STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235361	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHALET OF NILES, LLC	911 S 3RD ST NILES, MI 49120

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 0550 **Level of harm -** Actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat residents with dignity and respect and failed to provide an environment that promoted and enhanced resident quality of life for 1 of 12 residents (Resident #19) reviewed for dignity, resulting in the potential for feelings of frustration, depression, and loss of self-worth and an overall deterioration of psychosocial well-being. Findings include: Review of facility policy, DIGNITY no date, revealed, As an extension of appropriate interactions between staff and residents, the following will be practices of the facility: NOTE: Depending on scope and severity; what appears to be a dignity issue often can be interpreted and even meet the criteria for abuse. Conversations . 2. Staff will not speak in a manner that could be interpreted as even minimally condescending . as this can be interpreted as meeting criteria for abuse .5. Staff will ask the resident directly to answer questions pertaining to the resident whenever possible and not talk over the resident as this can diminish the resident's feeling of self-worth . General appearance/CIothing/Apparel . 6. Female residents who desire not to wear supporting undergarments such as a bra, will have this care planned. These garments should always be worn unless otherwise dictated by resident choice .Care 1. Staff will maintain resident privacy during all personal care .3. Should a resident have an episode of incontinence, staff will change them upon discovery of the episode . Note: Residents are to have all aspects of their dignity maintained by staff regardless of the resident's cognitive level or ability to realize or understand what is being said or done by others. Review of a Face Sheet revealed Resident #19 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #19, with a reference date of 6/24/2020, revealed a Brief Interview for Mental Status (BIMS) score of 2 , out of a total possible score of 15, which indicated Resident #19 was severely cognitively impaired. Further review of the MDS revealed Resident #19 required extensive for toileting and transfers by 2-person physical assist. Review of Resident #19's Care Plans revealed, Focus .I have a [DIAGNOSES REDACTED].Emphasize person-centered care strategies such as: Promotion of respect, dignity, & overall well-being. Date Initiated: 04/16/2019 Revision on: 04/16/2019 . Review of Resident #19's Care Plans revealed, Focus . I am incontinent of: Bladder and Bowel rt (related to) impaired cognition and impaired mobility . Revision on: 10/11/2018 .Goals . I will be clean, dry & odor free through the next review .Revision on: 02/27/2020 Target Date: 6/11/2020 .Interventions .Administer appropriate cleansing & peri-care after each incontinent episode. Date Initiated: 10/11/2018 . I have a self care deficit and I require staff assistance (extensive to total) with ADL's to maintain the highest possible level of functioning R/t my impaired cognitive status and Dx of [MEDICAL CONDITION] .Revision on: 05/17/2019 .Goal . I will maintain my current level of ADL functioning without a significant decline unless the disease process causes unavoidable deterioration thru next review .Revision on: 02/27/2020 Target Date: 06/11/2020 .Interventions . I am a two person assist with all transfers. Date Initiated: 08/01/2019 Provide assistance with all ADL's as required per the residents need dependence: Eating, Transferring, Bed Mobility, Bathing, Dressing, Personal Hygiene, Ambulation and Personal Hygiene. Date Initiated: 10/11/2018 .Ensure proper positioning while in the bed and/or chair. Date Initiated: 10/11/2018 .Focus .I am at an increased risk for alteration in skin integrity related to increased uncontrolled constant movement r/t [MEDICAL CONDITION]'s Chorea. I have multiple discolorations on my arms, legs, torso, and head, including a discoloration to my left eye (August 2020) r/t my involuntary movements from my chronic disease process. Date Initiated: 01/03/2019 .Goals . I will not develop any skin integrity issues thru next review, unless the disease process causes unavoidable deterioration .Revision on: 02/27/2020 Target Date: 06/11/2020 .Interventions . I have padded foam to my wall, headboard, footboard, and bed frame. I also have foam between my mattress on the floor and my bed frame for safety. Date Initiated: 12/23/2019 Revision on: 08/24/2020 I like to be on a matt or mattress next to my bed. Please place a mattress next to my bed and a fall matt on the floor along the edge of the mattress when I am in bed. . Revision on: 08/24/2020 .Focus I require long term care r/t a [DIAGNOSES REDACTED]. Goals . I will be content and my needs met with collaboration of facility staff and family thru next review Date Initiated: 01/09/2019 Revision on: 02/27/2020 Target Date: 06/11/2020 .Interventions .Assist me as needed with ADLS and personal care q (each) shift to keep me clean and comfortable Date Initiated: 01/09/2019 . According to https://ghr.nlm.nih.gov/condition/[MEDICAL CONDITION]-disease , [MEDICAL CONDITION] is a progressive brain disorder that causes uncontrolled movements, emotional problems, and loss of thinking ability (cognition). Review of Resident #19's Kardex (a guide for resident care) admitted : 9/26/2018, revealed, Safety . I like to be on a matt or mattress next to my bed. Please place a mattress next to my bed and a fall matt on the floor along the edge of the mattress when am in bed .Toileting . Toilet Use - I am totally dependent on staff for toileting needs .Dressing . Dressing - I am extensive assist with dressing .Bladder and Bowel Bladder Continence - I am incontinent. Bowel Continence - I am incontinent .Mobility I am a two person assist with all transfers . During an observation and interview on 8/23/2020 at 1:00PM, Resident #19 was seen from hall through open door, lying on her left side on floor mattress next to bed. Wearing a tank top shirt, no female supporting undergarment, plain socks, and a brief. The resident's forehead and face were pushed into the bolster that was between the floor mattress and the bed frame. The resident was flailing her arms, legs, and body. As the flailing increased, she became more wedged under the bed with her right leg on top of the bed and left leg completely under the bed. No fall mat was next to the floor mattress. Brief was soiled with soft, oozing bowel movement running out of top, and leg holes of brief. Resident had fecal matter on her back from side to side, and down both legs to mid-thighs. The floor mattress sheet had a wet brown substance resembling fecal matter and yellow liquid, resembling urine, approximately the width and half the length of the resident. This was the area of the sheet the resident was lying on. The sheet had come off the other length-half of the mattress the resident was not lying on. There, the mattress also had the wet brown substance and yellow liquid. A long spongy tube, resembling a pool noodle was attached to the frame with black narrow tape, resembling electrical tape. Part of the noodle was worn away exposing the metal frame. On the noodle was the same brown substance as what was on the resident, sheet, and mattress. Both the head board and foot board edges were covered with a noodle with wide silver tape, resembling duct tape, and black narrow tape. Parts of these noodles were also worn away exposing the boards. A sheet of black foam padding had been placed between the bed frame and floor mattress by the resident's head. Certified Nursing Assistant (CNA) P entered the room behind the surveyor and stated, I am not her aide and stood next to the surveyor looking down at the resident. CNA E entered room, performed hand hygiene and donned gloves. CNA P stated while looking at resident and donning gloves, Whoever feeds her needs to clean her up because she will poop right after she eats. CNA E stepped on resident's floor mattress to remove the soiled sheets and place a clean set on without cleaning or sanitizing the mattress. Both, CNA P and CNA E tried to get Resident #19 to roll over onto her back. They attempted to bribe resident with milk. CNA P took the resident's right foot by the sock and tried to turn her onto her back by pulling on her leg and foot. Resident #19 continued to flail from side to side with increased intensity. CNA P

