STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235298	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FATHER MURRAY, A VILLA CENTER	8444 ENGLEMAN CENTER LINE, MI 48015

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0554 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility Interdisciplinary team (IDT) failed to assess one (#298) of one sampled resident for self-administration of medications, resulting in medication being taken without staff present. Findings include: On 3/03/20 at 9:07 AM, during the initial tour Resident #298 was observed holding a nebulizer to their mouth. Staff was not present in the room during the time of this observation. On 3/03/20 at 9:08 AM, Nurse H was asked if Resident #298 was assessed to self-administer medication. Nurse H stated, No, (Resident #298) is not. On 3/3/20 at 9:12 AM, an unidentified Nurse went into Resident #298's room and was overheard to say, It's all done? and was observed to remove the nebulizer from the resident. A review of Resident #298's medical record revealed, physician's orders [REDACTED]. Further review of Resident #298's medical record revealed, Resident #298 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #298's Minimum data Set assessment dated , 2/26/20, noted an intact cognition and total dependence of staff for activities of daily living. Resident #298's medical record did not reveal an assessment or care plan for self-administration of medication. A review of the facility's policy titled, Preparation and General Guidelines, Medication Administration-General Guidelines, dated (NAME)2018, noted, Policy: In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescribes order to self-administer .
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure resident clothing and personal items were unpacked and/or delivered in a timely manner for two residents (R40, R248) of three reviewed for a comfortable homelike environment resulting in dissatisfaction with the environment provided and feeling ignored. Findings include: R248 On 03/03/20 at 10:47 AM, R248 was observed to be in bed. A large clear 3/4 full garbage bag which had food, books and some clothing was on an over bed table in a far corner on the left side of the room. A second large clear garbage bag was filled with various clothing items and had been left on a chair in the corner of the room to the right side of and behind the resident. In the wardrobe/closet a third large clear garbage bag of clothes was observed. Multiple clothing items on hangers were covered with another clear plastic bag. R248 was asked about concerns at the facility and expressed frustration as their clothing items had been placed into plastic bags, brought into the room and left as observed. R248 further noted that they had gone out to the hospital and returned to their current room five days before having been placed on isolation and had not been out of bed because the facility had not brought their wheelchair from their previous room. A wheelchair for the resident was not observed in the room or outside the door. R248 also noted they had a lock on their closet which was now missing and expressed concern related possible missing items because they had not been able to go through the items in the bags. On 03/04/20 at 5:19PM, R248 was observed again to be in bed all day. The large clear garbage bag of books, food and other items had been moved to an over bed table on the left side of the room in front of the window. The other large, clear garbage bag of clothes remained on a chair in the corner. A wheelchair was not observed to be in the room. On 03/05/20 at 8:41 AM, R248 was observed to be in bed. Their personal items remained in the large clear garbage bags and unsorted for R248. The bags of books and food items now rested on the floor of the room to the left side of R248's bed. The other items remained as before. A large black shoulder bag was observed on the floor. The resident reported personal papers and stationary items to be in the bag. A wheelchair was observed in the room. R248 reported they had asked to get up after breakfast but was still waiting for some oatmeal. A review of the clinical record for R248 revealed and admission into the facility on [DATE] and a readmission into the facility 02/27/20. [DIAGNOSES REDACTED]. An Adult Failure to Thrive [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] indicated intact cognition and the need for extensive assist of two persons for bed mobility, transfer, toilet use, dressing, hygiene and bathing. R40 On 03/03/20 at 1:10 PM and on 03/05/20 at 10:10 AM, R40 verbalized concerns related to return of belongings from a stay at a prior facility. R40 reported they had been at the current facility since December (2019) and had only just received the rest of their belongings. On observation, a bag containing some personal items and clothes rested on the floor near the foot of the bed on the right side. On 03/05/20, R40 continued and stated, No one ever hung up my clothes and no one asked to get me help to look through my stuff. It is all still in boxes in the closet. On observation of the inside of the closet, three stacked boxes were observed with no clothes placed on the shelves or hung up in the closet. The visible items included a pillow and some loose care supplies. R40 further reported they did not have a comfortable wheelchair to use and had been placed in a 'Geri-Chair' (padded recliner) and their power wheelchair was recently brought over but was not available to use. A wheelchair for R40 was not observed in the room or out in the hall. A review of the clinical record for R40 revealed and admission into the facility on [DATE]. [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] indicated an intact cognition and the need for extensive assist of one or two persons for bed mobility, transfer, toilet use, dressing, hygiene and bathing. On 03/05/20 at 9:22 AM, the concern for the belongings of R248 still in plastic bags after five days was discussed the Assistant Director of Nursing (ADON). The ADON indicated some concern and reported the belongings would be inventoried and reviewed with R248 and R248 would be assisted into their wheelchair if requested. The ADON was also asked about the belongings for R40 and acknowledged it had been a process which required the involvement of the Ombudsman to get the items back. The ADON also reported the power wheelchair had been placed downstairs while waiting for Therapy to evaluate R40 for their ability to use it and how the room configuration would have to be worked out so as to not infringe on the other resident's space. On 03/05/20 at 2:40 PM the Director of Nursing (DON) was asked about the expectation for putting belongings away after room transfer/admission to facility and for a home like environment and stated, The staff is to assist the patient with what they need depending on what they bring in. A review of the facility policy titled Resident Rights dated 11/28/2017 revealed: Purpose: It is the practice of this facility to provide for an environment in which residents may exercise their rights, each day. Our residents have certain rights and protections under Federal law. Our facility meets and provides these rights through care and related services at all times. Our facility will 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 right to a safe, clean, comfortable and home-like environment that allows independence as possible. The right to retain and use personal possessions.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**

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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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate an injury of unknown origin for one of one sampled resident (R#74) reviewed for investigation, resulting in the potential for undetected and unreported mistreatment or abuse. Findings include: A review of R#74's Minimum Data Set assessment revealed the resident was admitted into the facility on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was severely cognitively impaired and required staff supervision or limited assistance for activities of daily living. A review of R#74's medical record revealed the following: 12/28/2019 12:48 (PM) Health Status Note (nurses note) Note Text: Writer called to shower room for body assessment, noted multiple dark purple areas on upper left arm and two areas mid way on left arm, also noted left dark purple areas on left hip extending to posterior left thigh, right great toe also discolored, Resident denies pain at this time, Resident unable to recall any particulars D/T (due to) confusion, states I don't know what happened States the DR (doctor) ask me the same thing Resident able to ambulate without difficulties, No changes in mobility . 12/29/2019 13:36 (PM) Health Status Note (nurses note) Note Text: Resident .queried about discoloration to left thigh area and left posterior arm. Resident unable to recall what happened. Resident self transfers with use of cane, ambulates with steady gait . On 3/4/20 at 4:09 PM, the Nursing Home Administrator (NHA) was queried if there were any facility-reported incidents for R#74. The NHA indicated there were not any. On 3/5/20 at 9:42 AM, Unit Manager (UM) Nurse I was queried regarding R#74's injuries on 12/28/19. UM I indicated she had started her position in January 2020. UM I stated, Anything having to do with incidents would be from the Administrator. On 3/5/20 at 9:47 AM, the NHA was queried regarding an incident/investigation for R#74. The NHA stated, Let me ask the Director of Nursing (DON). She is pulling all of those. On 3/5/20 at 9:50 AM, the DON was queried regarding unexplained bruising noted in the resident's medical record on 12/28/19. The DON stated, I would expect an investigation into the bruising. At this time, the DON was asked to provide an incident/investigation for R#74's bruising on 12/28/19 for review. On 3/5/20 at 2:03 PM, the DON was queried regarding the investigation for R#74's injuries of unknown origin on 12/28/19. The DON provided an incident/accident (I/A) report that indicated five areas of discoloration on the resident's skin which were marked, Unknown origin. The I/A noted, Is there any reason to believe this event could constitute an allegation of abuse: No. When queried regarding the investigation into the injuries as well as the explanation for the injuries and why it was believed to not be abuse, the DON stated, I'm trying to think. I have to look it up. I need to check upstairs to find the investigation. The DON was asked to provide the investigation into/explanation of the injuries of unknown origin for review. No investigation into or explanation of R#74's injuries noted on 12/28/19 were received prior to survey exit. A review of the facility's policy/procedure titled, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, dated 11/28/17, revealed, Abuse Policy Requirements: It is the policy of this facility that reports of abuse (.including injuries of unknown source .) are promptly and thoroughly investigated. The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root case investigation and analysis will be completed. The information gathered is given to administration .Investigation of Injuries of Unknown Origin or Suspicious Injuries: must be immediately investigated to rule out abuse: i. injuries include but are not limited to, bruising of the inner thigh, chest, face, and breast, bruises of an unusual size, multiple unexplained bruises, and/or bruising in an area not typically vulnerable to trauma.