STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235226	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF GRAND BLANC	11941 BELSAY RD GRAND BLANC, MI 48439

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

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure wound care was provided to diabetic wounds to bilateral heels for one resident (Resident #77) of six residents reviewed for wounds, resulting in resident frustration and the potential for pressure ulcers to worsen, become infected and the increased likelihood for decline in overall heath status. Finding include: A review, of Resident #77's medical record, revealed an admission into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) assessment revealed the resident had [MEDICAL CONDITION](s) and scored a 15 on the Brief Interview for Mental Status that indicated intact cognition and needed extensive assistance with dressing, toilet use and personal hygiene. On 9/15/20 at 2:15 PM, an observation was made of Resident #77 sitting in her wheelchair in her room. When queried regarding any wounds, the Resident indicated they had a wound on each heal that had started with a blister prior to coming to the facility. When queried regarding a dressing on her feet, the Resident indicated they had a dressing on each foot that was done yesterday, with an observation made of shoes and socks on bilateral feet. The Resident reported not getting dressing changes on the wounds daily and stated, I have to beg them to do it, and indicated that the dressing was not done everyday. The Resident reported they thought the dressing was supposed to be daily and as needed but when she asked for the dressing to be done, staff tell her it is done once a day. The Resident voiced frustration and stated, the med book says stuff, I have no idea what. The Resident indicated she was not aware of the time of day the dressings were scheduled to be completed. A review, of Resident #77's medical record, revealed the following: -Dated 9/2/20, Nursing Admission Evaluation, left heel blister and right heel blister. -Dated 9/10/20, Progress Note, . Resident admitted to facility with bilateral heel diabetic ulcers. Wound #1 Left heel measures 4.8cm (centimeters) x (by) 4.5cm x UTD (unable to determine depth) on 9/7/20. Wound #2 Right heel measures 1.2cm x 1.0cm x UTD on 9/7/20 . treatment for [REDACTED]. Apply skin prep and cover with non-bordered dressing. Wrap with kerlix and secure with tape QD (every day) and PRN (as needed). A review of the Treatment Administration Record (TAR) for the month of 9/2020 for Resident #77, revealed the following schedule: -Apply skin barrier wipe cover with non-bordered foam. Wrap with kerlix secure with tape to left heel every day shift for wound care, start date 9/4/20 0700 (7:00 AM). The dressing was not documented as completed on 9/5/20, 9/6/20, 9/7/20, 9/10/20, 9/11/20, 9/12/20 with a note that indicated Completed by night shift nurse for today, and 9/15/20. -Apply skin barrier wipe cover with non-bordered foam. Wrap with kerlix secure with tape to right heel every day shift for wound care, start date 9/4/20 0700 (7:00 AM). The dressing was not documented as completed on 9/5/20, 9/6/20, 9/7/20, 9/10/20, 9/11/20, 9/12/20 with a note that indicated Completed by night shift nurse for today, and 9/15/20. -Apply skin barrier wipe cover with non-bordered foam. Wrap with kerlix secure with tape to left heel as needed for wound care, start date 9/3/20 1230 (12:30 PM). The dressing was documented as completed on 9/6/20 at 0140 (1:40 AM), 9/12/20 at 0705 (7:05 AM) and 9/12/20 at 2026 (8:26 PM). -Apply skin barrier wipe cove with non-bordered foam. Wrap with kerlix secure with tape to right heel as needed for wound care, start date 9/3/20 1215 (12:15 PM). The dressing was documented as completed on 9/6/20 at 0140 (1:40 AM), 9/12/20 at 0705 (7:05 AM) and 9/12/20 at 2026 (8:26 PM). On 9/17/20 at 12:50 PM, an interview was conducted with Nurse Unit Manager F, regarding Resident #77's dressing changes to bilateral heels. A review of the TAR and progress notes for the dressing changes revealed the Resident had a dressing change completed by the wound care nurse on 9/7/20 when the measurements were completed for the wounds. Further review revealed dressings completed on day shift 9/4/20 then not completed again until 9/6/20 at 1:40 AM. The review revealed 4 out of 13 days that the dressings were not completed. The Nurse Unit Manager was queried regarding an issue of a Resident that was diabetic with diabetic wounds to her bilateral heels without completed dressing changes as ordered. The Nurse Unit Manager indicated there was an issue regarding the lack of dressing changes and was unable to explain why the dressings had not been completed. The Nurse assigned care for the Resident on day shift for 9/5/20, 9/6/20, 9/7/20, 9/10/20, 9/11/20 and 9/15/20 was reviewed with the Unit Manager and reported that Nurse T had passed medication to Resident #77 on those days and would be responsible for the dressing changes on those days. On 9/17/20 at 1:19 PM, an interview was conducted with Nurse T regarding the lack of documented dressing changes for Resident #77's left and right heel diabetic ulcers. The Nurse indicated that when a dressing is completed, it was to be documented on the TAR in the medical record. The Nurse was unable to remember why the dressings had not been completed and reported she did not remember wrapping or unwrapping Resident #77's heel wound dressings. A review of the facility policy titled, Dressings, Dry/Clean, reviewed 1/2020, revealed, The purpose of this procedure is to provide guidelines for the application of dry, clean dressings. Preparation: 1. Verify that there is a physician's order for this procedure . 2. Review the resident's care plan, current orders, and [DIAGNOSES REDACTED]. 3. Check the treatment record . Documentation The following information should be recorded in the resident's medical record: 1. The date and time the dressing was changed. 2. Wound appearance, including wound bed, edges, presence of drainage. 3. The name and title of the individual changing the dressing. 4. The type of dressing used and wound care given. 5. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 6. How the resident tolerated the procedure. 7. Any problems or complaints made by the resident related to the procedure. 8. If the resident refused the treatment and reason(s) why. 9. The signature and title of the person recording the data .
