STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235120	A. BUILDING _____ B. WING _____	10/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARYCREST MANOR	15475 MIDDLEBELT RD LIVONIA, MI 48154

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake # 5. Based on observation, interview, and record review, the facility failed to provide appropriate assistance and documentation for bed baths, face and hand washing, and hair washing for one sampled resident (R199) that was dependent upon staff for the performance of activities of daily (ADLs) from a total of four sampled residents, resulting in the risk for diminished dignity and unmet care needs. Findings include: On 9/30/20 at 11:08 AM, R199 was met in their room for an interview. R199's hair was observed to appear greasy. R199 was queried on the care they were receiving at the facility and stated, I have only had two bed baths since I've been here. I cannot have showers because I have stitches. R199 was queried about her hair and stated, I feel awful with greasy hair, I am a very clean person. On 10/1/20 at 11:54 AM, Certified Nursing Assistant (CNA) F was met with for an interview. CNA F confirmed that they were assigned to provide care for R199. CNA F was queried on how often R199 was supposed to be receiving bed baths. CNA F stated, Twice weekly. On 10/1/20 at 12:29 PM, R199 was met in their room for an interview. R199's hair was again observed to appear greasy. R199 was further queried about the number of bed baths they had received while at the facility. R199 stated, I'm so confused, I think I've had two bed baths. I have not had my face or hands washed today. I need help with everything. The staff come in my room, say they will be right back, and then disappear. On 10/1/20 at 1:00 PM, a review of R199's ADL care plan revealed the following, Goal: Resident will be neat, clean, well-groomed .with assistance as needed through next review period. Goal Date: 12/18/2020. Effective Date: 9/21/2020-Present. Interventions: Please refer to therapy treatment plans for care plan interventions related to ADLs . Effective Date: 9/21/2020-Present. On 10/1/20 at 1:15 PM, a review of a document involving R199 titled, Bath By Day Report revealed that R199 had one bed bath on 9/30/20, since being admitted to the facility. On 10/1/20 at 1:25 PM, a review of R199's Electronic Health Record (EHR) indicated that R199 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of R199's most recent Minimum Data Set Assessment (MDS) revealed that R199 had an intact cognition and required assistance with all ADLs other than eating. On 10/1/20 at 2:30 PM, the Director of Nursing (DON) was queried regarding their expectations for staff when providing ADL care/bed baths to residents. The DON stated, Showers should be offered twice weekly as scheduled. If the resident refuses a shower, then a bed bath should be offered. On 10/1/20 at 2:45 PM a facility policy titled A.D.L. (Activities of Daily Living) Flow/Care Guide May 2008 revealed the following, Purpose: To document and provide individualized ADL care provided to the resident. 1. A flow record/guide will be developed for each resident. 2. The guide sheet will indicate the care that will be required for each resident on a daily basis. Individualized care needs will be documented as appropriate. 3. The associate or care provider providing care for the day/shift will document by signature that the care needs were provided according to the care guide.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed ensure a resident in isolation precautions was visited timely and or document activity provided for one sampled resident (R87) of one reviewed for choices and activities, resulting resident unaware of ability to participate in activities of choice and unmet care needs. Findings include: On 09/29/20 at 3:40 PM, the entry door to the room of R87 displayed a sign which indicated specific personal protection equipment (PPE) that needed to be worn for care of the resident. R87 was observed to be in bed with the TV on. R87 was asked how long they had been at the facility and reported around two weeks. R87 was asked about the care and if any activities had been provided or if invited to any activities, or been out of the room. R87 indicated they had not been out of their room because of the 14 day isolation. When asked about seeing someone from the activity department R87 did not recall a visit from anyone from the activity department. R87 expressed a desire to go outside when asked if they had been invited to Bingo. R87 further noted they did not think they would be allowed out and had not seen anyone because of the isolation precautions. A review of an undated activity assessment for R87 indicated: R87 was admitted into the facility on [DATE], was alert, able to make needs known, spoke clearly and had preferences for outside activity, walking, music, magazines, pet visits, social and spiritual interests. These items were indicated as very important to R87. An activity care plan created by the Activity Director indicated, resident to pursue own activity interests daily by next review. Provide leisure resources for in room use upon request. On 10/01/20 at 11:39 AM, the Activity Director (AD) was asked about R87 and their participation in activities and reported they usually do one on one activities for residents on 14 day isolation and record the activities provided to the resident on a log which can be scanned into the computer. The AD reported there were no activity logs for R87 and additional visits by activities had not been completed or documented since the assessment. When asked about the undated assessment the AD reported they had not personally completed the assessment and could not say when it was done. The AD further reported they do not date the assessment, but probably should. The AD suggested that magazines may have been given to R87 when the assessment was done by the activity aides. Magazines were not observed in R87's during the initial tour. On 10/01/20 at 12:27 PM, on review of the activity concerns with the Director of Nursing (DON), the DON reported that activities would best be able to address the concerns. A policy or procedure related to activity protocol and documentation was requested on 10/01/20 at 11:47 AM, but not received prior to survey exit.