STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235444	A. BUILDING _____ B. WING _____	05/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTWOOD NURSING CENTER	**16588 SCHAEFER DETROIT, MI 48235**

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes: MI 0, MI 4, MI 4, MI 3, MI 4. Based on interview and record review the facility failed to provide mental health services for one (R#602) who had a documented severe history of: [MEDICAL CONDITION], autism, auditory hallucinations, and aggressive behavior, resulting in an immediate jeopardy caused by the physical attack and abuse against another resident (R#603) (whom also had documented severe mental health needs and did not receive mental health services), continued unmet mental health needs, and the likelihood of future violent and aggressive behaviors towards others. The immediate jeopardy was identified on 5/22/20 at 11:19 a.m. The immediate jeopardy began on 5/15/20 at 8:15 p.m. when R#603 was observed being physically assaulted by R#602 via social media. The Administrator was notified of the Immediate Jeopardy on 5/22/20 at 3:45 p.m. and a plan for removal was requested. The immediacy was removed on 5/21/20 when R#602 was arrested by local law enforcement and removed from the facility. Surveyors verified the removal of the immediacy on site by record review and interview on 5/27/20. Although immediacy was removed, the facility's deficit practice was not corrected and remained isolated with harm that is not immediate jeopardy. Findings include: On 5/22/20 at 9:34 a.m., the facility submitted a facility investigation and other pertinent documentation regarding a facility reported incident (FRI) that occurred on 5/15/20. It was initially reported that R#603 had a fall out of the bed that was witnessed by R#602 (unwitnessed by staff), however the facility reported to the state agency as an injury of unknown origin due to the multiple injuries sustained to R#603's head and face. On 5/15/20 at approximately 11:10 p.m., R#603 was transferred to the hospital. On 5/21/20, a video appeared via social media, showing R#602 striking (with closed fists) R#603 multiple times on the head and face areas while whispering profanities, then placing R#603 on the floor. On 5/21/20 at 11:35 a.m., R#602 was arrested by local law enforcement. R#603 remains at the hospital. R#602 Review of R602's clinical record documented the Resident was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the admission Minimum Data Set (MDS) assessment dated [DATE], the Resident was cognitively intact (BIMS score of 13) and required one-person assistance with activities of daily living (ADLs). According to the Hospital Referral dated 5/9/20, R#602 (who had a history of [REDACTED]. R#602 stated the voices were telling him to hurt himself. The group home staff reported to the hospital social worker the Resident had been intermittently (not steady or continuously)) aggressive towards group home staff. According to the Risk Assessment, R#602 had risk factors that included: current [MEDICAL CONDITION], highly impulsive/reckless behavior, history of [MEDICAL CONDITION], and history of criminal behavior/violence. On 5/13/20 at 11:08 a.m. the attending psychiatrist reported and documented, .he reports seeing visions of someone murdering another person yesterday . On 5/13/20 at 3:57 p.m., a correspondence between the hospital and facility documented in Referral Comments stated, .Not stable from a psych prospective, no concerns of violence . can you take at your facility . On 5/13/20 at 3:59 p.m., the facility responded with, Yes. Willing to accept patient. Resident #602 arrived at the facility on 5/13/20 at 19:51 (7:51pm). Upon further record review for R#602, baseline care plans (nursing, dietary, behavior, mood, infection control, etc.) were not developed. Record review of R#602 also revealed the Resident was admitted without obtaining a Preadmission Screening/ Annual Resident Review (PASAAR Level I Screening- used to identify prospective and current nursing facility residents who meet the criteria for possible mental illness or intellectual/developmental disability, or a related condition and who may be in need of mental health services.) prior to nursing facility admissions. The PASAAR Level I Screening is typically completed by the transferring entity (i.e. the hospital, the community, or another nursing facility). On 5/28/20 at 11:20 a.m., during a telephone interview with Physician D stated, he was notified by the facility of R602's arrival to the facility on [DATE] at 7:39 a.m. Physician D stated he was surprised of the Resident's age was and prescribed an antipsychotic that is not usually given in a nursing facility. The nurse was uncertain why R#602 was prescribed the medication. Physician D ordered a psych consult due to the antipsychotic. Physician D assessed R#602 on 5/16/20 which was that Saturday. The Resident did not display behaviors or distress; however, Physician D was concerned with the appropriateness of R#602's admission into the facility. Physician D did think the Admissions Coordinator should have reviewed the Resident's other [DIAGNOSES REDACTED]. On 5/27/20 at 11:04 a.m., the Social Service Director A (SSD) was interviewed. The SSD stated, Psych services (psychiatrist, psychologist, and nurse practitioner) were coming into the facility on ce a week on Tuesday before the COVID-19 pandemic. They are now providing services virtually. The SSD was asked was R#602 referred to psych services upon admission. The SSD stated a referral was faxed over to psych services on 5/20/20 (on a Wednesday, presumptive next service date on 5/26/20). The SSD was asked about the delay in referring the Resident to psych services upon admission. The SSD stated, I had just returned to work on 5/7/20 and it had not been sent due to me being off. The SSD was asked was there someone