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** Based on observation, interview, and record review the facility failed to ensure mobility devices were within reach to be used for one resident (Resident #45) of five residents reviewed for mobility resulting in the inability to utilize a mobility device to reposition themselves and the potential for frustration, discomfort, pain, and/or development of a pressure ulcer. Findings include: During an observation and interview on 09/15/20 at 10:46 AM, Resident #45 was observed lying on his back in bed with the head of the bed elevated. The trapeze bar/enabler mobility device handle was placed around the top bar (rather than hanging freely so resident could reach/use it). Resident #45 was observed to not be able to reach the positioning mobility device trapeze bar handle. Resident #45 was asked if he could reach the handle and he stated, No. Resident #45 reached up and tried to grab the bar, but it was approximately one to two inches too far above his reach. Resident #45 reported he usually uses the bar, but he couldn't right now, and he swung his arm trying to grab the bar. Resident #45 clicked the call light on and Certified Nurse Aide D arrived and confirmed the handle of the trapeze bar was out of reach, proceeded to take it down, and it was then within reach of Resident #45. Resident #45 proceeded to grab the bar and reposition himself. Review of Resident #45's activities of daily living (ADL) self-care care plan, revised

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 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) 8/14/2020 stated, The resident has an ADL self-care performance deficit r/t (related to) .contracture injury deformity BLE (bilateral lower extremity; legs), Limited Mobility . with an intervention of Bilateral assist bars and trapeze bar to aide with bed mobility and positioning, revised 6/24/2019. Review of Resident #45's physician orders, included Resident has assist bars and trapeze (trapeze bar mobility device) for positioning. Review of the facility's Repositioning policy, revised 3/24/2017, stated, Assess residents who can reposition independently to determine the following: Is a positioning device needed to maintain independent positioning? and The purpose of this procedure is to provide guidelines for the assessment of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to send urine culture and sensitivity specimens in a timely manner for two residents (Resident #6 and Resident #49) of three residents reviewed for urinary tract infections, resulting in a delay in treatment and the potential for worsening of the infection,[MEDICAL CONDITION] and a decline in overall health and wellbeing. Findings include: Resident #6: A review of Resident #6's medical record, revealed an admission into the facility on [DATE] with a recent re-admission on 3/12/20 with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) assessment the Resident had intact cognition, had an indwelling urinary catheter and was total dependent of staff assistance for dressing, toilet use personal hygiene and bathing. Further review of Resident #6's medical record, revealed the following: On 9/6/20 at 2:05 PM, a progress note revealed, Residents urine straw colored increased mucous and sediment bldy (bloody) mucous noted, foley cath (catheter) changed #20fr (French)/30cc (cubic centimeters) balloon with cldy (cloudy) straw colored urine with sediment and bldy mucous noted, urine dipped and positive for lg (large) amts amounts)of leuk (leukocytes), blood, protein, [MEDICATION NAME], and sm (small) amt of [MEDICATION NAME] (Doctor's name) called and notified stat (immediate) u/a c&s (urinalysis culture and sensitivity) ordered and obtained to be sent (Doctor's name) wanted resident to go to hospital resident refusing at this time but if worsens before lab results rec'd (received) he would go. Resident febrile this am, 99.7 and afebrile at this time at 97.9 will continue to monitor. On 9/6/20, progress note, u/a (urinalysis) picked up but urine cx (culture) was unable to be taken. On 9/7/20 at 10:21 AM, progress note, urine culture picked up and sent to lab. On 9/8/20 1:42 PM, progress note, MD (Doctor) notified of UA results and pending C&S. MD also notified that resident has been febrile (100.5). No new orders at this time. Writer instructed to call MD back when C&S results are in. Will continue to monitor. On 9/10/20, progress note, Spoke with MD about urine culture results, shows > 100,000 ecoli but sensitivity report not completed as of yet. MD requests to wait to start abx (antibiotic) until he sees the sensitivity report specific to this organism. A review of the urine culture report revealed the sample was collected on 9/6/20, received on 9/8/20 and reported on 9/10/20. On 9/15/20 at 10:06 AM, an observation was made of Resident #6 lying in bed and the Resident was interviewed. A foley catheter was hanging on the side of the bed with a privacy cover over the top of the bag, small amount of yellow urine was observed in the tubing. The Resident indicated he has had urinary tract infections. Resident #49: A review, of Resident #49's medical record, revealed an admission into the facility 8/28/13 with a re-admission on 7/14/20 with [DIAGNOSES REDACTED]. A review of the MDS revealed the Resident was cognitively intact, had an indwelling urinary catheter and was total dependent of staff assistance for dressing, toilet use personal hygiene and bathing. Further review, of Resident 49's medical record, revealed the following: -On 8/11/20 at 3:27 PM, progress note, MD notified of temp of 100 last night. Sediments noted in urine, clear, and adequate output of 600. MD ordered CBC (complete blood count), U/A and culture and sensitivity. Resident afebrile on 1st shift today. Will continue to monitor. -On 8/17/20 at 1:00 PM, progress note, MD notified of UA results (>100,[MEDICAL CONDITION] ([MEDICAL CONDITION]-resistant Staphylococcus aureus), + (plus or positive) [MEDICATION NAME], WBC (white blood cells), and bacteria). MD ordered Doxacycline 100 mg (milligrams) bid (twice a day) for 14 days. Order repeated for clarification to MD via phone. A review of the urine culture report revealed the sample was collected on 8/11/20, received on 8/13/20 and reported on 8/16/20. On 9/15/20 at 10:13 AM, an observation was made of Resident #49 lying in bed. During an interview the Resident indicated he has had urinary tract infections. An observation was made of a foley catheter bag hanging on the frame of the bed and was covered for privacy. On 9/16/20 at 10:15 AM, an interview was conducted with Infection Control Preventionist (ICP) Nurse F and the Director of Nursing (DON) regarding Resident #6 and 49's urinary tract infections and the urine culture and sensitivities. A review of Resident #6 of urine culture and sensitivity ordered as stat (immediate) on 9/6/20, laboratory report indicated the specimen was collected on 9/6/20, received on 9/8/20 and the sensitivity not back until 9/11/20 with treatment started was reviewed with the ICP. A review of Resident #49's urine culture and sensitivity ordered on [DATE], not received by the laboratory until 8/13/20 with treatment not started until 8/17/20. ICP indicated that the stat urinalysis was picked up and taken by (name of laboratory service) to a nearby laboratory but the culture would not have been taken at that time due to the time it takes for a culture to grow, they are not considered to be stat and is processed later. When asked why the culture was not picked up at the time the urinalysis specimen and if the culture was done when the urinalysis was found to indicate an infection, the ICP stated, No, it will get lost and we will have to start all over again. The ICP explained that when the cultures were sent with the urinalysis to the nearby laboratory, the specimens would get lost and they would not be informed until after not receiving results, the laboratory was notified and the specimen or results were not available. The ICP stated, It's frustrating working with the lab, they won't take a stat culture to (nearby laboratory), they don't consider it stat when it takes so long to grow. The ICP indicated a urine culture and sensitivity would take 3 to 4 days to receive results. When queried regarding orders for culture and sensitivities that were not ordered as stat, the ICP stated, It would be picked up the next day unless it was early before lab came, and indicated the lab picks up specimens later in the day or evening and if the specimen was collected before lab pick up, the specimen would be picked up that day. The ICP stated, Now we don't send it (culture and sensitivity specimen) so they can pick it up the next day and it doesn't get lost. The specimens not received by the laboratory performing the culture and sensitivity until 2 days after ordered, the culture and sensitivity delayed two days after the urinalysis was done as stat or timely, but treatment was determined by the culture and sensitivity results that could be reported two days prior had the specimen arrived at the laboratory was reviewed with the ICP Nurse. The ICP stated, Right, it's frustrating. On 9/16/20 at 1:24 PM, an interview was conducted with ICP Nurse F regarding the culture and sensitivity specimens being picked up by laboratory services a couple days after the collection of the specimen. The ICP Nurse indicated she had called the laboratory and that on 9/7/20 the laboratory was closed for Labor day holiday so the specimen for Resident #6 was not received until 9/8/20. When queried regarding the specimen for Resident #49 that was collected on 8/11/20 but not received until 8/13/20, the ICP Nurse reported the laboratory didn't know why the specimen didn't make it to the lab and stated, That culture should have made it to the lab by the 11th. A review of the facility policy titled, Urinary Continence and Incontinence-Assessment and Management, revised 3/23/11, revealed, . 3. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible . 5. Identification and management of urinary tract infections will follow relevant clinical guidelines. Antibiotics will be used appropriately . Treating Symptoms of UTI or Urosepsis 16. Where indicated, the staff and physician will treat symptoms of a UTI or urosepsis .
