STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235634	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOX RUN VILLAGE	41215 FOX RUN 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.

(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 -** Some	**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** Based on observation, interview, and record review, the facility failed to ensure showers were provided as scheduled and per resident preference for three residents (R#'s 20, 14, and 5) of six residents reviewed for activities of daily living, resulting in verbalized complaints, feelings of frustration, and the potential for embarrassment and discomfort from poor personal hygiene. Findings include: R#20 On 9/15/20 at 9:40 AM, an interview with R20 was conducted in their room. R20 had difficulty with verbal communication, however; did nod or shake their head appropriately to answer simple questions. When queried if they were getting their scheduled showers, R20 shook their head to indicate they were not getting their showers. On 9/16/20 at 11:05 AM, the Director of Nursing (DON) was asked how resident showers were documented and indicated the Certified Nursing Aides (CNA's) were using paper shower sheets to document the hygiene care provided and nurses were to sign off on them. When queried how often residents were to receive showers, the DON explained that residents were supposed to receive showers either per the shower schedule or according to their individual preferences. A review of a facility document titled SHOWER AND BATH SHEET in the shower book at the nurses station was reviewed and indicated that based on their room number, R20 was to receive their shower on Mondays and Thursdays. A review of R20's Shower sheets were requested, provided, and revealed the following: A shower sheet signed by the CNA, but not the nurse that indicated a bed bath was given on 6/1/20. A shower sheet signed and dated by both the CNA and the Nurse on 6/15/20, however; the sheet did not indicate any type of hygiene activity (shower, bed bath, nail care, hair care, etc.) had been provided. A shower sheet for a shower given signed by the CNA on 6/18/20, but signed off by the nurse on 6/17/20. A shower sheet dated 6/22/20 signed by the nurse and the CNA that indicated R20 refused. A shower sheet dated 6/29/20 signed only by the nurse that indicated R20 refused. A shower sheet dated 6/30/20 signed by the CNA and the nurse that indicated a bed bath had been given. A shower sheet dated 7/6/20 signed by the nurse and CNA that indicated a bed bath had been given, as the resident refused their shower. The next shower sheet provided was dated 7/20/20 (14 days after the previous sheet). A shower sheet dated 7/25/20 signed by the CNA and the nurse that indicated a bed bath had been given. A shower sheet signed and dated by the CNA, but not the nurse on 7/27/20 that was left completely blank, and did not indicate any type of hygiene activity had been provided. A shower sheet signed by the CNA and the nurse on 8/3/20 that indicated a bed bath had been given. The next shower sheet provided was dated 8/31/20 signed by the CNA, but not the nurse. A shower sheet signed by the CNA and the nurse on 9/3/20 that indicated a bed bath had been given. A review of R20's clinical record was conducted and revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. A review of R20's Minimum Data Set (MDS) assessment dated [DATE] indicated R20 had unclear speech, was sometimes understood, and understood others sometimes. The MDS assessment further indicated R20 had a Brief Interview for Mental Status score of 11/15 which indicated moderately impaired cognition, was non-ambulatory and required extensive to total assistance of one to two staff members for transferring, bed mobility, personal hygiene and bathing. Resident #5 On 9/15/20 at 10:35 AM, R#5 was observed sitting in a wheelchair in their room. R#5 was asked how often they received showers at the facility. R#5 explained they usually received one shower a week, but would prefer two showers a week. Review of the clinical record revealed R#5 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the admission MDS assessment dated [DATE], R#5 had intact cognition and required extensive to total assistance of one person for personal hygiene. Review of facility provided shower sheets titled SHOWER AND BATH SHEET in the shower book at the nurses station was conducted. The book indicated that based on their room number, R#5 was to receive their shower on Wednesdays and Sundays. Review of R#5's shower sheets revealed the following: On 7/6/20 there were two shower sheets filled out, one, signed by the CNA and nurse and noted the shower had been given by Hospice. The other sheet was signed by a different CNA and had no nurse signature. On 7/20/20 the form was signed by the CNA, no nurse signature, and indicated a shower was given. On 7/27/20 the form was signed by the CNA, no nurse signature, and indicated a shower was given. On 8/3/20 the form was signed by the CNA, no nurse signature, and indicated a shower was given. On 8/9/20, the form was signed by the CNA, no nurse signature, and indicated a shower was given. On 8/19/20 the form was signed by the CNA and the nurse and indicated a shower was given. On 9/8/20 the form was signed by the CNA, no nurse signature, and indicated a shower was given. On 9/11/20 the form was signed by the CNA, no nurse signature, and indicated a shower was given. On 9/15/20 the form was signed by the CNA, no nurse signature, and indicated a shower was given. R#14 On 9/15/20 at 9:20 AM, R#14 was observed dressed, and sitting in a wheelchair