STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235602	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAZEL I FINDLAY COUNTRY MANOR	1101 S SCOTT RD SAINT JOHNS, MI 48879

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accurately assess/represent an accurate picture of the residents' status during the observation period (involving Resident #83, Resident #98 and Resident #76), resulting in inaccurate data for residents to Centers for Medicare and Medicaid and the potential for inaccurate information being presented to residents, responsible parties and families for up to 25 residents with bed rails. Findings include: Resident #83 (R83) According to the Minimum Data Set (MDS), dated [DATE], R83 was admitted to the facility on [DATE], was cognitively intact, needed two or more staff for bed mobility and had [DIAGNOSES REDACTED]. According to Section P on the MDS: Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. During an interview/observation on 3/11/20 at 9:11 AM, Resident # 83 was lying in bed and there were bilateral bed rails (enabler/grab bars) in up position at head of bed. R83 reported she used the grab bars for assisting with turning in bed and they did not restrain her in any way. Review of Resident #83's Physician Order, dated 2/11/2020, revealed, Enabler Bars to assist with bed mobility . Resident #98 (R98) According to the MDS, dated [DATE], R98 was admitted to the facility on [DATE], was cognitively intact, needed two or more staff for bed mobility and had [DIAGNOSES REDACTED]. During an interview/observation, on 3/11/20 at 9:36 AM, Resident # 98 was observed lying in bed; there were stationary, bilateral bed rails in the up position at the head of her bed. When asked if the bed rails kept her from getting out of bed or restrained her in any way, R98's husband W said and R98 agreed, No, they help her when turning in bed. R98's husband complained saying it made him angry, They told us the State won't let them put bedrails on the bed because they are restraints. I had to argue with them to get them for her. Review of Resident #98's Physician Order, dated 2/19/2020, revealed, Enabler bars on bed for bed mobility . In an interview, on 3/11/20 at 3:02 PM, MDS Coordinator F reported she was instructed by facility Administration that enabler bars were bed rails and she must code all bed rails as restraints. MDS Coordinator F reported the enabler bars were not being used as restraints but all 25 facility residents with enabler bars on their beds had been coded as restraints under Section P on their MDS. In an interview immediately following, Director of Nursing (DON) B confirmed that although no restraints were in used in the building, physician orders, entrapment measurements, signed consents had been obtained, and bed rails had been care planned for all 25 residents with enabler bars on their beds, it was her understanding that enabler bars were side rails, therefore considered restraints, and they needed to be coded on the MDS as restraints. DON B confirmed MDS Coordinators had been instructed to code all enabler bars on the MDS as Restraints. Resident #76(R76) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R76 was a [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected R76 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she required one person physical assist with locomotion on unit, hygiene, showering, eating, and two person physical assist with bed mobility, transfers, dressing, and toileting. During an interview and observation on 3/10/20 at 4:45 p.m. R76 reported going to [MEDICAL TREATMENT] three times weekly. R76 was noted to be in bed and appeared calm and well groomed. Review of the MDS dated , 1/30/20, reflected R76 had no record of [MEDICAL TREATMENT] services. During an interview on 3/12/20 at 2:37 p.m., MDS Nurse (MDSN) AA reported working with the facility for two years. MDSN AA reported, after reviewing R76 MDS from 1/30/20, she made a mistake on R76 MDS for 1/30/20 assessment and should have documented R76 received [MEDICAL TREATMENT] services. MDSN AA reported was unsure how it happened because R76 had been receiving [MEDICAL TREATMENT] services for some time and past MDS assessments reflected [MEDICAL TREATMENT] services. MDSN AA reported plan to make correction to R76 MDS assessment for 1/30/20 and continue to triple check assessments. MDSN AA reported R76 was the only [MEDICAL TREATMENT] resident at the facility at the time.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, intervention and record review, the facility failed to implement interventions to prevent pressure ulcers in one of four reviewed with pressure ulcers (Resident #105), resulting in the development of three facility acquired pressure ulcers, pain, and decreased quality of life. Findings include: Resident #105 (R105) On 03/10/2020 at 10:52 AM R105 was observed sitting in a wheelchair in her room and stated she had a lot of pain in lower center of her back and requested some pain medication. On 03/12/20 at 12:45 PM R105 was observed lying in bed on her back. R105's Minimum Data Set (MDS) assessment dated [DATE], indicated she was admitted to the facility on [DATE], and had a Brief Interview for Mental Status (BIMS), a short