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update interventions on the nutritional care plan, monitor the effectiveness of interventions, notify the physician and obtain weekly weights for a resident with significant weight gain, for one resident (Resident #39) of two residents reviewed for nutritional status, resulting in significant weight gain to go unmonitored and untreated with the potential for further weight gain and a decline in overall health and wellbeing. Findings include: A review of Resident #39's medical record, revealed an admission into the facility on [DATE] with a readmission on 9/2/20 with [DIAGNOSES REDACTED]. A review of the Minimum Data Set assessment revealed the resident was cognitively intact and needed limited assistance with dressing, toilet use and personal hygiene and needed supervision-oversight, encouragement or cueing with eating. A review of the Weight Summary in Resident #39's medical record, revealed the following: -Goal wight: no documented value. -IBW (ideal body weight) Range: 131.0-159.0. -Height: 62.0 inches. -Weight

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) on 3/17/20, 123.0 Lbs (pounds). -Weight on 4/24/20, 120.1 Lbs. -Weight on 5/19/20, 118.0 Lbs. -Weight on 6/1/20, 147.2 Lbs. -Weight on 7/14/20, 149.0 Lbs. -Weight on 7/29/20, 154.6 Lbs. -Weight on 8/12/20 at 2:44 PM, 153.5 Lbs. -Weight on 8/12/20 at 10:56 PM, 156.6 Lbs. -Weight on 9/2/20, 174.5 Lbs. -Weight on 9/9/20, 172.6 Lbs. -Weight on 9/15/20, 170.8 Lbs. A review of Resident #39's progress notes in the medical record, included the following Dietary Progress Notes: -Dated 6/2/20, Resident's 6/1 weight with a significant increase. BME>N. Resident was weighted using a Hoyer scale-observed by RD (Registered Dietician). Resident has been receiving a mech. (mechanical) altered/level 3 diet-with FA (food acceptance) usually >/=75%, also has a PEG tube-no tube feeding. Resident refusing reweights today, stated not feeling well. Resident is receiving a mech. Altered/level 3 diet, large portions and a daily oral nutritional supplement. Resident wants to discontinue the ONS, wants to continue with the large portions. Will continue to trend weights. Follow. -Dated 6/2/20, MD (doctor) notified of weight increase. Ensure Plus to be discontinued. -Dated 6/23/20, Weight warning: Value: 143.5 . Resident's readmit weight triggers for an increase compared to previous weights, however it is similar to her last weight prior to discharge to hospital. Resident has been receiving large portions for meals, with good acceptance. Possibly true weight increase. Do not recommend weight loss at this time. Will continue to trend weights, monitor FA. -Dated 6/23/20, Resident requesting to continue with large portions at mealtimes. tray card updated. Continue to follow. -Dated 7/30/20, Weight Warning: Value: 154.6 . Resident's readmit weight triggers for a significant increase. Resident treated for [REDACTED]. Some weight increase possibly r/t (related to) steroid tx (treatment), IV (intravenous) fluids. Some wight increase possibly true increase as resident with usual po (oral) intake of 100%. Will trend weights weekly. Continue to follow. -Dated 8/17/20, Weight Warning: Value: 156.6 .Resident's weekly weight triggers for a significant increase compared to previous month's weight. Resident with FA>/= 75% most meals, requests large portions, snack at night. She is also receiving steroid med daily-probably contributing to weight increase. Resident does not want to limit meal portion sizes at present. Will continue to follow up with resident. -Dated 9/3/20, Weight Warning: Value: 174.5 . Resident's readmit weight significantly higher. Resident receiving high amounts of steroids- may be reason for weight increase. Resident also continues to request large meal portions and HS (night) snack. Resident to be reweighed-will review. Continue to follow. -Dated 9/16/20, MD notified of resident's weight gain. No new orders. Will continue to follow. A review of Resident #39's care plan revealed the following that included revisions to the care plan and the date of the revisions: -Focus, The resident is at risk for nutritional declines (including unintentional weight loss, fluid volume deficits, and impaired skin integrity) r/t CAA (care areas) triggers. Nutritionally-pertinent diagnosis, [MEDICAL CONDITIONS], exacerbation, hx (history) tobacco abuse,[MEDICAL CONDITION](hypertension),[MEDICAL CONDITION](stroke), edentulous, anxiety, depression, resp. failure s/p trach, VDRF (ventilator dependent [MEDICAL CONDITION]), h/o (history of) dysphagia/feeding tube, weight gain-significant, PNA. Date Initiated 3/17/2020. Revision on 9/3/2020. - Focus, The resident is at risk for nutritional declines (including unintentional weight loss, fluid volume deficits, and impaired skin integrity) r/t CAA (care areas) triggers. Nutritionally-pertinent diagnosis, [MEDICAL CONDITIONS], exacerbation, hx (history) tobacco abuse,[MEDICAL CONDITION](hypertension),[MEDICAL CONDITION](stroke), anxiety, depression, resp. failure s/p trach, VDRF (ventilator dependent [MEDICAL CONDITION]), h/o (history of) dysphagia/feeding tube, weight gain-significant, refusing to be weighed. PNA. Date Initiated 3/17/2020. Revision on 9/16/2020. -Goal, The Resident will consume adequate nutrition on a daily basis in order to maintain body weight near 123 pounds without significant changes through the next review date. Date Initiated: 3/17/2020. Revision on: 3/17/2020. -Goal, The Resident will consume adequate nutrition on a daily basis in order to maintain body weight near 120-123 pounds without significant changes through the next review date. Date Initiated: 3/17/2020. Revision on: 5/04/2020. -Goal, The Resident will consume adequate nutrition on a daily basis in order to maintain body weight near 118-123 pounds without significant changes through the next review date. Date Initiated: 3/17/2020. Revision on: 5/15/2020. -Goal, The Resident will consume adequate nutrition on a daily basis in order to maintain body weight near 150 pounds without significant changes through the next review date. Date Initiated: 3/17/2020. Revision on: 6/2/2020. -Goal, The Resident will consume adequate nutrition on a daily basis in order to maintain body weight near 145 pounds without significant changes through the next review date. Date Initiated: 3/17/2020. Revision on: 8/7/2020. -Goal, The Resident will consume adequate nutrition on a daily basis in order to maintain body weight near 155 pounds without significant changes through the next review date. Date Initiated: 3/17/2020. Revision on: 8/25/2020. -Goal, The Resident will consume adequate nutrition on a daily basis in order to maintain body weight near 170 pounds without significant changes through the next review date. Date Initiated: 3/17/2020. Revision on: 9/17/2020. -Interventions included: Check for tube placement prior to water flushes, date initiated: 3/17/20, revision on: 4/23/20; Keep HOB (head of bed) elevated during and after water flushes administration, date initiated: 3/17/20, revision on: 4/23/20; Monitor FAR and fluid intake and offer alternative choices for refused food and fluids PRN (as needed), date initiated: 3/20/20, revision on 3/20/20; Monitor weekly/monthly weights for significant changes. (no [MEDICAL CONDITION] noted on admission), date initiated: 3/17/20, revision on: 9/16/20; Offer HS snacks and additional snacks as desired, date initiated 5/15/20; Provide diet as ordered: Regular consistency diet, thin liquids; setup. Monitor and record after meals, date initiated: 3/20/20, revision on: 7/15/20; Provide water flushes as ordered, date initiated; 3/17/20, revision on 4/27/20. Further review of the care plan for Resident #39 revealed a care plan with the focus The resident has unplanned/unexpected weight gain r/t Corticosteroid use, Overeating, date initiated 9/16/20. A review of the Resident #39's progress notes revealed the Resident was admitted to the hospital on [DATE] and returned on 7/14/20. Transferred to the hospital on [DATE] and returned on 7/29/20. Transferred to the hospital on [DATE] and returned on 9/2/20. Two weights were obtained in the month of August on 8/12/20. Further review of the medical record revealed a lack of documentation of the physician notified of the weight increase until 9/16/20. On 9/16/20 at 12:59 PM, an interview was conducted with Dietician AA regarding Resident #39's significant weight gain. An admission weight on 3/17/20 of 123.0 lbs., weight on 5/25/20 of 118.0 lbs., 6/1/20 of 147.2 and on 9/2/20 of 174.5 lbs. was reviewed with the Dietician. The Dietician reported the Resident had trended down a little and was put on a supplement then had an increase up to 147 lbs. When queried regarding interventions the Dietician reported she had talked to the Resident regarding cutting down her portions, but the Resident wanted to continue with the larger portions, the supplement had stopped and indicated other interventions such as salads would be difficult for the Resident to chew. When