STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235556	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WOODWARD HILLS HEALTH AND REHABILITATION CTR	39312 WOODWARD BLOOMFIELD HILLS, MI 48304

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

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F 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** This citation pertains to Intake Numbers: MI 275, MI 506, MI 901, MI 817, and MI 428. Based on observation, interview and record review, the facility failed to consistently provide routine showers as scheduled for six (R#s: 901, 905, 908, 909, 912, and 913) of seven residents reviewed for activities of daily living (ADLs), resulting in showers not being provided for dependent residents. Findings Include: Resident #901 A review of the clinical record revealed R#901 was originally admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the 5 Day Minimum Data Set ((MDS) dated [DATE] revealed R#901 had a BIMS (Brief Interview of Mental Status) score of 3 out of 15 which indicated severe cognitive impairment and required extensive assistance with two-person physical assist for bathing. The MDS revealed (0) behavior for rejection of care. A review of the facility's ADL care plan dated 3/27/20 revealed R#901 had a Self-care deficit R/T (related to) Decreased functional independence. Resident has multiple medical conditions that impacts abilities, good days and bad days with abilities. Bathing: Shower 2x per week. Staff to supervise and/or assist as needed for completion and safety . The Shower Schedule was reviewed and revealed R#901's scheduled shower days were Tuesday and Friday (7:00a - 3:00p). A 30 day review of the facility's Resident CNA (Certified Nursing Assistant) Documentation Record for April 2020 revealed the following: 4 /14/20 - (Not Documented) 4/17/20 NP (Not Performed) 4/21/20 - (Not Documented) 4/24/20 NP (Not Performed) Further review of the Resident CNA Documentation Record revealed the following explanation for care not provided: 4/14/2020 - No Documentation 4/17/2020 - 8:00a-2:45p Transfer Not Performed 4/21/2020 - No documentation 4/24/2020 - 7:00a-3:00p Bathing Not Performed A review of the facility's Progress Notes did not reveal R#901 refused their shower/bathing on 4/14, 4/17, 4/21, and 4/24/20. On 7/27/20 at approximately 3:15 p.m., a call was placed to CNAs 'D' and CNA 'E' and a message was left on the voice mail with no return call by the end the of the survey. During an interview on 7/27/20 at 3:26 p.m., when queried about R#901's missed showers/documentation, CNA 'F' stated, Usually if the documentation is blank, the service is not done . R#908 A Complaint was filed with the State Agency that alleged R#908 was not receiving consistent ADL care, including showers, and was observed looking not groomed. A review of R#908's medical record documented that the resident was originally admitted to the facility on [DATE] for therapy following a fall that resulted in a fractured femur (right hip). R#908 also had [DIAGNOSES REDACTED]. A review of R#908's MDS dated [DATE] documented that the resident had a BIMS score of three (severely cognitively impaired) and required extensive one person assist for most ADL care. R#908's care plan for ADL care documented, in part, the following: Self Care Deficit (Effective 4/27/20) .Interventions: Bathing Shower 2x per week . A review of R#908's shower records for the Month of May 2020 documented as follows: 5/16/20: Not Performed 5/20/20: Not Performed 5/27/20: Not Performed 5/30/20: Not Performed There was no documentation that indicated the resident had refused showers on the above dates. R#909 A Complaint was filled with the State Agency that alleged R#909 was not receiving consistent ADL care and when observed in the Hospital the resident's hair was unkempt and toes, heals and nails were not cared for and the resident has developed a pressure ulcer to the coccyx. Review of R#909's medical record revealed that the resident was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of R#909's MDS, dated [DATE] documented that the resident had a BIMS score of four (severely cognitive impaired) and required extensive one to two person assist for transfers, bed mobility and showering. R#909's record documented that they were to receive showers on Monday and Wednesdays. A review of R#909's shower record for April 2020 and May 2020 documented the following: 4/14/20: Bed Bath Performed - No shower 4/17/20: Not Performed 4/21/20: Not Performed 4/24/20: Not Performed 4/28/20: Not Performed 5/01/20: Not Performed R#905 On 7/21/20 the medical record for R#905 was reviewed and revealed the following: R#905 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. R#905's MDS with an ARD (Assessment Reference Date) of 3/8/20 revealed R#905 needed extensive assistance from facility staff with most of their activities of daily living. R#905's BIMS score was 15 indicating intact cognition. A review of R#905's care plan revealed the following: Admission#1-Self-Care deficit .Etiology-Self Care deficit R/T (related to): Decreased functional independence .Interventions: Bathing-Shower 2x (times) per week . A review of R#905's documented scheduled showers for March 2020 revealed the following: R#905 did not receive their showers on 3/14 and on 3/25. CNA documentation indicated R#905's showers were not performed R#912 On 7/23/20 at approximately 12:12 p.m., R#912 was observed in their room up in their wheelchair. R#912 was queried if they had any concerns regarding their care in the facility and they indicated that they had not received many of their showers. R#912 further indicated that they believed the facility did not have enough staff. On 7/23/20 the medical record for R#912 was reviewed and revealed the following: R#912 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#912's MDS with an ARD of 5/19/20 revealed R#912 needed extensive assistance with most of their activities of daily living. R#912's BIMS score was 15 indicating intact cognition. A review of R#912's documented scheduled showers for April and May 2020 revealed the following: R#912 did not receive their showers on 4/23, 5/4, 5/7, 5/11, 5/18 and 5/25. CNA documentation indicated R#905's showers were either not performed or were not completed. A review of R#912's care plan during April and May 2020 revealed the following: Focus-Admission #1 Self-Care deficit .Goals-Resident will demonstrate doing ADLs to the best of his/her ability. Staff will assist as needed .Interventions-Bathing: Shower 2x per week . R#913 On 7/23/20 at approximately 2:00 p.m., R#913 was observed in their room up in their wheelchair. R#913 was queried if they had any concerns regarding their care in the facility and they indicated they were not receiving their showers. R#913 indicated their scheduled showers were to be completed by the midnight shift staff and they could never give them showers. R#913 stated It was bad. On 7/23/20 the medical record for R#913 was reviewed and revealed the following: R#913 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#913's MDS with an ARD of 6/6/20 revealed R#913 needed extensive assistance with most of their activities of daily living. R#913's BIMS score was 15 indicating intact cognition. A review of R#913's documented scheduled showers for March and May of 2020 revealed the following: R#913 did not receive their showers on 3/28, 5/2, 5/27 and 5/30. CNA documentation indicated R#913's showers were either not performed or were not completed. A review of R#913's careplan during March and May of 2020 revealed the following: Focus-Admission #1 Self-Care deficit R/T decreased functional independence .Goals-Resident will demonstrate doing ADLs to the best of his/her ability. Staff will assist as needed .Interventions-Bathing: Shower 2x per week . On 7/22/20 at approximately 2:20 p.m., during a conversation with the Director of Nursing (DON), the DON was queried how often residents in the facility should be provided showers and they indicated they should be given 2 showers a week and also as needed. The DON was queried how the staff document when they give a shower and the DON indicated that it is documented in the

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

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) electronic medical record. A facility document titled Showering with an issue date of 2003 was reviewed and revealed the following: Policy-To cleanse and refresh the resident also to encourage exercise and stimulate circulation . Further review of the document did not reveal the facility standard for how many times a shower is to be provided.