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a baseline care plans for falls, pressure ulcers, smoking and isolation for two sampled residents (R139 and R448) of four reviewed for baseline care plans resulting in the potential for unmet care needs. Findings include: On 03/03/2020 at 12:01 PM, R448 was observed in a high positioned bed, and confused. A family member was at the bedside, and were was asked about R448 and any concerns they've had about the facility. Family Member G explained that R448 was at the facility because there were no isolation rooms at the facility's, sister facility which is where they would prefer R448 to stay as they believe that there is a difference in the level of care. A review of R448's medical record revealed that they were admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review revealed that the resident required extensive assistance with Activities of Daily Living, and was currently in isolation for Extended Spectrum Beta-Lactamase (ESBL, a bacterial infection). The medical record also revealed that the resident was admitted with pressure ulcers, and was considered high risk for falls. R448's care plan was reviewed and was observed as incomplete for falls, and indicated the following: The resident is (SPECIFY) risk for falls r/t (related to). Goals: The resident will be free of minor injury. Under Interventions, it was left blank. There was no focus, goals or interventions addressing the resident's isolation precautions or pressure ulcers. On 3/05/2020 at 2:46 PM, the Director of Nursing (DON) was asked about R448's baseline care plan failing to address falls, pressure ulcers and isolation. The DON reviewed the baseline care plan and acknowledged that it did not address those care areas and stated, It should be in the care plan. My expectation is that there will be care plans in place. R#139 A review of R#139's medical record revealed an admission smoking assessment done on 1/20/20, indicating that the resident smoked cigarettes and was deemed a safe smoker. A review of R#139's Minimum Data Set assessment dated dated 1/27/20 revealed that the resident was admitted into the facility on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was cognitively intact and was mostly independent with activities of daily living. Further review of R#139's medical record revealed the following: 2/11/2020 01:46 (1:46 AM) Behavior Narrative Note: Writer smelled smoke inside bathroom, and asking resident did (they) smoke inside of bathroom, resident denied and was not willing to provide proof .Resident presented with risk factors associated with smoking inside of facility, and writer verbalized facility policy . 2/11/2020 04:33 (4:33 AM) (Written by Nurse F) Behavior Narrative Note: Resident approached writer, and admitted that (they were) smoking in bathroom, handed over lighter that was on (them), and agreed to follow policy further more. Resident was agreeable to give lighter to nursing, which is locked up until further notice . A Smoking Risk Evaluation was done for R#139 again on 2/11/20 and deemed the resident an unsafe smoker. On 3/4/20 at 12:37 PM, R#139 was asked if they recalled any instances where they had been smoking in their room. The resident stated, No. When asked if they recalled an incident on 2/11/20 involving smoking in the facility, the resident stated, I don't know, and provided no further information. On 3/4/20 at 2:13 PM, Nurse F was interviewed and queried regarding R#139 smoking in their room. Nurse F indicated she did not know how R#139 obtained the smoking materials to be smoking in their room on 2/11/20. Nurse F was queried regarding the incident and started, It was on midnight shift. I definitely smelled smoke in there. When I went in there and asked if they were smoking, (R#139) immediately said no and ignored me. Around 3 or 4 AM they came out and handed me their lighter. Nurse F stated the resident admitted they had been smoking but denied having any other smoking items other than the lighter. A review of R#139's care plan revealed: The resident is a smoker. Resident will smoke with supervision as appropriate through review date. Residents smoking materials to be secured by facility staff. Instruct resident about the facility policy on smoking: locations, times, safety concerns. Date initiated 2/12/20. No smoking care plan was noted to be in R#139's record prior to 2/12/20. On 3/5/20 at 9:50 AM, the Director of Nursing (DON) was queried regarding R#139 smoking in their room on 2/11/20 and the resident's care plan. When asked what the facility procedure is for care planning for smokers upon admission into the facility, the DON stated, When they come in if they are a smoker then we would care plan under smoking. I thought the resident initially denied (smoking). The DON reviewed the medical record and stated, Oh, nevermind, the (admission) evaluation says (they do) smoke cigarettes, it triggered the progress note. When asked if she would expect a smoking care plan to be in place for R#139 prior to 2/12/20, the DON stated, Yes, I would've expected to see a smoking care plan sooner. A review of the facility's policy/procedure titled, Careplan Standard Guideline, dated 11/28/17 revealed, It is the practice of this facility to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care. The baseline careplan will .include the minimum healthcare information necessary to properly care for a resident . A review of the facility's policy/procedure titled, Smoking Guideline, dated 11/28/17 revealed, Interventions for safe smoking .will be included in the resident individualized smoking care plan.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with**

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) **timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify, evaluate, and implement a comprehensive care plan, to address the risks associated with the care of a resident with a known history of intravenous (IV) drug use for one resident (R39) of two reviewed for care plans, resulting in R39 leaving the facility with a PICC (Peripherally Inserted Central Catheter) line placement, on multiple leave of absences (LOA), not returning timely and with suspicions of drug use, and the potential for unmet care needs. Findings include: On 03/03/20 at 9:46 AM, R39 was observed in their room asleep. A PICC line, (used for long-term IV medication treatment) was observed in their right upper arm upper. R39 was asked why they were receiving IV treatment. R39 said, I have a brain fungus. A review of R39's medical record revealed that the resident was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review noted that the resident required extensive assistance with activities of daily living. A review of R39's care plan did not address the history of IV substance abuse or alcohol dependency. A review of the progress notes in the medical record noted the following regarding R39 not returning timely from LOA: [DATE] at 7:40 pm. Resident returned from LOA with PICC line protruding. IV medications where not administered. awaiting confirmation of PICC line placement. Physician will be in to examine resident 1/9/2020. 2/7/2020 07:31: Upon coming on to shift writer was made aware resident signed themselves out loa, resident stated they would be gone 30/45 mins. resident had not returned by 1030 unit manager, mid night supervisor, and physician made aware. physician stated that resident did not have permission to go LOA and it is getting out of hand that (R39) is not receiving medication. resident contacted at 1045 and resident stated (they) would be to the facility in five mins. resident did not arrive to the facility till 1155 (11:55 PM). A review of the medical record dated 2/5/20 at 12:20 AM, written by Licensed practical Nurse (LPN L) noted the following: Housekeeper notified writer that bottle of liquor found under bed. notified administrator and CM will cont (continue)to monitor. Res (Resident) (R39) educated on the risks of drinking alcohol and taking prescription medication. Res (R39) states that (they) understands. A review of the medical record dated [DATE]20 at 10:20 AM, written by Social Worker M noted the following: Writer, Admin (Administrator), and unit manager met with resident regarding the alcohol bottle that was found; Resident (R39) stated (their) visitor brought the alcohol inside the building. Admin (Administrator) stated to resident if that happens again, we (staff) has the right to search (their) room with (them) present in the room and a 30 day notice will be issued to resident (R39). Resident stated (they) had no clue about the alcohol in (their) room but (they) will inform (their) visitor that it is not allowed in the building. A review of the facilities Leave of Absence log book noted a time and date to leave R39 was allowed to leave the facility on the following dates (the majority of the log was not complete): [DATE]-left a 7:40 (am or pm) date and time incomplete 1/10/2020- left at 8 (am or pm) date and time incomplete 1/20/2020-left at 7 (am or pm) returned at 8:10 (am or pm) date and time incomplete 1/30/2020-left at 2:27pm, returned at 6:38pm (signature of person accepting responsibility completed, name unable to be deciphered, all other dates signed out states, self) 2/3/2020-Left at 8:38 (am or pm), returned at 9:47; Left at 8:10 (am or pm), returned at 8:45 (am or pm) date and time incomplete [DATE]20-Left at 6:54 (am or pm), returned 10 (am or pm) date and time incomplete [DATE]20 Left 2:03 (am or pm), returned 2/7/2020 at 2:42 (am or pm) date and time incomplete On 3/4/20 at 2:15 PM, the Director of Nursing (DON) was interviewed and queried about R39's LOA with access to their IV line. The DON stated, (R39 is alert and oriented. (R39) makes (their) own decisions. We can't keep (R39) from going on a leave of absence. (They) have a right to go. The DON was queried if it was safe to allow R39 to go on a leave of absence with access to an open IV line, with a known history of IV drug abuse. The DON stated, That's why it's called a history. (R39) has not used in a while. (R39) does not ask for pain medication. (R39) is very pleasant and a model resident. I wish all the residents were like (R39). The DON was asked if they knew the last time R39 used IV drugs. The DON, (R39's) been clean (stopped substance abuse) for a while. The DON did not provide a last time of drug use for R39 or any education that was provided to R39 regarding the care of the PICC while on LOAs. On 3/4/20 at 2:40 PM, R39 was interviewed and asked about their LOA. R39 said, I would go see my family when I go on a leave. I can't go anymore because they said I came back late. R39 