else that could have sent the referral to psych services. The SSD stated, Nursing could have sent referrals while I was off, but I usually send them. The SSD was then asked when should psych referrals be sent. The SSD then stated, I send them as soon as possible but no more than three days after admission. Lastly the SSD was asked if she was aware of the Resident's psych history. The SSD stated, I was not aware; however, I am now. The referral would have been sent immediately. R#603 Review of R603's clinician record documented the Resident was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the admission MDS assessment dated [DATE], the Resident was cognitively intact (BIMS score 13) and required supervision and one-person assistance with ADLs. According to the Hospital Referral from the psychiatric hospital dated 4/27/20, R#603 initially presented to the emergency room with suicide ideation and attempt (attempted to slice wrists) and increased depression over the past year. The Resident was transferred to the hospital's psychiatric unit on 4/28/20. Per the social worker's evaluation, R#603 was at high risk for suicide as evidenced by current suicide attempt, previous attempts/ideation, poor behavioral control/impulse control, and high emotional distress, and currently requires continuous redirection. The Resident also presented with poor judgement and cognitive impairment. Per the Behavioral Health Admission, R#603 also made statements of, not wanting to be on this earth anymore and getting someone mad at me and stabbing or shooting me. On 5/7/20 at 11:03 a.m., the facility accepted the Resident for admission. R#603 arrived at the facility on 5/7/20 at 16:57 (4:57 pm). Upon further record review for R#603, a baseline care plan for behavior/mood concerns regarding suicide ideation/attempt was not developed. Further record revealed R#603 did have a completed PASAAR Level I Screening completed by the transferring hospital dated for 5/5/20 and indicated the Resident has a current mental illness diagnosis, received treatment for [REDACTED]. This Resident had not been referred to mental health services from the time of admission (5/7/20) to the time of discharge (5/15/20). On 5/14/20, the attending Physician for R#603, recommended a psych consult for the use of an antidepressant medication. On 5/28/20 at 3:42 p.m., the SSD was interviewed and asked if she was aware of R#603's psych history and was the Resident referred to psych services. The SSD stated, No. The Resident had not been seen or referred to psych services and I was not aware of the history. On 5/28/20 on 3:11 p.m., the DON was interviewed and stated, I was unaware of R602's or R#603's prior psychiatric or

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

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) behavioral history. There was a small window when psych services and other ancillaries were not coming into the facility due to the COVID-19 pandemic. Psych services provided a tablet for virtual services about a week ago and the nurse practitioner provided services for the first time virtually on 5/26/20. On 5/22/20 review of the facility's policy titled Behavioral Health Services 2020 documented: It is the policy of this facility that all residents receive necessary behavioral health care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning . The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. This process includes: PASARR screening; obtaining history from medical records . ongoing monitoring of mood and behavior; care plan development and implementation, and evaluation . Behavioral health care and services shall be provided in an environment that promotes emotional and psychosocial well-being . The Social Services Director shall serve as the facility's contact person behavioral services provided by the facility and outside sources such as physicians, psychiatrists, or neurologist. On 5/27/20, the Administrator presented the facility's plan to remove immediacy. The plan included: 1. Identification of Residents Affected or Likely to be Affected: Include actions that were performed to address the citation for recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the facility's noncompliance and the date the corrective actions were completed. R602 was assessed by assigned nurse and denies hallucinations, thoughts of harming self or others and queried regarding allegation, R602 denied all allegations on 5/21/20 11:30am. R602 chart was reviewed and R602 has not exhibited any aggressive behavior as noted by the nurse since admission. On 5/21/20. R602 was transported by Detroit Police Department to an [MEDICATION NAME] Crisis Center 5/21/20 at 11:35 am. Physician and family informed regarding allegation of resident R602 and was made aware that R602 was transported to an [MEDICATION NAME] Crisis Center. Residents identified with like behaviors and a facility wide assessment for residents with identified behaviors. 2. Actions to Prevent Occurrence/Recurrence: Include actions the facility will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when those actions were completed. Admissions Director/DON were educated on adhering to the Admission Checklist to include notification to administrator prior to admission for any patients with severe psych history 5/22/20. All new admissions with a psych history will be reviewed by Social Worker to ensure that a patient with a 3877/3878 has been referred for Psych services and will have behaviors monitored according to the Behavior Management Policy. A new admits with identified psych history will have care to indicate non pharmalogical intervention to manage behaviors. Behavior logs will be reviewed in the clinical meeting to ensure interventions are initiated for patients exhibiting behaviors. 3. Date Facility Asserts Likelihood for Serious Harm No Longer Exists: May 22, 2020.