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 0550 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) stepped onto the floor mattress repeatedly telling the resident to turn onto her back. With Resident #19 still face-down and now on her left side, CNA P started to remove the resident's brief. Resident #19 turned onto her right side with now apparent fecal matter oozing out of her brief and onto the mattress and bed frame and noodle. CNA P pulled the brief off resident spilling more fecal matter on mattress and bed frame. CNA P again stepped onto the mattress with both feet. Resident #19 rolled onto her stomach. CNA P attempted to clean resident with resident lying on her stomach. CNA P stated, I can't see to clean her. Then stated to Resident #19, You are getting stuff on the bed frame and continued to try and clean fecal matter from resident's genital area by reaching under her. While reaching under Resident #19 to clean her, CNA P stated, That's nasty. With soiled sheet under resident, and resident still lying face down on her stomach, CNA P attempted to put a clean brief on the resident. CNA P then noticed resident had wedged herself under the bed between the mattress and bed frame. CNA P was the only staff at this time in the room with Resident #19 and surveyor. CNA P pleaded multiple times with resident to roll over onto her back. Director of Nursing (DON) B and CNA E entered the room and donned gloves. At resident's head, DON B kneeled on the soiled mattress. CNA P removed the soiled sheet from the mattress. Resident #19 had now flailed enough to have her right side, face-down, between the mattress and under the bed. DON B pleaded with resident to help move herself from under the bed. DON B, CNA P, and CNA E pulled resident from under the bed and onto the soiled mattress. CNA P put the clean brief under the resident and asked her multiple times to roll onto her back. DON B held resident's shoulders with CNA P kneeled on the soiled mattress and placed the brief on Resident #19 without cleaning resident's front peri area. CNA E stepped on the mattress and tried to put pants on Resident #19. CNA T stated, She (referring to Resident #19) needs a clean shirt on because it has pee on it. Observed Resident #19's socks speckled with fecal matter. Resident kept placing her right leg and on bed mattress with clean sheet. CNA E stated, We should put a sheet on the floor mattress; we got the main stuff off her. Without cleaning and sanitizing the mattress, CNA P placed a clean sheet over the soiled floor mattress. CNA E left the room and DON B and CNA P kneeled onto floor mattress next to Resident #19. DON B was concerned with the black foam padding and stated, It looks like it gets shredded. CNA P asked Resident #19 to Do a big roll-over and then we will let you sleep and have some chocolate milk. DON B asked Resident #19 if she needed help to roll onto her back. Resident #19 moved her right leg with jerking motions onto the bed mattress while lying on her stomach and her left leg got wedged under the bed. At this time, CNA Q entered the room and assisted DON B with putting a fitted sheet on floor mattress without cleaning or sanitizing it. DON B then removed Resident #19's tank top with some struggling. CNA Q placed a hospital gown on Resident #19 before noticing it did not have strings on it. CNA Q left the room to get another gown. CNA P entered room with clean gown, and DON B and CNA Q got it on Resident #19. Resident #19 was now flailing and rolling back and forth with increased intensity. DON B and all CNAs exited the room, leaving Resident #19 sitting on floor mattress alone. Resident #19 rolled onto her left side. Her gown began to come off from around her neck. Observed on 08/24/20 at 12:16 PM Resident # 19 was seen from hall through open door, on knees leaning on bed wearing only a short-sleeved cotton shirt and a brief. The brief was saturated with urine and fecal matter, drooping low enough to see from left to right through the leg holes. CNA D was assisting to feed resident. CNA D stated, (Resident # 19) usually has a bowel movement right after she eats and that is when she will get cleaned up. The staff that feeds her will clean her up after feeding her. I knew I'd have to clean her up after I fed her, so I waited to change her. During an interview on 8/25/2020 at 10:56 AM, CNA P stated, Peri-care with (Resident #19) you can usually roll her on her back and clean front to back. Because you are to clean from front to back. After I clean the front, I go clean her back (bottom). The CNAs are responsible for cleaning up the mats, mattresses, and walls. The urine and fecal matter should be cleaned up right away and by the aides. I put the sheet on the floor mattress because I don't want her lying on that dirty mattress that people step on. She prefers to lay on that mattress and people step and walk on it and she should not have to lay on that. A floor mat should be placed on the floor next to the mattress because (Resident #19) moves around a lot. During an interview on 8/25/2020 at 11:25 AM, DON B stated, Peri-care should not be done with the resident lying on their stomach. One reason is you cannot see if everything is clean and to do skin an evaluation. When fecal matter or urine is on the mattress it should be cleaned at that time and the aides are supposed to clean it. Then they notify housekeeping to come sanitize. The pool noodles and black foam should be cleaned at the time right when it is soiled and then staff should contact housekeeping to sanitize it. When you (referring to surveyor) were observing yesterday, I was hoping CNA P and CNA E knew what they were doing, and they did not. It was a disaster during the care. Dignity and peri-care were all done wrong. Review of the Psychosocial Outcomes Guide revealed that it is appropriate for the use the reasonable person concept to determine a resident's psychosocial outcome, which may not be readily determined when a resident may not be able to express their feelings, there is no discernable response, or when circumstances may not permit the direct evaluation of the resident's psychosocial outcome. Such circumstances may include, but are not limited to .cognitive impairments, or insufficient documentation by the facility; or when a resident's reaction to a deficient practice is markedly incongruent (or different) with the level of reaction a reasonable person would have to the deficient practice. Using the reasonable person concept, Resident #19 would not have wanted to be partially dressed, exposed, and with fecal matter on her and her mattress, and provided incontinence care in a manner that was dehumanizing and did not follow a person-centered care plan. Resident #19 was unable to voice evidence of harm, but it is reasonable to assume that Resident #19 would experience embarrassment, anxiety and avoidance due to the possibility of being vigorously cleaned while lying on her stomach on a mattress placed on the floor with staff walking on it, causing embarrassment and humiliation when cares were performed; potentially diminishing her level of participation in activities of daily living (ADL) which could increase the potential for skin breakdown. Resident #19 would likely have ongoing feelings of dehumanization if she had not been cognitively impaired.
F 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to document in the medical record a reason for the discharge that meets the federal requirements for discharge for 1 of 12 residents (Resident #42) reviewed for required discharge requirements, resulting in the potential for inappropriate discharges from the Facility. Findings include: Review of the facility policy Health Records (no date) revealed, It is the intent of the facility to have a health record system that facilitates the retrieval of information regarding individual residents .1. Each resident will have an active health record. This resident recrod shall be kept current, complete, legible, and available at all times to authorized personnel. 2. Record entries shall meet the following requirements: a. Record entries shall be made by the person providing or supervising the service or observing the occurrence that is being recorded .6. Discharge information shall be completed after the resident leaves the facility. The resident care staff shall record the date, time, condition of the resident, to whom released and the resident's planned destination (home, another facility). Review of the Fundamental of Nursing revealed, Patient care requires effective communication among members of the health care team. The medical record is an important means of communication because it is a confidential, permanent, legal documentation of information relevant to a patient's health care. The record is a continuing account of a patient's health care status and is available to all members of the health care team. Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations -). Elsevier Health Sciences. Kindle Edition. Review of the Fundamental of Nursing revealed, High-quality documentation is necessary to enhance efficient, individualized patient care. Quality documentation has five important characteristics: it is factual, accurate, complete, current, and organized. Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations -). Elsevier Health Sciences. Kindle Edition. Review of a Face Sheet revealed Resident #42 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an interview on at 08/25/20 at 10:40 A.M., LPN DD reported that a progress note definitely should have been written regarding Resident #42's transfer to the hospital. LPN DD reported that any time there is a change of condition and a resident is sent to the hospital physician notification and the transfer should be documented in a progress note. LPN DD reported that a physician order is required for discharge. Review of Resident #42's Hospital Record revealed that Resident #42 was transferred to the Emergency Department at (name omitted) hospital on [DATE] Review of Resident #42's Electronic Health Record (EHR) revealed no Nurses Note regarding Resident #42's hospital transfer. Review of Resident #42's Electronic Health Record (EHR) revealed no Physician Note regarding Resident

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F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) #42's hospital transfer. Review of Resident #42's Physician Orders revealed no order for Resident #42's transfer out of the facility. During an interview (via email) on 8/24/20 at 3:33 P.M., Nursing Home Administrator (NHA) A reported there were no progress notes, physician orders, or other documentation regarding Resident #42's discharge/transfer to the hospital. During an interview on 08/25/20 at 10:34 A.M., Licensed Practical Nurse (LPN) EE reported that any time a resident is transferred out of the facility a progress note regarding the residents condition, their destination, and the physician notification is completed. LPN EE reported that a physician order is required for discharge.