was queried regarding their substance abuse and the last time they used drugs in their IV. R39 said, I last used (drugs in the IV) this past September (2019). R39 continued and explained, in September after that time they got sick, woke up and could not walk or get out of bed or move. That they been in the hospital ever since. On 3/5/20 at 10:11 AM, Nurse L was contacted via phone and queried about R39's LOA on 2/7/20. Nurse L said, The report that I got from the prior nurse was that the resident (R39) did not come back on time from the LOA. (R39) missed (their) antibiotic. I once told (R39) that (they) could not go on a LOA. I knew about the IV drug history. I contacted the DON and Administrator about (R39) leaving and having a PICC line. I discussed with the Nurse Practitioner J (NP) about (R39) leaving with a PICC line. The NP J was concerned about (R39) leaving with a PICC line and the drug abuse history .I was concerned about (R39) leaving (alone). On 3/5/20 at 10:43 AM, Nurse R was called and queried about R39. Nurse R stated, According to our DON and Administrator, residents have a right to go on LOA if they are alert and oriented .I told the DON and Administrator that I had concerns when (R39) came back in January with the PICC dislodged. I knew (R39) had a drug history .We have the drug testing kits and we have to call the doctor for an order .The DON said that the resident has a right to make bad decisions. On 3/5/20 at 10:53AM, NP J was interviewed and queried about R39 substance abuse and LOA with the IV access. NP J, I agree 5,000% that (R39) should not go on a LOA due to (their) drug history and a PICC line. I tried to talk to the Administrator and the DON, but I was overturned by them. This is the only facility that I go to that allow residents with PICC lines to go on LOA. There's a risk. This facility does not have a policy for LOA. On 3/5/20 at 11:41 AM, Social Worker M was interviewed and questioned about the care plan, and psychiatric assessment criteria. Social Worker M said, I thought there was a Psych note in the medical record. The Behavioral Health log does not have (R39) as seeing behavioral health. Social Worker M was asked how they go about assessing residents for psychiatric evaluations. Social Worker M said, I usually look at their (resident's) history. If they have a mental or substance abuse history, I asked them if they want to speak with psych. It does not look like (R39) was evaluated for behavioral health. I was on a leave of absence when (R39) was admitted . I know some policies changed since then. On 3/5/20 at 2:48 PM, the DON was interviewed and queried about R39 patient centered care plan and psychiatric assessment upon admission. The DON said, We only care plan active diagnoses. Drug abuse is only (R39's) history. (R39) has never exhibited drug seeking behaviors. (R39) never asks for additional pain medications. There is no reason to add the IV drug abuse into the care plan. The DON was asked if R39 should have been offered behavioral health and the DON said, There is not a reason for (R39) to speak with behavioral health. The DON was informed the Social Worker M usually evaluates and offers behavioral health to residents with substance abuse history. The DON said, I don't know why (Social Worker M) would say something like that. (R39) does not need behavioral health. The DON was queried if a resident with a recent craniotomy, brain fungus, decreased mobility, and a child would be evaluated and offered behavioral health. The DON said, I'm sure that was discussed in the admission packet. (R39) has never asked to see psych. The previous day, the DON stated R39's LOAs were discontinued because one of the nurses stated R39 came back looking high. The DON was queried about stating being told that the resident looked high. The DON said, I miss-spoke. It was someone else. A review of the facility's policy Careplan Standard Guideline dated 11/28/17 noted the following: All resident/client will be evaluated for individual risk factors which may increase the chance of hospitalization .The resident care plan will incorporate risk factors identified in preadmission assessment, hospital records and admission, hospital records and admission evaluations, with changes in condition, reviewed and updated quarterly .The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to hold a timely care conference with an alert and oriented resident (R248) after readmission for one sampled resident of one reviewed for care conference concerns resulting in resident confusion as to diagnoses, reason for isolation and unmet care needs. Findings include: On 03/03/20 at 10:47 AM and 3:11 PM, R248 was asked about care concerns at the facility. R248 shook their head and reported they were not included

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) in the last care conference as someone just left a copy of physician orders on the table and must have done it while they were sleeping because it was there when they woke up. R248 reported they normally attend their care conferences. R248 further reported, they had questions about unfamiliar [DIAGNOSES REDACTED]. After a doctor had come in to talk with them, R248 reported they didn't understand what the plan of care was or why it was changed. R248 also confirmed a history of constipation. A review of the clinical record for R248 revealed and admission into the facility on [DATE] and a readmission into the facility 02/27/20. [DIAGNOSES REDACTED]. An Adult Failure to Thrive [DIAGNOSES REDACTED]. The last bowel movement documented per the electronic Tasks was on [DATE]. discharge documents indicate chronic constipation. The Minimum Data Set (MDS) assessment dated [DATE] indicated intact cognition and the need for extensive assist of two persons for bed mobility, transfer, toilet use, dressing, hygiene and bathing. On 03/05/20 at 9:22 AM, The Assistant Director of Nursing (ADON) was asked about a care plan meeting for R248 and upon review of R248's record reported R248 returned on 02/27/20 and a care management note had been entered but a care conference with the resident had not been held. When asked when a a care conference should be set up the ADON reported it usually should be within 48 hours after admission or readmission. When asked if R248 participates in the care planning normally, the ADON stated, Yes and that R248 was very alert and oriented. On 03/05/20 at 2:40 PM, the Director of Nursing was asked about the expectation on a time frame for a cognitively intact resident's involvement for care conferences on admission/readmission to facility. I have to double check, I'll get back to you. They do have the right to be involved in care conferences and discharge planning. We encourage it. A review of the facility policy titled Resident Rights dated 11/28/2017 revealed: Purpose: It is the practice of this facility to provide for an environment in which residents may exercise their rights, each day. Our residents have certain rights and protections under Federal law. Our facility meets and provides these rights through care and related services at all times. Planning and Implementing Care: Residents and/or resident representatives have the right to be fully informed of the medical condition in a language you they can understand, and to participate in your person-centered care planning and treatment, including the type of caregiver who provides services. Residents have the right to refuse and/or discontinue medications and treatments and to be fully informed of the risks and benefits, and to formulate an advanced directive, an informed decision. The right to be informed, in advance of changes to the plan of care. The right to receive the services and /or items included in the plan of care. The right to see the care plan including the right to sign after significant changes to the plan of care.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide for timely Activities of Daily Living (ADL) care including showers and incontinence care for seven (R7, R40, R73, R103, R168, R248, R449) residents reviewed for ADL care, resulting in dissatisfaction with the quality of care and unmet care needs. Findings include R40 On 03/03/20 at 1:10 PM and on 03/05/20 at 10:10 AM, R40 verbalized concerns related to showers not given. Shower days are reported as Saturday afternoon and Wednesday mornings. R40 reported that they were told the batteries for the shower gurney lift were dead and there were no back ups. R40 commented that the staff wants to give bed baths because they are easier and don't have to get them up. A review of the clinical record for R40 revealed an admission into the facility on [DATE]. [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] indicated an intact cognition and the need for extensive assist of one or two persons for bed mobility, transfer, toilet use, dressing, hygiene and bathing. R103 On 03/03/20 at 1:19 PM, R103 (roommate of R40) was asked about care at the facility and said, Showers are never quite given on time, like the one I missed yesterday. If they could get a team to just give showers on time. It's just part of being human. We should not have to chase them around to get a shower. On the weekend Saturday, Sunday and Monday they are understaffed. R103 noted showers are scheduled to be given on Monday mornings and Thursday afternoons. On 03/05/20 at 10:08 AM, R103 confirmed no bed bath or shower was given on Monday 03/02/20. A review of the clinical record for R103 revealed an admission into the facility on [DATE]. [DIAGNOSES REDACTED]. The MDS dated [DATE] revealed intact cognition and the need for the total assist of one person for bathing and limited assist of one for hygiene which includes combing the hair and shaving. A review of the bathing task documentation for the last thirty days revealed no shower was documented as given from 02/06/20 until 02/27/20 for six missed showers. The last bed bath or shower given was on 03/02/20 as a bed bath which R103 reported did not occur and who prefers a shower. R248 On 03/03/20 at 10:47 AM, R248 reported on query about daily care needs that they were not routinely assisted. R248 reported they had missed dinner as no one brought in a tray and had to settle for some wilted salad. R248 also reported they are not helped to the restroom when up in the wheelchair or to use the bed pan while in bed and has to hold it all day. When R248 asked to get up into their wheelchair the day before, R248 reported being told by the nurse that no batteries were available. A review of the shower schedule for R248 indicated R248's shower days are Tuesday morning and Friday afternoon. A review of the clinical record for R248 revealed an admission into the facility on [DATE] and a readmission into the facility 02/27/20. [DIAGNOSES REDACTED]. No bowel movement was documented per the electronic 'Tasks' since R248 returned to facility on 02/27/20. The Minimum Data Set (MDS) assessment dated [DATE] revealed intact cognition and the need for extensive assist of two persons for bed mobility, transfer, toilet use, dressing, hygiene and bathing. A review of the bathing task documentation