F 0686 **Level of harm -** 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** This citation pertains to Intake Numbers: MI 617, MI 211, MI 636, MI 020 and MI 428. Based on observation, interview and record review the facility failed to complete thorough skin assessments, implement timely interventions and continuously administer treatments per physician orders to prevent the development and worsening of a pressure ulcer(s) for three (R#901, R#907 and R#909) of five residents reviewed for pressure wounds, resulting in the development of a facility acquired Stage III (full thickness loss of skin) pressure ulcer that deteriorated to a Stage IV (full thickness skin and tissue loss that extends into muscle, tendons, ligaments or bone) that required hospitalization and debridement (removal of damaged tissue) of the wound for R#909 and the potential for further skin breakdown for R#901, R#907 and R#909. Findings include: A complaint was made to the State Agency (SA) that alleged R#909 was not turned or repositioned and developed a Pressure Ulcer at the Facility that required hospitalization and debridement of the wound. On 7/22/20 at approximately 2:00 PM, R#909 was observed lying in bed with full boots on both feet. The resident was sleeping and not able to answer questions at that time. On 7/27/20 at 9:25 AM, R#909 was observed in bed. R#909 was observed to be on a low air loss mattress, had a wound vac, an indwelling urinary catheter, and was receiving enteral nutrition (tube feeding) via an automatic feeding pump. R#909 was asked for permission to have the wound observed and consented. Wound Care Nurse 'C' was present and positioned R#909. The wound was observed to be round, approximately 3 inches in diameter with irregular edges. The peri-wound area appeared necrotic. A suction tube leading from inside the wound to the wound vac was visible with a translucent, occlusive dressing in place. The wound bed could not be visualized through the dressing. The wound vac was observed and had a small amount of serosanguinous drainage in the collection chamber of the wound vac. Review of R#909's medical record revealed that the resident was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of R#909's Minimum Data Set (MDS), dated [DATE], documented that the resident had a Brief Interview for Mental Status (BIMS) score of four (severely cognitive impaired) and required two person assist for transfers, bed mobility and toilet use. Continued review of the record documented that upon admission to the Facility, R#909 had a Braden Score (tool used to assess risk of a pressure sore) of 16 that indicated the resident was at mild risk for developing a pressure sore. An initial care plan titled, Potential for Impaired Skin Integrity with an effective date of 1/3/2020 documented, in part, .potential for impaired skin .incontinence .decreased mobility .Interventions . encourage or assist the resident, if needed, to turn and change positions every 2 hours .encourage resident to consume greater than 75% of food and fluids .manage urinary and fecal incontinence .monitor skin changes during daily bathing and routine care, especially over bony prominences for color change, warmth .pressure relieving mattress on bed .skin assessments upon admission, weekly and PRN (as needed) . A physician order dated: 1/6/2020 documented, in part, Low Air-Loss Mattress to be ordered 1/3/2020: Assess sacral area daily for redness or open areas. Notify physician of abnormal findings. (Document on paper Tx (treatment) sheet. The following were the only nurse observations of R#909's sacral area that were documented on paper Tx sheets from admission 1/3/2020 - 5/15/2020: 1/3/2020: .blanchable redness to bilateral heels, coccyx skin intact . 2/2020: No skin assessments form was completed for the month of February 2020 3/24/2020: No pressure ulcers noted 4/7/2020: Buttocks Red 4/18/2020: Open wound to buttocks/sacrum: width: 3.4 - length 1.25 (no signature noted, no units of measurements were noted) 5/1/2020: Blank form 5/15/2020: Sacrum: width: 6- length 5 (no units of measurement were noted). It should be noted that there were no other paper skin assessments noted in the resident's electronic record. A request for any paper documents pertaining to skin assessments was requested. None were provided by the end of the survey. Review of R#909's TAR (treatment administration record) noted daily initials starting 3/24/20 that indicated nurses Assess sacral area daily for redness or open areas . (document on paper Tx). It should be noted that no documentation on paper as indicated were noted following the identification of red buttocks on 4/7/2020. A Progress Note dated 4/18/20 and authored by Nurse T documented, in part, the following: .Wound present to buttocks/sacrum. TRIAD (wound paste) ordered and Wound Consult ordered . A Progress Note dated 4/21/20 and authored by Wound Physician (WP) U was reviewed and documented, in part, the following: Patient was seen in consultation for Wound Management .right buttock has a skin tear, coccyx has stage 3, with a necrotic tissue .Assessment and Plan .Right buttock skin tear, will use TRAID, need to have single sheet to transfer, Coccyx stage 3 will need low air loss mattress, need to turn frequently, need to use wedge . A Progress Note dated 4/22/20 and authored by Facility Wound Nurse C was reviewed and documented, in part, the following: Resident was seen by wound care regarding skin tear noted to right buttock and Stage 3 Ulcer noted to coccyx. Area to right buttock measures 2.7cm (centimeters) x .2 cm. Light serosanguineous drainage, no odor noted. Area to coccyx measures 1.9 cm x 2.5 cm x .3 cm. Light serosanguineous drainage, no odor noted. Per wound care physical area to be cleaned with wound cleanser, dried, Triad paste to be applied to both areas. A Progress Note dated 5/5/20 and authored by WP U documented in part, the following: Patient was seen and examined .right buttock wound, status unhealed .coccyx has stage 3, with necrotic tissue it has odor to it measuring 7.2 x 5.2 x 1.1 undermining 1.6 cm from 6-9 .Assessment and Plan .Right buttock skin tear now has joined the coccyx ulcer. Coccyx stage 3 with necrotic issue and odor, will change dressing to Dakins . A Progress Note dated 5/5/20 and authored by Physician Extender, Nurse Practitioner (NP) A was reviewed and documented as in part, the following: The patient is seen .abnormal lab results and follow up on sacral decubitus ulcer . has a stage 4 sacral decubitus ulcer and WP U has been following up .we did place a call to WP .regarding lab results and he is in agreement .ASSESSMENT AND PLAN: 1) Stage 4 decubitus ulcer .concerning for possible [DIAGNOSES REDACTED] or other worsening infection process .WP U is advising the patient be transferred to the hospital for complete evaluation . A review of R#909's TAR for the Month of April 2020 was reviewed. A treatment for [REDACTED].#909 did not receive treatment on the following dates: 4/24 (9 PM), 4/25 (9 AM), 4/25 (2 PM), 4/26 (9 AM), 4/26 (2PM), 4/27 (2PM), 4/29 (2PM). A review of R#909's Hospital Records dated 5/6/20 was reviewed and documented, in part, ED (emergency department) notes .Chief Complaint .Patient presents with Tailbone Pain .pt(patient)to ER from nursing home for debridement of ulcer on coccyx and MRI (magnetic resonance imaging) for [DIAGNOSES REDACTED] (infection of the bone) .Patient has a history of possible stage III Stage IV ulcer buttocks 3 x 5 cm, 7 x 5 cm and 1.76 cm deep around the 6 to 9 o'clock position .they have been using wound care .there is some necrotic tissue around the wound bed .Patient initiated [MEDICATION NAME] of 2.4 which I believe is related to dehydration .patient requires .stay because of the complex nature of the patient who had large wound infection with debridement . On 7/23/20 at approximately 11:30 AM, an interview was conducted with Wound Nurse C. Nurse C reported that they have been working at the Facility since April 2020. When queried as to the Facility protocol pertaining to wound care, Nurse C explained that residents should be assessed upon admission and they should be notified if there is evidence of a