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 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 develop and implement a person-centered care plan for 1 resident (Resident #19) of 12 residents reviewed for care plans, resulting in unmet safety interventions and care needs of the resident. Findings include: Review of a facility policy Baseline Care Plan Assessment/Comprehensive Care Plans date not available, revealed, Policy . The Comprehensive Care Plan will further expand on the resident's risks, goals and interventions using the Person-Centered Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs. These needs will be defined from observation, interviews, clinical medical record review and through assessments and CAAs. The facility Interdisciplinary team in conjunction with the resident, resident's family, surrogate or representative as appropriate along with a hands on caregiver, such as a Certified Nursing Assistant will discuss and develop quantifiable objectives along with appropriate interventions in an effort to achieve the highest level of functioning and the greatest degree of comfort/safety and overall well-being attainable for the resident Procedure .As the resident remains in the Nursing Home, additional changes will be made to the comprehensive care plan based on the assessed needs of the resident .9. The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues .10. The MDS/Care Plan Coordinator and/or ancillary MDS staff will attend the Morning /CQI meetings where in-depth review of the 24 Hour Report(s) since the prior Morning/CQl meeting are reviewed and discussed as well as new or changed orders, new admissions, readmissions, falls and other pertinent circumstances regarding the residents. They will then see that the care plans for these residents are revised and updated as necessary . Review of a Face Sheet revealed Resident #19 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #19, with a reference date of 6/24/2020, revealed a Brief Interview for Mental Status (BIMS) score of 2 , out of a total possible score of 15, which indicated Resident #19 was severely cognitively impaired. Further review of the MDS revealed Resident #19 required extensive for toileting and transfers by 2-person physical assist. Review of Resident #19's Physician order [REDACTED]. CNA may apply. May keep at bedside Review of Resident #19's Care Plan revealed, Focus I am incontinent of: Bladder and Bowel rt impaired cognition and impaired mobility .Revision on: 10/11/2018 .Goals .I will be clean, dry & odor free through the next review .Revision on: 02/27/2020 . Interventions . Administer appropriate cleansing & peri-care after each incontinent episode. Date Initiated: 10/11/2018 . Observed on 8/23/2020 at 1:00 PM Resident #19 receiving brief change and perineal care from CAN P . CNA P did not apply moisture barrier cream to buttocks and groin after changing resident's brief. Review of Resident #19's Progress Note 3/18/2020 14:20 revealed, Nursing Progress Note Note Text: IDT: Met to discuss res (resident) fall f/u (follow up), res is alert has a dx(diagnosis) of [MEDICAL CONDITION] which causes her to have involuntary moments, which she is care planned for, res also has meds for such condition, fall mattress in place as well as protective cushion all around her bed and wall. Res was noted to be between fall mattress and floor when found by CNA during rounds res had fell on mattress and mattress which caused part of her body to be on the floor, res family and dr was notified, res has no injuries noted no c/o pain or discomfort. IDT met to interview res and staff as well as go to res room to come up with a plan. Since res was on mattress that was planned but since mattress moved IDT discuss with dr and family of putting dycem underneath the mattress so in the case of a fall the mattress wouldn't move. DR and family thought it was a great idea, res and staff notified of intervention, dycem (a non-slip mat) was put into place care plan and orders updated . Review of Resident #19's Physician order [REDACTED]. Prescriber Written . Review of Resident #19's Care Plan did not indicate the dycem had been added to the care plan or Kardex for implementation and ensure a safe environment for the resident. During an observation on 8/23/2020 at 1:51, Director of Nursing (DON) B removed a wedge from under Resident #19's floor mattress. A dycem pad was not observed to hold the floor mattress in place. During an interview on 8/25/2020 at 10:56 AM CNA P stated, (Resident #19), I learned from working with her I noticed that right after she eats she has a bowel movement. You want to clean her up after she eats because she moves around so much. I tell the aides what her bowel pattern is. Most staff knows this. I will use both the care plan and Kardex. But if I had to choose, it would be the Kardex. The Kardex' is updated frequently and has accurate information here at this facility. (sic) During an interview on 8/25/2020 at 11:33 AM, Director of Nursing (DON) B stated, The facility has goals for (Resident #19) for an area for her she can move around on. She wants to be active and do stuff. Someone has to be with her all the time because she moves around so much, she could hurt herself or fall. It is not care planned; it does not spell it out. Care plans are important especially with a Kardex. They are what the staff uses to do what is best to care for the resident. To know the best way to care for that resident. Any nurse can add to a care plan. The ADON (Assistant Director of Nursing), DON, and MDS Coordinator go through the care plans to make sure they are updated. After a fall, skin issue, injury, medication, or some change, the care plan needs to be updated to direct the care of the resident. (Resident #19) has a mattress on her bed and then a second mattress on the floor. (DON B reviewed care plans with surveyor). The care plan says please place a mattress next to my bed and a fall mat on the floor along the edge of the mattress when I am in bed. It does not say anything about having a fall mat next to the mattress or a dycem. Any time she stands up she should have gripper socks on for safety, so she doesn't fall or slip; for traction. If she is standing the gripper socks need to be on. DON B reviewed resident care plan for gripper socks with surveyor and stated, I don't see gripper socks in her care plan I was hoping the staff you observed transferring (Resident #19) knew what they were doing, and they did not. She could get skin tears the way she was drug up over the foot rest. It was a disaster during the perineal care and transfer. Dignity, peri care, and transfer, were all done wrong.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe environment for 1 of 12 residents (Resident #19) reviewed for accidents and hazards, resulting in a fall during transfer and resident sliding under bed during care. Findings include: Review of a Face Sheet revealed Resident #19 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #19, with a reference date of 6/24/2020, revealed a Brief Interview for Mental Status (BIMS) score of 2 , out of a total possible score of 15, which indicated Resident #19 was severely cognitively impaired. Further review of the MDS revealed Resident #19 required extensive for toileting and transfers by 2-person physical assist. Review of Resident #19's Progress Note 3/18/2020 14:20 revealed, Nursing Progress Note Note Text: IDT: Met to discuss res (resident) fall f/u (follow up), res is alert has a dx(diagnosis) of [MEDICAL CONDITION] which causes her to have involuntary moments, which she is care planned for, res also has meds for such condition, fall mattress in place as well as protective cushion all around her bed and wall. Res was noted to be between fall mattress and floor when found by CNA during rounds res had fell on mattress and mattress which caused part of her body to be on the floor, res family and dr (doctor) was notified, res has no injuries noted no c/o pain or discomfort. IDT met to interview res and staff as well as go to res room to come up with a plan. Since res was on mattress that was planned but since mattress moved IDT discuss with dr and family of putting dycem underneath the mattress so in the case of a fall the mattress would not move. DR and family thought it was a great idea, res and staff notified of intervention, dycem (a non-slip mat) was put into place care plan and orders updated . According to https://ghr.nlm.nih.gov/condition/[MEDICAL CONDITION]-disease , [MEDICAL CONDITION] is a progressive brain disorder that causes uncontrolled movements, emotional problems, and loss of thinking ability (cognition). Review of

