| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235718 | A. BUILDING _____ B. WING _____ | 10/08/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **NOVI LAKES HEALTH CAMPUS** | **41795 W 12 MILE ROAD NOVI, MI 48377** |

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 0550<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This citation pertains to Intake #MI 431, MI 999 and MI 249 Based on interview and record review, the facility failed to ensure one (R#238) of three residents reviewed for dignity was treated in a dignified manner, resulting in the potential for diminished feelings of self-esteem, self-worth, and embarrassment. Findings Include: Review of a Facility Reported Incident (FRI) read in part, On Sunday, February 9, 2020 after brunch, a facility visitor informed weekend supervisor (Name Redacted, Registered Nurse (RN) I) of the resident (Name Redacted, R#238) being yelled at by a staff member in the dining room . (R#238) was questioned as to the events that occurred during dinner . (R#238) denies the allegation that the nurse yelled at him . On Monday, February 17, 2020, after having a regularly scheduled visit with (R#238) . resident does recall the incident of Licensed Practical Nurse (LPN) H yelling at him and he denied it on Sunday as he did not want (LPN H) to get into trouble . (R#238) stated that the nurse, (LPN H), voiced to resident nobody would want to sit by you and (LPN H) pulled his wheelchair away from the table and directed him to another table. Resident states that he felt dishonored during the incident and that (LPN H) was not empathetic . (LPN H) was immediately suspended, pending investigation . After investigation, the nurse was terminated for a failure to follow established (Name Redacted, facility) Customer Service Standards . Review of the closed record revealed R#238 was originally admitted into the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS) assessment dated [DATE], R#238 had intact cognition and required the extensive assistance of staff for locomotion on and off the unit. Further review of the FRI revealed interviews that read in part, Feb. 9, 2020 4:45pm, Called into room by (former) resident (Name Redacted, Former Resident J), she stated she was upset by something she saw at lunch inn (sic) the dining room. (Former Resident J) stated that a . Nurse with very short red hair was abusive to another resident. She stated that the nurse went up behind the resident and grabbed his W/C (wheelchair) which startled him and then said to him, no one around here wants to sit with you so you need to go back to your room. She then took the residents napkin and very roughly started to wipe the crumbs off of the resident. Stated the nurse also bent down and talked into the resident's ear, which she couldn't hear but the nurse had a very angry look on her face. She then grabbed the W/C and left pushing the resident. (Former Resident J) stated that she and her brother in law (sic) witnessed this. I then took (Former Resident J) to the dining room and she pointed out (R#238). I took (R#238) to his room and asked him if there was an incident with one of the nurses today at lunch, he was slow to answer and said, I think so . I asked if the nurse treated him roughly, he stated no, I asked if she spoke to him rude, he again stated no . (R#238) then made a statement, that nurse is always antagonistic with everyone . I then asked if it was the nurse with the short red hair and he stated yes . The interview was signed by RN I. An interview signed by Director of Social Services L, dated 2/17/20 at 2:00 PM read in part, .met with (R#238) this afternoon in regard to another resident voicing concerns regarding a staff members comments to resident. Resident expressed that during Sunday brunch as he was offering his seat to another resident, (LPN H) voiced to resident that nobody would want to sit by you, and (LPN H) proceeded to yank residents wheelchair away from the dining room table . Resident expressed that he believes that (LPN H) was not empathetic and he felt dishonored during the time of the above incident . Review of LPN H's personnel file revealed a PERSONNEL ACTION FORM with an effective date of 2/20/20 that revealed LPN H was terminated for, VOP - Violation of Policy and the comments read, Not following (Name Redacted, facility) Service Standards. On 10/8/20 at 11:04 AM, the Administrator, who served as the abuse coordinator, was interviewed, and queried about the incident with LPN H and R#238. The Administrator explained the incident was first reported by another resident at the facility (Former Resident J) and was initially denied by R#238, then later, R#238 stated the incident did happen at which time the facility started their investigation. The Administrator went on to explain that LPN H was terminated after the investigation because she did not adhere to the facility's standards of practice/care. Review of a facility policy titled, Resident Rights for Michigan with a review date 6/1/17 read in part, .A patient or resident shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, sexual preference, or source of payment . A patient or resident is entitled to exercise his or her rights as a patient or resident and as a citizen, and to this end may present grievances or recommend changes in policies and services on behalf of himself, or herself or others to the health facility or agency staff, to governmental officials, or to another person of his or her choice within or outside the health facility or agency, free from restraint, interference, coercion, discrimination, or reprisal . |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This citation pertains to MI 679 Based on interview and record review, the facility failed to ensure medications were administered per physician orders [REDACTED].