wound. They also indicated that weekly skin assessments should be completed by staff. When queried as to R#909, Nurse C stated that when they started at the Facility they conducted a full sweep of all the residents and determined that R#909 had a Stage III pressure ulcer to the coccyx that was facility acquired. Nurse C noted that they spoke with the Director of Nursing (DON) and that the resident started to treat with WP U. Nurse C indicated that they were not aware as to what was done prior to her hire to prevent the development R#909's pressure ulcer. On 7/23/20 at approximately 1:30 PM a phone interview was conducted with WP U concerning R#909. When queried as to their protocol pertaining to resident's with wounds, WP U reported that when wounds/pressure ulcers are noted by facility staff they are contacted and generally make weekly visits. Staff are to assess residents and ensure interventions, such as oral intake and turning/repositioning are done regularly, and treatments are completed. When asked specifically about R#909, WP U reported that they recalled R#909 had a decline in skin and was sent to the Hospital for debridement. On 7/27/20 at approximately 2:15 p.m., an interview was conducted with the DON, when queried about the Facilities policy pertaining to pressure sores and the missing treatment entries for R#909. The DON explained that treatments provided should be documented on the TAR when they are completed, and interventions should have been put into place and followed to prevent the development of pressure sores. On 7/28/20 at approximately 10:20 AM a phone interview was conducted with Nurse T pertaining to R#909 and the 4/18/20 note indicating the appearance of a wound. Nurse T explained that they generally worked weekends and recalled that Certified Nursing Assistant (CNA) W, who they believed was changing the resident, informed them of an issue with the resident's skin. Nurse T reported that they informed the doctor of their observation and an order was placed for treatment. Nurse T indicated that they were not to note the stage of the wound. On 7/28/20 at approximately 10:30 AM a phone interview was conducted with CNA W. When queried as to R#909's wound, CNAW reported that they recalled working frequently with the resident and for many months never noticed any wounds, but at some time in April (CNA W) could not recall the date, they noticed a large area was opening on the resident's bottom and

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) told Nurse T that something needed to be done. Resident #901 A complaint was filed with the SA on 6/27/20 that alleged facility staff failed to provide adequate and appropriate care to prevent and/or treat pressure sores. The complainant further explained 3 and half weeks after they (R#901) came to the (Name Redacted) facility. Their doctor, (Name Redacted) Dr. 'CC', called for an ambulance to have my husband taken to the hospital (Name Redacted) 'DD' again. Because R#901 was so bad with infection do (sic) to a stage 4 bed sore over his whole rear-end that they didn't even treat them for (sic) until 4/22/2020 when their nurse (Name Redacted) Nurse 'EE' saw it when they were leaning out of the bed. Then (Name Redacted) Nurse 'EE' alerted the family and (Name Redacted) Dr. 'CC' who order a bunch of tests and x-rays . Which also determined they had gotten pneumonia on top of everything else, urinary trac (sic) infection, severely dehydrated, severely malnourished. They (facility) hadn't taken care of their catheter, his penise (sic) was infected and oozing and split open. They were septic and their kidneys were starting to show injury . How does a full functional man come in for rehabilitation and leave on their death bed!! At the hospital they had to have 5 antibiotics. 5 surgeries to debreed (sic) their bed sore that covered their whole butt, perineum, and scrotum . they had to have a couple bags of blood due to all the debreedings (sic) they had to have. And all of this means R#901 has to suffer through for atleast (sic) a year. Because that is how long it will take for them sever (sic) bedsore will take to heal, and that is after weeks of depression for R#901 and family. Because we didn't know if they were going to survive this . All of this is a result of this (Name Redacted) facility not taking care of R#901 and doing their jobs. A review of the clinical record revealed R#901 was originally admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the 5 Day MDS dated [DATE] revealed R#901 had a BIMS score of 3 out of 15 which indicated severe cognitive impairment and required extensive assistance with two-person physical assist for activities of daily living. The MDS further revealed R#901 had 1 Stage II pressure sore that was not present upon admission, 2 Unstageable deep tissue injury with 1 present upon admission. The discharge MDS dated [DATE] revealed R#901 had 3 Unstageable slough/eschar pressure ulcers . Interventions: .Turning/repositioning program (Not checked) . The facility's care plan initiated on 3/27/20 revealed Focus: Potential for Impaired Skin Intergrity (sic). Goals: Residents skin will remain free from breakdown. Interventions: . Monitor skin for changes during daily bathing and routine care, especially over bony prominences for color changes, warmth, and induration. Notify physician and the responsible party for health care of all new skin breakdown and worsening of pressure areas . Encourage or assist the resident, if needed, to turn and change positions every 2 hours . Monitor lab values per MD order (i.e. Hgb (Hemoglobin, [MEDICATION NAME] .) and notify physician of abnormal findings . Record review of R#901's Braden Scale revealed a score of 14 (Moderate Risk) on 3/31/20, 4/3/20, and 4/10/20. Further review of an assessments dated 4/17/20 revealed a score of 17(Mild Risk). Review of the March Skin assessment dated [DATE] revealed R#901 had a scab on (R) right great toe. (R) leg. (L) left toe. small bumps on back & left side. The Skin Assessment for April 2020 revealed the following: Date: 4/1/2020, Treatment No.: A, Width: Blank, Length: 2 in (inch), Depth: 2 in, Stage: Blank, Comments/Description: Open area on (L) buttocks, Skin and feet dry and intact. Date: 4/3, Treatment No.: B, Width: 5.2, Length: 6.0, Depth: 0.1, Stage: U (Unstageable), Comments/Description: (R) buttock open area with bloody drainage and skin flap. Surrounding skin intact and moist. Wound edges attached. Date: 4/3, Treatment No.: A, Width: 7.0, Length: 9.0, Depth: - , Stage: U, Comments/Description: (L) buttock dark area 0 drainage. Date: 4/3, Treatment No.: C, Width: 1.0, Length: 2.0, Depth: 0.5, Stage: U, Comments/Description: dark area to coccyx 0 drainage. Date: 4/7, Treatment No.: A, Width: 5.4, Length: 8.1, Depth: Blank, Stage: Blank, Comments/Description: (L) buttock dark area unstageable. Date: 4/7, Treatment No.: B, Width: 6.0, Length: 9.0, Depth: Blank, Stage: Blank, Comments/Description: (R) buttock dark area unstageable. Date: 4/7, Treatment No.: C, Width: 1.5, Length: 2.0, Depth: 0.3, Stage: Blank, Comments/Description: Coccyx open area wound bed red, edges attached, surrounding skin intact. Date: 4/14, Treatment No.: A, Width: 3 in, Length: 2.5 in, Depth: Blank, Stage: Blank, Comments/Description: (L) buttocks. Date: 4/14, Treatment No.: B, Width: 2.5 in, Length: 3.5 in, Depth: Blank, Stage: Blank, Comments/Description: (R) buttocks. Date: 4/14, Treatment No.: C, Width: 1.5 in, Length: 1.5 in, Depth: 0.2, Stage: Blank, Comments/Description: Coccyx. Date: 4/24, Treatment No.: D, Width: Blank, Length: Blank, Depth: Blank, Stage: Blank, Comments/Description: Open area; slough in between coccyx. A review of the physician's orders revealed the following: 3/27/2020 at 06:45 pm Assess sacral area daily for redness or open areas. Notify physician of abnormal findings. (Document on paper Tx sheet). The only documented paper tx sheets for this resident are those noted above. It was also noted no indication of assessment was done on 4/10/20. An order dated 3/30/2020 at 02:23 pm read resident to receive, in part, the following:[MEDICAL CONDITION] Screen Monitoring .every shift . This treatment was not performed