for the last thirty days revealed the last bed bath or shower given was on 02/28/20. R7 On 03/03/20 at 10:37 AM, R7 was asked about care at the facility and reported there had been times when they were missed two or three times for brief changes and had missed showers a couple of times. When asked if they are offered or set up for brushing their teeth R7 replied the staff did not. R7 could not say why but thought it could be related to therapy, sometimes it is the weekend and other times things are just a little slow. R7 reported they were hard of hearing and were waiting for their hearing aids to be fixed. R7 was observed to have right sided weakness and reported it was a little hard to move in bed sometimes. A review of the clinical record for R7 revealed an admission into facility on 11/14/19 and a re-admission into the facility on [DATE]. [DIAGNOSES REDACTED]. The MDS dated [DATE] revealed the need for extensive assistance of one or two persons for bed mobility, transfer, locomotion, dressing, toilet use, hygiene (includes brushing teeth) and bathing, Functional Range of Motion was documented as a one for impairment to one side. A review of the bathing task documentation for the last thirty days revealed a bed bath was documented as given on 02/18/20 and 02/25/20 for one missed shower/bed bath. No other bed baths showers were not documented as given. On 03/05/20 at 9:22 AM, The Assistant Director of Nursing (ADON) was asked about showers not received for R40 and R103 and documentation of a bed bath for R103 when R103 prefers a shower and had reported neither was received. The ADON said they would check into it. The ADON was asked about the excuse of there not being batteries for the lifts and reported there were extra batteries in the utility rooms and that they could always get one from another floor. R449 On 03/03/2020 at 10:35 AM, R449 was asked about their stay in the facility and explained that there is a CNA (Certified Nursing Assistant) that is very snotty. R449 explained that they use a bed pan as they are unable to stand, and indicated that after done using the bed pan, the CNAs fail to wipe them, and then proceeds to place a clean brief on them indicating that R449 is not a heavy wetter. R73 On 03/03/2020 at 11:19 AM, R73 was asked about the care they have been receiving in the facility and explained that they were currently awaiting to get a shower. They further stated, that they have had incidents of needing to go to the bathroom and having to wait. R73 stated that they had been up since 6:30 AM this morning, and needed to take a bowel movement, but was told to wait until their shower time. R73 was currently still waiting. R73 was asked how that made them feel, and stated, Uncomfortable. R73 further explained that they have also been left wet in the bed due to not having anyone come to get them to the bathroom. Resident #168 On 3/3/20 at 9:17 AM, R#168 was observed in the dining room eating breakfast. The resident had on a white t-shirt underneath a plaid button down shirt, and brown pants. On 3/3/20 at 9:40 AM R#168 was observed in their wheelchair in the hallway. Their wheelchair cushion was observed to be soiled with food. The resident's white shirt had a red stain on and their brown pants were soiled with food particles and a visible stain. On 3/3/20 at 11:37 AM, R#168 was observed in the hallway, wearing the same soiled clothing. On 3/3/20 at 12:36 PM, R#168 was observed in the dining room eating lunch. The resident was wearing the same soiled clothing, and particles of their lunch food were noted to be dropping on their pants. On 3/3/20 at 3:11 PM, R#168 was observed in another dining room participating in activity with a group of

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) residents. The resident was observed to still be wearing the same soiled clothing as previously observed. On 3/4/20 at 8:56 AM, R#168 was observed in the dining room eating breakfast. The resident had on a button down shirt and lighter pants. On 3/4/20 at 9:29 AM, R#168 was observed sitting in the hallway. The resident's pants were soiled with food, and there were visible stains on the button down shirt, including a red stain. On 3/4/20 at 12:30 PM, R#168 was observed in the dining room eating lunch. The resident was wearing the same soiled clothing. On 3/4/20 at 2:23 PM, R#168 was observed in their room. When queried regarding their clothing, the resident was unable to provide an answer. Certified Nursing Assistant (CNA) K entered the room and was queried about how often staff changes resident's clothing when it is soiled. CNA K stated, Oh, well that's why I came in here, and to lay (R#168) down. We normally change them immediately if we see that they mess their clothes after eating or anything. I'm going to lay (the resident) down now and I'll change them. On 3/5/20 at 3:00 PM, the Director of Nursing (DON) was queried regarding clothes changes when soiled with food. The DON stated, Per the resident's allowment after the meal time, they should be offered to change their clothes. Some are more resistant than others. A review of R#168's Minimum Data Set assessment dated [DATE] revealed the resident was most recently admitted to the facility on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was moderately cognitively impaired and required extensive assistance from staff for dressing and hygiene. A review of the facility's policy/procedure titled, Assisting a Person with Dressing, revealed, Clothing must be changed every time it becomes wet or soiled. A review of the facility policy titled Resident Rights dated 11/28/2017 revealed: Purpose: It is the practice of this facility to provide for an environment in which residents may exercise their rights, each day. Our residents have certain rights and protections under Federal law. Our facility meets and provides these rights through care and related services at all times. Our facility will 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 right to receive the services and /or items included in the plan of care. The right to be treated with respect and dignity.
F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow a physician's order and provide lab work for one sampled resident (R39) of one resident reviewed for laboratory services, resulting in delayed treatment, worsening in condition, the lack of coordinated care, and hospitalization . Findings include: On 03/03/20 at 9:46 AM, R39 was observed in their room asleep. A Peripherally Inserted Central Catheter line (PICC, used for long-term intravenous/IV medication treatment) was observed in their right upper arm. R39 was asked why they were receiving IV treatment. R39 said, I have a brain fungus. A review of R39's medical record revealed that the resident was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. R39's medical record also revealed that the resident had a history of [REDACTED]. Further review noted that the resident required extensive assistance with activities of daily living. Additional review of R39's medical record revealed that R39 was receiving [MEDICATION NAME] B IV (used for life-threatening fungal infections. A side effect of [MEDICATION NAME] B is low potassium). A review of the medical record noted that R39 had a potassium level of 3.3 (normal level 3.5-5.0). Nurse Practitioner J ordered a Repeat potassium draw on 2/7/20. The order was implemented into the electronic medical record on 2/3/20. Upon further record review, the potassium lab result dated 2/7/2020 was not found in the electronic medical record. Further review of R39's medical record revealed, a lab result dated, 2/17/20 at 11:13 (10 days after the2/7/20 potassium order) noted the following: Potassium 2.2 .ordered to give Kdur 40 meq (potassium replacement supplement). R39's vital signs were as follows: Blood pressure 124/64, heart rate 46 (normal range for adults is 60 to 100 beats per minute; Imbalance of chemicals in the blood, such as potassium can result in a low heart rate and/or cardic arrhythmia). R39 was sent to the hospital for monitoring. R39 was admitted to the hospital on [DATE], with a [DIAGNOSES REDACTED]. On admission to the hospital, R39's potassium level was found to be 2, with a heart rate of 51. R39 was discharged from the hospital on [DATE] and readmitted to the facility. On 3/5/20 at 8:23 AM, the Director of Nursing (DON) was interviewed and queried about the Physician's order for R39's potassium to be drawn on 2/7/20. The DON stated, The lab was not drawn on 2/7/20. On 3/5/20 at 12:18 PM, a request for the facilities policy for Physician's Orders was made. The requested policy was not received from the DON prior to leaving the facility.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to turn and reposition a one sampled resident (R169) of eight residents reviewed for pressure ulcers, resulting in the likelihood of the development of pressure ulcers and/or the worsening of existing pressure ulcers. Findings include: On 03/03/20 at 9:32 AM, R169 was observed sleeping in bed positioned to face the right side of the bed. R169 did not respond to knocking or greetings. An abrasion was observed on the right wrist and dressing on right elbow. On 03/03/20 at 12:52 PM, R169 was in bed facing the right with the head of the bed up being fed by a seated staff member. R169 was observed to be positioned facing right at 1:47 PM and 3:13 PM. On 03/04/20 at 4:37 PM, LPN A was asked if R169 had any pressure ulcers and stated, Yes. A skin assessment observation was conducted with LPN A. R169 was awakened by LPN A and informed of the procedure and positioned to face the left side of the bed. R169 moaned in pain. On R169's right buttock near the right hip, a dressing with an irregularly shaped shadow of bloody drainage roughly two inches round was observed. R169's coccyx (tailbone) area was red and excoriated. LPN A was asked when R169's pressure ulcer dressing was changed, LPN A pulled at the edge of the dressing and R169 began to moan in pain. LPN A stated, The wound care nurses, I don't know their names, take care of the pressure sore. The date on the dressing was 3/3/20. R169's arms were mottled and several small reddened areas were observed. The skin on R169's legs and feet was intact, but no heel or ankle protection was observed. LPN A then repositioned R169 for comfort. Upon leaving the room LPN A instructed Certified Nurses Aide (CNA B) to float R169's heels. On 03/04/20 at 4:49 PM, LPN A was asked about the facility's policy and procedure for turning and repositioning residents and stated, It should be done every two hours. Yesterday we had an aide that wasn't one of our regulars. I told them that if they needed any help to come to me. Staffing can be challenging sometimes. On 03/04/20 at 4:57 PM, CNA B was asked about the the facility's policy and procedure for turning and positioning residents and stated, This is not my usual assignment, but I check them every two hours and turn them every two hours if they need to be turned. Record review of R169 Electronic Health Record (EHR) revealed R169 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] revealed R169 