#138) of one resident reviewed for medication administration, and failed to monitor and follow a physician's orders [REDACTED].#33) of two residents reviewed [MEDICAL TREATMENT] (HD), resulting in medications not administered per physician's orders [REDACTED]. Findings Include: Resident #138 A facility reported incident (FRI) was filed with the State Agency (SA) on 4/13/20 that alleged the resident was not provided her scheduled medication. Review of the facility's Investigation Summary/Actions Taken revealed the following: On Tuesday April 7, 2020 Social Services Director . met with R#138. . resident expressed . nurse (Licensed Practical Nurse - LPN 'K') gave resident all of her medications at one time last night prior to . going to sleep. Resident stated that she has two medications including a blood pressure med (medication) that they typically takes around 5 AM. Review of the Investigation Summary/Action Taken report further read: Assistant Director of Health Services (ADHS) 'F', spoke to Nurse (LPN 'K') about the alleged incident. LPN 'K' states During the night shift med pass I entered the resident's (R#138) room with 2 medication cups. One cup had the resident's night time medication and the other cup had the resident's morning [MEDICAL CONDITION] medication. The resident does not like to be woke up early and wants medication left at bedside, so I comply with her request . Upon entering resident's room, I noted both medication cups at bedside. Medications were still present in the cups. I told the resident I would have to discard the night medication since they were not taken. I have given (name redacted) R#138 her medications like this previous shifts because this is how she prefers it . During the course of the investigation resident's medication records were reviewed and showed that medications were signed out. Resident only receives [MEDICATION NAME] at 5 a.m. no other medications . Further review of report read, Nurse (LPN 'K') was educated in relation to this incident. (Name Redacted) LPN 'K' was educated on appropriate steps to take if resident wishes to self-administer medication . (Name Redacted) LPN 'K' was also educated for leaving medications at resident bedside On |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>10/8/20 at 10:40 a.m., a call was placed to LPN 'K' and a message was left on the voicemail. On 10/8/20 at 11:43 a.m., during an interview with ADHS 'F', when asked if R#138 was assessed for self-administration of medication, ADHS 'F' stated, No. When asked if medication should be left at the bedside at the resident's request, ADHS 'F' stated, No. ADHS 'F' further stated, . If there is a preferred time that the resident does not want to be woke up, we can change the med (medication) time for them. Review of the clinical record revealed R#138 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the Minimum Data Set (MDS) assessment dated [DATE] revealed R#138 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition and required extensive assistance with one to two-person physical assist for most of their activities of daily living (ADL) care. A physician's orders [REDACTED]. [MEDICAL CONDITION], take on empty stomach. Review of the Medication Administration Record [REDACTED]. The facility's Care Plan dated 03/02/2020 revealed the following: Problem: Resident has DX (Diagnosis) of [MEDICAL CONDITION] and at risk for complications. Goal: Resident will be free of adverse effects of [MEDICAL CONDITION]. Approach: Administer my medications as ordered. Discipline: LPN. Resident #33 On 10/5/20 at 10:15 a.m., R#33 was observed in bed. The over-bed table was next to the bed within reach. There were two 12 oz. (ounce) foam cups filled with water on the over-bed table. Each 12 oz cup held approximately 355 mls (milliliters) of fluid. When asked if they drink water from the cups on the over-bed table, R#22 stated, Yes. When asked if they received [MEDICAL TREATMENT] treatment, R#33 stated, Yes, I go to [MEDICAL TREATMENT] on Tuesday, Thursday, and Saturday. On 10/5/20 at 12:41 p.m., R#33 was in bed. There were still 2 cups of water at the bedside. When asked how much water she had drank, R#33 stated, Not too much, about 1/2 glass (cup). At that time R#33 had drank more than 1/2 cup of fluid from one of the cups. On 10/5/20 at 1:15 p.m., during an interview, when asked about R#33's fluid restrictions, Registered Nurse (RN) 'B' stated, (name redacted) R#33 knows how to control herself. We are