in their room. R#14 was asked about showers at the facility. R#14 explained they only get one shower a week, but it usually was a bed bath. R#14 was asked which they preferred, showers or bed baths. R#14 stated, Showers, but it hurts too much for me to stand. R#14 was asked if the facility provided a shower chair. R#14 explained they did, but usually they just gave bed baths. Review of the clinical record revealed R#14 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the MDS assessment dated [DATE], R#14 was cognitively intact and required the extensive to total assist of staff for personal hygiene. Review of facility provided shower sheets titled SHOWER AND BATH SHEET in the shower book at the nurses station. The book indicated that based on their room number, R#14 was to receive their shower on Mondays and Thursdays. Review of R#14's shower sheets revealed the following: On 8/24/20 the form was signed by the CNA, no nurse signature, and indicated a bed bath was given. On 9/4/20 the form was signed by the CNA and nurse and indicated a bed bath was given. On 9/7/20 the form was signed by the CNA and nurse and indicated a bed bath was given. On 9/10/20 the form was signed by the CNA and nurse and indicated a bed bath was given. On 9/12/20 the form was signed by the nurse, was blank except for Shower given by Hospice today written across the sheet. On 9/14/20 the form was signed by the CNA and nurse and indicated a bed bath was given. A review of a facility provided document titled, Annual Skill Competency-Care Associate was reviewed and read, .Resident Service/Care Plan, Can identify and locate necessary information to support support resident/guests with .Personalized bath schedule .Individualized personal preferences, routines and wishes .
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake # 0 Based on observation, interview and record review, the facility failed to ensure 1:1 supervision was provided and ensure a mechanical lift was utilized to prevent falls for three residents (R#15, R#1 and R#172) out of three residents reviewed for falls/accidents, resulting in R#15 sustaining laceration to the head, transfer

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

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) to the hospital emergency department and three staples to the head, R#1 sustaining multiple falls and head injury, and R#172 sustaining a skin tear when not transferred per their care plan, and the potential for continuous falls. Findings include: R#15 On 9/15/20 at approximately 9:30 AM, R#15 was observed sitting in a wheelchair in their room. The resident was alert, but unable to answer most questions asked. A review of R#15's clinical record documented that the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the resident's Minimum Data Set ((MDS) dated [DATE] indicated the resident was severely cognitively impaired and required extensive one and two person assist for Activities of Daily Living (ADL). The MDS indicated that the resident had sustained a fall prior to admission. Continued review of R#15's clinical record documented, in part, the following: An initial Admission Holistic Form (8/6/20): These are mood and expressions I may or have been exhibiting Dementia/confusion Combative Assist to bathroom .Supervision . I do wander .FALLS .I have had no injuries from falls .Date of last fall 8/2/20 .This is what I believe may have caused me to fall .poor balance .My Falls Risk Assessment .History of falls Dizziness/[MEDICAL CONDITION] unsteady gait Assistive devices. Unsafe transfer impaired vision/blind Cognition/Memory Hypertension Use of Diuretics. .I will need help to maintain a safe environment to allow me to ambulate freely to minimize injury or falls daily. I will need encouragement to use adaptive equipment to minimize falls or injuries from falls daily. I will need assistance with [MEDICAL CONDITION] precautions I will have a home that promotes safety. Progress note (8/7/20) authored by Nurse D . R#15 noted trying to ambulate without call light use and or walker and/or w/c (wheel chair) and to place on call light, resident stated, get the (expletive) away and started hitting at writer writer unable to assist writer and CNA (certified nursing assistant) address client together resident sitting on toilet noted smeared BM (bowl movement) in sink .and rails of bathroom. Resident refused staff to assist and swing soiled tissue at staff staff left in order not to agitate resident. Progress Note (8/7/20) authored by Social Worker (SW) F: Writer notified by nursing management to arrange for a companion for R#15 starting at soonest availability. Writer reached out to companion service (name redacted) who will start services today at 8 PM and will be continuous until writer notified to discontinue. Writer notified nursing of arrangements . Progress Note (8/8/20): Sitter at bedside the whole shift . Progress Note (8/10/20): .Resident quietly rested in bed with a sitter near the bedside . Progress Note (8/14/20) authored by Nurse D Writer standing in hallway when heard thump and someone yelling ouch. Writer went to distress call when noted resident on floor of room (# redacted). Resident noted dressed with skid free foot wear and hoyer lift in w/c resident head in bathroom and legs extended out of bathroom near w/c against wall noted in lock position, laying on right side of body. Sitter from (name redacted) companion service (name redacted) not in room. Resident alert and verbal at time of occurrence. Resident glass on floor told writer I just loss my balance that's all. Head to toe reveals laceration to right 5x2.5 with bleeding applied pressure