had a Brief Interview for Mental Status (BIMS) score of 13/15 indicating little or no impairment of cognition and needed limited assistance with Activities of Daily Living (ADLs) including bed mobility. The facility's Roster/Matrix (list of residents and their health concerns) dated 3/3/20 listed one of R169's health concern in column five, Pressure Ulcer(s) was coded S indicating Deep Tissue Injury(DTI). R169's admission progress note dated 01/09/20 at 5:48 PM, revealed, The resident has skin integrity concerns .Right thigh (front) - long purplish color bruises, Right thigh (rear) - back of entire leg has a purplish bruise, Other (specify) -Buttocks- both fold reddened . No pressure ulcer or DTI was documented at the time of admission . A skin assessment dated [DATE] at 11:46 AM, revealed R169's .Right buttock open area. A WOUND ASSESSMENT DETAILS REPORT, Wound: Right Gluteal. Assessment Date: 2/25/2020 10:49 AM .Size (cm) (centimeters) 2.60 x 2.10 x 0.00 (L x W x D). Clinical Stage Partial Thickness A photograph of the wound shows a stage two open area (partial thickness skin loss) with slough (accumulation of dead skin tissue) covering most of the wound bed. More recent pressure ulcer measurements were not found. R169's care plan, Focus -The resident has actual impairment to skin integrity (SPECIFY location) r/t (related to) . Interventions/Tasks. -Evaluate and treat per physicians orders. (Nursing). The care plan had no goals listed and no other interventions. R169's Medication Assessment Record (MAR) indicated, Float heels while in bed every shift -Order Date- 01/10/2020 1656 (4:56 PM) and Allevyn Wound Pad (Wound Dressings) Apply to Right Gluteal topically every day shift every other day for Skin cleanse w/NS (normal saline)-Order Date- 01/21/2020 1802 (6:02 PM). On 03/05/20 at 2:22 PM, the Director of Nursing (DON) was asked about the facility's policy and procedure for turning and repositioning residents and stated, There is no policy on that, it's a standard of practice, and the standard is to turn them every two hours. Review of the facility's policy and procedure Skin Management Guideline dated, Effective Date: 11.28.17 revealed, Elevating heels: For residents that cannot turn and reposition themselves, and Specified turning and repositioning. The policy and procedure did not specify the turning and repositioning interval.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM),**

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) **limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide restorative nursing services (to help maintain range of motion and abilities) per therapy recommendation and/or provide splint application for three sampled residents (R#156, R#113 and R#40) of five reviewed for limited range of motion (ROM), resulting in the potential for functional decline and pain. Findings include: Resident #156 On 3/4/20 at 8:54 AM, R#156 was observed in bed, with their legs bent up toward their body. R#156 shouted, My legs! My legs hurt me! R#156's Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had impairment in both lower extremities upon admission. A review of R#156's MDS assessment dated [DATE] revealed the resident was most recently admitted into the facility on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was moderately cognitively impaired and required extensive assistance from staff for mobility, transfers, dressing, and hygiene. Further review of R#156's medical record revealed the following orders: Discontinue PT (Physical Therapy) due to highest practical level achieved, refer to RNP (Restorative Nursing Program), Active, 8/13/2019. Occupational Therapy: Discontinued due to highest practical level achieved, refer to RNP (effective 8/13/19). A review of R#156's progress notes revealed nothing under restorative services when searched. Further review of R#156's medical record did not reveal any documentation of RNP services provided to the resident in (NAME)2019. A request was made from the facility for R#156's restorative services documentation from 2019, however, the facility only provided restorative services documentation from February 2020. On 3/5/20 at 9:25 AM, Nurse E was asked to provide proof that R#156 received restorative services per order in (NAME)2019. Nurse E stated, Okay, I will get back with you. On 3/5/20 at 9:50 AM, the Director of Nursing (DON) was asked to provide documentation that R#156 received restorative services per order in (NAME)2019. The DON stated, Let me check and see. On 3/05/20 at 2:03 PM, the DON was queried regarding the requested documentation for RNP services for R#156 in (NAME)2019. The DON stated, Oh, I thought it was for October. I have therapy recommendations for it from (NAME)13, 2019. When asked to provide documentation that the resident received the services per recommendation, the DON stated, I'm going to look again, I'm pretty sure we had something in place. Documentation of R#156's RNP services in (NAME)2019 was not received prior to survey exit. A review of the facility's policy/procedure titled, Restorative Nursing Guideline, dated 10/1/2019, revealed, Residents identified requiring Restorative Nursing services demonstrate the clinical need for the intensity, complexity and focus of a structure program that is not typically provided in the course of a usual and customary nursing plan of care .CNAs(Certified Nurse Assistant), Restorative Nursing Staff and/or Activities staff enter minutes of daily participation in Point of Care (POC), Compliance in daily program completion is monitored by the RNPM or nurse designee, RNPM/designee will complete progress notes at a minimum frequency of monthly .restorative notes include the resident's response to treatment, progress toward goals, the clinical rationale to continue the program and the estimated time to achieve program goals. R113 On 03/03/20 at 9:00 AM, R113 was asked about care at the facility and was observed to have limited range of motion in the hands and the legs were flexed with the thighs around 90 degrees to the abdomen (as one would sit in a chair). No splints were observed to be in use. R113 revealed the facility staff reported the splints were lost when R113 went to the hospital. R113 reported they were helping and when asked if R113 felt the contractures were worse since not wearing the splints R113 stated, Yeah. R113 further reported they were wearing the leg braces every other day and tolerated them. The braces were observed on 03/05/20 to be in a plastic bag in the closet of R113. A review of the clinical record for R113 revealed an admission into the facility on [DATE]. [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] indicated intact cognition and the need for total assistance of one or two persons for bed mobility, transfer, toilet use, locomotion, dressing, hygiene and bathing. Functional Range of Motion was indicated as impairment to both sides. R40 On 03/03/20 at 1:10 PM and on 03/05/20 at 10:10 AM, R40 was asked about the splints in the drawer of the night stand and reported, My hands aren't much good to do any thing with. R40 also reported the mattress they were laying on was not comfortable and had a well in it that made it hard to move around. R40 was observed to be in bed, the head of the bed up 30-45 degrees and leaned over toward the right side of the bed. R40's fingers on their hands were curled toward the palms and did not flex or extend fully. Hand splints were noted in the drawer of the bedside night stand. R40 indicated they could not put them on without help from staff. A review of the clinical record for R40 revealed and admission into the facility on [DATE]. [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] indicated intact cognition and the need for extensive assist of one or two persons for bed mobility, transfer, toilet use, dressing, hygiene and bathing. A review of the facility Restorative Nursing Program Recommendations form from Therapy signed 02/11/20 indicated R40 was referred on 02/08/20 for restorative exercises and splinting. Bilateral upper extremities with weights was indicated and a right upper extremity resting hand splint. A review of the Therapy progress report indicated R40 had progressed from a max assist for bed mobility to a moderate assist and had increased bilateral lower extremity strength from a two to a three. On 03/05/20 at 2:14 PM, the Therapy Director was asked about R40 and noted splints should be in the room, restorative could and should remain active during therapy and confirmed R40 should have restorative. The Therapy Director further noted a gap in therapy related to the need for authorization for more visits and the Assistant Director of Nursing (ADON) said residents can be on restorative continuously. The Therapy Director reported R113 was also referred to the Restorative Nursing Program (RNP). A Therapy note dated 01/17/20 revealed, Patient does not require skilled PT (physical therapy) at this time and referred to RNP for continue(d) care. Is skilled therapy needed to address impairment = no, patient has resting hand splint, knee extension splint and hip abduction splint. On 03/05/20 at 2:40 PM, the DON was asked about the expectation for providing restorative care and applying splints and stated, Per resident comfort. We have the CNAs do Restorative Care everyday of the week from ROM to Walk to dine and the dining process. The splints, depending on the order can be removed after 4 hours. If refused it's documented and the appropriate disciplines are notified.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain a tube feeding pole in a sanitary manner for one sample resident (#299) of two reviewed for tube feeding, resulting an unsanitary environment and the potential of the spread of infection. Findings include: On 3/03/20 at 9:00 AM, Resident #299 was observed in bed sleeping. Observed next to Resident #299's bed was a tube feeding pole and oxygen concentrator that had a buildup of dried tube feeding formula. On 3/05/20 at 3:00 PM, Resident #299 was observed in bed. Observed next to Resident #299's tube feeding pole, was the same buildup of dried tube feeding formula. A review of Resident #299's medical record revealed, Resident #299 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/05/20 at 3:33 PM, the Administrator was asked the facility's expectations for cleaning tube feeding formula off the poles. The Administrator stated, If the Nurses see it visibly soiled, they can wipe it, but housekeeping is responsible for cleaning it. A review of the facility's document titled (Facility) Healthcare Policy and Procedure Common Area Daily Cleaning Procedure undated, noted, . CLEANING PROCESS/DAILY DISINFECTING Travel the room in a set pattern, beginning by the door and working around the room until you return to where you started. Using a cleaning cloth saturated in disinfectant, wipe down all high touch areas as well as horizontal surfaces. Replace cleaning cloths as they dry out. Spot check walls and other vertical surfaces. Clean as needed with disinfectant. Spot check windows and clean with a separate dry cloth and glass cleaner as needed .