queried regarding other interventions and monitoring interventions, the Dietary manager indicated she had talked to the Resident about portion control but the Resident did not want to cut back on receiving large portions. The progress note on 7/30/20 that indicated weekly weights will be trended, but a review of the weights in the Weight Summary revealed one day in August, 8/12/20, that weights were documented with review of the resident transfering to the hospital on [DATE]. When queried regarding the lack of monitoring weekly weights, the dietician reported the resident did not like getting up in the Hoyer lift for weights. A review of the medical record revealed weights were not documented as refused but the task list was not able to be viewed past 30 days. The Dietician reported that after the resident had gone out to the hospital, she had been given steroids and IV fluids and indicated that could have contributed to the weight gain. When queried if the attending physician had been notified of the weight gain, the Dietician reported the physician had been notified on 6/2/20. When queried if the physician was notified of the increase from 8/12/20 of 153.6 and 156.6 to 9/2/20 of 174.5, the Dietician reported she had not contacted the attending physician of the weight gain and that the most recent time of the increase happened at the hospital and they (physicians) had seen her there. The Resident's nutrition care plan was reviewed with the Dietician. The Dietician was queried regarding interventions for the significant weight gain, the Dietician reported there was a care plan for risk for nutritional decline and there was an option to do a separate care plan but after a review, the care plan lacked focus, goals and interventions for the significant weight gain or for refusals for weekly weights. On 9/17/20 at 9:53 AM, an interview was conducted with Dietician AA regarding Resident #39's nutritional plan of care. The Dietician reported the physician was notified of the weight gain on 9/16/20 and there were no new orders at that time. The weight task from the medical record was reviewed with the Dietician and revealed a lack of documentation of refusals. The Dietician indicated she had talked with staff regarding documentation of refusals for weekly weights. The Dietician reiterated that the weight gain was not desirable but with the steroids and IV fluids the Resident had received at the hospital contributed to the weight gain. When queried if the IDT (interdisciplinary team) had reviewed the significant weight gain, the Dietician reported that the issue had not been brought up to the IDT but that she will bring up the issue. A review of the facility policy titled, Significant Weight Change, reviewed on 6/20/16, revealed, The purposes of this procedure are to determine the resident's who exhibit significant weight change and to increase their nutritional status through an interdisciplinary process. 1. Residents will be weighed as according to the weight policy. 2. The Food Service Manager or facility designee will review all weights for any significant changes. 3. If significant weight change has occurred the interdisciplinary team at Standards of Care meeting will review the resident's care plan, and up

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) date as necessary. 4. Nursing will notify family, physician, and RD of significant change per weight policy. 5. Dietitian or Dietetic Technician as allowed by state regulations, will follow up on all significant weight changes. A review of the facility policy titled, Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol, reviewed on 6/20/16, revealed, .Monitoring 1. The Physician and staff will closely monitor residents who have been identified as having impaired nutrition or risk factors for developing impaired nutrition. Such monitoring may include: a. Evaluating the care plan to determine if the interventions are being implemented and whether they are effective in attaining the established nutritional and weight goals. (1) Evaluating the resident's response to interventions should be based on defined criteria for improvement/worsening of nutritional status; for example, stabilization of weight, laboratory values, or food/fluid intake. (2) The Physician, with input from the staff, will determine the most appropriate intervals for weight assessments . 2. Monitoring is also required for residents whose current nutritional status is stable and or on a planned weight change program. Such monitoring may include: a. Recognizing deviations from the resident's usual habits and preferences, including mealtime habits, snacking, and food preferences. B. Observing for and documenting any sustained decline in appetite and/or food intake. Making note of how added supplementation, double portions or reduced calories has affected this. C. Observing for and reporting significant weight gain or loss .
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** Based on observation, interview and record review, the facility failed to operationalize policies and procedures of assessment for placement of a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube through the abdominal wall into the stomach to provide a means of nutrition and medication administration when oral intake is not adequate) prior to the administration of medication through a PEG tube for two residents (Resident #29 and Resident #43) of three residents reviewed for PEG tube medication administration, resulting in the potential for complications including choking, aspiration of medication and fluids into the lungs and the introduction of medication and fluids into the abdominal space. Findings include: On 9/16/20 at 4:58 PM, Nurse Z was observed during medication administration for Resident #43. The Resident had a PEG tube and received medication through the tube. The Nurse was observed at the medication cart in the hallway and prepped the medication to be given. The Nurse proceeded to the Resident and attached the syringe to the PEG tube, pulled back on the syringe and did not get any return in the tubing or syringe. The Nurse stated, I checked placement earlier, and proceeded to give water through the tube then added water to the crushed medications and gave each medication followed by water between each medication. On 9/16/20 at 5:12 PM, Nurse Z was observed during medication administration for Resident #29. The Resident had a PEG tube and received medication through the tube. The Nurse was observed at the medication cart in the hallway and prepped the medication to be given through the PEG tube by crushing the tablets and putting liquids into individual medicine cups. At the Resident's bedside, the Nurse inserted the syringe without the plunger into the end of the PEG tube and proceeded to administer a water flush and added water to the crushed medication and gave each medication followed by a water flush between each medication. On 9/16/20 at 5:40 PM, an interview was conducted with Nurse Z regarding administration of medication through the PEG tube for Resident #43 and 29. The Nurse was queried regarding checking placement of the PEG tube prior to medication administration. The Nurse reported she had checked placement at the beginning of her shift of all the Residents that had PEG tubes. When queried approximately what time that occurred, the Nurse reported she started checking Residents about 3:30 (PM). When queried that Resident #43 and 29's PEG tube placement was checked approximately one and a half to two hours prior to the administration of medication the stated, Right. The Nurse was queried regarding facility policy for checking placement of PEG tubes prior to administration of medication and indicated she was unsure of the policy. On 9/16/20 at 5:50 PM, an interview was conducted with the Director of Nursing (DON) and the Nursing Home Administrator. The DON was queried regarding the facility policy on monitoring PEG tube placement with administration of medication into the tube. The DON indicated she would look up the policy and stated, you check placement before giving the meds. When queried the time lapse between checking placement and giving the medications the DON stated, immediately prior to (giving the medication). A review of the facility policy titled, Administering Medications through an Enteral Tube, revised 12/21/2010, revealed, .Steps in the Procedure .17. For nasogastric, esophagostomy, or gastrostomy tubes, check placement and gastric contents: a. Attach 50 to 60 ml (milliliters) syringe containing approximately 10 cc (cubic centimeters) air. b. Auscultate the abdomen (approximately 3 inches below the sternum) while injecting the air from the syringe into the tubing. c. Listen for whooshing sound to check placement of the tube in the stomach. d. Pull back gently on the syringe to aspirate stomach content. e. If the stomach content can not be aspirated, pull back slightly on the tube to reposition. If the tube is still not patent, withhold medication and notify the physician .
