STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235619	A. BUILDING _____ B. WING _____	07/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHURCH OF CHRIST CARE CENTER	23575 15 MILE RD CLINTON TOWNSHIP, MI 48035

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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** This Citation Pertains to Intake Number MI 555. Based on interview and record review, the facility failed to institute and operationalize policies and procedures to ensure consistent, accurate, and timely skin assessment for one (#701) of three Residents reviewed for skin assessments, resulting in lack of documentation of a comprehensive skin assessment, the potential for delayed identification of a wound, pain, and infection. Findings include: An interview was conducted with Resident #701's Family Member Confidential Witness E on 7/8/20 at 8:25 AM. When queried regarding Resident #701, Confidential Witness E revealed the Resident had passed away. When asked about their stay in the facility, Confidential Witness E revealed the Resident went to the facility for rehabilitation after a stroke and being in the hospital. Confidential Witness E indicated the Resident had difficulty speaking but had not lost their cognitive abilities and stated, They could respond to yes or no questions. When asked, Confidential Witness E revealed the Resident did not have any open areas on their feet upon admission to the facility. Confidential Witness E then revealed they were a Registered Nurse (RN) and had always closely monitored the Resident's feet as they had diabetes mellitus. With further inquiry, Confidential Witness E disclosed Resident #701 had had slapped the bed with their hand when they were visiting them in the facility on 7/15/20 and they were able to discern, through yes and no questions, that the Resident wanted them to look at their feet. Confidential Witness E revealed after removing the boots and socks from the Residents feet, the Resident had a large red, open wound on the toes of their left foot. Confidential Witness E stated, I went to the nurses' station right away and asked (RN F) what had happened to (Resident #702's foot). When queried what they were told, Confidential Witness E replied, (RN F) didn't know anything about it. (The nurse) had that deer in the headlights look on their face. Confidential Witness E then said, I asked for the skin assessments. When asked, Confidential Witness E indicated RN F told them the Resident's admission skin assessment did not have anything on it related to their feet and stated, I asked the CNA (Certified Nursing Assistant) who was working and they didn't know anything either. Confidential Witness E revealed a wound care treatment was implemented by the facility after that. Confidential Witness E stated, There is no way they were giving (Resident #702) a shower or taking off their socks, they would have seen that (wound). With further inquiry regarding the wound, Confidential Witness E provided time stamped photographs dated 2/15/20. The photographs displayed redness along the second, third, and fourth toes with an open area on the dorsum area of the fourth toe. No scabbing was observed in the photographs. Record review revealed Resident #701 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident's was rarely/never understood and required extensive to total assistance to perform Activities of Daily Living. The MDS further revealed the Resident had Other open lesion(s) of the foot but did specified the Resident was not receiving any application of dressings to their feet (with or without topical medications). Resident #701 was discharged from the facility to the hospital emergency department due to a change in condition on 2/19/20. Review of Resident #701's care plans revealed the following care plans and interventions: -(Resident #701) has an ADL Self Care Performance Deficit r/t (related to) impaired balance, limited mobility . (Initiated: 2/7/20). The care plan included the intervention, Skin Inspection: Skin inspection each shift during care. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse (Initiated: 2/7/20). -(Resident #701) has Diabetes Mellitus (Initiated: 2/7/20). The care plan included the interventions, Complete full body assessment for breaks in skin. Report and treat as ordered (Initiated: 2/7/20) and Inspect feet with shower skin assessments for open areas, sores, pressure areas, blisters, [MEDICAL CONDITION] or redness (Initiated: 2/7/20). Review of Resident #701's progress note documentation in the medical record revealed the following: -2/7/20 at 9:12 PM: Skin/Wound Note . Skin assessed complete with no open areas noted . Scabs noted to left foot great toe, 2nd and 3rd digit . Bilateral heel reddened and blue skilled boots applied. This was the only Skin/Wound Note for Resident #701. -2/11/20 at 9:38 AM: Physician History and Physical . Skin: intact, no rash . -2/15/20 at 11:48 AM: Nurses . (Family) in to visit (Resident #701) and was demanding assessment records of skin. Staff explained to (family) that resident's toes had scabbing upon admission and subsequent skin assessments document scabbing of toes as well. NP (Nurse Practitioner) sent in to see family and resident. New orders written. -2/18/20 at 2:42 PM: Nurses . Applied treatment to