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on interview and record review, the facility failed to maintain 18 months of posted nurse staffing information, resulting in the potential for nursing staffing data not being available to the public upon request. Findings Include: On 3/4/20 at 11:30 AM, the Nursing Home Administrator (NHA) provided requested 18 months of daily staff postings. Upon review, multiple days of daily staffing information were not present. On 3/4/20 at 12:07 PM, the Assistant Administrator was queried if all daily postings for 18 months were present in what was provided for review. The Assistant Administrator stated, Yes. Well, I gave the (NHA) a list of dates that were missing. The Assistant Administrator confirmed there were missing dates and that not all 18 months of daily staff postings were retained. A review of the facililty's policy

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F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	(continued... from page 6) titled, Daily Staff Posting Guideline, dated 11/28/17 revealed, Retention: Posted nurse staffing information shall be maintained for 18 months and information made available to the public, upon written or oral request, at a cost not to exceed the community standard for copying.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to dispose of expired medications, store food and chemicals away from medication storage areas, appropriately store narcotic medication, label opened medications, and maintain cleanliness of medication carts for two medication rooms of three reviewed, and three medication carts of five reviewed, resulting in the potential for use of outdated drugs/biologicals, unclean medication areas, drug diversion or error, and the administration of ineffective or contaminated medication. Findings include: On 3/4/20 at 9:34 AM, the 2 South Back Medication Cart was reviewed with LPN (Licensed Practical Nurse) C. Upon review, two round, white tablets were observed to be sitting in an unmarked medication cup in the top drawer. When queried regarding the tablets, LPN C indicated she knew who they were for, but the resident did not want to take them yet. When queried regarding the medication, LPN C stated, They're Tylenol. When asked to clarify, LPN C indicated they were Tylenol 3's (with [MEDICATION NAME] - narcotic medication). LPN C stated, Normally I wouldn't do that. Further review of the cart revealed a loose, yellow pill at the bottom of the large middle drawer. LPN C took it and disposed of it without comment. On 3/4/20 at 9:43 AM, the 2 South Front Cart was reviewed with LPN O. Upon review, the two large middle drawers were noted to be dirty on the bottom, with visible debris, as well as a sticky red substance in the bottom of the drawer that stored liquid medications. When queried who maintains the cleanliness of medication carts, LPN O stated, The nurses. LPN O acknowledged the observed findings. On 3/4/20 at 10:40 AM, a Medication Storage and Labeling facility policy/procedure was request from the Nursing Home Administrator (NHA). On 3/4/20 at 12:02 PM, the NHA stated the facility did not have a Medication Storage and Labeling policy/procedure. On 3/5/20 at 1:10 PM, the 1 South Back Cart was reviewed with LPN P. Upon review, a bottle of prescription (Latanoprost) eye drops were noted to be open with no open date. LPN P was queried about the eye drops and confirmed there was no open date and stated, I'll take these out. A bottle of Vitamin C tablets and a bottle of [MEDICATION NAME] tablets were noted to have an expiration date of 1/20 (January 2020). When queried, LPN P removed the medications from the cart and indicated they should not be there. On 3/5/20 at 1:21 PM, the 1 North Back Cart was reviewed with LPN N. Upon review, a bottle of prescription (Latanoprost) eye drops were noted to be open with no open date. LPN N was queried about the eye drops and confirmed there was no open date. Further review of the cart revealed a loose, green pill at the bottom of the 2nd middle drawer, and a loose, white pill at the bottom of the 3rd middle drawer. When queried regarding the loose pills, LPN N took them and disposed of them without comment. On 3/5/20 at 1:33 PM, the 1 South Medication Room was reviewed with Unit Manager (UM) Nurse H. Upon review, a bag of medications was noted to be on the top shelf of one of the cupboards. Eight bottles of medications were noted to be in the bag and upon inquiry, UM H stated, That resident isn't here anymore. Pharmacy is supposed to take those. Eight bottles of multivitamins with the expiration date of 11/19 (November 2019) were noted in the room. When queried, UM H stated, Those shouldn't still be in here. A bottle of open Acetic Acid was noted with no open date. When queried, UM H stated, This should be dated. A container of chocolate candies was noted to be stored among IV flushes, IV tubing, and other medication supplies. When queried, UM H indicated the chocolates should not be there. Further review of the medication room revealed 22 IV antibiotic bags with expiration dates from February 2020. When queried, UM H stated they should have been disposed of and should not still be in the room. On 3/5/20 at 1:51 PM, the 2 South Medication Room was reviewed with LPN Q. An open container of [MEDICATION NAME] (prescription) cream was noted with no label and no open date. Upon inquiry, LPN Q stated it should be labeled with a resident's name and open date. A bottle of disinfectant spray and a bottle of furniture polish were noted to be stored in a cupboard containing medication supplies. When queried, LPN Q stated, Those can be disposed of, they are supposed to be away from the medication area. Further review revealed three bags of IV antibiotics in the medication fridge with an expiration date of 2/22/20. LPN Q stated, Those should've been disposed of. On 3/5/20 at 2:03 PM, the Director of Nursing (DON) was interviewed and asked about the facility's medication storage and labeling policy/procedure. The DON indicated the facility does not have one. When queried regarding the storage of narcotic medications in a medication cart in an unmarked cup, the DON stated, I would've expected that the nurse would take them and give them to the patient, and if they did not want the medication, she and another nurse should destroy them and sign off. When queried regarding general cleanliness of medication carts and loose pills in the carts, the DON stated, Nursing should be cleaning that. When asked about the expectation upon opening bottles of eye drops, the DON stated the eye drops should be dated upon opening. When queried regarding disposal of expired medications/biologicals, the DON stated, Expired medication should be removed timely. When queried regarding food or chemicals being stored in medication storage areas, the DON stated, That is not the expectation for chocolates to be in the medication room. The cleaner and furniture polish should be stored away from medications and supplies. Guidance for multi-dose vials according to the Centers for Disease Control (CDC) is as follows: When should multi-dose vials be discarded? Medication vials should always be discarded whenever sterility is compromised or cannot be confirmed. In addition, the United States Pharmacopeia (USP) General Chapter 797 (16) recommends the following for multi-dose vials of sterile pharmaceuticals: If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. Reference: https://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html (Page last reviewed: (NAME)20, 2019). The facility did not provide a policy/procedure/guidelines related to Medication Storage and Labeling prior to survey exit.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure meals were served palatable and attractive, for five sampled residents (#61, #136, #108, #191, #248 and #103) and four of four residents requesting anonymity who attended the resident group meeting, reviewed for food palatability, resulting in dissatisfaction with the meal experience. Findings include: Resident #61 On 3/03/20 at 10:40 AM, during the initial tour, Resident #61 was asked about the stay at the facility and stated, The meat is too tough. I'm tired of them sending salad with the wrong dressing. They will send me French I'm not supposed to have that. They will send me mashed potatoes I can't have. They send me cheese I can't have cheese. On 3/03/20 at 2:00 PM, Resident #61 was asked how the lunch was today. Resident #61 stated, Terrible, I didn't know what it was. Resident #136 On 3/03/20 at 10:44 AM, Resident #136 was asked about the food at the facility. Resident #136 stated, Tough meat every time and a lot of sandwiches. On 3/04/20 at 11:00 AM, during the resident council group interview, Residents explained, The Meat is too tough especially the pork chop and too dry, sometimes the temperature is off. It does not look good (appealing). Yesterday (Shepherd's Pie) it looked like slop. One Resident stated, I didn't touch it because it didn't look good. I didn't have anything yesterday. The group continued and explained, the breakfast toast is always burnt. Another Resident stated, Breakfast was horrible, it was biscuits and gravy. The Group was asked if they attend the food committee meetings. The group of Residents stated, Yea, but they don't listen to us. They said they have to go by the budget and that (Company) makes the menu. The group also mentioned that lately we get a lot of sandwich with cold meat and cheese. On 3/05/20 at 2:44 PM, the Director of Nutrition Services (DNS) was asked about the food in the facility. The DNS stated, I haven't had any complaints. On 3/05/20 at 3:36 PM, the Administrator was asked about the attractiveness of lunch served on 3/3/20, which was Shepherd's Pie. The Administrator stated, I helped served lunch and didn't hear any complaints. R108 On 03/03/20 11:10 AM, R108 was interviewed regarding the food palatability and frowned. R108 stated, Try some of it and good luck. On 03/04/2020 at 12:37 PM, R108 was observed in the dining room with a plate of meat balls, mashed potatoes with gravy, and green beans. R108 ate two of the meatballs and gave the rest to the the resident seated at the same table. R108 stood up and stated, Sit down and have lunch, you'll love it, then left the dining room. On 03/04/20 at 12:59 PM after all of the residents had been served a test tray of a breaded pork chop, mashed potatoes with gravy, and green beans