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation has two Deficient Practice Statements (DPS). Deficient Practice Statement #1: Based on observation, interview and record review the facility failed to ensure the narcotic count was accurate for one resident (Resident #37) of four medication carts inspected, resulting in the narcotic count for Resident #37 not being verified upon delivery from the pharmacy, at shift change and the potential for drug diversion. Findings Include: On 9/16/20 at 12:11 PM while inspecting Vent 3 Medication Cart, in the presence of Unit Manager G and Nurse H it was found Resident #37's narcotic count was documented incorrectly and corrected one day later. The medication label stated QTY (quantity) 118 but was corrected at 84 after 4 tablets were administered to the resident. Nurse H explained when pharmacy arrives with their medications, they go to the door to receive them. Once at their cart they sort through the medications to ensure they have their correct patients' medications. Nurse H reported remembering vaguely about this incident but not any specifics. Nurse H examined Resident #37's [MEDICATION NAME] blister pack and explained there is not enough room on the two packs for 118 tablets. It was verified by Unit Manager G and Nurse H the correct number of tablets (26) were remaining. The Unit Manager was queried as to protocol when the narcotic count is inaccurate. It was reported the nurses are supposed to correct it in the book, sign off with two nurses and report the discrepancy to the Unit Manager. Unit Manager G was not aware of this discrepancy. On 9/16/2020 at approximately 5:00 PM, a review was completed of Resident #37's [MEDICATION NAME] ([MEDICATION NAME]) Individual Patient's Narcotic Record. It revealed Resident #37 is prescribed [MEDICATION NAME] ([MEDICATION NAME]) 0.5 MG (milligrams) every 6 hours. 118 pills were documented as received from the pharmacy on 8/31/2020 by Nurse Q. The [MEDICATION NAME] pills were administered as stated below: - Administered on 9/1/20 at 12 AM by Nurse Q with 117 remaining - Administered on 9/1/20 at 6 AM by Nurse Q with 116 remaining - Administered on 9/1/20 at 12 PM by Nurse S with 115 remaining - Administered on 9/1/20 at 6 PM by Nurse O with 114 remaining At 11:30 PM on 9/1/20 Nurse P & O corrected the count from 114 to 84 and initialed both of their names next to the correction. They also wrote a note about the amount received which stated, Only 88 delivered from pharmacy, Nurse P and O signed their names next to the note above. - Administered on 9/2/20 at 12 AM by Nurse P with 83 remaining On 9/17/2020 at approximately 9:00 AM, review of Resident #37's medical record was completed, and it showed the resident was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 9/17/20 at 8:41 AM, an interview was conducted with Unit Manager G regarding Resident #37's narcotic count. The Unit Manager explained there has been a change in processes due to COVID-19 and the pharmacy now drops off the medication in bulk, instead of going to the individual medication carts. Unit Manager G stated anytime there is a correction in the narcotic book they (Unit Manager's) are supposed to verify the correction. Unit Manager G was not aware of the discrepancy until it was found alongside this writer yesterday. On 9/17/20 at approximately 9:25 AM, Nurse I was queried about medication drop off from the pharmacy. The nurse explained when pharmacy arrives each nurse goes to the entrance to collect their medications. With the controlled substances; they count all of them and verify the amount listed is what is received before signing off on them. On 9/17/20 at 1:25 PM, an interview was conducted with Nurse O regarding the [MEDICATION NAME] narcotic count for Resident #37. It was explained the [MEDICATION NAME] was counted at the beginning of the shift and it had been counted a few times prior and it was assumed the count was accurate. Nurse O stated in the evening at shift change the inaccuracy was discovered. It was further explained there were two blister packs (labeled 1 of

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Nurse Q was informed the Controlled Drug Record was signed stating 118 tablets were received on 8/31/20 with her signature (a verbal description was provided of Nurse Q signature and they confirmed it was theirs'). Nurse Q was further queried if 118 tablets could fit in two blister packs and the nurse stated if there were 118 tablets it would be three blister packs not two. On 9/21/20 at 10:00 AM, a review was completed of the facility policy entitled, Controlled Substances, revised 9/2015. The policy stated the following: .Controlled substances must be counted upon delivery. The nurse receiving the delivery, along with the person delivering the medication order, must count the controlled substances together. Both individuals must sign the designated narcotic record. If a discrepancy in the amount delivered is not agreed upon by the deliverer and nurse, the nurse must refuse the delivery by noting refusal on the manifest and keeping a copy .Nursing staff must count controlled drugs at the end of each shift .They must document and report any discrepancies to the Director of Nursing Services . Deficient Practice Statement #2: Based on interview and record review, the facility failed to obtain and administer medication as ordered for two residents (Resident #65 and Resident #77) of 6 residents reviewed for medication review, resulting in Resident #65 not receiving [MEDICATION NAME] (a [MEDICATION NAME][MEDICATION NAME] inhaler medication used to treat asthma and [MEDICAL CONDITION]) as ordered, with the potential of respiratory symptoms to go untreated and worsen and Resident #77 not receiving [MEDICATION NAME] powder (an antifungal medicine used to treat fungal or yeast infections of the skin) as ordered, with the potential of a skin infection to worsen. Findings include: Resident #65: A review of Resident #65's medical record, revealed an admission into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set assessment, revealed the Resident had moderately impaired cognition and was total dependent on staff for dressing, toilet use, personal hygiene and bed mobility. A review of Resident #65's medical record revealed the following progress notes: -Dated 9/11/20 at 6:24 PM, Nurses' Notes, MD (Physician) notified that [MEDICATION NAME] is unavailable. Medication has been reordered from pharmacy. Ok to hold until medication arrive per MD. -Dated 9/14/20 at 9:56 PM, Nurses' Notes, Late Entry: Note Text: MD notified that [MEDICATION NAME] has not arrived from pharmacy. MD states ok to continue to hold until it arrives. A review of the order for [MEDICATION NAME], dated 8/21/20, for Resident #65, revealed, [MEDICATION NAME] Aerosol 160-4.5 MCG/ACT, 2 inhalation inhale orally two times a day related to [MEDICAL CONDITION]. A review, of Resident #65's Medication Administration Record [REDACTED]. On 9/16/20 at 12:43 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #65's [MEDICATION NAME] inhaler medication. The DON indicated that the Resident had an inhaler upon admission and staff had tried to find it but the inhaler had come up missing on 9/11/20. The pharmacy had been notified for a replacement but the inhaler had not been sent from pharmacy. The DON reported the medication was too soon to be refilled and pharmacy had not sent a replacement inhaler. The DON stated, On Monday (9/14/20) when we came in, we found that it still wasn't in. When queried if the pharmacy let the facility know through the weekend that it was not going to be replaced, the DON stated, No, not until we contacted them when on Monday, it still was not here. Monday morning (9/14/20) we found out it was filled too soon and we had to pay for it. It was a break down on communication. The DON indicated the facility had to pay to have the inhaler replaced. Resident #77: A review, of Resident #77's medical record, revealed an admission into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) assessment revealed the resident had [MEDICAL CONDITION](s), scored a 15 on the Brief Interview for Mental Status that indicated intact cognition and needed extensive assistance with dressing, toilet use and personal hygiene. A review of Resident #77's MAR indicated [REDACTED]. Apply to groin topically two times a day for redness for 14 days apply to groin and coccyx, with a start date on 9/3/20 at 5:00 PM, was documented as not given on 9/3/20 at 5:00 PM and documented as not given on 9/5/20, 9/6/20, 9/7/20 at 9:00 AM. The medication had been documented as given in the evening, as scheduled at 5:00 PM, on 9/5/20, 9/6/20, and 9/7/20. A review of Resident #77 progress notes in the medical record, included the following: -Dated 9/3/20 at 4:15 PM, .[MEDICATION NAME] Powder, Apply to groin topically two times a day for redness for 14 days apply to groin and coccyx. Med not received from pharmacy. -Dated 9/5/20 at 9:09 AM, .[MEDICATION NAME] Powder, Apply to groin topically two times a day for redness for 14 days apply to groin and coccyx. awaiting drug -Dated 9/6/20 at 10:06 AM, .[MEDICATION NAME] Powder, Apply to groin topically two times a day for redness for 14 days apply to groin and coccyx. awaiting drug order -Dated 9/7/20 at 2:47 PM, .[MEDICATION NAME] Powder, Apply to groin topically two times a day for redness for 14 days apply to groin and coccyx. drug on order On 9/17/20 at 1:02 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #77 not receiving the [MEDICATION NAME] powder medication as ordered for 9/3/20, 9/5/20, 9/6/20, and 9/7/20 for the morning dose. The DON reported the facility did not have the medication in the pharmacy stock medication and stated, We started ordering it so it is house stock now, and indicated the medicated powder can be ordered from central supply. The DON indicated reading the progress notes in the morning on 9/4/20 that it was not available and stated, so we made that switch to have as house stock and always be available. The Resident's MAR indicated [REDACTED]. A review of the Nurse that passed medication revealed Nurse T was assigned care of the Resident on those days. On 9/17/20 at 1:19 PM, an interview was conducted with Nurse T regarding Resident #77's [MEDICATION NAME] powder medication for the groin and coccyx area. The Nurse reported she was unable to find the medicated powder for the Resident and stated, She (Resident) had her own personal bottle in her room. The Nurse reported she did not apply any of the personal bottle stock of medication and was unaware the medicated powder was available from central supply. A review of the facility policy titled, Administering Medications, revised 5/2018, revealed, Policy Statement. Medication shall be administered in a safe and timely manner, and as prescribed . 3. Medications must be administered in accordance with the orders, including any required time frame . 15. If a drug is withheld by nursing judgement or physician order code, refused by resident, or given at a time other than the scheduled time, the individual administering the medication shall code the MAR indicated [REDACTED]. Notify the physician within 24 hours unless a medical emergency .