performance-based cognitive screener for nursing home (NH) residents, score of 09 (08-12 Moderate Impairment). R105 required extensive (weight bearing support) assistance of two plus persons in bed mobility (how resident moves to and from lying position, turns side or side, and positions body while in bed) and for transfers (how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet). R105 same MDS assessment revealed a functional limitation in range of motion (ROM, limited ability to move a joint that interfered with daily functioning or placed resident at risk of injury) in both her upper extremities (shoulder, elbow, wrist, hand). The same MDS assessment determined R105 was at risk for the development of pressure ulcers and had developed one unstageable pressure ulcer with suspected deep tissue injury in evolution (purple or maroon area of discolored intact skin due to damage of underlying soft tissue damage. The area may be preceded by tissue that was painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue) during her admission to the facility. R015's same MDS assessment indicated, under skin and ulcer treatments, her treatment did not include a turning/repositioning program (a consistent program for changing the resident's position and realigning the body). In review of R105's hospital history and physical, dated 02/15/2020, revealed she was admitted to the hospital following a fall at home that caused an increase in her chronic lower back pain. R105's discharge summary dated 02/15/2020, revealed an indeterminate collapse of the T-12 vertebral body (middle spine, T12 bears the most weight of any [MEDICATION NAME] vertebra, making it the strongest [MEDICATION NAME] vertebra, but also the most susceptible to stress-related injuries). In review of R105's Weekly Skin Summary dated 02/28/2020, a partially fluid filled blister with suspected deep tissue injury was first noted on her left heel and suspected deep tissue injury was first noted on her right lateral heel. Weekly Skin Summary dated 03/03/2020 indicated R105 had a stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough (non-viable yellow, tan, gray, green or brown tissue)) noted on her mid back, with granulation tissue (red tissue with cobblestone or bumpy appearance), present. Centers for Medicare and Medicaid Services (CMS's) Long-Term Care Facility Resident Assessment Instrument (LTCF RAI) 3.0, Version 1.17, October 2019; indicated Stage II pressure ulcers should not be coded as having granulation tissue, as by definition they do not have this extent of tissue damage. The same source indicated suspected deep tissue injury required vigilant monitoring due to the potential for

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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 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) rapid deterioration and should be reflected in the care plan. During an interview on 03/12/20 at 9:49 AM Assistant Director of Nursing (ADON) T confirmed R105 had developed 3 pressure ulcers since her admission. ADON T stated R105's mid-back was a Stage II pressure ulcer and did not have granulation tissue (indicative of a stage III pressure ulcer). ADON I stated R105's was turned every two hours and as needed and was not care planned to avoid positioning on her spine. ADON T stated R105 was not a side sleeper but was agreeable to 30-degree side positioning. In review of R105's pressure ulcer care plan dated 03/05/2020, Frequent turning and repositioning; 2 assist was instructed. The same care plan did not indicate to avoid positioning on R105's spine or how often to turn and reposition in bed and when in her wheelchair. According to the National Database of nursing Quality Indicators (NDNQI) website at https://members.nursingquality.org/NDNQIPressureUlcerTraining/Module3/PressureUlcerSurveyGuide_16a1.aspx, avoid a 90-degree side-lying position and position residents in a 30-degree side-lying position; use pillows, blankets or positioning devices to maintain body alignment and prevent pressure on bony prominences. The same source indicated to consider frequent smaller shifts in position if the resident could not tolerate the 30-degree side-lying position. CMS's October 2019's LTCF RAI revealed pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning . and an existing pressure ulcer may put residents at risk for further complications or skin injury. The National Pressure Ulcer Advisory Panel's website at http://www.npuap.org/wp-content/uploads/2016/04/Pressure-Injury-Prevention-Points-2016.pdf, in a document titled Pressure Injury Prevention Points, it was recommended to reposition weak individuals in chairs hourly and to avoid positioning the individual on body areas with pressure injury.