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	235298	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FATHER MURRAY, A VILLA CENTER	8444 ENGLEMAN CENTER LINE, MI 48015

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) was requested. The breading on the pork chop was soggy and salty. The pork chop was fatty and chewy. The mashed potatoes and green beans were adequately prepared and served. R191 On 03/03/20 at 11:57 AM, R191 was interviewed regarding the food palatability and stated, The food is my only complaint. All they give us is chicken, pork chops, or roast beef and they never heard of any other seasonings other than kosher salt. On 03/04/20 at 2:00 PM, R 191 was asked about lunch today and stated, it wasn't too bad, but you're here. A good lunch happens every three months or so. On 3/4/20 at 12:20 PM, a test tray was obtained to check for food palatability. The breaded pork chop was found to be mostly bone, with very little meat. The meat that was remaining, had large amounts of grizzle and fat. There was a very small amount of edible meat on the pork chop. R103 On 03/03/20 at 1:19 PM R103 what asked about concerns and reported they did not want to be nit picking and stated, The food. The food is at best at a minimum, just a sandwich and potato chips and they are are horrible. We would like a regular meal for dinner like at lunch. It's bad enough we get a weak sandwich. The food committee is non effective. We have asked for changes and it's like we hear you, now be quiet and then go away. R103 was then asked about being offered an evening snack and R103 and their roommate both laughed out loud and R103 shook their head and stated, No. A review of the clinical record for R103 revealed an admission into the facility on [DATE]. [DIAGNOSES REDACTED]. The MDS dated [DATE] revealed intact cognition and the need for limited assistance with eating. R248 On 03/03/20 at 10:47 AM, R248 reported on query about daily care needs that they were not routinely assisted. R248 reported they had missed dinner as no one brought in a tray and had to settle for some wilted salad brought up from the kitchen. On 03/05/20 at 8:47 AM, R248 was observed to be in bed with the breakfast to the left side on an over the bed table. R248 lifted the lid off a small plastic bowl and revealed some dry cereal. No milk was observed on the tray. R248 lifted the lid on the large plate and revealed one slice of bread cut in half at an angle. R248 commented they were lactose intolerant and did not receive any eggs or meat. R248 further reported they had requested oatmeal after receiving the current tray but had not received it. On query of staff, a bowl of oatmeal was removed from the dietary aides cart as they were headed toward the elevator and provided to the resident. A review of the clinical record for R248 revealed and admission into the facility on [DATE] and a readmission into the facility 02/27/20. [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] revealed intact cognition and the need for limited assistance with eating. On 03/04/20 09:21 AM, Certified Nursing Assistant (CNA) S was asked about the serving of sandwiches at dinner ant stated, They have been having sandwiches for a few days, it won't be the same sandwiches, not every day, they have a sandwich and soup and some alternates. On 03/03/20 at 10:12 AM, a resident who wished to remain anonymous stated, Supper is lacking, it is not a warm meal, not nutritious, just a sandwich and chips. On 03/04/20 at 1:18 PM, large pieces of bone and left over pieces of the pork chop were observed on six of 15 plates in the central dining room. A review of the Resident Food Committee minutes from September 2019 through February 2020 revealed no requests to have sandwiches for dinner. (A policy related to food preferences was requested but not received prior to survey exit.)
F 0809 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an evening snack was consistently offered to one sampled resident (R103) and four of four residents requesting anonymity who attended the resident group meeting, resulting in resident's dissatisfaction and the potential for unmet resident care needs. Findings include: On 3/04/20 at 11:19 AM, during the resident council meeting, the Residents were asked about being offered and receiving evening snacks. All four of the Residents agreed and explained, Sometimes when they decided to give it. One resident stated, I didn't get one last night. The Residents explained that sometimes the snacks are placed at the Nurses Station and one person may take them all and there is none left. On 3/05/20 at 2:44 PM, the Director of Nutrition Services (DNS) was asked how the evening snacks are brought to the floor. The DNS stated, We bring them to the units between 7:00 PM - 7:30 PM and the aides walk around with the snacks and pass them out. The DNS was asked has there been any complaints regarding residents not getting snacks. The DNS stated, No. R103 On 03/03/20 at 1:19 PM R103 was asked about being offered an evening snack and R103 and their roommate both laughed out loud and R103 shook their head and stated, No. A review of the clinical record for R103 revealed an admission into the facility on [DATE]. The Minimum Data Set Assessment ((MDS) dated [DATE] revealed intact cognition.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation has Three Deficient Practice Statements (DPS). DPS #1. Based on observation, interview, and record review the facility failed to store nasal cannulas (for respiratory care treatment) in a sanitary manner for two sampled residents (R108 and 169) and one unsampled resident (R124) of five residents reviewed for respiratory care with the potential for the preventable spread of infections. Findings include: R169 On 03/03/20 at 9:18 AM, was observed sleeping in bed. It was noted that R#169 was using oxygen via a nasal cannula attached to an oxygen concentrator. R169's wheel chair in the corner of the room was observed to have a portable oxygen tank in an oxygen tank holder and the nasal cannula was wrapped around the tank with the tip exposed. on 03/03/20 at 10:40 AM, Nurse A was asked about the facility's policy and procedure regarding respiratory care equipment when not in use and stated, That is not stored properly, the bag is right there, I'll just get a new one. Record review of R169's Electronic Health Record (EHR) revealed R169 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) assessment dated [DATE] revealed R169 had a Brief Interview for Mental Status (BIMS) score of 13/15 and needed limited assistance with Activities of Daily Living (ADLs). R108 On 03/03/20 at 11:15 AM, R108 was interviewed regarding the care received at the facility. During the interview an oxygen concentrator was observed next to the bed and the nasal cannula was hanging from the handle on top of the concentrator with the tip exposed. R108 was asked about the oxygen and stated, I don't need it right now. I do it all by myself. On 03/04/20 at 9:08 AM, Nurse C was asked if R108 was able to use the respiratory care equipment unassisted and stated, No. Nurse C was asked about the facility's policy and procedure regarding the storage of respiratory care equipment when not in use and stated, It should be in that bag. Nurse C then picked up the nasal cannula and placed it in the bag hanging from the oxygen concentrator. Record review of R108's EHR revealed R108 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS dated [DATE] revealed R108 had a BIMS score of 13 indicating an intact cognition and needed supervision with ADLs. R124 On 03/04/20 at 9:24 AM, R124 was observed sleeping in bed using oxygen via a nasal cannula connected to a oxygen concentrator. R124's wheelchair in the corner of the room was observed to have a portable oxygen tank in an oxygen tank holder and the nasal cannula was hanging from the oxygen tank with the tip exposed. On 03/04/20 at 9:30 AM, Nurse D was asked about the facility's policy and procedure regarding the storage of respiratory care equipment when not in use and stated, There should be a date on it and it should be in a bag. I'll get rid of this one. (R124) doesn't get up too often. On 03/05/20 at 11:08 AM, the Director of Nursing was asked about the facility's policy and procedure regarding the storage of respiratory care equipment when not in use and stated, When not in use they should be in the bag and labeled. All of the residents have bags and sometimes don't use them, but the staff are educated to look for infection control issues. Review of the Facility's undated policy and procedure titled, Oxygen Administration revealed, the storage of respiratory care equipment when not in use was not addressed. DPS#2. Based on interview and record review the facility failed to follow-up on [MEDICAL CONDITION] (TB) skin test results for two sampled residents (R108 and 169) of five residents reviewed for Infection Control Prevention resulting in the potential of the preventable spread of infection. Findings include: R108 Record review of R108's Electronic Health Record (EHR) revealed R108 was admitted on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) assessment dated , 01/15/20 revealed R108 had a Brief Interview for Mental Status score of 13/15 indicating an intact cognition. Further record review revealed that R108 had refused the TB skin test on admission. No further evidence of resident education, chest X-rays, or symptom screening was found in the medical record. R169 Record review of R169's EHR