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) Resident #19's Physician order [REDACTED]. Prescriber Written . Review of Resident #19's Care Plan did not indicate the dycem had been added to the care plan or Kardex for implementation and ensure a safe environment for the resident. During observations on 8/23/2020 and 8/24/2020, dycem was not observed under Resident #19's floor mattress. Review of Resident #19's Kardex (a guide for resident care) admitted : 9/26/2018, revealed, Safety . I like to be on a matt or mattress next to my bed. Please place a mattress next to my bed and a fall matt on the floor along the edge of the mattress when am in bed .Toileting . Toilet Use - I am totally dependent on staff for toileting needs .Dressing . Dressing - I am extensive assist with dressing .Bladder and Bowel Bladder Continence - I am incontinent. Bowel Continence - I am incontinent .Mobility I am a two person assist with all transfers . Review of Resident #19's Progress Notes 8/12/2020 11:56 (AM) revealed, Note Text: IDT: Met to discuss res (resident) skin issues as well as res dx (diagnosis) of [MEDICAL CONDITION]'S DISEASE . res has involuntary moments . res has several intervention in place to keep her safe as possible padding cushions on head board and foot board, mattress and padding on floor, a Baroda chair with padding all around, res has discoloration noted to both bilateral lower legs, arms, and around head, res tends to try and scoot under bedframe, res has been care planned for fall precautions with floor mat and res being on floor, IDT: discussed padding floor with more floor mats trying to protect res from bruising. Family and dr agrees with intervention and IDT: and staff will cont (continue) to discuss best way to protect res . Review of Resident #19's Progress Notes 8/19/2020 at 11:20 (AM) revealed, .res has involuntary movements which causes her arms and legs to flail all over the place . During an observation and interview on 8/23/2020 at 1:00 PM, Resident #19 was seen from hall through open door, lying on her left side on floor mattress next to bed. The resident's forehead and face were pushed into the bolster that was between the floor mattress and the bed frame. The resident was flailing her arms, legs, and body. As the flailing increased, she became more wedged under the bed with her right leg on top of the bed and left leg completely under the bed. No fall mat was next to the floor mattress. A long spongy tube, resembling a pool noodle was attached to the frame with black narrow tape, resembling electrical tape. Part of the noodle was worn away exposing the metal frame. Both the headboard and foot board edges were covered with a noodle with wide silver tape, resembling duct tape, and black narrow tape. Parts of these noodles were also worn away exposing the boards. A sheet of black foam padding had been placed between the bed frame and floor mattress by the resident's head. CNA P attempted to put a clean brief on the resident. CNA P then noticed resident had wedged herself under the bed between the mattress and bed frame. Director of Nursing (DON) B and CNA E entered the room. Resident #19 had flailed enough to have her right side, face-down, between the mattress and under the bed. DON B, CNA P, and CNA E pulled resident from under the bed and onto the mattress. DON B was concerned with the black foam padding and stated, It looks like it gets shredded. DON B asked Resident #19 if she needed help to roll onto her back. Resident #19 moved her right leg with jerking motions onto the bed mattress while lying on her stomach and her left leg got wedged under the bed. Resident #19 was now flailing and rolling back and forth with increased intensity. During an observation and interview on 8/23/2020 at 1:51 PM, DON B entered Resident #19's room as did Maintenance I with wheeled tool cart. Maintenance I stated, I don't want this frame exposed. I bought the black mats. Maintenance I discussed with DON B how to close gap between frame and floor. Maintenance I suggested to place black foam pad between frame and floor. DON B removed wedge from under bed mattress exposing bare floor and no dycem. DON B exited room. Maintenance I stated, I'm trying to make things safer and safer (referring to Resident #19) but I don't know what to use because of sanitizing reasons. The black pad is a dense foam that is not a fall mat. The noodles break away too easy. Observed on 8/23/2020 at 2:06 PM, DON B, CNA E, and CNA P enter Resident #19's room with a tilt-in-space positioning chairs (Broda chair). Resident #19 was on the floor mattress lying on her left side with her face in the black foam padding between the metal framing of her bed. CNA P asked resident to roll towards the chair. CNA E and DON B placed a gait placed under left side of resident. DON B and CNA T rolled the resident onto her back. Abruptly, the resident rolled back onto her left side. DON B and CNA P got resident onto her back. CNA E stepped on mattress to sit resident up. Resident slipped off side of mattress onto bare floor. There was no fall mat next to the floor mattress and resident was not wearing any gripper socks on. She had on a plain pair of pink socks. DON B and CNA P used the gait belt to lift the resident off the floor and to stand up. While DON B and CNA P held Resident #19 up, Resident #19 flailing's increased. CNA E tried to get the leg rest to fold down so they could place the resident in the chair. DON B and CNA E rested Resident #19 on the edge of the leg rest and seat. Resident #19 flailing again increased and slid down the leg rest. DON B, and CNA P, and CNA E, lifted Resident #19 with the gait belt and slid her into the Broda chair. CNA P stated, I don't want her to get a skin tear be careful. During an interview on 8/25/2020 at 11:33 AM, DON B stated, (Resident #19) has a mattress on her bed and then a second mattress on the floor. (DON B reviewed care plans with surveyor). The care plan says please place a mattress next to my bed and a fall mat on the floor along the edge of the mattress when I am in bed. The care plan doesn't say anything about having a fall mat next to the mattress. Any time she (referring to Resident #19) stands up she should have gripper socks on for safety, so she doesn't fall or slip, for traction. If she is standing the gripper socks need to be on. She was not wearing any the day you watched the transfer. DON B reviewed Resident #19's care plan for gripper socks with surveyor and stated, I don't see gripper socks in her care plan (resident #19) cannot use the lift because she moves around a lot and could hit her head. I was hoping the staff knew what they were doing the day you watched the transfer and care and they did not. It was a disaster during the care and transfer. Dignity, peri-care, and transfer were all done wrong. True she could have skin tears with the transfer. Her safety issue is her hitting her head. She is like a 2-man dead- man lift. There was no mention as to whether physical therapy had reviewed Resident #19's transfer status to ensure the safest transfer possible.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain concentrators/filters for 2 residents (Resident #13, #14), reviewed for respiratory care, resulting in the potential for respiratory infections and exacerbation of respiratory conditions. Findings include: Resident #13 Review of a Face Sheet revealed Resident #13 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #13 was cognitively impaired. During an observation on 8/23/20 at 12:50 PM., Resident #13's oxygen filter was completely covered with a thick covering of dust., the tubing was not dated. The concentrator was parked up against the wall next to Resident #13's bed. During an observation on 8/24/20 at 12:37 PM., Resident #13's oxygen concentrator at the end of her bed, next to the foot of her bed. Resident #13's oxygen filter was completely covered with a thick covering of dust. Resident #14 Review of a Face Sheet revealed Resident #14 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #14, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #14 was cognitively intact. During an observation on 8/25/20 at 12:40 PM., observed Resident #14's oxygen concentrator was extremely soiled with sticky residue (spilled pop/pop bottles on night table next to concentrator noted), the concentrator was also noted to be heavily soiled with dust, and residue on the top, sides, back, front and wheels. Resident #14's oxygen concentrator was noted to have a filter on the back and sides, the filters were heavily soiled with a thick coating of dust. During an interview on 8/25/20 at 12:44 PM., Resident #14 reported she wears her oxygen at night only. Resident #14 reported it has been a while since someone has come and cleaned her (Resident #14's) oxygen concentrator. During an interview on 8/25/20 at 3:45 PM., Director of Nursing (DON) B reported housekeeping was responsible for wiping/sanitizing oxygen concentrators. DON B reported nursing was responsibly for changing oxygen (O2) tubing and filters on Sundays.