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide treatment and services to restore as much normal bowel and bladder function as possible in one of one resident reviewed for incontinence (Resident #105), resulting in the potential for decreased quality of life, skin breakdown and the potential for infections. Findings include: Resident #105 (R105) On 03/10/2020 at 10:52 AM R105 was observed sitting in a wheelchair in her room. R105's Minimum Data Set (MDS) assessment datd 02/26/2020, indicated she was admitted to the facility on [DATE], and had a Brief Interview for Mental Status (BIMS), a short performance-based cognitive screener for nursing home (NH) residents, score of 09 (08-12 Moderate Impairment). R105 required extensive (weight bearing support) assistance of two plus persons for transfers and toilet use (how resident uses the toilet room, commode, bedpan; transfers on/off toilet; cleanses self after elimination; changes pad; and adjusts clothes). The same MDS assessment revealed R105 was frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least one episode of continent of continent voiding) and frequently incontinent of bowel (2 or more episodes of bowel incontinence, but at least one continent bowel movement during a 7-day look-back period); and no trial toileting program (scheduled toileting, prompted voiding, or bladder training) had been attempted to manage 105's bladder or bowel incontinence. In review of R105's hospital history and physical, dated 02/15/2020, revealed she was admitted to the hospital following a fall at home, when walking with her walker, that caused an increase in her chronic lower back pain. R105's discharge summary dated 02/15/2020, revealed an indeterminate collapse of the T-12 vertebral body (middle spine, T12 bears the most weight of any [MEDICATION NAME] vertebra, making it the strongest [MEDICATION NAME] vertebra, but also the most susceptible to stress-related injuries). Restorative Licensed Practical Nurse (LPN) E was interviewed on 03/12/2020, and stated the only time she did a bowel and bladder assessment was when staff notified her that a resident had a change. LPN E confirmed a bowel and bladder patterning assessment had not been completed for R105. According to Centers for Medicare and Medicaid Services (CMS's) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0, Version 1.17, October 2019; an individualized, resident-centered toileting program may decrease or prevent urinary and bowel incontinence. Each incontinent or resident found at risk for incontinence should be identified, assessed, and provided with individualized treatment and services to achieve or maintain as normal elimination as possible. The same source advised a toileting trial should include observations of at least 3 days of toileting patterns with prompting to toilet and of recording results in a bladder record or voiding diary. The same source advised a bowel toileting program should be based on an assessment of the resident's unique bowel pattern and the provider may want to consider assessing the resident for adequate fluid intake, adequate fiber in the diet, exercise and scheduled times to attempt bowel movement. The same source revealed many incontinent residents (including those with dementia) respond to a toileting program (habit training/scheduled voiding, bladder rehabilitation/bladder retraining, prompted voiding), especially during the day. Residents should be reevaluated whenever there was a change in cognition, physical ability, or urinary tract function.
F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide medical justification for the use of bed rails and attempt less restrictive devices for bedrails (involving Resident #83 and Resident #98), resulting in the potential for the misuse of bed rails and increased risk for hazards for up to 25 residents that had bed rails on their beds. Findings include: Resident #83 (R83) According to the Minimum Data Set, dated dated [DATE], R83 was admitted to the facility on [DATE], was cognitively intact, needed two or more staff for bed mobility and had [DIAGNOSES REDACTED]. During an interview/observation on 3/11/20 at 9:11 AM, Resident # 83 was lying in bed and there were bilateral bed rails (enabler/grab bars) in up position at head of bed. R83 reported she used the grab bars for assisting with turning in bed and they did not restrain her in any way. Review of Resident #83's Physician Order, dated 2/11/2020, revealed, Enabler Bars to assist with bed mobility. No directions specified for order. No medical [DIAGNOSES REDACTED]. Review of R83's Care Plans and Medical Record revealed no evidence that appropriate alternatives were attempted prior to installing bed rails. Resident #98 (R98) According to the Minimum Data Set, dated dated [DATE], R98 was admitted to the facility on [DATE], was cognitively intact, needed two or more staff for bed mobility and had [DIAGNOSES REDACTED]. During an interview/observation, on 03/11/20 at 09:36 AM, Resident # 98 was observed lying in bed; there were stationary, bilateral bed rails in the up position at the head of her bed. When asked if the bed rails kept her from getting out of bed or restrained her in any way, both R98's husband W, said and R98 agreed, No, they help her when turning in bed. Review of Resident #98's Physician Order, dated 2/19/2020, revealed, Enabler bars on bed for bed mobility. No directions specified for order. No medical [DIAGNOSES REDACTED]. Review of R98's Care Plans and Medical Record revealed no evidence that appropriate alternatives were attempted prior to installing bed rails. In an interview, on 3/11/20 at approximately 3:30 PM, Director of Nursing (DON) B agreed that physician orders [REDACTED].