to stop bleeding, bleeding stopped after 3.5 minutes noted indentation with swelling to back of head side of head no further skin concerns with occurrence. Writer retrieved two staff members (names redacted) resident assisted off floor x 3 person .noted blood alongside wall of bathroom .sitter from (name redacted) monitoring service after assist with transfer. Sitter educated to not leave client side without informing staff when leaving .Ice pack applied to head x 10 minutes MD (medical doctor) notified of occurrence .notified daughter and recommends resident have cat scan Bleeding has stopped. Patient last seen by staff at 1 PM in room with sitter . ambulance arrived on campus at 3 PM to take patient to (name redacted) Hospital . Progress Note (8/14/20) 10:48 PM: .patient alert oriented, came from the (name redacted) Hospital via ambulance around 7:30 PM .Dr. (name redacted) was informed if it is ok to remove staples in 5-7 days. Patient has 3 new staples on the top of head .from 7:30 PM will continue to monitor. Progress note (8/16/20): sitter was asleep as well tried to wake sitter x3 sitter woke up on the 3rd time, writer gave sitter instruction not to sleep on duty d/t res being high risk for falls. A Resident Incident Report Form (I/A) dated 8/14/20 documented, in part, the following: Detail Event Type: Found on floor .Fall involved the following device: wheelchair .Event observed: No .Event Description (see progress notes dated 8/14/20 authored by Nurse D (as documented above) .Steps taken to Prevent Recurrence (Actions) Companion Service sitter not to leave client side unattended .res transported to (name redacted) Hospital vial EMS for further testing, res returned 3 hours later with 3 staples to rt side of .scalp, 24/7 sitter in place, Companion Service manager notified of their staff leaving res alone in the room without notifying our staff first . On 9/16/20 at approximately 12:50 PM an interview was conducted with Nurse D. Nurse D indicated that they had worked in the Facility for [AGE] years. When queried about the incident involving R#15 that occurred on 8/14/20, Nurse D reported that the resident had been transferred from the Memory unit and was showing behavioral issues when they first arrived. As such, the resident was assigned a 1:1 companion 24/7 to ensure the resident remained safe. Nurse D indicated that Social Worker (SW) F arranged the service and a 1:1 companion(s) came from (name redacted) companion service. Companion G (name redacted) was assigned to R#15 on 8/14/20. Nurse D reported that she heard the resident yelling from their room and when she went to see what was wrong she found the resident on the floor, half inside their bathroom and half in their room. Noticed blood and a laceration to the head and indicated that the resident was sent to the hospital and had three staples. Nurse D stated that Companion G was not in the room and did not provide any notice that they were leaving and stated, had she done so, we would have made sure someone else was with the resident as they needed 1:1 care. Nurse D stated she contacted the Companion Service to report the incident. On 9/16/20 at approximately 1:16 PM, a phone interview was conducted with SW F. SW F was queried as to their involvement when scheduling private Companions for the residents. SW F indicated that they usually receive notice from nursing staff that a resident needs 1:1 supervision and then they contact (name redacted) Companion Service to schedule. SW F also indicated that they arrange payment with the resident and/or family. When asked for the Policy pertaining to outside Companions that enter to provide 1:1 supervision, SW F reported that they are to remain with the resident and if, for any reason, they need to leave the resident's room, they are to inform nursing staff. On 9/16/20 at approximately 4:20 PM, an interview was conducted with the Administrator pertaining to R#15's fall on 8/14/20. The Administrator recalled the event and indicated that the Facility utilizes (name redacted) Companion Service that provides private pay supervision to residents. The Administrator stated that due to Covid-19 the Facility was primarily using (name redacted) Companion Service for its residents. When asked if the Facility had a policy and/or contract that would define the expectation of private companions that employed by a service selected by the Facility, the Administrator reported that there was not a specific policy. The Administrator further indicated that if any facility resident, including R#15, receives 1:1 supervision from an outside source selected and scheduled by the facility, they should be supervised 100% of the time and if they need to leave the resident for any reason they are advised to inform the facility so that a staff member can assist the resident. R#1 On 9/14/20 at approximately 10:00 AM, Resident #1 was observed in their room sitting on a wheelchair. The resident was alert, but had difficulty answering many questions asked. The resident was able to ask for assistance to adjust their pants. A review of R#1's clinical record documented the resident had been admitted to the facility on [DATE], readmitted [DATE] through 6/23/20 and readmitted on [DATE] with [DIAGNOSES REDACTED]. A MDS (4/30/20) documented that the resident had a Brief Interview for Mental Status (BIMS) score of 8/15 (moderately impaired) and required extensive two person assistance for all transfers and bed mobility. Continued review of the resident's clinical record documented, in part, the following: Entry note (2/17/20) 11:09 AM: Resident admitted with confusion. Observed not following simple instruction. Resident