giving her water. When asked how much fluid should be at the bedside, RN 'B' stated 250 milliliters (ml) at bedside. On 10/5/20 at 2:10 p.m., RN 'B' had removed one of the cups of water that was on the over-bed table. A review of the clinical record revealed R#33 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. further review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed R#33 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated moderately impaired cognition for decision making skills. Review of physician's orders [REDACTED]. Complete [MEDICAL TREATMENT] Center Communication Observation under 'Other Clinical Observation' and send with resident. Once A Day on Tue, Thu, Sat. 11/08/2019 Open Ended Medications - Order Set Encourage FR (Fluid Restrictions) - 1000 (ml) Fluid Restriction 240 ml for breakfast and lunch from dietary 180 ml for dinner from dietary 120 ml day shift from nursing 120 ml evening shift from nursing 100 ml night shift from nursing Three Times A Day - 06:00 AM - 02:00 PM, 03:00 PM - 10:00 PM, 11:00 PM - 06:00 AM 07/11/2019 Open Ended Treatments - No drinks left at beside by staff. Encourage resident to not self-serve fluids, to ask nurse if she is thirsty. May offer mouth swabs if over 1000 ml for the day. Three Times A Day 06:00 AM - 02:00 PM, 02:00 PM - 10:00 PM, 10:00 PM - 06:00 AM 01/16/2019 Open Ended Treatments - Monitor AV (Arteriovenous) shunt daily for redness, swelling, signs of infection, pain, warmth exudate, tenderness, numbness, and extremity swelling distal to shunt. Notify physician of any changes. Three Times A Day 06:00 AM - 02:00 PM, 02:00 PM - 10:00 PM, 10:00 PM - 06:00 AM 09/10/2020 Open Ended Medications - Give only 50 mg of [MEDICATION NAME] vs. 100 mg during mornings of [MEDICAL TREATMENT] per Nephrologist (Name Redacted) -- due [MEDICAL CONDITION] during [MEDICAL TREATMENT] Once A Day on Tue, Thu, Sat 07:30 AM A review of the facility's Care Plans revealed the following: Start Date: 09/22/2018 Last Reviewed/Revised: 09/15/2020 11:30 AM PROBLEM: Resident is risk for dehydration/fluid imbalance r/t fluid restriction of 1000 cc (cubic centimeters)/daily. GOAL: Resident will remain adequately hydrated and will not display s/sx (signs/symptoms)dehydration. APPROACH: Administer Meds per orders, observe for side effects and reports as needed. APPROACH: Document fluid restriction of 1000 cc/day on HD [MEDICAL TREATMENT] communication form. APPROACH: Labs per doctor's orders. APPROACH: Observe for and report to the RD (Registered Dietitian)/MD as needed any decreases in p.o. (oral) intakes. APPROACH: Observe for clinical s/s dehydration: dry mouth, thirst, restlessness, irritability, tenting skin turgor, dry mucous membranes, sunken eyes, dry/warm skin, decreased urinary output, etc. APPROACH: Offer fluids with meals, medication passes, snacks, and activities. Resident is on 1200 cc/day fluid restriction. On 10/7/20 at 10:40 a.m., an interview was conducted with the Director of Health Services (DHS). When asked about the two cups of fluids on R#33's over-bed table, the DON explained maybe R#33 had asked for water during mealtimes and the cups weren't removed . The facility's policy titled Guidelines for Self-Administration of Medications with a revised date of 5/22/2018 revealed the following: .PURPOSE: To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is a part of their plan of care. PROCEDURES: 1. Residents requesting to self-medicate or has self-medication as a part of their plan of care shall be assessed using the observation . Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for [REDACTED]. Review of a facility policy titled Guidelines for Fluid Restriction dated 05/11/16 revealed the following: .PURPOSE: To ensure fluids are provided within the physician order [REDACTED]. Upon receipt of a physician's orders [REDACTED]. 2. Intake and Output monitoring shall be initiated upon receipt of the order. 3. The Director of Health Services and Director of Food Services shall collaborate to establish preference and needs by department and shift. 4. The Dietary Department shall record established breakdown by meal on tray card. 5. The Nursing Department shall record established breakdown by shift and document in the EHR (Electronic Health Record). 6. Fluid consumption shall be reviewed by shift to determine adjustments necessary in the fluid intake of the resident on the restriction in order to meet their established fluid needs. 7. The resident and/or responsible party should be educated regarding the reason and importance of fluid restriction. 8. Should the resident and/or responsible party chose not to comply with the recommended fluid restriction a Self Determination of Care should be completed explaining the risk(s) of noncompliance. 9. If the resident and/or responsible party continues to refuse recommended care intervention after the risk(s) have been explained an order should be obtained to discontinue the fluid restriction. 10. The water pitcher should be removed from the bedside. 11. The resident should be periodically assessed for appropriateness and continued need for fluid restriction . |
| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This citation pertains to intake MI 999. Based on observation, interview and record review, the facility failed to ensure interventions were in place to prevent injury for one resident (R#35) of four residents reviewed for accidents/hazards, resulting in the increased potential of R#35 sustaining an injury from a fall. Findings include: On 10/5/20 the medical record for R#35 was reviewed and revealed the following: R#35 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#35's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/9/20 revealed R#35 needed extensive assistance from two facility staff with most of their activities of daily living, to include transfers to bed. R#35's BIMS score (brief interview of mental status) was eight indicating moderately impaired cognition. On 10/05/20 at approximately 9:50 a.m., R#35 was observed in their wheelchair in the doorway to their room. R#35 was queried if they had any falls in the facility and they indicated that they had. R#35 was unable to provide further details into their falls. On 10/05/20 at approximately 3:50 p.m., R#35 was observed in their room, lying in bed sleeping. R#35 was observed to not have any fall mat's (protective mattresses used to prevent injury when falling out of bed) on either side of their bed. Two fall mats were observed rolled up behind R#35's nightstand. On 10/06/20 at approximately 7:52 AM, 9:15 AM, 11:01 AM and 2:01 PM, R#35 was observed in their room, lying in their bed sleeping. R#35 was observed to not have any fall mats on either side of their bed. Two fall mats were observed rolled up behind R#35's nightstand. On 10/07/20 at approximately 9:33 a.m., R#35 was observed in their room, lying in their bed sleeping. R#35 was observed to have two fall mats behind the head of the bed and nightstand. No fall mats were on the floor to prevent injury from falling. R#35's bed was observed not to be in the lowest position. On 10/07/20 at approximately 10:08 a.m., R#35 was observed in their room, lying in their bed sleeping. R#35 was observed to have two fall mats still rolled up behind their nightstand. No fall mats were observed on the floor to prevent injury from falling. R#35's bed was still observed not to be in the lowest position. R#35's room was observed with LPN (Licensed Practical Nurse) D. LPN D was queried if R#35 was supposed to have fall mats on the floor, on each side of their bed and they stated, yeah. LPN D was queried if R#35 was a fall risk and they stated, yeah LPN D was then observed lowering R#35's bed to the lowest position and placing both fall mats that were located behind the night stand on each side of R#35's bed. LPN D was queried why R#35 wasn't provided the fall mats and didn't have their bed in the lowest position and they indicated that they didn't know. A physician's orders [REDACTED]. Another physician's |

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| F 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>orders [REDACTED]. An IDT note (Interdisciplinary Team) on 9/29/2020 revealed the following: IDT Review fall: Resident is a (R#35 demographics) admitted to the campus on 9/3/20 and is being skilled for L4 (Lumbar 4) [MEDICATION NAME] process fracture. On 9/28/20 resident observed on bedroom floor towards the door. Resident stated that she was trying to go to the bathroom and that she is used to being independent. Resident assessed for pain and injury. Denies hitting head, a small skin tear noted to right forearm. Cleansed and covered with dressing .Floor mats placed next to resident's bed to ensure residents safety .Goal is to keep resident safe and free from injury . A review of R#35's care plan reveled the following: Problem: Resident at risk for falling R/T (related to): impaired mobility, impaired cognition, weakness, balance and ambulation deficits . Goal: Resident will work with staff within limitations to help reduce likely hood <sic> of falls and mitigate injuries .Approach: Bilateral floor mats Keep bed in lowest position with brakes locked . On 10/08/20 at approximately 1:38 p.m., the Director of Health Services (DHS) was queried regarding R#35's fall interventions. R#35's plan of care was reviewed with the DHS including having R#35's bed in the lowest position and R#35's need for fall mats to prevent injury. The DHS was queried if R#35's interventions should be in place and they indicated they should be. On 10/08/20 a facility document titled Fall Management Program Guidelines (effective date-5/31/17) was reviewed and revealed the following: Policy-Falls Management Program Guidelines .Purpose- .(Name of Corporation) strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures . (Corporation) recognizes even the most vigilant efforts may not prevent all falls and injuries. In those cases, intensive efforts will be directed toward minimizing or preventing injury . Procedure: 1b. Care plan interventions should be implemented that address the resident's risk factors . 4. Any orders received from the Physician should be noted and carried out 5. The resident care plan should be updated to reflect any new or change in interventions |