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that medications were administered as ordered in 2 sampled residents (R83 and R458), from a total of 11 residents observed during medication pass, resulting in 3 errors out of 29 opportunity for errors and a medication error rate of 10.34%. Findings include: Resident #458(R458) Review of the Face Sheet dated, 3/4/20, and Hospital Discharge Summary(HDS), received by the facility on 3/3/20 at 1:16 p.m., reflected R458 was a [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The HDS reflected R458 was alert and oriented to person, place and time. During an observation and interview on 3/10/20 at 11:37 a.m., during medication pass, Registered Nurse (RN) K reported plan to give R458 an albuterol nebulizer treatment. RN K reported R458 was on droplet isolation related to positive influenza A(Flu). R458 was in bed with head of bed elevated and leaned forward with oxygen via nasal cannula in place. R458 appeared short of breath evidenced by very labored breathing and rocking back and forth and coughing. R458 stated, I can't catch breath, feels like I am going to die. This surveyor verified RN K had

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F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML nebulizer solution ready for R458. R458 stated, feels like I am starving for air. RN K reported to R458 the oxygen was set at 3 liters. RN K started the nebulizer treatment at 11:43 a.m. RN K remained in R458 room until nebulizer was completed at 11:50 a.m. and informed R458 he would return on about 15 minutes to recheck lung sounds. RN K unlocked the central medication cart and verified R458 had an open box of [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML and no noted [MEDICATION NAME] nebulizer treatment for [REDACTED]. The orders reflected R458 had an active order for [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML 1 dose inhale orally four times a day for [MEDICAL CONDITION] that started on 3/4/20. Review of the Medication Administration Record(MAR), dated 3/1/20 through 3/31/20, reflected R458 was administered [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% 1 vial inhale orally on 3/10/20 at 11:51 a.m.(the same time this surveyor observed RN K administer [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML). In addition the MAR indicated [REDACTED]. Review of the facility Nursing Progress Notes, dated 3/10/20, reflected no documentation for R458 related to the use of [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML in place of [MEDICATION NAME] Nebulizer Solution (2.5 MG/3ML) 0.083% or the documentation discrepancy on the MAR indicated [REDACTED]. During an observation on 3/11/20 at 9:45 a.m. R458 was observed being transferred on a stretcher out of the building by Emergency Medical staff. During an observation and interview on 3/12/20 at 10:55 a.m. RN R unlocked the Central medication cart and verified R458 did not have [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% available to administer from the pharmacy. RN R reported in that situation medication must be pulled from the Omnicell machine(pharmacy locked backup on site). RN R reported was unsure why [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% was not available for R458 but when RN R sent R458 out to hospital on [DATE] was the first time RN R had cared for R458 but otherwise would have contacted the pharmacy. RN R verified all other [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% in Central medication cart had other resident names on them. RN R reported nurse staff not able to use other resident medication and must pull from Omnicell. Review of the Pharmacy Omnicell Report on 3/12/20 at 1:00 p.m., provided by the Director of Nursing (DON) B for dates between 3/3/20 through 3/11/20, reflected one single dose of [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% on 3/7/20 at 1:42 p.m. removed for R458. During an interview on 3/12/20 at 1:12 p.m. DON B reported wound expect nurse staff to follow physician orders [REDACTED]. DON B reported would expect nurse to document correct medication that was administered on the MAR. Review of the Hospital admission records, dated 3/11/20, reflected R458's admission [DIAGNOSES REDACTED]. As of the completion of the survey on 3/13/20, the facility failed to provide any documentation. Resident #83 (R83) According to the Minimum Data Set, dated dated [DATE], R83 was admitted to the facility on [DATE], was cognitively intact, needed two or more staff for bed mobility and had [DIAGNOSES REDACTED]. During an medication administration observation/interview, on 3/12/20 at 9:33 AM, Licensed Practical Nurse (LPN) C prepared and administered to R83: Calcium 600 mg + Vit D (200 IU) one tab PO and Iron tab 325 mg one tab PO from stock medications. When reviewing the orders with the medications administered, LPN C stated, I'm sure that's what we've been giving her. LPN C stated she thought she had probably been making medication errors but said, That's all we get to give. LPN C stated she had not recognized the error until Surveyor reviewed the order with her. (Review of the