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the manufacturer's recommendation for the co-administration of [MEDICATION NAME] and [MEDICATION NAME] sulfate for one resident (#128) out of five residents reviewed for medication regimen resulting in the potential for inactivation or malabsorption of the antibiotic with an ineffective treatment regimen for a diagnosed infection. Findings include: According to the Admission Record, printed on 9/17/2020, Resident #128 was a [AGE] year old male originally admitted to the facility on [DATE] and readmitted on [DATE] following a hospital stay with the [DIAGNOSES REDACTED]. According to the Medication Administration Record [REDACTED]. The [MEDICATION NAME] sulfate was administered at 9:00 AM. On 9/14/2020, Resident #128 had been prescribed the antibiotic [MEDICATION NAME] 500 mg for a urinary tract infection to be taken twice a day, the administration times were set at 9:00 AM and 5:00 PM. According to the drug reference Epocarates, [MEDICATION NAME] should be given two hours before or six hours after [MEDICATION NAME] sulfate, because the [MEDICATION NAME] sulfate may interfere with the absorption of the [MEDICATION NAME]. The drug reference also directed that the antibiotic should be taken at evenly spaced times each day. On 09/16/20 at 02:54 PM, Licensed Practical Nurse (LPN) E was interviewed. LPN E displayed the package of [MEDICATION NAME] for Resident #128, and stated that she had administered the medication that morning, along with the [MEDICATION NAME] sulfate. When asked about the times, she said that when it is entered as twice a day, the computer would auto populate the time as 9:00 AM & 5:00 PM; if it was put as every 12 hours it would be administered that way. LPN E stated that she thought everyone knows that antibiotics should be administered at regular intervals to maintain the level of the antibiotic in the blood. LPN E stated that she was unaware that [MEDICATION NAME] should not be given with medications containing minerals, like [MEDICATION NAME] sulfate.

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.**

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) Based on observation, interview and record review, the facility failed to ensure that insulin medication was locked, when unsupervised by authorized personnel, and that medication was not left at Resident #29's bedside unsupervised, resulting in the potential for diversion and/or accidental ingestion of prescription medications for residents residing within the 100 Hall unit of the facility. Findings include: On 9/16/20 at 5:12 PM, Nurse Z was observed during medication administration for Resident #29. The Resident had a PEG tube and received medication through the tube. The Nurse was observed at the medication cart in the 100 hallway. The Nurse placed insulin medication, a syringe and the glucometer into an open box of alcohol wipes that was positioned on the top of the medication cart. The Nurse prepped the medication to be given through the PEG tube by crushing the tablets and putting liquids into individual medicine cups. The Nurse, finding she did not have enough of one of the medications, placed the medications, that were crushed and the liquids that were positioned on a tray, into the medication cart and left the cart to retrieve the medication from a storage area, leaving the insulin medication and syringe on the top of the medication cart. The Nurse went out of sight of the medication cart and upon returning to the area, did not have the medication with her and indicated she would have to go to another medication storage area to retrieve the medicine. The Nurse went down the end of the 100 hallway and out of sight of the medication cart that had the insulin and syringe on the top of the cart. The Nurse returned, took the tray with the medication out of the locked medication cart and finished prepping for medication administration. The Nurse went into Resident #29's room that was across the hall where the medication cart was positioned. The insulin and syringe remained on the top of the medication cart. The Resident required personal protective equipment (PPE) to be donned due to contact precautions. The Nurse removed the PPE and left the room went to retrieve the insulin, syringe and glucometer that was in the opened box of wipes. The medications on the tray, remained at the Resident's bedside, leaving the medication unattended. The Nurse went down the 100 hall and out of sight of the Resident's room and medication cart. Upon returning the Nurse indicated she had gone to wash her hands, brought the box of alcohol wipes, syringe and insulin into the Resident's room. On 9/16/20 at 5:50 PM, an interview was conducted with the Director of Nursing and the Nursing Home Administrator (NHA) regarding the unattended, unsecured medications during the observation of medication administration with Nurse Z. The NHA indicated the box of wipes needed to be removed from the medication cart due to possible contamination. A review of facility policy titled, Storage of Medications, revised 6/23/16, revealed, Policy Statement. The facility shall store all drugs and biological's in a safe, secure, and orderly manner. Policy Interpretation and Implementation . Maintaining Storage and Preparation Areas. 2. The Nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . Locked Compartments. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biological's shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others . A review of facility policy titled, Administering Medications, revised 5/2018, revealed, . Safety of Medication Cart. 9. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide . No medications are kept on top of the cart .