left foot toe, skin dark discolored and dry . -2/18/20 at 4:53 PM: physician progress notes [REDACTED].Patient was noticed with worsening wound over left foot for which is currently receiving topical antibiotic ointment and daily wound care. (Family) was at bedside it was also concerned about increased drainage and redness from the site . Left foot examination; [DIAGNOSES REDACTED] and moist skin involving the dorsum of the left foot including the dorsum of the toes . Assessment and plan: 1. Left foot infection suspect a combination of bacterial and fungal; patient was started today on Keflex (antibiotic) in addition to [MEDICATION NAME] cream (antifungal cream), continue daily wound care and will consult podiatry to see (Resident) . -2/19/20 at 12:41 AM: Nurses . MD notified of wound on left 5th toe, MD assessed ordered new treatments and started resident on antibiotics r/t (related to) [MEDICAL CONDITION] in left foot . -2/19/20 at 6:00 AM: Nurses . Resident b/p (blood pressure) noted to be 74/43 (low- normal 12/80), skin is pale, respirations is 28 (normal 16-20) with 5 liters of 02 (oxygen), sats are fluctuating between 86-90%. Pulse is fluctuating between 104-110 (normal 60-100) . Dr. given update, received orders to transfer to the hospital due [MEDICAL CONDITION] . Review of Resident #701's Weekly Skin Evaluation assessments revealed the following Skin Evaluation: Indicate any areas of redness, scratches, bruises, open areas or unusual findings documentation: -2/7/20: Abdomen Peg tube site intact with no redness/ drainage to area . Right hand (back) Amputation to 4th digit on right hand . Left toe(s) Scabs noted to left foot great toe, 2nd and 3rd digit . Bilateral heel redden and blanchable . Bruising to bilateral upper extremities and posterior hands . -2/11/20: No Findings Noted. -2/14/20: No Findings Noted. On 7/8/20 at 1:15 PM, a phone interview was attempted to be completed with RN F. A message was left with a return phone number. Review of Resident #701's paper CENA (Nursing Assistant) Resident Skin Audit forms revealed the following: -2/11/20- Reddened peri area and scabbed areas on both of the Resident's feet. The form indicated Concern found- action taken and was signed by a Nursing Assistant and a Licensed Nurse. -2/14/20: No areas of altered skin integrity identified. The form was signed by a Nursing Assistant and a Licensed Nurse. -2/18/20: Bruising, open area, and a rash were identified on the Residents left toes. The form was signed by a Licensed Nurse but did not indicate what, if any, actions were taken. An interview was conducted with the facility Administer and Director of Nursing (DON) on 7/8/20 at 2:30 PM. When queried regarding inconsistencies in Resident #701's skin documentation, the DON reviewed the documentation and stated, It should be on there. With further inquiry, the DON indicated staff should always indicate any skin abnormalities, including feeding tubes, on the paper Skin Audit form which is completed by Nursing Assistants when they assist Residents with showering. When queried regarding the wound on the Resident's left toe being identified by the Resident's family member and not facility staff and the photograph dated 2/15/20 of the Resident #701's left foot, both the Administrator and DON were unable to provide an explanation how the

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) wound was not identified by facility staff. A face to face interview was completed with RN F on 7/8/20 at 3:10 PM. When queried regarding Resident #701, RN F indicated they were unable to recall the Resident's name. After reviewing their documentation in the Resident's medical record, RN F stated, I remember them now. When asked about the Resident's left foot wound, RN F revealed the Resident's family member had came to them and was quite upset because we weren't doing anything so I had the doctor go in and look at it. RN F was then shown the picture provided by Confidential Witness E. When asked if the picture was of Resident #701's wound, RN F stated, Yes, that's it. I completely remember. When queried regarding documentation indicating the area was scabbed when the picture they identified as the Resident's wound was open and not a scab, RN F replied, It looks like maybe the scab came off. Resident #701's Skin Evaluation and Skin Audit documentation was reviewed with RN F at this time. When queried regarding the inconsistencies in the documentation, RN F stated, I see what you're saying. It doesn't add up. RN F was then queried regarding facility policy/procedure related to the CENA Resident Skin Audits and stated, The CNA's fill it (form) out on Resident bath days. When queried if nursing staff observe Resident skin before signing the form, RN F replied, No, only if there is a problem. When asked how they knew if the Nursing Assistant was examining all of the Resident's skin, including their feet and what type of bathing activity was provided, RN F stated, There are some good Aides that you trust. No further explanation was provided. Review of facility policy/procedure entitled, ADL Safe Care Practice (Effective: 11/2012) revealed, Observe the Resident's skin for any redness, rashes, broken skin, tender places, irritation, reddish or blue-gray area of skin over a pressure point, blisters, or skin breakdown .