attempting to get in and out of bed multiple times. Resident hospitalized due to fall. Contacted Home Support and DPOA (Durable Power of Attorney) DPOA in agreement to Home Support, 24 hours 1:1 supervision for 2 days. Caregiver informed to start tonight at 10:00 PM, relief will arrive at 7 am and stay till 3 PM. An I/A (dated 2/18/20) documented, Date reported 2/18/2020: Incident date: 2/19/20 .Incident Time: 3:16 PM Event Description and Presence of Injury: At approx 3:16 Staff approached nursing station and stated, (name redacted) needs to know if patient is on blood thinners .Upon arrival into room, Afternoon aide sitting with resident in room resident laying on right side of body with pillows surrounding neck .Resident stated, 'I don't know what happened one minute I am in chair and the next I am on floor' Resident did state 'I hit my head right side and both my shoulder hurts,' Staff reports her sitter left at approx 3:10 PM. Resident alert and noted some confusion which is usual state. This occurrence was unwitnessed .No available units in area for ambulance .first responders arrived on campus and placed on cervical collar .resident left via stretcher at 4 PM .Steps taken to Prevent Recurrence: Agency will inform staff and give verbal report to staff when coming and leaving facility .Staff was immediately inserviced that res with scheduled 24 hr sitter is not to be left alone in the room at anytime, CNA is not to sign (Companion Service) paperwork at the end of their shift they are to inform sitter to find the nurse for signature .manager notified of incident to reeducate his staff that they are not to leave the room until their replacement is in the room for face to face report, if replacement is not available a CNA is to be pulled to sit with the resident until one is available, nursing has been informing .sitter as they come on to their shift that they are not to leave the room to use the bathroom or get a drink unless staff is in the room to monitor the resident . A hospital record (date of evaluation

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) 2/18/20) documented, in part: Patient .presenting to emergency department due to a fall she had been just here in the hospital where she was admitted for several days due to old rib fractures .she was discharged to (name redacted) facility yesterday according to the staff and family they report they got was that she was found on the floor and states that she stood up and lost balance and fell forward .she states she hit her head on the right side she did not lose consciousness she said the headache was improving .she is having some right shoulder pain and right hip pain . An I/A form dated 3/5/20 documented, in part, the following: Incident date: 3/5/20 .Incident time: 1:05 PM .Fall: chair (out of) .Event description: Writer was walking by the dining room and noticed resident was laying on the floor with nurse educator .resident verbalized that she noticed that several others were leaving the dining room and she was trying to leave as well . An I/A form dated 4/13/20 documented, in part, the following: Incident Date: 4/13/20 .Incident time 12:05 PM .Fall: Chair (out of) .Event Description: Writer was coming out of another resident's room when she heard resident shout I fell .She verbalized that she had hit her head .She denied having pain .no bruising, skin tears .She verbalized she didn't know why she stood up . An I/A for dated 4/23/20 documented, in part, the following:Incident Date: 4/23/20 .Incident Time: 12:15 AM .Fall: found on the floor Event Description: Resident found sitting on the floor near bed, resident transferred from wheelchair to bed by self w/o (with out) assistance, did not use call light .Steps taken to Prevent Recurrence (Actions) .Encourage resident to use call light for assistance CC (name redacted) Manager H offer assistance with transfers and getting ready for bed, continue with safety checks while res is in the room, engage the res in conversation . An I/A dated 4/30/20 documented, in part, the following Incident Date: 4/26/20 .Incident Time: 6:00 PM .Fall: ambulating (while) .Event Description: Resident is going to be sent to hospital due to fall with head injury .per supervisor res fell and sustained a big laceration on the left side of her head with bleeding .transferred resident to (name redacted) Hospital .Conclusion of Investigation: CNA was collecting dinner trays when she went into room .aid told her to take her time and she would be back to get tray .by the time the aid got to the end of hall she heard a loud boom .resident uses w/c but can ambulate with unsteady gait, resident uses 02 .and does not always remove it when she gets up from chair .recently had private sitter discontinued, poor safety awareness . Steps taken to Prevent Recurrence .continue with plan of care .CC (name redacted) Manager H res returned from Hosp. on 4/30/20 with 24/7 sitter x14 days for strict isolation precautions, sitter to provide companionship and safety, staff to monitor for room safety frequently . A Hospital record (4/29/20) documented, in part: .patient does have a left frontal scalp hematoma with laceration with sutures .:. A care plan dated 2/27/20 was provided by the Facility and documented, in part, the following: Goals .need help to maintain a safe environment to allow me to ambulate freely to minimize injury or falls daily .Care Plan Approaches to address risks check .24 hr continuous sitter at bedside throughout day/night (on hold 4/10/20), Non skid foot wear for transfer/ambulation, assistance provided for all needs. Monitor vitals and pain assessment frequently .hand written