F 0689 **Level of harm -** Immediate jeopardy **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** This citation pertains to intakes: MI 0, MI 4, MI 4, MI 3, MI 4. Based on observation, interview, and record review, the facility failed to provide supervision to prevent a [AGE] year old vulnerable male resident (R603) from physical abuse and injury inflicted by a [AGE] year old male resident (R602) who had a previously documented severe psychiatric history ([MEDICAL CONDITION], auditory hallucinations, autism, and aggressive behavior), resulting in head trauma, fracture to left middle finger, soft tissue swelling to left wrist, left sided soft tissue swelling to the head, and soft tissue swelling to bilateral lower face and subsequent hospitalization in addition to the likelihood of compromised safety for all residents that resided in the facility. The immediate jeopardy was identified on 5/22/20 at 11:19 a.m. The immediate jeopardy began on 5/15/20 at 8:15 p.m. when R603 was observed being physically assaulted by R602 via social media. The Administrator was notified of the Immediate Jeopardy on 5/22/20 at 3:45 p.m. and a plan for removal was requested. The immediacy was removed on 5/21/20 when R602 was arrested by local law enforcement and removed from the facility. Surveyors verified the removal of the immediacy on site by record review and interview on 5/27/20. Although immediacy was removed, the facility's deficit practice was not corrected and remained isolated with harm that is not immediate jeopardy. Findings include: On 5/22/20 at 9:34 a.m., the facility submitted a facility investigation and other pertinent documentation regarding a facility reported incident (FRI) that occurred on 5/15/20. It was initially reported that R#603 had a fall out of the bed that was witnessed by R#602 (unwitnessed by staff), however the facility reported to the state agency as an injury of unknown origin due to the multiple injuries sustained to R#603's head and face. On 5/15/20 at approximately 11:10 p.m., R#603 was transferred to the hospital. On 5/21/20, a video appeared via social media, showing R#602 striking (with closed fists) R#603 multiple times on the head and face areas while whispering profanities, then placing R#603 on the floor. On 5/21/20 at 11:35 a.m., R#602 was arrested by local law enforcement. R#603 remains at the hospital. R#602 Review of R602's clinical record documented the Resident was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the admission Minimum Data Set (MDS) assessment dated [DATE], the Resident was cognitively intact (BIMS score of 13) and required one-person assistance with activities of daily living (ADLs). According to the Hospital Referral dated 5/9/20, R#602 (who has a history of [MEDICAL CONDITION] and ASD (Autism Spectrum Disorder) presented from the group home he resided with concerns of worsening auditory hallucinations and paranoid delusions. R#602 stated the voices were telling him to hurt himself. The group home staff reported to the hospital social worker the Resident had been intermittently (not steady or continuously)) aggressive towards group home staff. According to the Risk Assessment, R#602 had risk factors that included: current [MEDICAL CONDITION], highly impulsive/reckless behavior, history of [MEDICAL CONDITION], and history of criminal behavior/violence. On 5/13/20 at 11:08 a.m. the attending psychiatrist reported and documented, .he reports seeing visions of someone murdering another person yesterday . On 5/13/20 at 3:57 p.m., a correspondence between the hospital and facility documented in the Referral Comments which stated, .Not stable from a psych prospective, no concerns of violence . can you take at your facility . On 5/13/20 at 3:59 p.m., the facility responded with, Yes. Willing to accept patient. Resident #602 arrived at the facility on 5/13/20 at 19:51 (7:51pm). Upon further record review for R#602, baseline care plans (nursing, dietary, behavior, mood, infection control, etc.) were not developed. R#603 Review of R603's clinician record documented the Resident was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the admission MDS assessment dated [DATE], the Resident was cognitively intact (BIMS score 13) and required supervision and one-person assistance with ADLs. According to the Hospital Referral from the psychiatric hospital dated 4/27/20, R#603 initially presented to the emergency room with suicide ideation and attempt (attempted to slice wrists) and increased depression over the past year. The Resident was transferred to the hospital's psychiatric unit on 4/28/20. Per the social worker's evaluation, R#603 was at high risk for suicide as evidenced by current suicide attempt, previous attempts/ideation, poor behavioral control/impulse control, and high emotional distress, and currently requires continuous redirection. The Resident also presented with poor judgement and cognitive impairment. Per the Behavioral Health Admission, R#603 also made statements of, not wanting to be on this earth anymore and getting someone mad at me and stabbing or shooting me. On 5/7/20 at 11:03 a.m., the facility accepted the Resident for admission. R#603 arrived at the facility on 5/7/20 at 16:57 (4:57 pm). Upon further record review for R#603, a baseline care plan for behavior/mood concerns regarding suicide ideation/attempt was not developed. On 5/27/20 at 10:49 a.m., the Admissions Coordinator (J) was interviewed with the Regional Director of Marketing (E) present was interviewed. The