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) revealed R169 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Infection Prevention and Control readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS revealed R169 had a BIMS score of 13/15 indicating an intact cognition. Further record review revealed that R169 had received TB skin tests on 12/20/19 and 01/10/20. Both tests recorded the results as Pending. On 03/05/20 at 11:58 AM, the Director of Nursing (DON) and the Infection Control Preventionist, Nurse E was asked about the facilities policy and procedure on performing and documenting TB skin test results and the DON reviewed the resident's EHR. The DON later stated that (R169) was sent to the hospital on the 21st (of December and returned on the 22nd) and there was a negative chest X-rays on 12/30/19 from the hospital and (R108) had a chest X-ray at the hospital on 3/23. No explanation for the lack of the TB skin test results for R108 and R169 was offered. Review of the facility's 2017 policy and procedure titled, Infection Prevention and Control Manual Transmission-Based Precautions dated 2017 did not address the administration of documentation of TB skin testing or the documentation of TB skin testing results. Deficient Practice Statement #3 Based on observation, interview and record review, the facility failed to implement appropriate infection control precaution interventions for three sampled residents (#'s 14, 166, and 448) of three residents reviewed for infection control, resulting in the potential for the spread of infection/contagion throughout the facility. Findings include: On 03/03/2020 at 12:01 PM, R448 was observed in bed with a family member at the bedside. The outside of R448's the door was observed to have Personal Protective Equipment (PPE) hanging from it. R448 appeared confused and could not provide an answer as to why they were on contact precautions. Family Member G was observed wearing gloves and no other PPE, and were asked if they knew why R448 was in isolation, and indicated, I'm not sure. Family Member G was asked about the gloves they were wearing and stated, At the hospital, they told me to wear them if I was going to touch (R448), so I decided to put them on while here. Family Member G was asked if the facility had educated them on wearing PPE and/or isolation concerns. Family Member G stated, No. A review of R448's medical record revealed that they were admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review revealed that the resident required extensive assistance with Activities of Daily Living, and was currently in isolation for Extended Spectrum Beta-Lactamase (ESBL, a bacterial infection). On 03/03/2020 at 12:48 PM, Family Member G was observed taking R448's used styrofoam cup out of their room while wearing gloves. Family Member G indicated that R448 had been waiting over an hour to get ice water, and had learned from another family member where they could obtain it themselves. Family Member G was observed walking back toward R448's room after obtaining ice water from inside the main dining room on the 1st floor with the styrofoam cup, gloves balled up in left hand entering back into R448's room. On 03/05/2020 at 2:46 PM, the Director of Nursing (DON) was asked how the facility handles educating family members who are visiting residents that are on precautions. The DON stated, There is a stop sign on the door that says see nurse before entering the room. That's how they are to be made aware that the family member is too be educated. Sometimes family members blow by that. A review of the facility's policy, Infection Prevention and Control Manual Transmission Based Precautions did not address educating visitors of residents that are in isolation. On 3/03/20 at 8:52 AM, during the initial tour, the room that belonged to Resident #14 (bed 3) and #166 (bed 1) was observed with an isolation cart hanging on the door, without a displayed sign with the contact information or to see a Nurse before entering the room. A visitor was observed at the bedside of Resident #14, without PPE on, talking to Resident #14. The visitor exited out of the room at 8:56 AM. The visitor was not observed to complete any hand hygiene. On 3/03/20 at 10:21 AM, a sign for the type of contact precautions was not observed on the door of Resident #14 and #166. On 3/03/20 at 11:51 AM, a red sign for contact precautions was observed on the door along with an isolation cart, which displayed Stop, contact and gloves (picture of a gown and gloves), next to the hanging isolation cart. On 3/03/20 at 11:52 AM, Resident #14 and #166 was interviewed. Resident #166 was observed in bed. Along the wall next to Resident #166's bed were two large red trash bins. Resident #166 was asked if they had an infection or if they had been treated for [REDACTED].#166 stated, No. Resident #14 was asked if they had an infection or if they had been treated for [REDACTED].#14 stated, No. On 3/03/20 at 11:55 AM, Nurse H was asked what type of infection Resident #166 has. Nurse H stated, The entire room has lice. Nurse H was asked if the sign that was observed on the door noted to use an isolation cap. Nurse H stated, It doesn't, but should say that. On 3/04/20 at 9:25 AM, the room that belonged to Resident #14 and #166 was observed without the isolation cart hanging from the door. Observed in bed two was an unidentified resident, that had been admitted to the room. On 3/05/20 at 9:25 AM, Resident #14 was asked if their room had been deep cleaned before their new roommate came into the room. Resident #14 stated, They cleaned the room. Resident #14 was asked if it was a normal cleaning or did, they remove things from the room and if they had to leave out of the room. Resident #14 stated, No. They just cleaned it. Resident #14 A review of Resident #14's medical record revealed, Resident #14 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#14's Minimum Data Set assessment dated , 2/23/2020, noted an intact cognition and extensive assistance with activities of daily living. Further review of Resident #14's medical record revealed a progress note, 2/26/2020 21:51 (9:51 PM) *Physician/PA (Physician Assistant)/NP (Nurse Practitioner)- Progress Note (Narrative) Text: Internal medicine progress note. Recent exposure of head lice patient was treated seen by infectious disease . 19:51 (7:51 PM) *Health Status Note (nurses note) Text: Resident received lice treatment. Treatment was on residents scalp for forty five minutes. Residents hair was combed thoroughly to see if any lice was present. No lice was observed during lice treatment. Continued review of Resident #14's medical record did not reveal an order to start or discontinue isolation, or a care plan for isolation. Resident #166 A review of Resident #166's medical record revealed, Resident #166 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#166's Minimum Data Set assessment dated , 11/18/19 noted an impaired cognition and extensive assistance with activities of daily living. Further review of Resident #166's medical record revealed a progress note, 2/23/2020 19:56 (7:56 PM) *Health Status Note (nurses note) Note Text: Resident received lice treatment. Residents hair was combed thoroughly. Nurse observed lice on the residents scalp. Lice treatment was placed on residents scalp for forty five minutes. On 3/05/20 at 1:32 PM, the DON was asked the procedure for taking residents off isolation precautions. The DON stated, They were treated on the 24th (February) and completed treatment on the 24th, it was a one time treatment. The resident that had the lice was in bed two and they have been discharged . The DON was explained that the isolation cart was hanging from the door on 3/3/20. The DON stated, That should have been taken down. The room would be cleaned. The DON was asked when was the new resident admitted into the room. The DON stated, Yesterday. (3/4/20). On 3/5/20 at 10:40 AM, the director of housekeeping was asked if Residents #14 and 166 room was deep clean after they came off isolation. The Director of housekeeping stated, No. They did not tell me. The room was not deep clean. The Director of housekeeping was asked the procedure for notification of discontinued isolation. The Director of housekeeping stated, We get a list from the stand-up meeting in the morning. We removed everything out of the room. We take down the curtains, remove the residents and wipe down everything. It takes like 45 minutes to and 1hour.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a safe, sanitary environment, resulting in the potential for accidents, the potential for pest entry into the facility, and the potential for reduced air quality. Findings include: During a tour of the facility on 3/4/20 between 11:00 AM and 11:45 AM, the following items were observed: 1. In the second floor dining room, there was a 3 ft section of chair rail missing from the wall, and the remaining strip of chair rail was pulled away from the wall and sticking out at an angle. There were also numerous areas of torn wallpaper. On 3/4/20 at 3:15 PM when queried about the piece of chair rail sticking out from the wall, Maintenance Supervisor H stated We need to add some nails. 2. Exterior door #6, which lead out to the trash compactor area, had a large gap along the bottom edge of the door, which could allow pest entry into the facility. When queried on 3/3/20 at 3:15 PM, Maintenance Supervisor H was unaware of the gap in the exit door, but stated he would check that out. 3. There were numerous stained ceiling tiles throughout the 2nd floor hallway. 4. In the hallway outside room [ROOM NUMBER], the lighting level appeared to be very dim. The ceiling light fixture was observed with reduced illumination. The lighting level was measured with a light meter, and was found to be 1.25 foot-candles. The required lighting level for corridors should be 15 foot-candles. 5. In the first floor lounge, the wall mounted heating and air conditioning units near the

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F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 9) vending machine and on the North wall, had interior filters that were coated with dust. On 3/3/20 at 3:20 PM, when queried about the dusty filters, Maintenance Supervisor H stated They're on somebody's schedule right now.