F 0692 **Level of harm** - 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** This Citation Pertains to Intake MI 130. Based on observation, interview and record review, the facility failed to ensure beverages were within reach for two (#'s 703 and 704) and fourteen non-sampled Residents on the Second and Fourth Bays of the facility and failed to operationalize policies and procedures to ensure adequate oral intake was provided and documented for one (#702) of three Residents reviewed for dehydration, resulting in beverages being inaccessible to Residents, lack of documentation of oral intake, and Resident #702 experiencing a change in condition and requiring emergency treatment and hospitalization for dehydration. Findings include: A tour of the Second Bay of the facility was completed on 7/8/20 beginning at 11:15 AM. During the tour, 10 Residents had beverages in their rooms that were not within their reach including Resident #703 and Resident #704. On 7/8/20 at 11:30 AM, Resident #703 was observed laying in bed in their room. The Resident's water cup was noted not within the Resident's reach, approximately three feet away from their bed on a stationary table. An interview was conducted with the Resident's at this time. When asked if they were hungry, Resident #703 stated, I'm always thirsty. When asked about their water and availability of beverages, Resident's #703 did not provide a response. Record review revealed Resident #703 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE] revealed Resident's #703 was severely cognitively impaired and required total assistance to perform ADLs. Review of Resident #703's care plans revealed a care plan entitled, Alteration in nutritional status potential for inadequate oral intake, beverage intake, difficulty chewing/swallowing, needs a mechanically altered diet (Initiated: 11/1/19; Revised:12/18/19). The care plan included the intervention, Offer snacks/beverages in between meals, PRN, and with activities (Initiated: 11/1/19). At 12:00 PM on 7/8/20, Nursing Assistant D was observed providing care to Resident #704 from the hallway of the facility. The Resident was sitting in a wheelchair with an overbed table positioned in front of them. Nursing Assistant D exited the room at 12:05 PM and an interview was conducted with the Resident at this time. The Resident was noted to have contractures in both of their hands but no limitations in movement were observed in the Resident's neck. The overbed table remained positioned directly in front of the Resident with nothing on it. A cup of water was across the room, on the Resident's dresser. When queried regarding their water being on the dresser, Resident's #704 indicated they could not get to it when it was on the dresser. With further inquiry regarding the frequency their water is not placed within their reach, Resident's #704 stated, Yes, it is usually on the table on the other side of the room. When asked if they are able to drink the water without assistance is positioned in front of them on the table, Resident #704 indicated they could. Resident #704 was then asked how they are able to get a drink of water when they want it and stated, I use the push button call light. The call light was observed hooked to the bed not within the reach of the Resident's. Resident #704 was then asked about the location of their call light and replied, I can't reach it where (Nursing Assistant D) put it. When queried how often their call light is positioned somewhere they cannot reach it, Nursing Assistant D displayed a sorrowful facial expression but did not provide a response. When queried if their water being placed somewhere they could not reach it was a concern, Resident #704 replied, Yes. Record review revealed Resident #704 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required limited assistance with eating and extensive assistance to complete all other ADLs. Review of Resident #704's care plans revealed a care plan titled, Alteration in nutritional status: Difficulty chewing/swallowing r/t (related to) dysphagia AEB (As Evidenced By) needs mechanical soft chopped . (Initiated: 4/19/17; Revised: 1/22/20). The care plan included the intervention, Offer snacks/beverages PRN (as needed) and activities (Initiated: 4/19/17). An interview was conducted with Nursing Assistant C on 7/8/20 at 12:10 PM. When queried regarding facility policy/procedure related to water/beverages for Residents, Nursing Assistant C revealed facility Nursing Assistants pass out water to Residents. When asked if the water cup should be within the Resident's reach, Nursing Assistant C