on 4/6/20 on the 11:00p -7:00a shift and 4/10/20 on the 3:00p - 11:00p shift. A physician order dated 4/3/2020 at 1:43 pm documented, Medication Triad Wound Dressing paste SIG: apply 1 applicatorful by topical route 2 times per day and as needed apply to bilateral buttocks and coccyx. This treatment was not performed on 4/10/20 at 9:00p. On 7/23/20 at 11:35 a.m., during an interview with Wound Care Nurse 'C', when asked about R#901's wound care treatments and missed entries, Wound Care Nurse 'C' explained that they had started on the floor the end of April/beginning of May, and was not sure of R#901's wound care. The DON was also not aware of R#901's care at the facility as they were new to the position. On 7/23/20 at 12:10 p.m., when asked about the blanks on R#901's TAR, the Administrator stated, I will check. When queried how it could be determined if R#901's treatment was completed if it were not documented, the Administrator stated, In the progress notes. At that time, the progress notes were reviewed along with the Administrator. There were no entries documented that R#901 refused any treatments. Review of the facility's Medical Progress Notes dated 4/25/20 at 7:01 p.m., read in part: DISCHARGE Diagnoses: [REDACTED]. Bilateral buttock decubitus ulcer infection. b. Pneumonia. c. UTI (urinary tract infection. 2. [MEDICAL CONDITION] secondary to inadequate intake and also [MEDICAL CONDITION] . 3) Blood cultures positive for cocci in clusters . 5) Acute kidney injury, secondary to the inadequate intake and dehydration . 10) Bilateral buttock decubiti, probable infection . Further review of the Progress Notes revealed PHYSICAL EXAM BEFORE DISCHARGE: . EXTREMITIES: . Bilateral lower extremities normal, other than the buttock decubiti. SKIN: Bilateral buttock wounds, stage 2. They are getting worse. Also, sacral ulcer is also noted. NURSING HOME COURSE: .In the second week of April, the patient was found to have COVID-19 pneumonia, for which the patient moved to the (Name Redacted) special COVID Unit . Later, he was going into a septic way because of UTI and decubiti infection . His wounds are not getting better. They are getting worse. To prevent further problem, I initiated the transfer to (Name Redacted) local Hospital 'DD' ER . The patient needs wound debridement of the bilateral buttocks. That is why I sent him. Otherwise, he will go into more septic. R#901's Medical Records obtained from Hospital 'DD' were requested and reviewed, and read in part the following: 4/25/2020 @ 2249 - Discharge 05/19/2020 @ 2000 Visit [DIAGNOSES REDACTED]. Acute kidney injury (CMS/HCC) Yes Urinary tract infection associated with indwelling Yes urethral catheter, sequela Hospital [MEDICAL CONDITION] (CMS/HCC) (primary) 4/26/2020 - Yes . Pressure injury of sacral region, stage 4 (CMS/HCC) 4/25/2020 - Yes . Discharge Final Diagnosis: [REDACTED].#907 A complaint was filed with the State Agency (SA) on 3/23/20 that alleged staff failed to prevent and treat pressure sores. On 7/21/20 at 12:55 p.m., during a telephone call, the Complainant stated, There was a time when it was four days in a row there was no changes of the dressing of their (R#907's) wounds. they are supposed to date when dressings are changed. I noticed on March 7th the bandages were dated March 3rd. I called the Administrator and told her. She wasn't on duty, so I talked to (Name Redacted) Nurse Supervisor 'O' and he went in and changed them (bandages). The Complainant further stated, I have pictures that show date and times of bandages. A review of the clinical record revealed R#907 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the 5 Day MDS dated [DATE] revealed R#907 had a BIMS score of 5 out of 15 which indicated severe cognitive impairment and required extensive assistance with one to two-person physical assist for ADLs. The MDS further revealed R#907 had 2 - Stage II pressure sores upon admission, 1 - Unstageable slough/eschar upon admission, 1 - Unstageable deep tissue injury, and 2 - Venous and Arterial Ulcers. A review of the facility's care plan effective 2/01/2020 revealed the following: Focus: Potential for Impaired Skin Integrity. Goals: Residents skin will remain free from new or worsening skin breakdown. No new breakdown will occur. Interventions: .Monitor skin for changes during daily bathing and routine care, especially over bony prominences for color changes, warmth, and induration. Notify physician and the responsible party for health care of all new skin breakdown and worsening of pressure areas. Pressure relieving mattress on bed. Skin assessments upon admission, weekly and PRN. Implement skin protocol as appropriate. Encourage or assist the resident, if needed, to turn and change positions every 2 hours. Review of the TAR and Physician's Orders revealed the following: Start Date: 02/27/2020 11:26 am - Cleanse right lower leg and right middle leg with normal saline, apply solosite (wound gel), ABD (pad use to absorb discharges from heavily draining wounds) and kerlix (gauze used for wound care) every day. The TAR was blank for 3/6/20 and 3/14/20. Start Date: 02/11/2020 03:14 pm. - Triad Wound Dressing paste. SIG: apply 1 applicatorful by topical route to bilateral buttocks. The

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	235556	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WOODWARD HILLS HEALTH AND REHABILITATION CTR	39312 WOODWARD BLOOMFIELD HILLS, MI 48304

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) TAR was blank for 3/5/20 and 3/15/20 (7:00a - 3:00p shift), 3/6/20 and 3/14/20 (3:00p - 11:00p shift). Start Date: 02/05/2020 08:02 pm - Heel Protectors while in bed. The TAR was blank 3/5/20 and 3/15/20 (7:00a - 3:00p shift), 3/6/20 and 3/14/20 (3:00p - 11:00p shift). On 7/23/20 at 12:10 p.m., during an interview, when asked about blanks on R#907's TAR, the Administrator stated, I will check. When asked how it could be determined if R#907's treatment was completed if it was not documented, the Administrator stated, In the Progress Notes. R#907's Progress Notes were reviewed along with the Administrator. There were no entries documented that R#907 had refused any of their treatments. On 7/23/20 at 2:20 p.m., an interview was conducted with Dr. 'AA'. When asked how often the treatment dressings should be changed for residents with wounds, Dr. 'AA' stated, Check skin daily. Sacral area and heels if patients have a wound. On 7/23/20 at 2:55 p.m., during an interview with LPN 'BB' who was assigned to care for R#907, when queried about the blanks on the TAR, LPN 'BB' stated, Things like that happen at (Name Redacted) facility the way the schedule is set up. Some people work 8 hours and some work 12 hours. I probably worked half of that shift and was not responsible for that documentation. I can't really remember . a lot of people were going in and out. On 7/27/20 at approximately 2:15 p.m., an interview was conducted with the DON, when queried about the missing treatment entries on R#907' TAR, the DON explained that treatments provided should be documented on the TAR when they are completed. A review of the Facility Policy titled, Pressure Ulcer/Injury Protocol (undated) documented, in part, the following: Policy: Based on the Comprehensive Assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individuals clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing .3. Identify the resident at risk of developing pressure ulcers; the level and nature of risks including specific conditions, causes and/or problems, needs and behavior; and identify the presence of pressure ulcers .The following are examples of risk factors .impaired/decreased mobility and decreased functional ability .exposure of skin to urinary and fecal incontinence .under nutrition, malnutrition and hydration deficits .once the assessment has been completed immediately develop a plan of care .10. If there is any change in the patient's skin condition, the nurse . should review and revise the patients care plan. 14. If a determination is made that the development of a pressure sore was unavoidable, it must be documented by the nurse and physician that the elements for an unavoidable pressure ulcer were met .