F 0808 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure appropriately thickened liquids were provided as ordered for one resident (Resident #35) of five residents reviewed for therapeutic diets, resulting in the potential for further difficulty in swallowing, dehydration, or aspiration (Entry of secretions, food, or any foreign material into the airway that travels below the level of the true vocal folds). Findings include: During an observation on 9/15/20 at approximately 10:30 AM, in Resident #35's room on the bedside table was a plastic cup with a label that stated, Water-Nectar Thick and contained nectar thick water. Next to this cup was a foam cup labeled 9/15 which was approximately 12 ounces full of regular thin (not thickened) water. The thin liquid appeared to be one fourth consumed as it was three fourths full. During an interview on 9/15/20 at 11:31 AM, Resident #35 confirmed she worked with speech therapy and wasn't supposed to have thin liquids. During an interview on 09/16/20 at 10:42 AM, Registered Dietitian A confirmed Resident #35 was working with speech therapy services and wasn't to receive thin liquids except for when speech therapy staff was present. During an interview on 9/16/20 at 10:43 AM, Speech Language Pathologist (SLP) B confirmed she worked with Resident #35 at lunch on 9/15/2020, but not prior on that day (the thin liquid was found in Resident #35's room at approximately 10:30 AM which would have been approximately 1.5-2 hours before lunch). SLP B confirmed she didn't leave any thin liquid in Resident #35's room on 9/15/2020. Review of Resident #35's medical diagnoses, dated 9/17/2020, included [MEDICAL CONDITION] and dysphagia (difficulty swallowing). Resident #35's most recent brief interview for mental status score, dated 7/24/2020, was 10 which reflected moderately impaired cognition. Review of Resident #35's progress note, dated 4/22/20, stated, .Site of originally identified infection: lungs/ respiratory .Resident on ABX (antibiotics) for PNA (pneumonia) . ST (speech therapy) changed resident to thickened liquids d/t (due to) swallowing issues. Review of Resident #35's physician orders [REDACTED]. Review of Resident #35's Hydration Risk Evaluation, dated 9/5/2020, stated, Oral/Nutritional Risk Factors (identify if the resident has any of the following): .Swallowing problems and Dehydration risk as evidence by medical dx (diagnosis) reliance on staff for fluids . Review of Resident #35's progress note, dated 8/28/20, stated .ST (Speech Therapy); Vital Stim (uses electrical current to stimulate the muscles responsible for swallowing) techniques to improve pharyngeal (part of throat) swallow - therapeutic trials of thin liquids via 4 oz (ounce) cups. Review of the facility's Therapeutic Diets policy, revised 3/21/2011, stated, Mechanically altered diets, as well as diets modified for medical or nutritional needs, will be considered therapeutic diets. . The Food Services Manager will establish and use a tray identification system to ensure that each resident receives his or her diet as ordered.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review, the facility failed to adhere to infection control practices for 1) Transmission based precautions for three residents (Resident #28, Resident #29 and Resident #39), 2) Disinfection of equipment for three residents (Resident #21, Resident #29 and Resident #43), and 3) Hand hygiene for one resident (Resident #50) out of 21 residents reviewed for infection control practices, resulting in the potential for illness, outbreaks, and transmission of infectious organisms. Findings include: On 9/15/20 at 9:45 AM, an initial tour of the facility was completed. An observation was made of Resident #28 and 39, who resided in the 100-hall unit, with transmission-based precaution equipment of personal protective equipment (PPE) hanging on the outside of the door. There was no sign that indicated the Residents were on transmission-based precautions, instruction for what PPE was to be used upon entering the Resident's rooms or direction to seek the nurse prior to entering the Resident's room. On 9/15/20 at 10:37 AM, an interview was conducted with Housekeeping Staff BB regarding transmission-based precautions for Resident #28 and 39. Staff BB was queried what kind of precautions Resident #39 required. The Staff stated, They have signs right on the door, but upon walking up to the room, stated, usually right there, and pointed to a space below the PPE on the door. When queried what the staff would wear into the room, the staff indicated they would put on what was hanging on the door. The equipment included, gown, gloves, and a procedure mask. When queried if entering the room required an N95 respirator mask, the Staff stated, I have one on my cart, and if it says it then I wear it in the room, otherwise I use this mask (pointing to the procedure mask) and have the goggles on. On 9/15/20 at 10:50 AM, an observation was made of Nurse V putting signs on Resident #28 and 39's doors that indicated what PPE to wear in the room and instruction for PPE use. The Nurse indicated transmission-based precaution signs were to be on the doors and was unsure why signs were not on the Resident's door. A review of the needed items on the signs included an N95 respirator mask to be worn in the room. When queried regarding the use of the N95 mask, the nurse indicated the sign says to put the mask (procedure mask) over the N95 mask and stated, Yes, they are to wear the N95 in the room. On 9/16/20 at 4:29 PM, an observation was made of Nurse O during medication administration for Resident #21. The Nurse performed blood glucose monitoring using a glucometer that was brought into the room during medication administration. The Nurse performed the blood glucose test by obtaining a drop of blood from the Resident's finger. After completion of the testing, the Nurse wiped the monitor with alcohol wipes and returned the glucometer back into the medication cart where the glucometer was stored. On 9/16/20 at 4:40 PM, an interview was conducted

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) with the Director of Nursing. When queried what the facility policy was regarding cleaning glucometers between residents, the Director of Nursing reported the staff were to use a bleach wipe to clean glucometers after use and that education would be provided to the Nurse. On 9/16/20 at 4:58 PM, an observation was made of Nurse Z during medication administration for Resident #43. The Nurse prepped the medication and placed a glucometer into a box that had alcohol wipes. Prior to medication administration the Nurse performed blood glucose monitoring with the glucometer that was brought to the Resident's room in the box with alcohol wipes. After completing the blood glucose test, the nurse wiped the glucometer with alcohol wipes and replaced the glucometer back on top of the wipes in the box. On 9/16/20 at 5:12 PM, Nurse Z was observed during medication administration for Resident #29. The Resident had a PEG tube and received medication through the tube. The Nurse was observed at the medication cart in the 100 hallway. The Nurse placed insulin medication, a syringe, and the glucometer into an open box of alcohol wipes that was positioned on the top of the medication cart. The Resident required personal protective equipment (PPE) to be donned due to contact precautions. The Nurse entered the Resident's room without the box of alcohol swabs, syringe, insulin, and glucose monitor. The Nurse removed her PPE and left the Resident's room to retrieve the insulin, syringe and glucometer that was in the opened box of wipes. The medications on the tray remained at the Resident's bedside, leaving the medication unattended. The Nurse went down the 100 hall and out of sight of the Resident's room and medication cart. Upon returning the Nurse indicated she had gone to wash her hands, brought the box of alcohol wipes, syringe and insulin into the Resident's room after donning PPE. The Nurse placed the box on top of the heat register in the room. The Nurse performed blood glucose monitoring by obtaining a drop of the Resident's blood onto the glucometer strip. After completed with medication administration, the Nurse took off PPE and performed hand hygiene, took the tray that had the glucometer on it and the box of alcohol wipes with the insulin medication and placed the box on top of the medication cart. The Nurse cleaned the glucometer with an alcohol wipe and placed the monitor into the box of alcohol wipes without letting the monitor dry completely. The Nurse was queried if she cleaned the monitor with alcohol wipes and stated, Yes. When queried what the facility policy was for cleaning glucometers after use between residents, the Nurse responded, Alcohol. On 9/16/20 at 5:50 PM, an interview was conducted with the Director of Nursing and the Nursing Home Administrator (NHA) regarding the lack of infection control practices during glucose monitoring and the cleansing of the monitor between resident use. The DON indicated the glucose monitor was to be cleansed with bleach wipes. The NHA indicated the box of wipes needed to be removed from the medication cart due to possible contamination. On 9/17/20 at 9:10 AM, an observation was made during medication administration for Resident #28 of Respiratory Therapist (RT) U administering breathing treatments. RT U reported Resident #28 was under transmission-based precautions for 14 days to monitor for Covid-19 after returning to the facility. The RT donned the appropriate PPE and approached the Resident and assisted in positioning the Resident in bed and moved the bedside table. The RT retrieved the oxygen saturation monitor from her pocket by going under her isolation gown with her gloved hand. The RT opened the nebulizer treatment apparatus and with her gloved hand, reached into her pocket to take out the inhalation medication. After completion of the inhalation medication, the RT rechecked the Resident's oxygen saturation, cleaned the oxygen saturation monitor with an alcohol pad and reached back under the isolation gown to put the monitor back into her pocket with her gloved hand. The RT did not perform hand hygiene prior to retrieving the monitor and medication from her pocket under the isolation gown or when replacing the oxygen saturation monitor back into her pocket. On 9/17/20 at 1:02 PM, an interview was conducted with Infection Control Preventionist (ICP), Assistant Director of Nursing, Nurse F regarding infection control practice in the facility. The Resident in transmission-based precautions and the administration of inhalation medication and monitoring of oxygen saturation with the Respiratory Therapist reaching into her pocket with gloved hands, underneath the isolation gown, was reviewed with the ICP Nurse. The ICP Nurse reported the Staff should not put the medication in her pocket or put clean gloves on to get the medication and oxygen saturation monitor out of their pocket. When queried regarding the facility cleaning policy of glucometers between resident use, the ICP Nurse indicated that the glucose monitors were to be cleaned with bleach wipes and allowed to dry prior to storage. A review of the facility policy titled, Isolation-Categories of Transmission-Based Precautions, revised 7/12/20, revealed, . Signs to Alert Staff and Visitors of Infections . 3. Signage will be placed on the resident's room door to alert staff and visitors of the need to see the nurse or other designee prior to room entry to allow for instructions on precautions . A review of the facility policy titled, Blood Sampling-Capillary (Finger Sticks), revised 2/9/11, revealed, Purpose. The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees . Steps in the Procedure . 7. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use . A review of the facility policy titled, Administering Medications, revised 5/2018, revealed, . Infection Control Practices 14. Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) when these apply to the administration of medications. During an observation on 09/15/20 at 12:18 PM, Certified Nurse Aide (CNA) C was observed assisting Resident #50 with her meal. Resident #50 was holding a slice of buttered bread and CNA C in assisting the resident, with bare hands, grabbed the bread, tore the bread into smaller pieces and fed the bread to Resident #50. Registered Dietitian A was present and observed the bare hand contact with resident food and went to get CNA C disposable gloves when questioned. Review of the 2013 Food and Drug Administration's Food Code stated, 3-301.11 Preventing Contamination from Hands .FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as .single-use gloves .