Admissions Coordinator confirmed being in the position for three weeks and could not give details of R#602's admission, however the Regional Director of Marketing (E) confirmed he approved the admission of R#602 into the facility. The Regional Director of Marketing was asked was he, the Director of Nursing (DON), and/or Administrator aware of R#602's behaviors prior to admission. The Regional Director of Marketing stated, I was aware of intermittent aggression towards staff in February. There was nothing noted in the hospital referral that indicated the Resident exhibited current aggression, so I felt confident to admit the Resident based on the information given by the hospital. The DON nor the Administrator were made aware of the Resident's psychiatric history. Had they been aware, R#602 would have been put in a private room. On 5/28/20 at 3:11 p.m., the DON was interviewed and stated, I was unaware of R602's or R#603's prior psychiatric or behavioral history. They were both admitted for COVID-19 monitoring. If I were made aware prior to admission, the Residents would have been placed in a private room with one to one supervision for at least 72 hours. Once I learned of the incident that was recorded on 5/15/20 and viewed on 5/21/20, R#602 was place on one to one supervision until the police arrived. When the incident initially presented as R#603 having a fall, the Resident was moved closer to the nurse's station for increased monitoring and supervision. On 5/22/20 review of the facility's policy titled Accidents and Supervision 2019 documented: The residents environment remains as free of accident hazards as is possible; and each resident receives adequate supervision. This includes: identifying hazards and risk;

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F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) evaluating hazards and risks; implementing interventions to reduce hazards and risk; and monitoring and modifying interventions when necessary . Identification of Hazards and Risks- the process through which the facility becomes aware of potential hazards and the risk of a resident having an avoidable accident . All staff (e.g., professional, administrative, etc.) are to be involved in observing and identifying potential hazards while taking into consideration the unique characteristics and abilities of each resident . The facility should make a reasonable effort to identify the hazards and risk factors for each resident . Various sources provide information about hazards and risk factors: .medical history, facility assessment, and individual observation . This information is to be documented and communicated across all disciplines . Supervision- The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: Based on the individual residents' assessed needs and identified hazards. On 5/27/20, the Administrator presented the facility's plan to remove immediacy. The plan included: 1. Identification of Residents Affected or Likely to be Affected: Include actions that were performed to address the citation for recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the facility's noncompliance and the date the corrective actions were completed. R602 chart was reviewed and R602 as assessed by the nurse denies observation of R602 exhibiting any aggressive behavior since admission. Following allegation as reported by Washtenaw Detective R602 was queried about allegation, R602 denied all allegations on 5/21/20 11:30am. Local police were notified immediately of allegation as reported by Detective and R602 was transported by Detroit Police Department to an [MEDICATION NAME] Crisis Center on 5/21/20 at 11:35am. R603 was assessed on 5/15/20 by assigned nurse to have been observed on the floor and was sent out to the hospital for further intervention. R603 remains in the hospital for clinical intervention and services at this time. R603 will be assessed for care and interventions upon return to the facility. An Investigation was initiated on 5/15/20 to include nuerochecks, SBAR along with a chart review by the DON and reported to LARA for further review. 2. Actions to Prevent Occurrence/Recurrence: Include actions the facility will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when those actions were completed. A facility wide audit was completed for residents who currently reside in the building to ensure appropriate room placement with respect to preference and appropriateness. Admissions/DON/SW was educated to on the appropriate room placement of new admits to the building. New admits will be reviewed in clinical meeting to ensure appropriate room placement per preference. A facility wide audit was completed on 5/22/20 to identify resident with behaviors. Residents identified to have a history of behaviors requiring supervision care plans were reviewed and revised to include a task to monitor behaviors in EMAR. Residents assessed to be exhibiting behaviors that require supervision will be managed according to behavior management policy. A facility wide audit was completed to ensure that current residents feel safe in the facility, Guardian angel program will be initiated to ensure resident needs and concerns are addressed according policy. A skin sweep was conducted to assess residents with cognitive impairment for skin alterations. Residents identified to have skin alterations will be managed according to Skin Care Management policy. 3.Date Facility Asserts Likelihood for Serious Harm No Longer Exists: May 22, 2020.