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.** Based on observation, interview and record review the facility failed to ensure medications were not expired in 1 of 1 locked medication rooms, resulting in the potential for decreased efficacy of the medications which were expired. Findings include: During an observation on 8/24/20 at 12:31 PM., observed the medication room, in the stock medication cupboard noted 3 bottles of stress formula with zinc dietary supplement with an expiration date of 4/20/20. Observed in the small

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) refrigerator was a brown bag with 4 bottles single use vials pnuemovax vaccination 23, with expiration dates of 8/7/20. During an interview on 8/24/20 at 12:35 PM., Licensed Practical Nurse (LPN) G reported that 3rd shift is responsible for going through the cupboards and medication room, and carts to check for expired medications on a nightly basis. LPN G reported if a medication is expired it is suppose to be returned to the the pharmacy, and the pharmacy will send back a new bottle of medication. Review of a facility Policy and Procedure revealed Medication Storage in the Facility: Policy: Medications and biological are stored safety, securely, and properly following the manufacturer or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures: 1 . Pharmacy (name omitted) dispenses medications in containers that meet legal requirements for stability. 2. Medications are not to be transferred medications in containers in which they were received. 3. Medication rooms, carts, and medication supplies are locked or attended by person with authorized access: Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock. They will be disposed of according to drug disposal procedures, and reordered from the pharmacy if a current order exists.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to label and date food product, ensure plumbing is in good repair, and ensure cleanliness of food contact surfaces. These conditions resulted in an increased risk for cross contamination and an increased risk of food borne illness that affected all 39 residents that consume food from the kitchen. Findings include: According to the 2013 FDA Food Code section ,[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) .refrigerated, READY-TO -EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5C (41F) or less for a maximum of 7 day . According to the 2013 FDA Food Code section ,[DATE].15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: .(B) Maintained in good repair. During observation and interview on [DATE] at 10:15 AM a brief initial tour was conducted of kitchen was done with Dietary Aide (DA) O. Upon entering the cooler, one half of a watermelon was wrapped in clear plastic wrap without labeling and dating. DA O stated, The watermelon had to have been for dessert last night. It should have been dated. I was not here when the watermelon was used. Observed DA O dated watermelon [DATE] use by [DATE]. Noted DA O was not aware when watermelon was first used and labeled with a date she was not in the facility. Further touring of the cooler revealed a tray of 6 (six) dished bowls of cut mixed fruit without labeling and dating. DA O stated, That fruit is good for 3 days from last night and dated the tray [DATE] use by [DATE]. A tray of halved sandwiches wrapped in clear plastic wrap without labeling and dating was observed. DA O stated, These sandwiches were for last night's snack cart and were not passed out. Two-1-gallon jugs of milk, half full, 1-white milk, 1-chocolate milk, without labeling and dating. DA O stated, The milk was made yesterday for last night's snack cart. I'm not sure if it was passed. Observed 4 (four) trays of drink in glasses without labeling and dating. DA O stated, The trays aren't labeled and dated because we will use them today for lunch. Observed DA O label and date the 4 (four) trays [DATE]. Observed ,[DATE]-pound carton of yogurt seal broke and half-full, without labeling and dating. Observed part of a tomato wrapped in plastic wrap without labeling and dating. DA O removed the yogurt and tomato to the trash. Entered walk-in freezer at 10:33 AM and observed an opened bottle of soda. DA O stated, That belongs to staff. DA O exited freezer due to space constraint and left door open. Surveyor exited freezer at 10:34 AM. DA O returned at 10:37 AM to close door. Observed on [DATE] at 10:38 AM underneath dishwasher sink with 2 (two) blankets, 1-green, 1-white, on the floor under the sink soaked with water and brown debris. The water on the floor was spreading to the door leading to the resident dining area. DA O stated, The kitchen had a flood this morning. The kitchen has been flooding since Thursday or Friday last week. If the blankets are not on the floor to soak up the water, the water will run out into the dining room and someone might slip. Observation of the faucet to rinse sink was loose and could be manually moved off base. DA O stated, Maintenance is waiting for parts to fix it. Observed dirty dishes/pots/pans in dishwasher room sink. DA O stated, I rinse all dishes in here because there is a garbage disposal instead of using the 3-compartment sink. After rinsing the dishes, I take them all to the 3-compartment to do the rest. During an observation and interview on [DATE] at 10:14 AM, observed with DA M, a clear plastic ice-scoop, scoop end down in the holder on the wall next to the ice machine in the main dining area. The scoop was resting in cloudy water approximately ,[DATE] deep. DA M stated, That ice scoop is used to fill the coolers with ice for resident bedside waters. During an interview on [DATE] at 12:19 Maintenance Director I stated, There are a lot of things going in that area (referring to the dishwashing area and garbage disposal). That is why there is a bucket there near the drain. The water in the bucket comes from the garbage disposal. The floor is sloped towards the door that leads to the dining room. The floor drains can handle the water. A tile curb needs to be put in. The garbage disposal was set cock-eyed and needs to be completely re-plumbed. I got the new ring last Friday and just need time to get it installed during afterhours. I want to cut the floor and put in a channel. The floor has settled and has caused the slope. The drain needs to be extended. Staff should not put blankets down on the floor. I've told them not to keep them on the floor. During an interview on [DATE] at 10:09 AM Dietary Manager (CDM) H stated, Staff knows the rules. Food that has been opened should be labeled with the open date and expiration date. Staff are to use the date labels along with initials. Everything should be dated and labeled no matter when it is to be used. The sandwiches should have been dated and labeled. The night cook is responsible for setting up the snack cart and gets put out at nursing station. The CNAs then pass them out. I want my staff to be held accountable. I go through coolers and freezers every day to check dates and throw expired things out. I expect my staff to do the same thing. The parts are in for the garbage disposal and it will be worked on right away. The blankets should have been put in the soiled laundry right away after soaking up the water and not left there. The ice scoop should not be resting in melted ice in the holder. During a follow up tour of the kitchen at 10:08 AM on [DATE] and interview with Certified Dietary Manager (CDM) H, found clean utensils were stored in covered containers under the prep line. A review of the clean utensils found metal tongs with stuck on food debris behind one of the end pieces, stored in a container with other clean utensils. When the debris was shown to CDM H it was taken back to be washed again. At 10:25 AM on [DATE] Observation of the ice machine scoops found a half inch of stagnant water in the clear ice scoop holder. When asked who uses the clear scoop, CDM H stated, CNA's use it for resident water pass. When the scoop was pulled out of the holder it was noticed that some transparent flecks were floating in the stagnant water, when asked if he could see these flecks, CDM H stated, Yes. At this time a review of the inside of the ice machine found numerous black dots on the front of the inside plastic shield as well as an area in the corner of the plastic shield (an inside portion of the ice machine) covered in black accumulation. At this time, CDM H grabbed a single use wiping cloth and was able to wipe away some of the observed black debris stuck on the inside of the machine. At 10:28 AM on [DATE], Maintenance I arrived in the dining room and was asked when the last time the ice machine had been cleaned? Maintenance I stated that his back up was supposed to have cleaned the machine when he was off on leave. Maintenance I stated, it was due now and he will clean the machine. When asked how often the machine is supposed to get cleaned, Maintenance I stated, Monthly. According to the 2013 FDA Food Code section ,[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch .
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** Based on interview and record review the facility failed to ensure the medical director or their designee attended a quality assessment and assurance meeting at least quarterly, resulting in the potential for the decline in overall medical care provided and decreased oversight of the implementation of resident care in the facility. Findings include: Review of the facility's Quality Assurance and Performance Improvement Program committee meeting minutes revealed neither the medical director nor their designee physically or virtually attended a committee meeting from December 2019 to August 2020. In an

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F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) interview on 8/25/20 at 10:59 AM, Nursing Home Director A (NHA) indicated the medical director did not attend a QAPI meeting physically prior to COVID 19 for the months of December 2019, January 2020, or February 2020. NHA A indicated once COVID 19 visitor restriction were implemented in mid-March, the medical director has not been allowed entrance to the building from mid-March to the present. NHA A indicated the medical director did not attend a QAPI meeting during that time virtually. NHA A indicated had discussions with the medical director regarding QAPI meetings but did not document the discussions and did not document the medical director's responses or contributions to QAPI meetings. Review of the facility's policy Quality Assurance Performance Improvement (policy was not dated), revealed .Our Quality Assurance and Performance Improvement Program (QAPI) represent our facility's commitment to continuous quality improvement. The program ensures a systematic performance evaluation, problem analysis and implementation of improvement strategies to achieve our performance goals .The facility shall establish an inter-disciplinary QAPI Committee. The committee shall consist of, at a minimum, a chairperson, director of nursing services, physician, and three other facility staff members. Additional staff members may be included when their expertise is needed .
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** Based on observation, interview and record review the facility failed to: 1.) perform proper hand hygiene/glove use during peri care for 3 residents (Resident #20, #15, & #19), 2.) use proper technique for Personal Protection Equipment (PPE) use in 1 (Resident #6) reviewed for infections, and 3.) ensure shared resident equipment was properly cleaned and sanitized, resulting in the potential for the spread of infection, cross-contamination and disease transmission for all residents residing in the facility. Findings include: During an observation on 8/23/20 at 1:16 p.m., noted the public/resident telephone (corded office style) in the resident sitting/book room to be visibly soiled on the hand piece. Observed on the face of the phone the numbers were visibly soiled with dust an debris, the inside of the hand piece had a sticky on substance. During an observation on 8/23/20 at 1:12 p.m., observed 2 vital machines located at the entryway to the 200 hall. Both vital machines were noted to be soiled on the cords. Noted the vital machines had a white medical tape holding the cords together, the tape on both machines was dingy in color. The finger probes (which check the oxygen in the blood once placed on a resident's finger) on both vital machines were noted to have a dry crusted substance in the crevasses. During an interview 8/23/20 at 2:41 p.m., Licensed Practical Nurse (LPN)F reported the vital machines should be sanitized between each resident. During an observation on 8/23/20 at 1:21 p.m., observed in room [ROOM NUMBER], around the base of the toilet a large amount of rust colored buildup. The toilet seat riser was noted to be visibly soiled on the seat, under the seat, and various areas of the metal frame. During an observation on 8/24/20 at 7:40 a.m., observed 2 vital machines near the 200 unit. Both machines were visibly soiled, with dust/debris. The fingers probes were visibly soiled with a crusted substance in the crevasses. During an observation on 8/24/20 at 7:45 a.m., observed a sit to stand lift outside room [ROOM NUMBER]. The lift was visibly soiled with dust, debris, and food crumbs on the base where residents plant their feet. The knee area had a crusted substance on it and appeared to have various other areas with a dried spillage/splatter white in color. During an observation on 8/24/20 at 8:40 a.m., observed a hoyer lift to be visibly soiled on the frame with a dried light brown spillage/splatter on it. During an interview on 8/24/20 at 8:45 a.m., Certified Nurse Aide (CNA) J reported she has no idea how often the hoyer is cleaned. During an interview on 8/24/20 at 9:00 a.m., Licensed Practical Nurse (LPN) L reported hoyer, sit to stand lifts, and vital machines are to be cleaned between each resident use. During an observation on 8/24/20 at 9:18 a.m., observed the public/resident telephone (corded office style) in the resident sitting/book room to be visibly soiled on the hand piece. Observed on the face of the phone the numbers were visibly soiled with dust an debris, the inside of the hand piece had a sticky on substance. The table the phone was on, was visibly soiled with an area with a dried coffee spillage in the form of a coffee cup ring. During an observation on 8/24/20 at 12:53 p.m., observed in the medication storage room a dorm size refrigerator was noted to be soiled on the inside with dirt, debris and crusted dried sticky substance on the inside of the door, bottom shelf, as well as the bottom drawer. LPN G reported 3rd shift is suppose to clean the refrigerator, and/or whomever sees it visibly soiled. During an observation on 8/24/20 at 4:26 p.m., observed the public/resident telephone (corded office style) in the resident sitting/book room to be visibly soiled on the hand piece. Observed on the face of the phone the numbers were visibly soiled with dust an debris, the inside of the hand piece had a sticky on substance. The table the phone was on, was visibly soiled with an area with a dried coffee spillage in the form of a coffee cup ring. During an interview on 8/25/20 at 11:10 a.m., Housekeeper (Hsk) S reported housekeeping was responsible for cleaning the lifts. Hsk S reported housekeeping is responsible for all common areas, and high tough surfaces. During an observation on 8/25/20 at 11:22 a.m., observed 2 vital machines near the 200 hall and nurses station. Both vital machine finger probes were visibly soiled with dried crusted substance in the crevasse. During an observation on 8/25/20 at 11:29 a.m., observed a sit to stand near room [ROOM NUMBER] was visibly soiled on the base of the stand where residents plat their feet while being assisted to stand. the knee area had a dried white substance on it, in various areas. During an interview on 8/25/20 at 11:35 a.m., CNA D indicted he does not know who cleans the sit to stand lifts, hoyer lifts, vital machines, or wheelchair. CNA D reported he never cleans the equipment. During an interview on 8/25/20 at 11:40 a.m., CNA Y reported 3rd shift CNA/nursing staff was responsible for cleaning wheelchairs. CNA Y reported housekeeping is responsible to clean sit to stand, hoyer lifts and anything visibly soiled. CNA Y reported there was no completed checklist for housekeepers or CNA/nursing to ensure the cleaning was completed. During an interview on 8/25/20 at 11:45 a.m., Maintenance Director (MD) I reported sit to stand lifts, hoyer lifts are cleaned by housekeepers daily. MD I reported CNA/nursing staff are responsible to clean vital machines between each resident. MD I reported any staff who notices something soiled should be cleaning/sanitizing the equipment/items. MD I reported there are no log/assignment sheets for either housekeepers/nursing staff to complete that the equipment is being clean and sanitized. MD I reported all lifts, and or resident shared equipment should be clean after each use, and when visibly soiled. MD I reported CNA/nursing staff are responsible for cleaning wheelchairs when they are visibly soiled, and at least once weekly. Review of a facility Policy revealed: Cleaning and Disinfection of Resident-Care Items and Equipment Policy/Document #IC-504 Clinical Infection Prevention and Control: Policy Statement: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current Center for Disease Control (CDC) recommendations for disinfection and the The Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard d. Reusable items are cleaned and disinfected or sterilized between residents .