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement a program that monitors antibiotic use.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement an effective antibiotic stewardship program, resulting in the potential for the development and transmission of Clostridioides difficile or antibiotic resistant organisms. Findings include: According to the facility policy Infection Control Program - Antibiotic Stewardship, dated as revised 11/28/2017, This facility has established an infection prevention and control program that includes protocols to establish a system for antibiotic stewardship as well as the use and monitoring of adverse effects of antibiotics. The policy defined antibiotic stewardship as: A program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by [MEDICAL CONDITION]. The policy directed that the antibiotic stewardship program include the pharmacist review and monitoring of antibiotic use and stewardship, tracking of antibiotic use, and the education of the staff and residents about antibiotic stewardship. The following indicators of antibiotic monitoring were to be incorporated into the program, the number of days of antibiotic use per 1,000 days of resident care and outcome surveillance of the incidence for antibiotic resistant of organisms for residents who had received at least one antibiotic. At least quarterly, the infection control program was to compile and report to the Quality Assurance and Performance Improvement (QAPI) program the antibiotic use of the facility, the resistance data, the antibiotic prescribing practices of each practitioner, including the indications of antibiotic use, the lab results, and the number of indwelling catheters and the criteria for the catheters, and the infection control program was to provide feedback to each prescribing practitioner of their antibiotic prescribing practices. According to the Centers for Disease Control and Prevention (CDC), Antibiotic Stewardship for Nursing Homes, published in 2015, Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of [REDACTED]. The CDC also recommended that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use. Antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics when followed over a year. Similar to the findings in hospitals, studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrhea infections from [MEDICAL CONDITION], increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic-resistant organisms. Nursing homes contracting laboratory services can request reports and services to support antibiotic stewardship activities. One report that Nursing homes can request from laboratories is a summary report of antibiotic susceptibility patterns from organisms isolated in cultures. These reports, also known as antibiograms, help inform empiric antibiotic selection (i.e., before culture results are available) and monitor for new or worsening antibiotic resistance. According to the CDC, Clostridioides difficile (c dif) is a germ (bacteria) that causes life-threatening diarrhea. It is usually a side-effect of taking antibiotics. These infections mostly occur in: people 65 and older who take antibiotics and receive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235226	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF GRAND BLANC	11941 BELSAY RD GRAND BLANC, MI 48439

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F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) medical care; people staying in hospitals and nursing homes for a long period of time; and people with weakened immune systems or previous infection with [DIAGNOSES REDACTED]. Symptoms might start within a few days or several weeks after you begin taking antibiotics. [DIAGNOSES REDACTED] can easily spread from person to person. [DIAGNOSES REDACTED] is a major health threat. In 2017, there were an estimated 223,900 cases in hospitalized patients and 12,800 deaths in the United States. During an interview on 9/16/2020 beginning at 10:15 AM. the Director of Nursing (DON) and the Infection Preventionist Registered Nurse (IPRN) Staff F stated that the facility did not have an antibiogram and the facility did not have an antibiotic prescribing practices report for prescribers, that she gives to prescribers or medical director for review or present to the QAPI. The facility did not do an antibiotic days report or present that information to the QAPI . When preparing the monthly report, she did not put on the line listing infections that did not meet criteria, unless the prescriber insisted on treating the culture report. For those antibiotics prescribed based on the culture report that did not meet the criteria, she spoke to the prescriber and had them document in the medical record the benefits of the treatment. The IPRN, F, reported that, based on her observations of infections and culture reports, there have not been any resistant organisms or Clostridioides difficile develop in the facility.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer pneumococcal vaccination as recommended by the Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices for one resident (Resident #33) out of five residents reviewed for immunizations, resulting in the potential for the development of pneumococcal pneumonia with illness and hospitalization . Findings include: According to the Admission Record, printed on 9/17/2020, Resident #33 was a [AGE] year old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Upon review of the Clinical - Immunizations tab of the Electronic Medical Record on 9/17/2020, it was noted that Resident #33 had not received both of the recommended pneumococcal vaccinations, the 13-valent pneumococcal conjugate vaccine (PCV13) and the 23-valent pneumococcal [MEDICATION NAME] vaccine (PPSV23). On 8/15/2018, before the change in recommendations, Resident #33 had received the PPSV23 vaccination, but had not received the PCV13 vaccination. On 8/7/2018, the guardian of Resident #33 had signed the consent form for pneumococcal vaccine, one of the signed consent forms indicated that the facility had administered the PPSV23 vaccine. According to the Centers for Disease Control and Prevention (CDC), Streptococcus pneumoniae (pneumococcus) can cause serious illness, [MEDICAL CONDITION], meningitis, and pneumonia with bacteremia (invasive) or without bacteremia (noninvasive). On 9/4/2015, the CDC's publication, Morbidity and Mortality Weekly Report (MMWR) had published Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP). The recommendation was ACIP changed the recommended interval between PCV13 followed by PPSV23 (PCV13-PPSV23 sequence) from 6-12 months to =1 year for immunocompetent adults aged =[AGE] years. On 11/22/2019 the MMWR published Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal [MEDICATION NAME] Vaccine Among Adults Aged =[AGE] years: Updated Recommendations of the Advisory Committee on Immunization Practices and changed the recommendations to Shared clinical decision-making is recommended regarding administration of PCV13 to persons aged =[AGE] years .If a decision to administer PCV13 is made, PCV13 should be administered first, followed by PPSV23 at least 1 year later. During the infection control program interview with the Director of Nursing (DON) and the Infection Preventionist Registered Nurse (IPRN), staff F, on 09/16/20 at 10:15 AM, the IPRN F stated that she looks at each admission for which pneumonia shot they needs, goes through the house once a year to audit pneumonia vaccinations and update consents to assure that each resident got the needed vaccines. The IPRN F stated that she did not keep a record for pneumonia vaccinations for the residents of the facility. IPRN F was asked about the pneumococcal vaccination for Resident #33 and replied, I will look it up and get back with you. On 9/17/20 at 10:37 AM, the DON sent an email with this response I have investigated the pneumonia vaccine in question and have placed a call with residents guardian to obtain verbal consent in the presence of 2 nurses to administer PCV 13. I am awaiting a return call. The facility policy for Pneumococcal Vaccine, dated as revised 1/2020, directed that All residents will be offered the Pneumococcal Vaccination(s) to aid in preventing pneumococcal infections (e.g. pneumonia) unless contraindicated. Current CDC and APIC (sic) recommendations recommend to wait at least 1 year should separate PCV13 (13-valent pneumococcal vaccine) and PPSV23 (23-valent pneumococcal [MEDICATION NAME] vaccine). As of November 2019, the CDC and APIC no longer recommend PCV13 for residents _>[AGE] years of age. PCV23 should be offered first, then based on physician decision, PCV13 will be considered.