at 10:18 AM, an interview was conducted with CNA 'K'. When asked about what PPE should be don/doffed for residents on droplet precautions, which included R2, CNA 'K' reported you don't need to wear gowns, only face mask and eye protection. When asked where you would clean the face mask off, CNA 'K' pointed to the table in the hallway and stated use the purple sani-wipes. When asked to clarify if that should be done in the room or in the hallway, CNA 'K' reported not in the rooms, in the hallway. On 3/4/25 at 10:26 AM, an interview was conducted with IP 'B'. When asked to confirm the process to don/doff PPE for residents on droplet precautions, IP 'B' reported it was recommended to wear a gown if providing care, but just out of an abundance of caution. When asked about the cleaning of the face shields, IP 'B' reported that should be done in the resident rooms prior to going into the hallway.			

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	634595	A. BUILDING _____ B. WING _____	3/6/2025

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	On 3/4/25 at 10:32 AM, the resident's room door was closed, with signage on the door indicating they were on droplet precautions. An interview was conducted with the resident at that time. When asked about their current isolation status, R2 reported they had been sick with the flu since last Tuesday (2/25/25) and they never felt so sick on their life. Review of the clinical record revealed R2 was admitted into the facility on 5/24/23 and readmitted on 10/7/24 with diagnoses that included: radiculopathy lumbar region, chronic pain due to trauma, fusion of spine thoracolumbar region, influenza due to other identified influenza virus with other respiratory manifestations, type 2 diabetes mellitus with unspecified complications, and acquired absence of right leg below knee.			
F0881 SS= D	Antibiotic Stewardship Program §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to consistently maintain a system that monitored antibiotic use, this had the ability to affect any resident	F0881		

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	prescribed an antibiotic in the facility of the 47 residents that resided in the facility at the time of the survey. Findings include: Review of the facility's February 2025 "Infection Control Form" line listings revealed 5 pages of documented infections in the facility. None of the identified infections were identified to have met or not meet the criteria for infection. The area was left blank on all five pages. None of the infections were identified as resolved or ongoing. None of the infections were identified as Nosocomial (in house acquired) or Community acquired. The area was left blank. Most of the identified infections failed to note signs and symptoms of the infection. Further review of the documentation revealed additional blank sections revealing the surveillance log to be incomplete. On 3/6/25 at approximately 11:10 AM, the facility's Infection Control Preventionist (ICP) "B" was interviewed and asked about the incomplete antibiotic review for February 2025. ICP "B" stated they had been very busy lately and was unable to maintain the data. ICP "B" was asked how they ensured that all resident listed on the five pages met criteria for an infection if the data is incomplete. ICP "B" stated they hung the McGeer checklist at each nurses station for the nurses to follow. No further explanation was provided. A review of a facility policy titled " ... Antibiotic Stewardship Program" revised			

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	January 2025, documented in part " ... It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program ... The facility uses the ... updated McGeer criteria ... to define infections ..."			
F0919 SS= E	Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the facility's 'wireless' call light communication system was fully operational and had adequate alternate interventions for residents to summons help. This deficient practice has the potential to effect all residents, including R142, R144, R143, R344, and one anonymous resident (AR). Findings include: R142 On 3/4/25 at 9:55 AM, the door to the room was closed. There were no audible or visual	F0919		

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	signals that any call lights were activated. Upon entry into the room, R142 was observed seated upright in bed, wearing a cervical collar. The resident reported they were extremely upset and had been waiting for their medication now for over an hour and was in pain. When asked about their pain level on a scale of 0-10 with 10 being the worst, R142 reported their current pain level was a "5". When asked if they pressed the call light for help, they reported their roommate did (for them). Review of the clinical record revealed R142 was admitted into the facility on 2/19/25 with diagnoses that included: nondisplaced posterior arch fracture of first cervical vertebra, Huntington's disease, unspecified injury of head, contusion of right hand, and unspecified displaced fracture of second cervical vertebra. According to the Minimum Data Set (MDS) assessment dated 2/25/25, R142 had intact cognition and was dependent on staff for most activities of daily living (ADLs). R144 On 3/4/25 at 10:09 AM, R144 (roommate of R142) was observed laying in bed with an ice pack to their left hip area. When asked about whether they had any concerns, R144 reported their only concern was the call lights were not working. They further reported they were given a bell and pointed to the bell on their bedside table. The bell was observed to			