replied, Yes, always. A brief tour of the Second Bay unit was completed with Nursing Assistant C at this time. When queried regarding observation of multiple Resident's water cups not being within their reach, Nursing Assistant C replied, Shouldn't be. Nursing Assistant C was then observed repositioning the water cups to within the reach of the Residents. On 7/8/20 at 12:15 PM, an interview was completed with Nursing Assistant D. When queried regarding observation of Resident #704's call light and water not being in their reach upon them exiting the room following the provision of care, Nursing Assistant D did not provide an explanation. A tour of the Fourth Bay facility was completed on 7/8/20 beginning at 12:15 PM. During the tour, four Residents had beverages in their rooms not within their reach. Resident # 702 Review of intake documentation for Resident #702, dated as received on 2/12/20, revealed Resident #702 was in the hospital at the time related to dehydration. The intake documentation further detailed Resident #702 is not offered water and their water is placed out of their reach at the facility. Record review revealed Resident #702 was originally admitted to the facility on [DATE] and discharged on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required supervision to extensive assistance to perform Activities of Daily Living (ADLs) including one person supervision for eating. The MDS further indicated the Resident triggered for a nutritional Care Area Assessment (CAA) on 1/28/20. Review of Resident #702's medical record revealed the following progress note documentation: -2/6/20 at 10:21 AM: Nurses Data: Resident slept entire shift. Refused dinner x 3. Pressed lips together offer fluids and food . Physician notified. No new orders. -2/6/20 at 3:11 PM: Nurses Data: Resident has slept all shift. VS within normal limits. -2/7/20 at 11:19 AM: Nurses Data: Writer received in report that resident has been sleeping since yesterday, slept through all meals and was still asleep when writer came on to shift. Resident was moaning and groaning during care, would not open her eyes, mouth clenched unable to administer any medication . Resident lethargic would not respond using any kind of words . (Physician) notified, assessed resident, sent out 911 to (Hospital) . -2/7/20 at 1:42 PM: physician progress notes [REDACTED]. Patient was seen today per nursing staff request . apparently the patient has been somnolent since yesterday, refusing meals. Currently the patient is obtunded, responds to tactile stimulus . Assessment and plan . Patient will be sent STAT 911 via ambulance to ED for further care . An interview was conducted with Hospital Social Worker B on 7/8/20 at 10:00 AM. When queried regarding Resident #702, Hospital Social Worker B revealed the concerns related to the Resident had been pertaining to adequate fluid intake to prevent dehydration and a decline in condition upon admission to the hospital. Review of Resident #702's closed/discontinued care plans revealed the Resident did not have a care plan in place related to nutrition. Resident #702's medical record also contained an assessment titled, Long Form Nutritional Risk Assessment (Dated 1/28/20). The assessment included the following, Admission . Estimated Nutritional Needs . 4.b 2032 mL Fluid per day (minimum 1500 mL/day) . Risk Assessment: At risk for Unintended Weight Loss . Inadequate PO (oral) intake, ALZ (Alzheimer Disease) . needs assistance, cueing and encouragement with PO intake . Care Plan: Consume at least 75% of meals/fluids; Adequate hydration . Provide necessary assistance at meal time and between meals . Monitor oral intake of food and fluids . Snacks at PM and hs (bedtime) . [MEDICATION NAME] with carb steady (nutritional supplement)- 4 ounces TID (three times a day) with med pass . Offer snacks/beverages in between meals, at activities, and PRN (as needed) . Provide assistance . Provide 1440 cc (cubic centimeters- 1 cc= 1 mL) fluids with means, provide water/beverages at bedside, at activities and