F 0712 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that the resident and his/her doctor meet face-to-face at all required visits.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure timely physician visits for two (#605, #606) of six residents reviewed, resulting in the potential for unmet medical needs. Findings include: R#605: According to R#605's medical record, the resident had re-admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The physician's last order was on 10/11/19. There are no additional physician's progress notes, assessments or orders. On 5/24/2020, R#605 had been involved with a resident to resident altercation and sustained a swelling on the right side of his temple area. During an observation on 5/27/2020 at 11:30 a.m. the resident did not recall the altercation and did not have any visible bruises of swelling on his face or head. During an interview with the Administrator and Director of Nursing (DON) on 5/28/2020 at 2:30 PM, they both reported the facility's medical record department did not have any additional documentation from R#605's physician. The DON said that she would call the resident's physician and see if there were assessments, or notations that the physician had not sent over to the medical records department. On 5/28/2020 at 3:45 PM the DON said that she had spoke with R#605's physician and there were no documentation or assessments for R#605 since 10/11/2019. R#605's physician said that he would be to the facility in the morning to assess R#605. R#606: According to R#606's medical record, the resident had re-admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The physician's last signed order on 12/9/19, but had no corresponding physician's note, or assessment. The last documentation by the attending physician for R#606 was in 2016. R#606 was being seen by the Senior Wellness Group for his aggressive behaviors and two medications had been adjusted. There are no documents by the attending physician to indicate he was aware of the resident's psychiatric condition or change in medications. On 5/24/2020, R#606 had been involved with a resident to resident altercation and did not sustain any injury. During an observation on 5/27/2020 at approximately 11:30 a.m., the resident did not have any visible injuries, and was not able to be meaningfully interviewed due to his cognition status. On 5/28/2020 at 3:45 p.m., the DON reported that she had reached out to R#606's attending physician and confirmed there were no additional physician assessments or documentation. R#606's physician told the DON he would be at the facility in the evening. During an observation on 5/27/2020 at 11:30 a.m. the resident did not recall the altercation and did not have any visible bruises of swelling on his face or head.
F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to perform any facility-wide assessments to identify and determine the necessary resources to provide competent care for its residents, resulting in inadequate knowledge of the facility population and inadequate resources to care for residents and unmet care needs potentially affecting all 100 residents of the facility. Findings include: On 5/27/2020 at 9:40 A.M., during an interview with the Administrator, the facility's Quality Assurance (QA) program and facility assessment was reviewed. At this time, the Administrator said that she had only been at the facility for approximately two weeks, and had not been able to locate all the QA meeting notes, nor a facility-wide assessment. There was no facility assessment form in the facility's survey binder, or QA binder that was located in the Administrator's office. The facility assessment must address or include the resident population which includes the care required by the resident population considering the types of diseases, physical and cognitive disabilities. The facility assessment also includes staff competencies and services provided that are necessary to care for this population. A review of the Form CMS - 672 dated 5/27/2020 was conducted and confirmed that the facility had 32 resident's with documented psychiatric [DIAGNOSES REDACTED]. The Form CMS- 672 also indicated that the facility had identified 23 residents with behavioral healthcare needs. Since there is no facility assessment, it cannot be determined if the facility had ensured that staff had adequate training or services to provide care to this specific population within the facility. On 5/27/2020 at 9:50 AM, during an interview with the Director of Nursing, she said that she had not participated in a facility wide assessment to determine the needs specific to the facility's resident population. On 5/28/2020 at approximately 3:00 PM, during a telephone interview the Administrator confirmed that the facility had not performed a facility wide assessment to determine any additional resources the facility may need to provide care for its resident population.