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 Numbers: MI 617, MI 443, MI 211 and MI 817. Based on interview and record review the Facility failed to ensure fall safety measures were put in place to prevent falls and ensure falls were timely reported for two residents (R#907 and R#908) out of four residents with a high risk for falls, resulting in resident #908 sustaining a laceration to the back of the head, emergency transfer to the hospital requiring stitches and pain and R#907 not timely assessment and delay in treatment for [REDACTED]. Findings include: R#908 A complaint was filed with the State Agency that alleged R#908 fell at the Facility and sustained an injury that required four staples to the head and a hospital stay. A review of R#908's medical record documented that the resident was originally admitted to the facility on [DATE] for therapy following a fall that resulted in a fractured femur (right hip). R#908 also had [DIAGNOSES REDACTED]. A review of R#908's Minimum Data Set ((MDS) dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of three (severely cognitively impaired) and required one to two person assist for transfers and bed mobility. An initial Safety Skills assessment dated [DATE] documented R#908 had a High Fall Risk Score of 19 and had a history of [REDACTED]. A nursing note dated 4/28/20 and authored by Nurse Y documented, in part, the following: Patient observed on the floor at the foot of the bed laying on right side leaning on right elbow .no injury noted at this time .transferred back to wheelchair .patient interviewed .trying to help roommate who had fallen out of bed .patient seated at nursing station . A nursing note dated 5/10/20 at 7:52 and authored by Nurse X documented, in part, the following: At 6:40 PM resident was in his wheelchair eating dinner. Aide walked in found resident on floor called out for assistance .discovered abrasion to the back of resident's head and blood on resident's shirt .Asked resident how did the fall happen .I don't know, I guess I slipped .Writer called on physician .and informed physician of anticoagulation medication. Physician ordered resident to be sent out 911 . On 7/22/20 at approximately 9:00 AM, the Administrator was asked to provide all Investigation/Accident (I/A) reports for R#908. On 7/22/20 an I/A was provided for R#908's fall that occurred on 5/10/20. The Administrator reported that was all the I/A's pertaining to R#908. A second I/A pertaining to the fall that occurred on 4/28/20 was provided on 7/27/20. The I/A for the incident that occurred on 4/28/20 documented, in part, the following: Date of Incident: 4/27/20 .Time of Incident: 8:00 PM. 2. State exact location of Incident .in patients bedroom at the foot of bed sitting on butt .3. Describe what you observed at the scene of the incident: (a) Statement by resident .patient states he was trying to help his roommate .4 .call light was attached to wheelchair .6 unable to stand alone .18 .Initial corrective action/taken Recommendation for prevention of similar occurrence .when patient awake keep in close observation, patient up front with nurse (emphasis added) .25. Was there a medical cause that may have contributed .gait/balance deficiencies .physician signature (NP) A. Care Plans pertaining to R#908 were reviewed on 7/22/20 and documented in part, the following: Admission .Fall Risk .Etiology: Risk for Falls .History of falls; Unable to ambulate without assistance .unable to transfer without assistance (Effective 4/27/20) .Goals: Resident will remain free from injuries (Effective 4/27/20) .Interventions: Clean up spills immediately (4/27/20), PT(physical therapy) and/or OT(occupational therapy) evaluation as ordered, Maintain room and pathways free of clutter (Effective 4/27/20), Continually assess ability to use call light (Effective 5/5/20) .(Keep glasses clean and fit .(Effective 5/5/20). It should be noted that the corrective action initiated after R#908's fall on 4/28/20 that stated: When patent awake keep in close observation, patient up front with nurse was not incorporated into R#908's care plan as recommended. The I/A pertaining to the incident that occurred on 5/10/20 documented in part, the following: .Date of Incident: 5/10/20: Time of Incident 6:54 PM. 2. State exact location of Incident: Resident's Room between bed and dresser. 3. Describe what you observed at the scene of the incident (a) Statement by resident .: 'I don't know, I guess I slipped' .(b) Statement by staff, roommate: Fall was unwitnessed .Did resident have an alarm on (a negative line was filled in) .8. Appearance of involved part: Bleeding-Yes-Describe (back of head) .Indicated on diagram location of injury and check below .Type of Injury: Laceration .Abrasion (back of head) .Treatment ordered: .sent to hospital . 18. Initial corrective action taken .Order for Dycem .Name of person reporting incident . LPN X .Name of CNA A hospital record dated 5/11/20 was reviewed and documented in part, Date of Admission: 5/10/20 .Chief Complaint: Fall .History of Present Illness: .(R#908) was found on the floor yesterday evening by staff at the nursing facility .fall was unwitnessed .noted to have a laceration in the back of the scalp and was confused as well as agitated .patient was disoriented and calling for help. (R#908) would yell any time I touched or tried to speak to them .able to tell me . name and that it 'hurts all over' .Assessment 1. Fall, with scalp laceration, Staples placed in ER (emergency room) . An attempt to contact Nurse Y via phone was made during the survey. No return call was made. On 7/27/20 at approximately 2:00 PM an interview was conducted with Nurse X pertaining to the fall on 5/10/20. Nurse X reported that they did not witness the fall and could not recall what interventions were in place for R#908 to prevent falls. On 7/28/20 at approximately at 10:00 AM an interview via phone was conducted with NP A pertaining to R#908 NP A stated that they no longer provided services for the Facility and could not recall details about the resident and the event. When queried as to whether interventions recommended in an I/A report should be put into place for residents that are at risk for falls, NP A stated, Yes. On 7/28/20 at approximately 10:30 AM an interview was conducted with CNA W. CNA W was queried as to the incident that occurred on 5/10/20. CNA W reported that they had found R#908 lying on the floor in the room and called the nurse. When asked what fall interventions were implemented for R#908, CNA W reported that they generally worked on the weekends and was not made aware of the interventions implemented to prevent falls for R#908 and/or other residents in the Facility. CNA W stated that they knew R#908 liked to try and get up and move on their own and that they would try to do the best they could to keep the resident safe. An interview was conducted with the Administrator on 7/28/20. When queried as to why no interventions, including the recommendation noted on the 4/27/20- I/A that stated Initial corrective action/taken Recommendation for prevention of similar occurrence .when patient awake keep in close observation, patient up front with nurse was not implemented following the fall on 4/27/20, the Administrator reported that the incident on 5/10/20 happened during dinner time and due to COVID-19 the residents were not able to eat in the main dining room. When queried as to whether additional interventions other than eating in a dining room could have been implemented to protect R#908 who was at risk for falls, the