notes fall mats .no low bed .3/5/20: fall in dining room, ice pack to rt forehead .4/13/20 (word not legible) for sitter 4/23/20: Fall in bedroom .continue to use non-skid for transfer and ambulation .provide assistance to all needs .continue to remind res to use call light assistance and wait for help,. On 9/17/20 at approximately 11:20 AM, a phone call was made to the Manager H of (name redacted) Companion Service. A voicemail was left. No further communication was made prior to the end of the survey. On 9/17/20 at approximately 11:40 AM, an interview was conducted with the DON. When queried as to the incidents pertaining to R#15 and R#1 who were left in their rooms unsupervised, the DON stated that ultimately the facility is responsible for residents in need of 1:1 supervision. On 9/17/20 at approximately 12:15 PM, an interview was conducted with the Administrator regarding R#1's falls. The Administrator reported that R#1 initially was provided 1:1 supervision via the Companion Service and later the service was removed as the resident was noted to have improved. It should be noted that the resident care plans document the service was place on hold on 4/10/20. R#1 had continued falls on 4/13/20, 4/23/20 and 4/26/20. R#172 A review of R172's clinical record was conducted and revealed R#172's Minimum Data Set assessment dated [DATE] indicated R172 had mild cognitive impairment and required total assistance of two staff members for transferring. On 9/16/20 at 2:08 PM, a review of a facility reported incident investigation file for R172 was conducted. The file contained an untitled document dated 9/24/19 at 10:15 PM that read, .Incident Summary: Staff member allegedly transferred Resident with a gait belt resulting in her being lowered to the floor. Resident was discovered to have a superficial skin tear following the incident . Investigation Summary/Actions Taken: On 9/24/19 at approximately 10:15 PM, care associate was unable to move a hoyer (mechanical lift used for transferring residents) lift to the Resident's room for a transfer from Resident's wheelchair to her bed. Resident requires extensive assist and the use of a hoyer lift for transfers per her care plan. Care associate returned to Resident's room, used a gait belt and attempted a one person transfer. Resident's feet began to slide during the transfer and care associate lowered Resident to the floor .and went to get help. Care Associate returned with another care associate and two lifted Resident into her bed. After transfer, care associate noted skin tear to the back of Resident's right upper arm/shoulder .Care associate was interviewed and stated she was aware of Resident's care plan and the need for a hoyer lift. Care associate acknowledged she did not ask for assistance prior to lowering Resident to the floor. Care associate acknowledged that she transferred the Resident improperly .Care associate was given corrective action for failing to follow the facility's transfer policy and inservice education on the community's policy on Lifting, Transfer, and Bed Mobility before returning to work . A review of a document titled, Staff Notes contained in the investigation file was reviewed. The notes were dated 9/24/19 at 10:15 PM, and revealed a hand written statement from Certified Nursing Aide/Care Associate (CNA) 'B' that read: I was getting Hoyer lift to proceed to (room # redacted, resident name redacted). I was pushing the lift. It kept on stopping, not allowing it to be pushed. So I went to resident's room attempted to transfer her myself from wheelchair to bed. Resident started to slide, so I lowered resident to the floor .and went to get help. Then my co-worker and I lifted her off the floor and put her in bed. After that I noticed a skin tear on her right shoulder. I went to tell the nurse what happened. Continued review of the investigation file included a signed interview with Certified Nursing Assistant (CNA) 'B' that read, What happened yesterday? I was getting the Hoyer to transfer (R172) but the Hoyer kept stopping. I went down to her room and put a gait belt on her and attempted to transfer her from the wheelchair to the bed .When I lifter <sic> her she started to slide and I lowered her to the floor .I left the room and got (CNA 'C') to help get her from the floor to the bed .When you got the Hoyer and was <sic> bringing it down the hall way <sic> you knew she was a 2 person with a Hoyer. Why didn't you get a second person? I don't know. Why didn't you go to another floor and get another Hoyer? I've worked on the 3rd floor and they don't have a Hoyer up there. I assumed going to get one from another floor wasn't an option. We just in-serviced about this 2 weeks ago what happened. I don't know I made a mistake. A review of a signed interview from CNA 'C' contained in the file was reviewed and read, What happened on Tuesday, September 24, 2019? .I didn't do nothing but help her get the resident off the floor. (CNA 'B') told me that the Hoyer was broke. She said she tried to transfer (R172) with the booties on and she started to slide and she lowered her to the floor. She asked me to help get the resident off the floor. Then she came out and told (Licensed Practical Nurse (LPN) 'D') that the resident had a skin tear on her back .Did (CNA 'B') ask you to help lift the resident prior to you assisting (CNA 'B') when the resident was on the floor? No. A review of R172's care plans included in the investigation file were conducted and hand written on the care plan was the following: .Resident will now transfer (with) Hoyer lift as of 5/3/19 . A review of Licensed Practical Nurse (LPN) 'D's progress note dated 9/24/19 