F 0841 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility.** Based on interviews and record review, the facility failed to ensure the Medical Director (MD) fulfilled his responsiblity of implementing the facilities policies and procedures, attending the Quality Assessement and Assurance (QAA) meetings to coordinate resident care. This deficient practice affected all 100 vulnerable residents and resulted in the potential for inadequate care. Findings include: On 5/27/2020 at 9:40 A.M., during an interview with the Administrator, the facility's QAA program was reviewed. At this time, the Administrator said that she had only been at the facility for approximately two weeks, and had not had a QAA meeting, nor had she met with the Medical Director. A review of the QAA meeting notes and 'sign-in' sheets from July 2019 through February of 2020 indicated that the Medical Director had not attended any of the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0841 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) QAA meetings. There are no documentations to indicated the MD was consulted or assisted with reviewing or implementing any resident care policies. The QAA meeting notes in January 2020 had the following documentation; Medical Director (MUST ATTEND QUARTERLY MEETINGS). During an interview at 5/28/20 at 1:10 PM, The Director of Nursing said that she has not met with the MD to discuss any facility wide policy revisions. The DON said it has been a challenge to have the MD respond to concerns regarding 24 hour emergency physician cover and the facility changes surrounding the COVID-19 pandemic. The DON said that On 5/28/2020 at 4:45 PM during a phone interview with the MD, he said that he did not attend the last QAA meeting because it was cancelled due to the COVID-19 pandemic. He could not recall the date of his last QAA meeting, or when he had last visited the facility. The MD said he has taken the facility's phone calls regarding patient care, but had not engaged in revising any new policies regarding the COVID-19 or infection control pracitices. According to the facility's Medical Director's Responsiblities, (undated/unsigned), the facility retains a physician designate as MD, to coordinate the medical care provided by attending physicians, and to assist with development and implementation of resident care policies. 1. The Medical Director's responsibilities include participation in: a. Administrative decisions including recommending, developing and approving facility policies related to resident care of physical, mental and psychosocial well-being; b. Issues related to the coordination of medical care identified through the facility's QA committee and other activities related to the coordination of care; c. Organizing and coordinating physician services and services provided by other professionals as they relate to resident care; d. Participate in the Q.A. Committee. 2. Medical Director will work with the facility's clinical team to provide surveillance and develop policies to prevent the potential infections of residents.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on interview and record review the facility failed to have a quality assessment and assurance program that performed systemic analysis that improved care for the residents resulting in the potential for deficient practices to go undetected and healthcare needs to go unmet for all 100 residents currently in the facility. Findings include: On 5/27/2020 at 9:40 A.M., during an interview with the Administrator, the facility's Quality Assurance (QA) program was reviewed. At this time, the Administrator said that she had only been at the facility for approximately two weeks, and had not been able to locate all the QA meeting notes. She said, A QA meeting had been planned for this month until this situation arose and changed our focus. A review of the facility's '2020 QA binder' revealed that the last QA meeting occurred in February 2020 (no specific dates). There was only a 'sign-in' sheet which did not include the Administrator, the Director of Nursing (DON), the Medical Director (MD), nor were there any nursing staff members present. There was no associated notes or updates included with this 'sign-in' sheet. The 'sign-in' sheet documented the following participants; Staff Development, Social Services, Business Office Manager, Dietary Manager, Human Resources, and the Life Enrichment Director. The next entry for the 2020 QA meetings was January 2020 (no specific day) and included the Administrator, the Business Office Manager, Dietary Manager, Human Resources, and Life Enrichment Director. There was no DON, no MD, nor were there any nursing staff members present. The agenda identified the following bullet points; Administrator: - Casper report - compliance reporting - union issues - financial update - FRIs (facility reported incidents). DON: - incident/accident summary - wound report - compliance round reports - staffing needs - consultant reports - All F tags citation audits - chart audits. Infection control/Inservice (should be more) - Monthly IC reports, In-service updates MDS: LOCD - MDS/case mix - QI report - Care plan compliance / not Dietary: Dietary consultant - Dietary Sanitary report - inconsistency of weight audit - F371 audit summary. Human Resource: Employee Injury report - work comp status - employee new hire/termination report - criminal background check - employee evaluations Business Office: trust report - cash collections - private collections - outstanding collections - F156 advance beneficiary notice- F160 Conveyance of funds upon death Social Services: behavior management - discharges - psyche medication - guardianship - ACD Life Enrichment: resident council meeting reports - calendars/events - infection control/cleaning supplies Pharmacy : must attend quarterly meeting Medical Director: must attend quarterly meetings. There are no written documentation's with this report. There are no identified concerns, no system analysis, or plans of improvement. There are no actions or plans of improvement. There is no report of past actions or improvement activities or projects. It is noted that the Ftag numbers reference numbers, F371, F160, and F165, have not been utilized since November 2017. The QA binder for 2019 was reviewed. A meeting note dated October 2019 (no day) had no sign-in sheet and documented plans for physical upgrades for the facility in regards to ceiling tiles in resident's room. The last meeting in the 2019 QA binder was dated July 19, 2019. There was no sign-in sheet, only meeting minutes that referenced sub committees. During an interview with the Director of Nursing (DON) on 5/27/2020 at 9:50 AM, she said she had not participated in a QA meeting, but had only been the DON at the facility since April of 2020. During an interview with the Administrator on 5/28/20 at 3:00 PM, she said she could not locate any additional QA meeting notes, and could not locate any current audits, or process improvement plans that were in progress. During an interview with the Medical Director (MD) on 5/28/20 at 4:45 PM, he said he had not participated in a QA meeting for several months. The MD said he had planned on attending the meeting that had been scheduled in April, but due to the Covid-19 pandemic it was canceled. The MD could not recall the last QA meeting he had attended, nor what issues were discussed.
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 that Quality Assessment and Assurance (QAA) committee meetings were composed of the required committee members, or were held quarterly, resulting in the potential for lack of coordination of medical care and delayed resolution of facility issues that has the potential to affect all 100 residents residing at the facility. Findings include: On 5/27/2020 at 9:40 A.M., during an interview with the Administrator, the facility's Quality Assurance (QAA) program was reviewed. At this time, the Administrator said that she had only been at the facility for approximately two weeks, and had not been able to locate all the QAA meeting notes. She said, A QAA meeting had been planned for this month until this situation arose and changed our focus. A review of the facility's '2020 QAA binder' revealed that the last QAA meeting occurred in February 2020 (no specific day). The 'sign-in' sheet indicated that none of the following were present; the Administrator, the Director of Nursing (DON), the Medical Director (MD), the Pharmacy, nor were there any nursing staff members present. The 'sign-in' sheet documented the following participants; Staff Development, Social Services, Business Office Manager, Dietary Manager, Human Resources, and the Life Enrichment Director. The next entry for the 2020 QAA meetings was January 2020 (no specific day). The 'sign-in' sheet indicated that the meeting included the Administrator, the Business Office Manager, Dietary Manager, Human Resources, and Life Enrichment Director. However, there was no DON, no MD, no Pharmacy, nor were there any nursing staff members present. The QAA binder for 2019 was reviewed. A meeting note dated October 2019 (no day) had no sign-in sheet to determine which member of the QAA committee were present. The last meeting in the 2019 QAA binder was dated July 19, 2019. There was no sign-in sheet, only meeting minutes that referenced sub committees. It is unable to be determined who participated in that QAA committee meeting. During an interview with the Director of Nursing (DON) on 5/27/2020 at 9:50 AM, she said she had not participated in a QAA meeting, but had only been the DON at the facility since April of 2020. During an interview with the Administrator on 5/28/20 at 3:00 PM, she said she could not locate any additional QAA meeting notes, and could not locate any current audits, or process improvement plans that were in progress. During an interview with the Medical Director (MD) on 5/28/20 at 4:45 PM, he said he had not participated in a QAA meeting for several months. The MD said he had planned on attending the meeting that had been scheduled in April, but due to the Covid-19 pandemic it was canceled. The MD could not recall the last QAA meeting he had attended, nor what issues were discussed. The MD could not recall when the last time he visited the facility.