(e.g. stethoscopes, durable medical equipment). i. Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards (e.g. bedpans. Urinals). According to https://www.cdc.gov/infectioncontrol/guidelines/disinfection/healthcare-equipment.html, .Environmental surfaces also could potentially contribute to cross-transmission by contamination of health-care personnel from hand contact with contaminated surfaces, medical equipment, or patients . floors become contaminated with microorganisms . by contact with shoes . The removal of microbes is a component in controlling health-care-associated infections . the CDC Isolation Guideline recommends that noncritical equipment contaminated with .body fluids, secretions, or excretions be cleaned and disinfected after use. The same guideline recommends that, in addition to cleaning, disinfection of the .environmental surfaces .is indicated for certain pathogens, e.g., [MEDICATION NAME], which can survive in the inanimate environment for prolonged periods . According to https://classroom.synonym.com/, Expanded [MEDICATION NAME] is a porous, lightweight foam material. The problem arises in that the porosity also provides a harbor for bacteria . Bacteria and other microorganisms feast on these particles . Reuse of expanded [MEDICATION NAME] gives these organisms a chance to grow between uses. Review of a Face Sheet revealed Resident #19 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an observation and interview on 8/23/2020 at 1:00PM, Resident #19 was seen from hall through open door, lying on her left side on floor mattress next to bed. The resident's forehead and face were pushed into the bolster that was between the floor mattress and the bed frame. Resident's brief was soiled with soft, oozing bowel movement running out of top, and leg holes of brief. A long spongy tube, resembling a pool noodle (cylindrical piece of foam) was attached to the frame with black narrow tape, resembling electrical tape. Part of the noodle was worn away exposing the metal frame. On the noodle was the same brown substance as what was on the resident, sheet, and mattress. Both the headboard and foot board edges were covered with a noodle with wide silver tape, resembling duct tape, and black narrow tape. Parts of these noodles were also worn away exposing the boards. A sheet of black foam padding had been placed between the bed frame and floor mattress by the resident's head. CNA E stepped on resident's floor mattress to remove the soiled sheets and place a clean set on without cleaning or sanitizing the mattress. Both, CNA P and

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) CNA E tried to get Resident #19 to roll over onto her back. Resident #19 rolled onto her stomach. CNA P attempted to put a clean brief on the resident. CNA P then noticed resident had wedged herself under the bed between the mattress and bed frame. CNA P was the only staff at this time in the room with Resident #19 and surveyor. Director of Nursing (DON) B and CNA E entered the room. Resident #19 had now flailed enough to have her right side, face-down, between the mattress and under the bed. DON B pleaded with resident to help move herself from under the bed. DON B, CNA P, and CNA E pulled resident from under the bed and onto the soiled mattress. DON B and CNA P kneeled onto floor mattress next to Resident #19. DON B was concerned with the black foam padding and stated, It looks like it gets shredded. DON B asked Resident #19 if she needed help to roll onto her back. Resident #19 moved her right leg with jerking motions onto the bed mattress while lying on her stomach. CNA E exited room after doffing gloves and performing hand hygiene. After 2 minutes, CNA E re-entered room washed hands for 17 seconds and donned gloves. CNA P exited room to retrieve supplies. CNA P re-entered the room and donned gloves without performing hand hygiene. CNA E doffed gloves, washed hands with soap and water for 8 seconds and exited the room for additional cleaning supplies. CNA E re-entered the room and washed her hands for 10 seconds while saying the alphabet and donned gloves. CNA P placed the fitted sheet partially on the floor mattress while CNA E removed soiled sheet and placed the fitted sheet at the head-of-the floor mattress with the same gloves she used to partially remove the soiled sheet. Both CNAs placed 2 chuck pads on clean fitted sheet. While trying to get Resident #19 to turn onto her back, CNA P stepped onto the mattress repeatedly. CNA P started to remove brief while resident was on her left side. Resident #19 turned onto her right side with soiled brief rubbing the fecal matter against the bed and black foam padding. CNA P pulled the brief off resident spilling fecal matter on the mattress and bed frame. CNA P stepped onto mattress with both feet attempting to clean resident while resident laying on her stomach. Using a washcloth, CNA P attempted to clean fecal matter from Resident #19 while she laid on her stomach. CNA P stated, I can't see to clean her. CNA P grabbed a clean washcloth with the same gloves she used to clean the fecal matter. CNA P said to resident, You are getting stuff all over here and on the bed frame as she continued to clean Resident #19 who was lying on her stomach. CNA P stated, That's nasty. With the soiled sheet still under resident and resident lying on stomach, CNA P attempted to put a clean brief on the resident. At this time, CNA P noticed Resident #19 had wedged herself under the bed between the mattress and bed frame. As the only staff in the room, CNA P pleaded multiple times with resident to roll over who was still on her stomach. DON entered room used hand sanitizer donning gloves. A entered room and washed hands with soap and water 12 seconds. DON on knees at residents head. T took soiled sheet off mattress. Resident now on right side between mattress and bed on floor. DON B and CNA E entered room and donned gloves. DON B, CNA P, and CNA E pulled Resident #19 out from under the bed onto soiled mattress. CNA P put clean brief under resident who was still on her stomach. DON B rolled Resident #19 onto her back and CNA P placed brief on resident while kneeling on soiled mattress and without cleaning front perineal area. CNA E stepped on soiled mattress trying to put pants on resident. CNA P stated to CNA E and DON B, She needs a clean shirt on because it has pee on it. Observed resident's wearing socks soiled with fecal matter. Resident #19 kept placing her right foot with soiled sock up on clean bed sheet. CNA E stated, We should put sheet on floor mattress because we got the main stuff of her. Do you want me to put a gown on her? DON B asked resident and she agreed to wear gown. DON B stated, We got to get this mat pushed over because I'm worried, she will get down there (referring to under the bed). DON B continued to kneel on soiled mattress while CNA P finished putting the fitted sheet on the floor mattress without cleaning it. DON B said she was concerned with the black foam padding stating, It looks like it gets shredded. CNA E doffed her gloves, washed hands with soap and water for 10 seconds and left room to get a gown. In meantime, DON B and CNA P kneeled on mattress with resident waiting for CNA E. Resident #19 was again on her back with her right leg up on bed mattress and left leg wedged under bed. CNA Q entered room with a clean gown and donned gloves without performing hand hygiene. CNA P doffed gloves and left room to get Resident #19 some milk without performing hand hygiene. CNA Q took care of soiled clothing and sheet, doffed his gloves and left the room without performing hand hygiene. During an observation and interview on 8/23/2020 at 1:51 PM DON B and Maintenance I entered Resident #19's room without performing hand hygiene. Maintenance I stated, I don't want this frame exposed. Maintenance I suggested to DON B that the black foam padding should be placed between the bed frame and floor. DON B removed wedge from under bed mattress exposing bare floor and no dycem. DON B exited room the room without performing hand hygiene. Maintenance