was conducted and read, Per (CNA) the hoyer lift is not working so she just transferred res. (resident) by herself from wheelchair to bed but resident's socks start <sic>to slide (CNA) lowered res. down on the floor and went to ask for another (CNA) to put res. in bed, then she noticed that res. got a skin tear on her right upper arm, I assessed the skin tear, it is superficially open skin, thin skin is rolled open, tried to unrolled <sic> it and covered back on, with slight bleeding, cleansed with NS, (normal saline) pat dry, TAO (wound treatment) applied and covered with .non-adherent strips and 4x4 gauze, secured with Kerlix, no c/o pain during the procedure family notified, logged in Dr.'s log book . On 9/16/20 at 4:40 PM, an interview with the facility's Administrator was conducted regarding R172's improper transfer. The Administrator indicated R172 was a two person mechanical lift and CNA 'B' attempted to transfer her by herself using a gait belt. The Administrator further indicated CNA 'B' had been suspended pending the investigation, been given one-to-one inservice and received a written warning regarding the incident. A review of a facility provided policy titled, Fall Management version dated 2/2020 documented, in part, the following: Policy: To minimize and/or decrease the risk of falls through a interdisciplinary review of guest/resident and to develop individualized care/service plan approaches .3. Guest/resident with identified 1 or more risks will be considered at risk for falls and the Falls Prevention protocols will be initiated .10. DON and/or designee will review 24 Hour Report and audit falls documentation to ensure it is complete and accurate, to include completion of investigative protocols, review of care plan and updating of Holistic Assessment .DON and/or designee will

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) report fall trends any action plans developed to keep guest/residents safe from falls and/or decrease frequency of falls . A review of a facility provided policy titled, Lifting Transfer Bed Mobility Local Review version dated 2/2018 was conducted and read, .2-person Total Body Lift is used the resident Cannot bear weight or Offers minimal or no assistance with the lift/transfer .2 individuals (trained staff persons) are required when using the Total-Body lift .Procedure: .7. Each guest's/resident's care or service plan will address care approaches if a mobility need is identified to include type of lift .8. Type and level of assistance required for a guest's/resident's transfer mobility will be communicated to staff. Information will include device to be utilized, number of staff required for bed mobility and/or transferring assistance.
F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure monthly medication regimen reviews were completed and pharmacist recommendations were acted upon by the physician for six residents, (R#'s 2, 3, 4, 5, 8, and 9) of seven residents reviewed for medication regimen reviews, resulting in the potential for the lack of communication of recommended medication changes. Findings include: R#2 On 9/17/20 at approximately 10:00 AM, review of facility provided monthly medication regimen reviews (MRR's) from January 1, 2020 through September 16, 2020 for R#2 revealed there were no MRR's for March or April 2020. A pharmacist Consultation Report dated 2/24/20 and another dated 7/29/20 indicated R#2 had a PRN (as needed) order for an anxiolytic (anti-anxiety medication), without a stop date. The pharmacist's recommendation read, .Please add stop date to PRN [MEDICATION NAME] . Rationale for Recommendation: CMS (Centers for Medicare and Medicaid Services) requires that PRN orders for non-antipsychotic [MEDICAL CONDITION] drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the PRN order . The form was noted to be blank when it came to one of the three areas for the physician to accept or decline the recommendation and had not been signed by a physician. A review of R#2's physician orders [REDACTED].#2 continued to have an active order for PRN [MEDICATION NAME] with no stop date. A pharmacist Consultation Report dated 6/30/20 indicated R#2 was on [MEDICATION NAME] (anti-psychotic medication) 25 mg (milligram) HS (at bedtime), no behaviors have been charted. The pharmacist's recommendation read, .Please consider attempting a gradual dose reduction (GDR) to [MEDICATION NAME] 12.5 mg while concurrently monitoring for reemergence of target behaviors and/or withdrawal symptoms. Rationale for Recommendation: CMS requires that antipsychotics, used to treat an enduring condition other than dementia, be evaluated at least quarterly with documentation regarding continued clinical appropriateness . The physician signature line was noted to be blank. A review of R#2's physician orders [REDACTED].#2 had an increase of [MEDICATION NAME] to 25 mg two times a day. R#5 On 9/17/20 at approximately 10:00 AM, review of facility provided MRR's from January 1, 2020 through September 16, 2020 for R#5 revealed a MRR dated 6/27/20. The form did not contain a physician response, nor was it signed by a physician. It is also noted there were no MRR's for July 2020. A pharmacist Consultation Report dated 6/27/20 indicated R#5 had a PRN order for an anxiolytic, without a stop date: [MEDICATION NAME]. The pharmacist's recommendation read, Please add stop date to PRN [MEDICATION NAME] and rationale if to continue beyond 14 days. Rationale for Recommendation: CMS requires that PRN orders for non-antipsychotic [MEDICAL CONDITION] drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the PRN order . The form was noted to be blank when it came to one of the three areas for the physician to accept or decline the recommendation and had not been signed by a physician. A Review of R#5's physician orders [REDACTED].