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) Administrator reported that they could. Resident #907 A complaint was filed with the State Agency (SA) on 3/23/20 that alleged the resident fell and sustained an injury, and the facility staff failed to make out an incident report on the resident's fall. On 7/21/20 at 12:55 p.m., during a telephone interview, the Complainant stated, During a two-week period he (R#907) had two falls. The first fall was late at night (March 10th or early in the morning on March 11th. It was never documented until it was reported to the Administrator. They got the doctor (Dr. 'I') to notice the lump. It was a new CNA gentleman (CNA 'J') who rolled him out of bed, pick him up, and put him back in the bed and didn't say anything. They didn't even call me. The second fall was on March 22nd. The nurse rolled him to change him and he fell out of bed . He (R#907) had a brain bleed and was in the hospital 29 days before going to (Name Redacted) Hospice . He passed away on May 18th. A review of the clinical record revealed R#907 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the 5 Day MDS dated [DATE] revealed R#907 had a BIMS score of 5 out of 15 which indicated severe cognitive impairment and required extensive assistance with two-person physical assist for bed mobility and toilet use. The discharge MDS dated [DATE] revealed R#907 had (1) fall with no injury, (1) fall with an injury that was not major, and no falls with a major injury. A review of the facility's care plan dated 2/1/20 revealed R#907 revealed the following: Focus . Fall risk . resident will remain free from injuries . Assess resident's balance, endurance, gait, stability and ability to perform ADL's safely . Maintain record of falls and evaluate for patterns . Make sure that all staff members are aware that resident is at high risk for falls . Toilet resident per their request. If resident is unable to request, toilet and/or check brief for wetness every 2 hours and as needed . Low bed. There was no care plan for bed mobility. Fall #1 Review of the facility's I/A (Incident/Accident) dated 3/11/20 at 4:30 p.m., revealed the following: .Fall Risk Score 21 (High Risk). BIMS: 5/15. 1. Date of Incident: 3/10/20 (it should be noted that the 3/10 date was scratched and replaced with 3/11/20, however resident had reported event occurred the evening prior 3/10/20) . Time of Incident: 4:30 p.m . 2. State exact location of Incident (where did it occur): In residents bedroom . 3. Describe what you observed at the scene of the incident: (a) Statement by resident: Self reported to family stating he fell last night out the bed and a staff member picked him up and put him back in the bed . 5. State the effect of the Accident/Incident on the resident .: Resident complained of pain . 7. Was a body exam completed? Yes . 8. Appearance of involved part: Swelling: Yes. Describe: Knot on the (R) Posterior of head. Pain: Yes . 10. Examination revealed: Knot noted on the right posterior of the head . Treatment ordered: Sent to hospital . 18. Initial corrective action taken/Recommendation for prevention . Bed in lowest position . 20. Name of person reporting incident: (Name Redacted) License Practical Nurse (LPN) 'K' . Physicians' Statement 23. Extent of Injury: Hematoma (scalp hematoma of (R) temporal parietal area . Review of the Investigation submitted by the facility revealed the following: Allegation: Fall out of bed. History and Physical: .Resident's BIMS score is 5/15 and he is alert and orientated times 2. (Name Redacted) R#907 is a two person transfer lateral scoot with locomotion at wheelchair level and toileting at bed level. Summary: On 3/11/2020, around 4:30 pm, (Name Redacted) reported to his sister (Name Redacted) (Family Member 'G') that he fell out of bed the previous night (3/10/20). (Name Redacted) Family Member 'G' requested to speak to the Administrator and discussed the findings. (Name Redacted) family Member 'G' stated that there was 'bump' noted on the resident's head. Nursing Administration and (Name Redacted) NP (Nurse Practitioner) 'A' and (Name Redacted) Dr. 'I' were notified, and resident was evaluated. It was determined that resident should be sent out for a CT (Computed Tomography) scan. Several staff members were interviewed regarding this allegation by phone . (Name Redacted) CENA (Certified Nursing Assistant) CENA 'J' stated that he changed resident, however there was fall and the resident did not fall out of bed . During the evening shift into the midnight shift, there was no report of the fall from the staff or the resident. Conclusion: The facility was immediately able to rule out abuse and an injury of an unknown origin. (Name Redacted) R#907 was able to state that he rolled out of bed with CENA ('J') present in the room and the CENA ('J') assisted him back to bed . Review of the facility's Grievance Documentation, Investigation & Follow-up form submitted by R#907's wife revealed the following: .Nature of Concern 3/11/2020: Resident's sister stated that resident had a bump on his head and that resident reported to her that he had rolled out of bed last night . Investigation 3/11/2020: Administrator interviewed assigned nurse, no fall was reported to her, Administrator and ADON interviewed assigned CENA ('J') and CENA 'J' stated that no fall occurred with him. Interviewed resident and (Name Redacted) R#907 stated that he did fall. Action Taken 3/11/2020: CENA was followed up with and asked again if fall occurred with resident. Follow Up 3/11/2020: (Names Redacted) NP 'A' and Dr. 'I' evaluated resident. Resident was sent out to (Name Redacted) Local Hospital 'L' for a CT scan . As a precautionary measure and previous concerns, facility assigned resident 1:1 (one-on-one) companion . Review of physician's Progress Notes dated 3/13/2020 at 12:15 a.m., revealed Visit Date: 3/11/2020 . Patient was reported to have fallen out of bed. Patient actually reported this himself to his sister who came to visit him this afternoon. She then discussed with nursing, and they asked me to evaluate the patient . Patient tells me he describes the incident as that he rolled towards the right side of the bed onto his right side and fell off the bed; however, his sister also tells me that when she came into the room the patient stated somehow nursing staff was involved in the incident . the patient is clear that he did roll off the right side of the bed onto the floor, and he feels he struck the right side of his posterior head. The progress notes further revealed . very small scalp hematoma along the right upper temporal area . somewhat swollen, and patient reports it is a little bit tender there . On 7/22/20 at 1:45 p.m., during an interview, the Administrator was asked if CENA 'J' still worked at the facility. The Administrator stated CENA 'J' no longer work here. I will get the phone number. At that time CENA 'J's personnel record was requested. The Administrator returned at 2:20 p.m., and stated, The resident was alert times three and reported that he had fallen, and the resident was able to state who the aide was that helped him get back in bed. On 7/22/20 at 2:31 p.m., a telephone interview was conducted with CENA 'J'. When asked about the incident with R#907, CENA 'J' explained that they were in orientation and new to the facility and was working the midnight shift. I got to work at 7pm and did not see him (R#907) until about 10pm. I just happened to be coming down the hall. I heard him (R#907) cussing. I called the Charge Nurse (LPN 'K'). He was not my patient, but anybody can answer a call light . That was my first time seeing him. I asked if I could help him and he said, 'I'm wet.' He was on the phone with wife. His wife was pi**ed and on the phone complaining about something . I propped something behind his back. I changed him . He (R#907) did not have a fall . When asked if R#907 was a one or two-person assist, CENA 'J' stated, I'm not sure. That was my first time seeing him. I'm a big guy. I'm 6 feet . and weigh over 250 pounds. I've been a CNA for over [AGE] years . I know what I'm doing . When asked if they still worked at the facility, CENA 'J' stated, No, they let me go. When asked why they were let go, CENA 'J' stated, I'm not sure . On 7/22/20 at approximately 2:40 p.m., during an interview, when queried about CENA 'J"s statement that R#907 did not have a fall while being changed, the Administrator stated, The resident was alert times three and reported that he had fallen, and the resident was able to state who the aide was that helped him get back in bed. On 7/27/20 at 3:18 p.m., a call was placed to LPN 'K', who was assigned to R#907 and a message was left on the voicemail. There was no return call by the end of the survey. Fall #2 Review of the facility's I/A (Incident/Accident) dated 3/22/20 at 13:45 p.m., revealed the following: .Fall Risk Score (Blank). BIMS: (Blank) 1. Date of Incident: 3/22/20. Time of Incident: 13:45 p.m . 2. State exact location of Incident (where did it occur): In residents room. Resident rolled off bed. 3. Describe what you observed at the scene of the incident: (a) Statement by resident: Resident states he fell , rolled off bed while being changed (b) Statement by (staff, .) (Name Redacted) LPN/Companion 'S', who observed: was changing resident and yelled out for help from staff because resident had rolled off bed . 5. State the effect of the Accident/Incident on the resident .: Resident hit head on nightstand and has laceration to forehead (right side near eyebrow) . 7. Was a body exam completed? Yes . 8. Appearance of involved part: Bleeding: Yes . Pain: Yes . 9 . Type of Injury: Laceration (1 cm - centimeter) 10. Examination revealed: Laceration/bleeding to right forehead near eyebrow. Resident states forehead hurts, but no other pain or discomfort. 11. Can the involved part be moved freely without pain? No. If no, please have resident describe pain: Aching/burning pain. 12. Did functional status change immediate post incident? No. 13. If head injury or loss of consciousness occurred: No loss of consciousness. 14. Was a Neuro check on the chart? No . 16. Treatment ordered: Apply bandage, X-ray, Sent to hospital . 17. Family/Responsible Party Notification: (Names Redacted) . Date: 3/22/20 Time: 14:20 p.m. 18. Initial corrective action taken/Recommendation for prevention of similar occurrence: Nurse educated nurse (LPN/Companion 'S') on proper technique for changing resident in bed . 20. Name of person reporting incident: (Name Redacted) Registered Nurse (RN) 'T' . Physicians' Statement 23. Extent of Injury: Blank . Comments: Not seen sent to hospital. Review of the Investigation submitted by the facility revealed the following: . Summary: On 3/22/2020, around 1:45 pm, (Name Redacted) (R#907) was assisted with bed level toileting. Resident did have a 1:1 companion (Name Redacted) LPN 'S' , LPN 'S' was changing (R#907) in bed. LPN 'S' gathered her supplies before starting to change resident. (Name Redacted LPN 'S' began to change resident, turning him and