R83's Physician orders [REDACTED]. Give 1 tablet by mouth one time a day for supplement and [MEDICATION NAME] Tablet 27 MG. Give 1 tablet by mouth in the morning for [MEDICAL CONDITION].) In an interview, on 03/12/20 at 10:10 AM, Payroll Specialist D reported she placed the orders the stock meds. Payroll Specialist D pulled up on the computer the last three months of orders placed and there was no [MEDICATION NAME] 600 Tablet 1500 (600 Ca) MG (Calcium [MEDICATION NAME]) or [MEDICATION NAME] Tablet 27 MG among the orders. A tour of the stock meds in the Central Supply revealed no [MEDICATION NAME] 600 Tablet 1500 (600 Ca) MG (Calcium [MEDICATION NAME]) or [MEDICATION NAME] Tablet 27 MG on the shelf. Payroll Specialist stated, I don't believe we have plain Calcium (without Vitamin D) or [MEDICATION NAME] 37 mg. If it is specific for the resident, we order it and give it directly to the nurse on the unit. In an interview, on 03/12/20 at 10:31 AM, Director of Nursing (DON) B reviewed R83's Calcium and Iron medication orders and said, Yes, they are med errors. In an interview, on 03/12/20 at 11:21 AM, DON B reported she had found that R83 had a blister pack with [MEDICATION NAME] Tablet 27 MG in the medication cart that had been sent by the Pharmacy, but there was no blister packs sent from the Pharmacy of [MEDICATION NAME] 600 Tablet 1500 (600 Ca) MG (Calcium [MEDICATION NAME]) in the medication cart. DON B confirmed LPN C indeed made two medication errors on 3/12/20 with these medications. Review of R83's Medication Administration Records since her admission on 2/06/20, revealed LPN C documented she administered Iron eight times to R83 during that timeframe and therefore made eight medication errors. R83's MAR indicated [REDACTED].

F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to prevent a significant medication error as evidenced by eight duplication of medication episodes of [MEDICATION NAME] including inaccurate documentation for 1 resident (R458) out of 11 observed during medication pass resulting in the potential for drug toxicity and heart arrythmias. Findings include: Resident #458(R458) Review of the Face Sheet dated, 3/4/20, and Hospital Discharge Summary(HDS), received by the facility on 3/3/20 at 1:16 p.m., reflected R458 was a [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The HDS reflected R458 was alert and oriented to person, place and time. During an observation and interview on 3/10/20 at 11:37 a.m., during medication pass, Registered Nurse (RN) K reported plan to give R458 an albuteral nebulizer treatment and obtained supplies from the medication cart including an oxygen saturation machine. RN K borrowed a stethoscope from the skilled nursing cart and carried the oxygen saturation machine and stethoscope into R458 room that had a stop sign outside the door with direction to see nurse. RN K reported R458 was on droplet isolation related to positive influenza A(Flu). R458 was in bed with head of bed elevated and leaned forward with oxygen via nasal cannula in place. R458 appeared short of breath evidenced by very labored breathing and rocking back and forth and coughing. R458 stated, I can't catch breath, feels like I am going to die. RN K put on gown, mask, and gloves that were located just inside R458's room. This surveyor verified RN K had [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML nebulizer solution ready for R458. RN K placed the oxygen saturation machine directly on R458's bedside table next to R458 and place on R458's left ear lobe. RN K used the stethoscope from around his neck to listen to R458 lung sounds on the front and back while R458 continued to cough and placed the soiled stethoscope back around his neck. R458 stated, feels like I am starving for air. RN K reported to R458 the oxygen was set at 3 liters. RN K started the nebulizer treatment at 11:43 a.m. RN K remained in R458 room until nebulizer was completed at 11:50 a.m. and informed R458 he would return on about 15 minutes to recheck lung sounds. RN K picked up oxygen saturation machine from R458's bedside table with same gloved hands and place in uniform pocket. RN K removed stethoscope form neck with same gloved hands and placed on bedside table by door and removed gown, mask, and gloves, washed hands and picked up soiled oxygen saturation machine from bedside table and removed stethoscope from neck and carried both to the medication cart and placed the soiled oxygen saturation machine directly on the top of the medication cart and place the soiled stethoscope around his neck without sanitizing either piece of equipment. RN K continued to document at the medication cart located in the Central hall after touching the soiled equipment. RN K unlocked the central medication cart and verified R458 had an open box of [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML and no noted [MEDICATION NAME] nebulizer treatment for [REDACTED]. RN K exited the room and entered the Central Dining room, where six other residents were observed for lunch, and administered medication to male resident with same soiled stethoscope around his neck. At 12:04 p.m. RN Kreturned to medication