#5 continued to have an active order for PRN [MEDICATION NAME] with no stop date. R#9 On 9/17/20 at approximately 10:00 AM, review of facility provided MRR's from January 1, 2020 through September 16, 2020 for R#9' revealed there were no MRR's for January, February, March, April, May or July 2020. On 9/17/20 at approximately 10:00 AM, A review of R3, R4' and R8's monthly medication regimen reviews performed by the consultant pharmacist were requested and provided by the facility. The reports provided were titled, Consultation Report and each report contained the pharmacist's recommendations, and three areas on the form where the physician could either accept the pharmacist's recommendations, accept the recommendation with modifications, or could decline the recommendations and provide a rationale for doing so, as well as a line for the physician to sign the form. Review of the monthly forms revealed the following: R#3 A pharmacist 'Consultation Report' dated 6/30/20 indicated R3 received three different vitamin supplements. The pharmacist's recommendation read, .Please consolidate therapy by discontinuing these supplements and beginning a multivitamin with minerals. Rationale for Recommendation: The use of multiple supplements may increase the changes of therapeutic duplication or adverse effects . The form was noted to be blank when it came to one of the three areas for the physician to accept or decline the recommendation. It was further noted the form was not signed by the physician. A pharmacist 'Consultation Report' dated 8/23/20, identical to the report dated 6/30/20 indicated R3 received three different vitamin supplements. The pharmacist's recommendation read, .Please consolidate therapy by discontinuing these supplements and beginning a multivitamin with minerals. Rationale for Recommendation: The use of multiple supplements may increase the changes of therapeutic duplication or adverse effects . The form was noted to be blank when it came to one of the three areas for the physician to accept or decline the recommendation and had not been signed by a physician. A review of R3's current physician orders [REDACTED]. R#4 A review of R4's pharmacist 'Consultation Report' dated 4/30/20 was conducted and read, .Recommendation: Please add stop date for PRN (as needed) [MEDICATION NAME] and rationale if to continue beyond 14 days. Rationale for Recommendation: CMS (The Centers for Medicare and Medicaid Services) requires that PRN orders to non-antipsychotic [MEDICAL CONDITION] drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the PRN order . The form was noted to be left blank and unsigned by the attending physician. A review of R4's physician's orders [REDACTED]. dated 7/29/20 was conducted and read, .Recommendation: Please consider consolidating therapy by discontinuing [MEDICATION NAME] (iron) and Vitamin B12 and begin MVI (multi-vitamin) with iron. Rationale for Recommendation: The use of multiple supplements may increase the chances of therapeutic duplication or adverse effects . The form was noted to be blank when it came to one of the three areas for the physician to accept or decline the recommendation and had not been signed by a physician. A second review of R4's physician orders [REDACTED]. R#8 A review of R8's pharmacist 'Consultation Report' dated 1/29/20 was conducted and read, .Comment: (R8) has a PRN order for an anxiolytic with no stop date: [MEDICATION NAME]. CMS requires that PRN orders for non-[MEDICAL CONDITION] drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the PRN order. HOSPICE patients are not exempt. Recommendation: Please add stop date to PRN [MEDICATION NAME] ([MEDICATION NAME]) . The form was noted to be blank when it came to the areas for the physician to accept or decline the recommendation and did not include a signature from the physician. A review of R8's physician orders [REDACTED]. It was noted the order did not list a stop date. On 9/17/20 at 11:40 AM, the Director of Nursing (DON) was queried about the facility's process for the monthly medication regimen reviews. The DON explained that during the COVID-19 pandemic if the pharmacist had a recommendation for the physician, the physician was e-mailed a copy of the recommendation, was expected to fill it out with whether they accepted or declined the recommendation and the physicians were supposed to ensure the consultation reports were returned to the facility so they could be filed in the resident's records. When queried why the provided 'Consultation Reports' were left blank and the physicians did not address the recommendations for R3, R4, or R8, the DON had no explanation. A review of a facility provided policy titled, Medication Regimen Review revised 3/2020 was conducted and read, .7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR (Medication Regimen Review) and the Director of Nursing to act upon the recommendations contained in the MRR. 7.1 For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either accept and act upon the recommendations contained within the MRR, or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected. 7.2 The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been take to address it. 7.2.1 If the attending physician has decided to make no change in the medication, the attending physician should document the rationale in the residents' heath record. 8. Facility should alert the Medical Director where MRRs are not addressed by the attending physician in a timely manner .