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) cleaning him up. R#907 began to have a bowel movement. Once resident was finish, LPN 'S' continued to provide care to resident and when resident was on his left side, (Name Redacted) R#907 reached over to his nightstand and rolled over the bed. During the change of position, R#907 was witnessed to bump his head on the nightstand. LPN 'S' immediately assessed the resident and called for help . The on call physician was called and it was determined that resident was going to be sent out 911 . Resident was sent to Local Hospital 'L'. Conclusion: . R#907 was able to state that he rolled out of bed with a Nurse present in the room . On 7/22/20 at approximately 2:20 p.m., during an interview, when queried if the companion/sitter that was in the room at the time of R#907's fall was a CNA, the Administrator stated, The LPN/Companion was also the person changing the resident. When asked who was in the room with LPN/Companion 'S', the Administrator stated, At the time, it was just the nurse (LPN 'S') and the patient. The Administrator was queried if R#907 was a one or two-person assist with bed mobility and toilet use. The Administrator stated, I'll have to check. On 7/23/20 at 9:22 a.m., during a phone interview LPN/Companion 'S' was asked if they still worked at the facility and stated, No, I was fired . When queried if they provided care for R#907 while at the facility, LPN/Companion stated, I was asked to be (Name Redacted) R#907's sitter that day. He had a bowel movement and I was doing peri-care and (Name Redacted) R#907 reached over attempted to get in his side drawer of the nightstand. I was not able to catch his full body so (Name Redacted) R#907 rolled over onto the floor. When asked if they were providing care for R#907 alone, LPN/Companion 'S' stated. Yes. When asked if R#907 was a one or two-person physical assist with bed mobility/toileting, LPN/Companion 'S' explained from their knowledge they (R#907) were a one-person assist and it was their first time caring for them. When asked if they had checked R#907's care guide before providing peri-care, LPN/Companion 'S' stated, (Facility's Name) has a transfer sheet called 'Happy Feet' and it read assist times one . Review of the facility's care plans effective 2/01/2020 - Review: 5/01/2020 revealed the following: Focus: Self Care Deficit. Goals: Resident will demonstrate doing ADLS to the best of her/her ability. Staff will assist as needed. Interventions: . Toileting: Assist resident with toileting. Assist with peri-care, if resident is unable to cleanse themselves . The care plan did not indicate if R#907 was a one or two-person assist with toileting. Focus: Alteration in Mobility. Goals: Resident will maintain maximum function while here at the facility. Interventions: . Assist resident to maintain proper body alignment. Encourage mobility, within physician's orders [REDACTED]. Ensure personal items of need are provided and within reach On 7/23/20 at 11:15 a.m., during an interview, when queried about specific care plans for R#907's bed mobility during toileting and how it could be determined if R#907 required one or two-person physical assist, the Administrator stated, I'll have to check. I don't think we have a specific care plan . At that time, the Administrator was asked what was the 'Happy Feet' guide? There was no explanation and R#907's 'Happy Feet' guide was guide was requested. On 7/23/20 at 12:26 p.m., an interview was conducted with Corporate MDS Nurse 'P' and new MDS Coordinator Nurse 'Q' (since May 2020) in regard to the bed mobility and toilet use code that documented R#907 was a two-person physical assist. MDS Nurse 'P' explained the CNAs' look back period was 7 days from the ARD. The CNA coded the resident was assisted by two people at least 7 times . CNAs gauge it by the resident's transfer status . Bed mobility is not a solid order for the patient . They have to go by the transfer order. It depends on the resident's ability . When queried about the 'Happy Feet' guide, MDS Nurse 'P' stated, The 'Happy Feet' guides staff on how many people it takes to safely transfer a person. This is for transfer only. When asked if the CNAs used the Kardex as a guide to provide care, MDS Nurse 'P' stated, I will find the Kardex. A review of R#907's electronic record was reviewed along with MDS Nurse 'P' and MDS Coordinator 'Q'. the Kardex Instructions could not be reviewed and revealed Error. MDS Nurse 'P' stated, I will contact IT (Information Technology). R#907's care plan was reviewed along with MDS Nurse 'P' and MDS Coordinator 'Q'. The care plan did not address bed mobility. MDS Nurse 'P' stated, I don't know why bed mobility is not there. Further review of the PT/OT (Physical Therapy/Occupational therapy) Notes revealed the following: PT/OT: 2/2/20 Total dependence with attempts to initiate (Bed Mobility). PT: 2/28/20 - 3/16/20 Recertification same as 2/2/20. OT: 2/26/20 - 3/16/20 - addressed upper body dressing, hygiene, and self-feeding. This evaluation did not address bed mobility at that time. On 7/23/20 at 1:22 p.m., during an interview with the DON, when queried about R#907 bed mobility and toileting status, the DON explained she was new to the position and did not have any knowledge of R#907. When asked how physical assistance for bed mobility and toilet use is determined, the DON stated, By therapy, nursing and CNAs . The medical record for R#907 was requested from Local Hospital 'L' revealed the following: admitting [DIAGNOSES REDACTED]. Chief complaint: Fall . Ataxia (loss of full control of bodily movements), Trauma (primary), Subdural hematoma, acute . HCAP (healthcare associated pneumonia) . Discharge to hospice facility on 04/17/202 . CT (Computed Tomography - medical imaging procedure) of the head showed subdural hematoma . Further review of the medical record read . Wife reports he was making progress with pt/ot up until lst fall approx. 10 days ago, after 1st fall, wife noticed him slow to respond, spacing him out, reports altered mental status changes, reports decreased comprehension since then. Reported that he mentioned that he blacked out after fall . Reports nausea and vomiting . Imaging Studies: Head CT without contrast from 3/22/2020 3:20PM . Comparison: 3/11/2020 There is a left parasagittal subdural hematoma with thickness approximately 9 mm (millimeter) near the left frontal lobe with extension over the tentorium with (sic) is focally thickened on the left side with a thickness of 2.2 cm (centimeter). It predominantly extends along the left side of the tentorium. There is also a low-density subdural lateral to the higher density to the left of the falx (small [MEDICAL CONDITION] shaped fold dura matter) . There is some subdural hemorrhage over the anterolateral aspect of the left frontal lobe with a thickness of approximately 4 mm . admitted to ICU (Intensive Care Unit) for Q (every) 1 hr (hour) neuro check . On 7/28/20 a review of the Facility's Policy titled, (Name of Facility Redacted) issue date 9/28/17 was conducted. The Policy documented, in part, the following: Purpose: It is the policy of the facility to identify each resident at risk for falls and to adequately plan care and implement procedures to prevent falls .Fall Committee: .4. To review each fall related accident/incident in order to assess for possible cause to determine appropriate interventions to prevent similar occurrences . It should be noted that the Facility was asked to provide all Facility Policies pertaining to Falls. No additional Fall Policies were provided by the end of the survey.