cart and retrieved the soiled oxygen saturation machine from the top of the medication cart and place in uniform pocket and returned to R458's room. RN K put on a gown, mask, and gloves and removed the oxygen saturation machine from his uniform pocket and placed on R458 bedside table and attached to R458 left ear lobe with gloved hands. RN K removed the same soiled stethoscope from his neck and listened to R458 lung sounds anterior and posterior. RN K placed the soiled stethoscope and oxygen machine directly on the bedside table by the door, removed gloves, gown and mask and washed hands with soap and water and picked up soiled equipment, exited R458 isolation room and placed soiled oxygen saturation machine directly on top of central medication cart and soiled stethoscope around neck without cleaning equipment. Review of the Physician orders, dated 3/1/20 through 3/31/20, reflected R458 had an active order for [MEDICATION NAME] Nebulizer Solution (2.5 MG/3ML) 0.083% 1 vial inhale orally four times a day for SOB, wheezing that started on 3/7/20. The orders reflected R458 had an active order for [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML 1 dose inhale orally four times a day for [MEDICAL CONDITION] that started on 3/4/20. Review of the Medication Administration Record(MAR), dated 3/1/20 through 3/31/20, reflected R458 was administered [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% 1 vial inhale orally

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) on 3/10/20 at 11:51 a.m.(the same time this surveyor observed RN K administer [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML). In addition the MAR indicated [REDACTED]. Review of the facility Nursing Progress Notes, dated 3/10/20, reflected no documentation for R458 related to the use of [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML in place of [MEDICATION NAME] Nebulizer Solution (2.5 MG/3ML) 0.083% or the documentation discrepancy on the MAR indicated [REDACTED]. During an observation on 3/11/20 at 9:45 a.m. R458 was observed being transferred on a stretcher out of the building by Emergency Medical staff. During an observation and interview on 3/12/20 at 10:55 a.m. RN R unlocked the Central medication cart and verified R458 did not have [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% available to administer from the pharmacy. RN R reported in that situation medication must be pulled from the Omnicell machine(pharmacy locked backup on site). RN R reported was unsure why [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% was not available for R458 but when RN R sent R458 out to hospital on [DATE] was the first time RN R had cared for R458 but otherwise would have contacted the pharmacy. RN R verified all other [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% in Central medication cart had other resident names on them. RN R reported nurse staff not able to use other resident medication and must pull from Omnicell. Review of the Pharmacy Omnicell Report on 3/12/20 at 1:00 p.m., provided by the Director of Nursing (DON) B for dates between 3/3/20 through 3/11/20, reflected one single dose of [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% on 3/7/20 at 1:42 p.m. removed for R458. During an interview on 3/12/20 at 1:12 p.m. DON B reported wound expect nurse staff to follow physician orders [REDACTED]. DON B reported would expect nurse to document correct medication that was administered on the MAR. Review of the Hospital admission records, dated 3/11/20, reflected R458's admission [DIAGNOSES REDACTED]. As of the completion of the survey on 3/13/20, the facility failed to provide any documentation.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure dating of multi-dose medication containers according to manufacturer's recommendations and accepted professional principles with accurate open and expiration dates resulting in the potential for the administration of expired medications and uncontrolled symptoms and disease states. Findings include: According to a document titled, Medication Storage Guidance, provided by the facility, [MEDICATION NAME] and [MEDICATION NAME]were good up to 28 days after opening. [MEDICATION NAME] was good up to 42 days after opening. According to manufacturer's recommendations, Tresiba FlexTouch pen contained an ultra long-acting [MED] and should be discarded 56 days after opening, if not refrigerated. According to regulatory guidelines found at F 761, .facility staff should date the label of any multi-use vial when the vial is first accessed .If a multi-dose vial has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. On 3/11/2020 at 10:54 AM, the north hall medication (med) cart was inspected, accompanied by Registered Nurse (RN) L, and the following diabetes medication pens observed: For Resident #2 (R2), a [MEDICATION NAME] (long-acting [MED]) pen with an open date of 3/7 and no expiration date written on the pen label. For R22, a [MEDICATION NAME] (rapid-acting [MED]) pen with an open date of 2/13 and an expiration date of 3/26 written on the label. The pen had a needle attached to it and the cap was loose in the zip