I stated, I'm trying to make things safer and safer (referring to Resident #19) but I don't know what to use because of sanitizing reasons. The black pad is a dense foam. The noodles break away too easy. Observed black foam padding to be porous and not a cleanable surface. The pool noodles was a porous non-cleanable material with pieces missing leaving metal frame and bars exposed. Maintenance I left the resident's room and re-entered without performing hand hygiene either time. During an observation on 8/23/2020 at 2:06 PM DON B, CNA E, and CNA P entered Resident #19's room with a Broda chair. CNA E stepped on and off floor mattress with clean sheet. Observed on 8/24/2020 at 8:41 AM Resident #19 sitting on floor mattress with floor mat next to it. Two (2) noodles were attached to the foot board of the bed with duct tape and electrical tape. A noodle with grey duct tape was attached to the head-of-bed. Black foam padding was on the bed frame. During an interview on 8/25/2020 at 10:56 AM CNA P stated, Hand hygiene needs to be done because you pass germs from one room to another. Hands should be done as long as it takes me to sing the Happy Birthday song. Peri-care with (Resident #19) I can usually roll her on her back and clean her privates from front to back. Because you are to clean from front to back. After I clean the front, I go clean her back (bottom). The CNAs are responsible for cleaning up the mats, mattresses, and walls. The urine and fecal matter should be cleaned up right away and by the aides. The resident prefers to lay at the foot of the bed. I put the sheet on the mattress because I do not want her lying on that dirty mattress that people step on. She prefers to lay on that mattress and people step and walk on it and she should not have to lay on that. A floor mat should be placed on the floor next to the mattress because (Resident #19) moves around a lot. During an interview on 8/25/2020 at 11:33 AM DON B stated, Hand washing should be done to prevent the spread of infection. Hand hygiene should be done entering and exiting a room, visibly soiled, and any contact with something that would be a potential for infection. At the facility when entering a room, hand sanitizing is used. Hand washing with soap and water should be done for 20 seconds vigorously with soap and water and then rinse with a total 40-60 seconds. We tell the staff to sing Happy Birthday twice or the alphabet. Staff need to don (put on) gloves when going into a room, going from soiled to clean, and any time gloves are soiled. Hand hygiene should be done each time before and after donning/doffing gloves. Perineal (peri-care) care should not be done with the resident lying on their stomach. One reason for this is, is you cannot see if everything is clean and to do skin evaluation. When fecal or urine matter is on the mattress it should be cleaned at that time. The aides are supposed to clean it up wherever it is, on the toilet, mattress, anywhere. Then the aides should notify housekeeping to come sanitize. The pool noodles and black foam pad should be cleaned at the time right when it is soiled and then contact housekeeping to sanitize it. The facility did a facility education on cleaning surfaces because the aides thought housekeeping should do the cleaning and housekeeping thought aides should do it. Aides are to clean when their resident does it. The material of the noodles and foam are porous. I noticed that the material does not stay together and comes apart. If it is soiled, they should just be taken off. If I was in there and just cleaned them, I would replace it. The noodles and foam are accessible to staff to replace them. Staff is used to replacing the pool noodles. The black foam pad has not been used in the facility for very long. The pool noodles have been used for a while. The facility did a facility education on cleaning surfaces because the aides thought housekeeping should do the cleaning and housekeeping thought aides should do it. Aides are to clean it when their resident does it. The material of the noodles and foam are porous. I noticed that the material does not stay together and comes apart. If it is soiled, they should just be taken off. If I was in there and just clean it at that time and then replace it. The noodles and foam are accessible to staff. Staff is used to replacing the pool noodles. The black foam has not been used in the facility for very long. The pool noodles have been used for a while. (Resident #19) has a mattress on her bed and then a second mattress on the floor. Resident #20 Review of the facility Admissions Record revealed Resident #20 was a [AGE] year-old male originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment, completed on 7/3/20, revealed Resident #20 required extensive assistance with 2-person assistance for toileting. Brief Interview for Mental Status (BIMS), on 7/3/20, revealed Resident #20 was moderately cognitively impaired. During an observation on 8/25/20 at 11:45 AM, Resident #20 was lying in bed in his room. CNA U and CNA Y entered Resident #20's room to perform incontinence care. CNA U held Resident #20 on his right side while CNA Y cleansed his anus and buttocks. CNA Y was not observed doffing soiled gloves or performing hand hygiene. CNA Y placed a clean brief under Resident #20, laid Resident #20 flat and CNA Y closed his brief. Both CNA's pulled him up in bed and pulled his sheet up to his waist. In an interview on 8/25/20 at 3:34 PM, Director of Nursing B (DON) indicated during incontinence the facility's expectation regarding glove use and hand hygiene

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235361	A. BUILDING _____ B. WING _____	**08/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHALET OF NILES, LLC	**911 S 3RD ST NILES, MI 49120**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) was staff should change their soiled gloves and perform hand hygiene after cleansing the perineum and buttocks before moving to a clean area of the body or clean task. Resident #15 Review of the facility Admissions Record revealed Resident #15 was an [AGE] year-old female originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment, completed on 6/15/20, revealed Resident #15 required one person for assistance for transfers and toileting. Brief Interview for Mental Status (BIMS), on 6/15/20, revealed Resident #15 was moderately cognitively impaired. During an observation on 8/25/20 at 12:22 PM, Resident #15 was seated in her Broda wheelchair (wheelchair design for comfort and proper positioning) in the shower room. Certified Nursing Assistants U and Y (CNAs) assisted Resident #15 on to the shower room toilet. Resident #15 urinated and defecated into the toilet and CNA U transferred Resident #15 to standing, while CNA Y cleansed urine and feces from Resident #15's perineum and buttocks. CNA Y was not observed doffing soiled gloves or performing hand hygiene. CNA Y with soiled gloves pulled up Resident #15's clean incontinence brief and pants. Resident #6 Review of the facility Admissions Record revealed Resident #6 was a [AGE] year-old male originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Brief Interview for Mental Status (BIMS), on 5/19/20, revealed Resident #6 was moderately cognitively impaired. During an observation on 8/23/20 at 3:45 PM, Register Nurse Z (RN) stood outside Resident #6's room with a vital signs machine. On Resident #6's door was a yellow sign, that designated the PPE that should be donned prior to entering the room as gown, gloves, face shield, and N95 mask. RN Z donned no additional PPE besides a surgical mask and entered Resident #6's room to take his vital signs. RN Z exited Resident #6's room and left the vital signs machine outside of his room. No sanitization of the vital sign machine (shared resident care equipment) was observed. RN Z walked across the hall and entered another resident's room and engaged in resident care. In an interview on 8/23/20 at 3:45 PM, RN Z indicated Resident #6 was a resident that goes out of the facility for [MEDICAL TREATMENT]. RN Z indicated residents that go to [MEDICAL TREATMENT] were place on droplet precautions due to the potential exposure to COVID19 while in the community. RN Z indicated did not wear the designated PPE in Resident #6's room and did not clean the vital signs machine used to checked Resident #6's vital signs.