F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235634	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOX RUN VILLAGE	**41215 FOX RUN ROAD NOVI, MI 48377**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices related to droplet isolation precautions for three residents (R7, R225, and R16) of 8 residents reviewed for infection control, resulting in the potential for the spread of respiratory infections. This deficient practice had the potential to affect all 23 residents who resided in the facility. Findings include: On 9/15/20 at approximately 8:30 AM, an entrance conference for the annual re-certification survey was conducted with the facility's Director of Nursing (DON). During the entrance conference, the DON was asked if they had residents who were positive for the COVID-19 virus. The DON indicated they did not. The DON was then asked about new admissions, or re-admissions from the hospital and what type of precautions were taken for those individuals. The DON explained that when residents admitted or readmitted from the hospital or community, they were placed on droplet isolation precautions for 14 days and were monitored for signs and symptoms of the COVID-19 virus. When queried about what personal protective equipment (PPE) was to be used when caring for those residents, the DON indicated that an N95 face mask, a face shield or goggles, an isolation gown, and gloves were to be worn. R#7 On 9/15/20 at 10:30 AM, an observation of R7's room revealed the room door closed with an isolation cart containing PPE in the hallway outside of the room. A sign on the door indicated the room was on droplet precautions and those entering the room should be wearing an N95 face mask, a face shield, an isolation gown, and gloves. It was also observed a nurses computer cart was outside of the room. After knocking on the room door, the door was opened and Nurse 'A' was observed (from the hallway) in the room administering medications to R7. Nurse 'A' was not observed to be wearing an isolation gown while providing care to R7. A review of R7's clinical record was conducted on 9/16/20 at 1:04 PM and revealed they were transferred to the hospital on [DATE] and re-admitted to the facility on [DATE]. A physician's orders [REDACTED]. It was also discovered that upon re-admission, R7 had been monitored for signs and symptoms of the COVID-19 virus. R#225 On 9/15/20 at approximately 10:00 AM, an observation of R#225's room revealed the room door closed with an isolation cart containing PPE outside the room. Signs on the door indicated those entering the room should be wearing an N95 face mask, a face shield, an isolation gown and gloves due to droplet precautions. Nurse A was interviewed and asked what PPE was required to enter R#225's room. Nurse A explained if no patient care was to be done, a gown was not needed and that a surgical mask could be worn. Review of the clinical record revealed R#225 was admitted from a hospital on [DATE] and was on Strict Droplet Isolation x 14 days per physician orders. R#16 On 9/15/20 at approximately 9:15 AM, R#16 had a sign on their door that indicated the resident was on droplet precautions that required staff/visitors to enter the room with PPE equipment that included: 1. Gown (full cover torso from neck to knee), 2. Mask or Respirator, 3. Goggles or Face Shield and 4. Gloves. Aide I was observed in R#16's room assisting the resident with breakfast. When asked why they were not wearing the PPE as indicated on the sign outside the resident's door, Aide I stated that they were from an Agency and were not aware that they should be wearing the PPE and the sign was posted in the morning. Nurse D who was assigned to the resident confirmed that the resident was on precautions and should have been wearing the required PPE. Review of the clinical record revealed R#16 was admitted from a hospital on [DATE] and was on Strict Droplet Isolation x 14 days per physician orders. On 9/16/20 at approximately 4:25 PM, the Administrator indicated that Aide I should have been wearing proper PPE and was in-serviced as to proper protocol. On 9/17/20 at 10:35 AM, an interview was conducted with the Assistant Director of Nursing (ADON) E who also served as the facility's Infection Preventionist. ADON E was queried about PPE and droplet precautions. ADON E explained any residents admitted from, or coming back from a hospital or other facility were immediately placed on droplet precautions for 14 days. ADON E further explained full PPE was required, N95 mask, face shield, gown and gloves were to be worn when entering the room for any reason, not just patient care. ADON E was asked if a surgical mask could be worn. ADON E explained a N95 mask was required. A review of a facility provided policy titled, Infection Prevention and Control Preventing Transmission of Infectious Agents dated 6/2019 was reviewed and read, .Transmission Based precautions: Transmission-Based Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission .2. Transmission Based precautions include: .Droplet precautions: Use Droplet Precautions for patients known or suspected to be infected with pathogens transmitted by respiratory droplets .