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	be a small (hotel-style) bell in which the top was pressed and made a ting-like noise. R144 also reported they were worried that with their doors having to be shut because of the flu outbreak, the staff weren't able to hear the bell. When asked if they experienced anything like that since they were given the bell to use, R144 reported yesterday they had to wait a long time (over a half hour) and frequently used the bell for their roommate's need for help as well. At that time, R144 was requested to activate both the call light and the bell to see about staff's response. No staff responded after about five minutes. The resident further stated they had already done that for their roommate before this surveyor entered the room and they were still waiting without any response from facility staff. Review of the clinical record revealed R144 was admitted into the facility on 2/21/25 with diagnoses that included: fracture of unspecified part of neck of left femur. According to the MDS assessment dated 2/27/25, R144 had intact cognition and required partial/moderate assistance with most ADLs. R143 On 3/4/25 at 9:54 AM, observation of R143's room revealed they were in a room that was at the end of the hallway. There was a sign on the door that requested staff left the door			

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	open. During this time, the wifi connection on this surveyor's laptop computer stopped functioning a few doors away from R143's room. The connection didn't resume until this surveyor returned to the nursing station (closer to the center of the second floor). On 3/4/25 at 12:15 PM, the door to R143's room was observed closed. At that time, an interview was conducted with R143. When asked about the sign on the door requesting to keep it open, R143 reported that was because their call lights on the bed don't work. "I'm at the end of the hall and if the door is closed, you can't hear the bell." R143 was observed with a hotel-like bell on their bedside table. The resident further reported Maintenance had been in several times to check but the call light still doesn't work. They further reported the other day, they had been ringing their bell off and on and staff did not respond. Review of the clinical record revealed R143 was admitted into the facility on 2/17/25 with diagnoses that included: acute respiratory failure with hypoxia, obstructive sleep apnea, chronic kidney disease stage 3b, and influenza due to other identified influenza virus with other respiratory manifestations. According to the MDS assessment dated 2/23/25, R143 had intact cognition and required assistance with most activities of daily living. R344			

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	During an observation completed on 3/4/25 at approximately 11:10 AM, R344 was observed sitting in their wheelchair. R344 was wearing a sling on their right arm. R344 had a hotel-like bell on their table. R344 was queried about the stay at the facility and staff assistance. R344 reported that they had to wait longer for staff assistance when they called for help. When queried about the call light in the room and bathroom. R344 reported that they were not sure if the lights worked properly outside and/or if the staff were not checking. They added that the call bell on the table was not loud enough and while they were in the bathroom they were asking the staff members to leave the bathroom door open so they could "yell" for help. When queried if there were any pattern with the long wait times such as certain days, times etc., R344 added that it was throughout the day, they felt it was more during the shift change. Anonymous Resident (AR) During an observation completed for AR on 3/5/25 at approximately 9:05 AM. AR was observed in their bed and they had a tracheostomy (an opening surgically created through the neck into the trachea/windpipe to allow air to fill the lungs). AR also had a hotel-like call bell on their table. AR was communicating by typing their responses on their cell phone. When queried about their care at the facility and staff assistance, AR			

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	reported that they had to wait longer when they called for assistance. They reported that with their condition (with tracheostomy) it was important they received timely assistance. On 3/4/25 at 12:15 PM, an interview was conducted with Certified Nursing Assistant (CNA 'E'). When asked about their assignment, they reported they were working with CNA 'F' on the second-floor north unit and further reported they were from an agency. When asked about the call light system and how they were notified of a resident needing help, CNA 'E' reported there was a sound on the page monitor (box at second floor nursing alcove). When asked if they utilized a pager, they reported when they were here the last time, they got one then, but they did not today. They further reported this was only their second time working at the facility and the last time they worked, they were on the first floor. On 3/4/25 at 12:23 PM, an interview was conducted with CNA 'F'. When asked about the facility's call light system and how they became aware of a resident needing assistance, CNA 'F' reported there was a musical alert and pointed to a small black box at the nursing alcove. CNA 'F' then pressed a button to show the most recent alert showed room 254 alerted at "2:48 AM" and the current time showed as "2:49 AM" and a date of "11/16/10".			