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) PRN. Encourage fluid intake . Comments: Resident is on consistent carb diet . PO intake varies, approximately 50% of for meals/fluids . receives adequate supplements in between meals to meet the estimates nutritional and hydration needs . Upon request for documentation pertaining to Resident #702's oral intake, hydration, and nutrition, the Director of Nursing (DON) provided a report of intake titled, Documentation Survey Report for January and February 2020. Review of the documentation revealed the total Intake: Amount of fluids at meals less than 800 milliliters (mL) for all meals on the following dates: -1/19/20: 600 milliliters (mL) -1/20/20: 200 mL -1/21/20: 540 mL -1/23/20: 560 mL -1/30/20: 750 mL -1/31/20: 480 mL -2/2/20: 320 mL -2/3/20: 120 mL -2/4/20: 200 mL -2/5/20: 750 mL -2/6/20: No fluid intake -2/7/20: 300 ml Review of the provided report also revealed, during Resident #702's stay at the facility, revealed the Resident did not receive any snacks, during morning, evening, or night shift, on 1/26/20, 2/3/20, 2/5/20, and 2/6/20. The documentation further revealed the following dates in which the Resident did not receive snacks and/or consumed 0 to 25% of the provided snack: -1/19/20: Evening shift; consumed 0 to 25%. No snack given on Day or Night shift. -1/20/20: Evening shift; consumed 0 to 25%. No snack given on Night shift. -1/21/20: Evening shift; consumed 0 to 25%. No snack given on Day shift. -1/22/20: Evening shift; consumed 0 to 25%. No snack given on Day or Night shift. -1/23/20: Evening shift; consumed 0 to 25%. No snack given on Day or Night shift. -1/24/20: Evening shift; consumed 0 to 25%. No snack given on Day or Night shift. -1/25/20: No snack given on Day or Night shift. -1/27/20: Evening shift; consumed 0 to 25%. No snack given on Day or Night shift. -1/28/20: No snack given on Day shift. -1/29/20: Evening shift; consumed 0 to 25%. No snack given on Day or Night shift. -1/30/20: Evening shift; consumed 0 to 25%; No snack given on Day or Night shift. -1/31/20: Evening shift; consumed 0 to 25%. No snack given on Day or Night shift. -2/1/20: Evening shift; consumed 0 to 25%. No snack given on Day shift. -2/2/20: Evening shift; consumed 0 to 25%. No snack given on Day or Night shift. -2/4/20: No snack given on Day or Night shift. The documentation provided for February 2020 also included a section tilted Fluids-PRN (as needed). The only documentation included was NA (not applicable) on 2/3/20. Review of Resident #704's Medication Administration Record [REDACTED]. An interview was completed with the Director of Nursing (DON) on 7/8/20 at 1:30 PM. When queried regarding facility policy/procedure pertaining to availability of beverages/hydration for Residents, the DON indicated water is provided to Residents. When queried if water/beverages should be maintained within Resident's reach per facility policy/procedure, the DON replied, Always. Observations of all Residents on the Second and Fourth Bays of the facility who did not have water and/or a beverage within their reach were reviewed with the DON at this time. The DON proceeded to state that they would in-service staff. An interview was conducted with Registered Dietician (RD) A on 7/8/20 at 1:46 PM. When queried regarding Resident's #702's hydration status, RD A reviewed the Resident's documentation and stated, Their fluid needs were 2100 mL (per day). When queried regarding facility policy/procedure pertaining to follow up and documentation for Resident's identified as being at risk for altered nutrition, RD A stated, It depends on the status, status change, etc. When queried why Resident's #702 did not have any follow up nutritional documentation in their medical record when documentation reveals they were consuming less that their needs related to hydration, RD A reviewed the documentation of fluid intake and indicated they believe that staff are just not documenting intake. When queried if intake is supposed to be documented per facility policy/procedure, RD A replied, Yes. RD A then stated, (Resident #702) was also getting four ounces of med pass TID. When queried regarding Resident's #702 meeting their hydration needs, with 12 ounces (355 mL) of additional fluid, RD A did not provide an explanation and indicated they round on Residents eating in the dining room during the day to ensure they are eating and drinking. When asked how they are able to accurately observe 40-80 Resident's intake, RD A indicated they are present in the dining room. When queried regarding the Resident's being transferred to the hospital and admitted for dehydration, RD A was unable to provide an explanation. An interview was conducted with the facility Administer and Director of Nursing (DON) on 7/8/20 at 2:30 PM. When queried regarding documentation indicating Resident #702 did not receive adequate intake to meet their hydration needs, transfer to the hospital for altered mental status, and [DIAGNOSES REDACTED]. Review of facility policy/procedure entitled, Nutrition and Hydration Care (Reviewed: 10/10/09) revealed, Dehydration . Most Residents need at least 6 cups of liquids to stay hydrated .