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure pain medication was provided timely for a resident in need of pain medication for one non sampled resident (R146) of two residents reviewed for pain management, resulting in a delay in treatment of [REDACTED]. A call light for room [ROOM NUMBER] had been activated at 6:12 AM and was answered at 6:36 AM, 24 minutes after activation. On 10/01/20 at 6:36 AM, CNA B was asked about staffing on the midnight shift and reported they felt it was always short. CNA B reported at times there had been only one aide for the side. That morning they were caring for 16 residents as the another aide was a one to one. On 10/01/20 at 6:42 AM, a nurse aide was observed to be seated in front of the call light kiosk. The nurse aide was asked if anyone was in room with the call light activated and reported they were not sure. The aide then stood up walked about ten feet to the doorway of R146 and confirmed there was a resident in the room and identified them as R146. The aide entered the room and upon exit reported R146 needed a pain pill. The call light was then turned off and no longer appeared on the kiosk screen. On 10/01/20 at 6:50 AM, a medication pass for R146 was observed with Nurse C. Nurse C asked R 146 what their pain level was and R146 reported it to be a seven out of ten. (A four, five or six is moderate pain, 7 is severe pain and 8 or is extreme pain and 10 is the worst possible pain.) An opioid pain reliever [MEDICATION NAME] 5 milligrams (mg) /325 mg was given to R146, 48 minutes after call light activation. On 10/01/20 at 6:53 AM, R146 was observed to be hunched down slightly in bed. R146 was asked

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 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) about staff response to the call light and reported with a flat affect, it was too long today. A review of the facility policy titled, Answering Call Lights with review date of November 2018 revealed, Purpose: To respond to the resident ' s needs and requests in a timely manner. 9. Answer the call light as soon as possible. Prioritize needs and any individual needs per resident summary. On 10/01/20 at 12:41 PM, the DON was interviewed about concerns identified at the facility and was asked about appropriate call light response time and reported it should be answered as soon as possible. The DON was asked about a wait time of 40 minutes and reported it should be answered as soon as possible unless there is another resident emergency. A review of the facility records for R146 revealed and admission into the facility on [DATE]. A review of R146's revealed a care plan dated 9/16/20 and titled at risk for pain with Goals: resident's pain will be managed at a tolerable level at pain at or below goal. Verbalizations of comfort, ability to participate in activities of daily living. A number to indicate a tolerable level of pain was not indicated in the care plan.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and record review the facility failed to ensure a secondary thermometer was placed in the walk in freezer and washed serving pans were stored in a sanitary manner potentially affecting all residents who eat meals from the kitchen in a census of 79, resulting in no thermometer to confirm the temperature of the freezer is maintained and the potential for the growth of disease causing organisms. Findings include: On 09/29/20 at 1:55 PM, a tour of the kitchen was conducted with the General Manager (GM). In the walk in freezer the GM was asked to locate the internal thermometer for the freezer and it was not located. An observation of the drying area by the dishwasher revealed multiple serving pans in various sizes nested together on the shelves. Greater than ten pans were observed to have drops of water at the edges and visible water on the surfaces. When touched the pans were still warm and on separation of the pans water was visible on the pans nested inside each of them. A thin peel of burnt colored food debris was pulled off the underside rim of one of the pans. When asked about the pans and the warm moist environment for the growth of organisms the GM indicated they would have kitchen staff set the pans out to air dry. On 09/30/20 at 9:20 AM, the GM reported two thermometers were added to the freezer and they in-serviced staff on pots and pans to be air dried before stored. A review of the facility policy titled, Dish and Pot Washing dated 03/15/20 revealed, Policy: All dishes and Pots are to be rinsed off of all food debris and scrubbed if necessary. All dishes and pots are to be washed in the dish machine .Procedure: 1. While wearing protective gloves, spray all food debris from dishes and pots. Pots will need to be scrubbed off. 2. Tray all dishes in the appropriate dish rack and place in dish machine. 3. Run the machine for its full cycle. Once the machine has stopped, open the door and load another rack. 4. Allow dishes and pots to air dry on dish rack. 5. When dishes and pots are dry, remove your gloves and wash your hands in the hand sink. 6. Remove all clean dishes and pots from rack. Place all clean items in the correct locations, making sure all pots and pans are stored upside down. 7. Repeat process until all dishes and pots have been washed, dried and put away.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review the facility failed to ensure hand hygiene was completed during PPE removal by one of three staff observed during medication pass, resulting in the potential for the spread of infection. Findings include: On 10/01/20 at 8:00 AM, Nurse D was observed to pass medications for a resident. The door to the resident room indicated the use of a gown, gloves, mask and eye protection for patient care. Nurse D administered an inhaler to the resident and noted no cups were available for the resident to swish and spit some water after the administration. Nurse D then began to remove their PPE. Nurse D then pulled their gloves off and without completing hand hygiene reach behind their head and broke the collar on the plastic gown rolled the gown down and off toward the front. Nurse D then exited the room. No hand hygiene was performed. On 10/01/20 at 12:40 PM during a review of concerns with the Director of Nursing (DON), the DON was asked about the need to complete hand hygiene after glove and PPE removal and confirmed it was needed. A review of the facility policy titled, Standard Precautions Measures Table: Hand Hygiene dated 09/20/20 revealed, Perform hand hygiene immediately before gloves are applied and after gloves are removed, between resident contacts and when otherwise indicated to avoid transfer of microorganisms to other residents or environments.