lock bag. A [MEDICATION NAME] pen with an open date of 2/7 and no expiration date. For R60, a [MEDICATION NAME] (long-acting [MED]) pen for with an open date of 2/20 and an expiration date of 3/11 written on the label, 8 days too early. For R108, An [MEDICATION NAME] (rapid-acting [MED]) pen with an open date of 2/26 and no expiration date written on the label. A second [MEDICATION NAME] pen with an open date of 3/7 and no expiration date written on the label. A Tresiba FlexTouch pen with an open date of 2/22 written on the label and no expiration date written on the label. According to a document titled, Medication Storage Guidance, provided by the facility's pharmacy, for Latanoprost (for [MEDICAL CONDITION]) , Date when opened and discard after 6 weeks .Unless otherwise noted above, or facility policy is more stringent, all multi-dose containers will be considered to be expired on the ate on the actual container as indicated by the manufacturer . On 3/11/20 at 2:02 PM, the central-north med cart was inspected, accompanied by Assistant Director of Nurses (ADON) M. Approximately six [MED] pens had expiration dates written in a thick, felt-tipped marker on the labels. When asked, ADON M said she didn't know if the expiration dates on the [MED] pens had been added since the morning. For R109, a bottle of Latanoprost 0.005% eye drops (for [MEDICAL CONDITION]) with no open or expiration dates written on the label on the bottle. Also in the med cart were many stock bottles of over-the-counter meds. The bottles had open dates written on them, and expiration (or discard) dates of exactly one year later written on each bottle. The manufacturer's recommended expiration date for each med were months and even years after the hand-written expiration dates. Someone didn't know what they were doing. On 3/11/20 at 2:22 PM, the west med cart was inspected, accompanied by RN K. In the med cart, many stock bottles of over-the-counter meds had open and expiration (or discard) dates of exactly one year later written on each bottle. The manufacturer's recommended expiration date for each med were months and even years after the hand-written expiration dates. One bottle of [MEDICATION NAME] chewables (vitamins for eyes) had an expiration date of 2/10/21 written on the bottle. The manufacturer's expiration date was 12/2020. One bottle of Aspirin 325 milligrams had an expiration date of 1/25/21 written on the bottle. The manufacturer's expiration date was 5/2020. On 3/11/2020 at 2:45 PM, ADON T was interviewed. When asked how nurse's are to date-label meds like [MED] pens, ADON T said nurses were to write open and expiration dates on the pens. Each med cart has this information, ADON T said. On 3/12/20 at 8:00 AM, RN R was interviewed. When asked, RN R admitted she was instructed to check and label [MED] pens with expiration dates in the north-central med cart 3/11/2020 morning. The facility had no policy/procedure, reflecting regulatory guideliens, to detail how datee-labeling was to be done.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement principles of infection control during resident care in 1 of 1 (R458) sampled residents on isolation percautions, from a total sample of 22 residents reviewed for infection control, resulting in the potential spread of infection. Findings include: Resident #458(R458) Review of the Face Sheet dated, 3/4/20, and Hospital Discharge Summary(HDS), received by the facility on 3/3/20 at 1:16 p.m., reflected R458 was a [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The HDS reflected R458 was alert and oriented to person, place and time. During an observation and interview on 3/10/20 at 11:37 a.m., during medication pass, Registered Nurse (RN) K reported plan to give R458 an albuteral nebulizer treatment and obtained supplies from the medication cart including an oxygen saturation machine. RN K borrowed a stethoscope from the skilled nursing cart and carried the oxygen saturation machine and stethoscope into R458 room that had a stop sign outside the door with direction to see nurse. RN K reported R458 was on droplet isolation related to positive influenza A(Flu). R458 was in bed with head of bed elevated and leaned forward with oxygen via nasal cannula in place. R458 appeared short of breath evidenced by very labored breathing and rocking back and forth and coughing. R458 stated, I can't catch breath, feels like I am going to die. RN K put on gown, mask, and gloves that were located just inside R458's room. This surveyor verified RN K had [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML nebulizer solution ready for R458. RN K placed the oxygen saturation machine directly on R458's bedside table next to R458 and place on R458's left ear lobe. RN K used the stethoscope from around his neck to listen to R458 lung sounds on the front and back while R458 continued to cough and placed the soiled stethoscope back around his neck. R458 stated, feels like I am starving for air. RN K reported to R458 the oxygen was set at 3 liters. RN K started the nebulizer treatment at 11:43 a.m. RN K remained in R458 room until nebulizer was completed at 11:50 a.m. and