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	When asked if they were to also utilize a pager, CNA 'F' reported they were, but confirmed they were not. CNA 'F' then opened a drawer at the nursing alcove and retrieved a pager but reported it didn't work. When asked about the wrong date/time on the call light response box, CNA 'F' reported if you set it to the correct time/date, it will revert back the next day. When asked how they were able to know if someone else turned the light off, or how long it took to respond, CNA 'F' reported they were not sure. When asked about the use of the hotel-like bells, CNA 'F' reported those were difficult to hear when the doors were closed. They further reported the call light system does not work consistently and frequently looses wifi signal. On 3/5/25 at 8:50 AM, an interview was conducted with the Director of Nursing (DON) and the Assistant Administrator (AA 'A'). When asked about the facility's call light system, both AA 'A' and the DON reported they were aware the system didn't function at times and if the button wasn't held down long enough it might not activate and reported the facility had bids on a new system. The DON confirmed residents were given an additional metal bell to ring. When informed of the concerns identified with residents and observations from 3/4/25 of the metal bell not being audible when doors to the rooms were closed due to the			

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	current flu outbreak, concerns from residents, and interviews with staff not having all components of a fully functioning call light system, the DON confirmed the pagers were to be utilized as part of that system and was not aware the call alert box on the nursing alcove had any concerns with incorrect dates/times. On 3/5/25 at 1:17 PM, AA 'A' reported they recently signed a contract to install a new call light system and the target date to finish the installation was at the end of this month on the 31st. Review of the documentation provided directed the facility "To place an order, sign quote and return with payment information ..." This quote was signed by facility staff and dated "3-5-2025". On 3/5/25 at 1:45 PM, AA 'A' was asked if the facility had any documentation of discussion or quotes obtained prior to 3/5/25 (after the survey team identified a concern). On 3/5/25 at 2:24 PM, AA 'A' reported they had been in discussion about the call light system verbally and also had emails of quotes from other vendors. On 3/5/25 at 2:31 PM, review of the additional documentation provided by AA 'A' revealed one quote from "5/22/2024". On 3/6/25 at 9:15 AM, an interview was conducted with the Maintenance Director (Staff 'H'). When asked about how the facility			

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	monitored their call light system to ensure it was functioning properly, Staff 'H' stated when there was a complaint with call lights not working they would then check the batteries which were in the box where the call light went into the wall in the resident rooms. Staff 'H' reported there was no light in the hallway, or in the rooms and bathrooms. Staff 'H' further reported their system was not hard-wired, but was wireless and dependent upon the wifi signal. They reported the transmitter was located on the first-floor top of the ceiling and at times the wifi signal would cut out (not function) due to signal loss and sometimes was interfered. Staff 'H' reported at times, when the wifi signal cut out, it would start again in a few minutes. When asked to confirm if they did any room audits to ensure the call lights were functional, Staff 'H' reported they did not, they waited for complaints. Staff 'H' further reported the system was set up to show an alert on the monitor at the nursing desk if there was a low battery or the system wasn't working. When asked if the staff should be using pagers as part of the call light system, Staff 'H' reported they should and there was also a small junction box at the nursing desk in the hallway that looked like a radio that staff could see which rooms were going off. When asked about the incorrect dates/times visible on the small junction box, Staff 'H' reported they were not aware of any concerns like that but would check it out and			

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	follow-up. There was no additional follow-up by the end of the survey. Review of the specific call light system documentation provided by the facility dated "October 2013" documented, in part: "...Testing Personal Help Buttons (PHBs) is an important part of ensuring that residents are completely protected. Not only does it guarantee button operation, but, more important, it reminds the resident of the crucial and convenient part of the CarePoint safety system. NOTE: [Specific Name of System] recommends that communities test PHBs monthly and supplement these tests with a program to ensure that residents remember them and know how to use them...System Setup...SmartCare makes a sound at every new alert...If a Network Monitoring Station is disconnected from the network for any period of time, it may be necessary to re-sync the display...SmartCare stores information in Microsoft Access database files..." This documentation further identified the system was complete when pagers were utilized. According to the facility's policy titled, "Call Lights: Accessibility and Timely Response" dated January 2025: "...The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for			

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	assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response...All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light...Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied...Ensure the call system alerts staff members directly or goes to a centralized staff work area...All staff members who see or hear an activated call light are responsible for responding..."			