informed R458 he would return on about 15 minutes to recheck lung sounds. RN K picked up oxygen saturation machine from R458's bedside table with same gloved hands and place in uniform pocket. RN K removed stethoscope form neck with same gloved hands and placed on bedside table by door and removed gown, mask, and gloves, washed hands and picked up soiled oxygen saturation machine from bedside table and removed stethoscope from neck and carried both to the medication cart and placed the soiled oxygen saturation machine directly on the top of the medication cart and place the soiled stethoscope around his neck without sanitizing either piece of equipment. RN K continued to document at the medication cart located in the Central hall after touching the soiled equipment. RN K unlocked the central medication cart and verified R458 had an open box of [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML and no noted [MEDICATION NAME]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235602	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAZEL I FINDLAY COUNTRY MANOR	**1101 S SCOTT RD SAINT JOHNS, MI 48879**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) nebulizer treatment for [REDACTED]. RN K exited the room and entered the Central Dining room, where six other residents were observed for lunch, and administered medication to male resident with same soiled stethoscope around his neck. At 12:04 p.m. RN Kreturned to medication cart and retrieved the soiled oxygen saturation machine from the top of the medication cart and place in uniform pocket and returned to R458's room. RN K put on a gown, mask, and gloves and removed the oxygen saturation machine from his uniform pocket and placed on R458 bedside table and attached to R458 left ear lobe with gloved hands. RN K removed the same soiled stethoscope from his neck and listened to R458 lung sounds anterior and posterior. RN K placed the soiled stethoscope and oxygen machine directly on the bedside table by the door, removed gloves, gown and mask and washed hands with soap and water and picked up soiled equipment, exited R458 isolation room and placed soiled oxygen saturation machine directly on top of central medication cart and soiled stethoscope around neck without cleaning equipment. Review of the Physician orders, dated 3/1/20 through 3/31/20, reflected R458 had an active order for [MEDICATION NAME] Nebulizer Solution (2.5 MG/3ML) 0.083% 1 vial inhale orally four times a day for SOB, wheezing that started on 3/7/20. The orders reflected R458 had an active order for [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML 1 dose inhale orally four times a day for [MEDICAL CONDITION] that started on 3/4/20. Review of the Medication Administration Record(MAR), dated 3/1/20 through 3/31/20, reflected R458 was administered [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% 1 vial inhale orally on 3/10/20 at 11:51 a.m.(the same time this surveyor observed RN K administer [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML). In addition the MAR indicated [REDACTED]. Review of the facility Electronic Medical Record vitals, dated 3/3/20 through 3/10/20, reflected R458 had a documented temperature greater than 99.0 degrees Fahrenheit on 16 occasions up to 101.8 degrees Fahrenheit. During an observation on 3/11/20 at 9:45 a.m. R458 was observed being transferred on a stretcher out of the building by Emergency Medical staff. During an observation and interview on 3/12/20 at 10:55 a.m. RN R unlocked the Central medication cart and verified R458 did not have [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% available to administer from the pharmacy. RN R reported in that situation medication must be pulled from the Omnicell machine(pharmacy locked backup on site). RN R reported was unsure why [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% was not available for R458 but when RN R sent R458 out to hospital on [DATE] was the first time RN R had cared for R458 but otherwise would have contacted the pharmacy. RN R verified all other [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% in Central medication cart had other resident names on them. RN R reported nurse staff not able to use other resident medication and must pull from Omnicell. RN R reported R458 was on isolation and required common use items such as stethoscope and oxygen saturation machine be cleaned after use before contact with surfaces outside of isolation. Review of the Pharmacy Omnicell Report on 3/12/20 at 1:00 p.m., provided by the Director of Nursing (DON) B for dates between 3/3/20 through 3/11/20, reflected one single dose of [MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) 0.083% on 3/7/20 at 1:42 p.m. removed for R458. During an interview on 3/12/20 at 1:12 p.m. DON B DON B reported would expect nurse staff to follow physician orders [REDACTED]. DON B reported would expect nurse to document correct medication that was administered on the MAR. DON B reported would expect to clean common use items including stethoscope after use in isolation room. As of the completion of the survey, the facility failed to provide any documentation.