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** This citation pertains to Intake Numbers: MI 817 and MI 428. Based on observation, interview, and record review, the facility failed to ensure indwelling urinary catheter care was documented as completed for one resident (R#909), of three residents reviewed for indwelling urinary catheters, resulting in a formal complaint to the State Agency, and the potential for the development of infections and complications from indwelling urinary catheters. Findings include: Review of the complaint submitted to the State Agency on 7/22/20 indicated, .complainant states the catheter was not being cleaned properly or attended to per doctors orders. On 7/27/20 at 9:25 AM, R#909 was observed in bed. R#909 was observed to have a low air loss mattress, a wound vac, tube feeding being delivered via pump, and an indwelling urinary catheter. An observation of the catheter tubing leading to the drainage bag revealed cloudy, yellow urine with white sediment collected in the tubing. A review of R#909's clinical record was conducted on 7/27/20. Review of the record revealed R#909 admitted to the facility on [DATE] and had several discharges (to the emergency room) and re-admissions to the facility. A review of a progress note from Nurse Practitioner (NP) A on 4/30/20 indicated R909 had been seen for concerns with [MEDICAL CONDITION]. A review of a nursing progress note dated 5/4/20 was reviewed and read, .Upon PVR (post void residual, urine still remaining in the bladder after voiding) 936 (milliliters), nurse writer notified NP (name redacted). Order given to insert Foley (indwelling urinary catheter) . Continued review of R909's clinical record indicated a section on the Treatment Administration Record (TAR) for R909's catheter care to be documented as given starting 5/4/20. It was discovered that on 5/6/20, R909 discharged to the emergency room and was re-admitted on [DATE]. The re-admission nursing note on 5/15/20 read, .during skin assessment writer observed 18 FR (French, the size of the catheter) foley . Review of R909's re-admission treatment orders were conducted and did not reveal an order for [REDACTED]. It was noted the facility changed their electronic medical record software effective June 1, 2020. A review of the TAR's and the Certified Nursing Aide (CNA) Task list in the new software was conducted and did not reveal any orders or tasks to perform indwelling catheter care since the facility's migration to the new electronic software. On 7/27/20 at approximately 11:45 AM, an interview with CNA 'B' was conducted regarding where in the medical record they documented catheter care. CNA 'B' reported they documented it in their task list under the toileting task. On 7/27/20 at 12:15 PM, a review of the toileting task in R#909's clinical record was conducted and revealed two questions for responses from the CNA's regarding toileting. The first question requiring a response was about self-performance and toilet use, such as whether the resident was independent, needed levels

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) of assistance, or were totally dependent with toilet use. The second question that required a response was regarding how much assistance the resident required, such as no physical help, or assist from one, or two staff members. It was noted neither task indicated any information regarding catheters, or catheter care. On 7/27/20 at 1:45 PM, an interview with the facility's Director of Nursing (DON) was conducted regarding who performed catheter care and where in the record it was documented. The DON reported Nurses and CNA's could provide catheter care and there should be an order for [REDACTED]. At that time, the DON was asked to provide evidence of catheter care provided for R#909. By the end of the survey, no documentation was provided that indicated R#909 had been receiving routine catheter care since their re-admission to the facility on [DATE]. A review of a facility provided policy titled, INDWELLING/CATHETER POLICY dated 10/19 was conducted, and read, .6. Cleanse catheter site daily with soap and water, unless otherwise ordered by a physician . It was noted the policy did not address the facility's responsibility for documenting the care had been rendered. The facility was asked if they had any additional information to provide regarding the concern; none was provided by the end of the survey.
F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #MI 428. Based on observation, interview, and record review the facility failed, to timely assess and monitor weight changes, ensure food acceptance records were recorded and obtain weekly weights as ordered for one (R#909) out of three residents reviewed for weight loss. This deficient practice resulted in a significant weight loss, malnutrition and the insertion of a peg tube (percutaneous endoscopic gastrostomy-tube used to provide feeding when oral intake is not adequate). Findings include: A complaint was made to the State Agency that alleged R#909 developed a Stage IV Pressure Ulcer at the Facility that required hospitalization and the insertion of a PEG tube. On 7/27/20 at 9:25 AM, R#909 was observed in bed. R#909 was observed to be on a low air loss mattress, had a wound vac, an indwelling urinary catheter, and was receiving enteral nutrition via an automatic feeding pump. R#909 appeared thin and was alert and able to answer questions. Review of R#909's medical record revealed that the resident was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of R#909's Minimum Data Set (MDS), dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of four (severely cognitive impaired) and required two person assist for transfers, bed mobility. Continued review of R#909's medical record indicated that on 1/5/2020, R#909 weighed 105.8 lbs. A progress note dated 1/6/2020 documented, Will continue regular diet and will add Plus 2 (a nutritional supplement) TID (three times daily) for weight loss .feeds .self .and denies any difficulty chewing or swallowing . A progress note dated 4/13/20 and authored by Nurse Practitioner NP A documented, in part, .is being evaluated today for protein/calorie malnutrition .ASSESSMENT AND PLAN .1.) Protein/calorie malnutrition with weight loss. The patient will have reevaluation by the dietitian .will await further recommendations from the dietitian. We will start weighing at least three times per week .no areas of skin breakdown are noted . Continued review of the resident's medical record documented the following weights for the month of April 2020: April 1, 2020: 102.2 lbs. April 8, 2020: 96.6 lbs. No additional weights for the month of April 2020 were noted in the resident's medical record as ordered by NP A on 4/13/20 (3X per week). The next weight noted in the resident's medical record was 5/15/2020 (the date the resident returned from the Hospital with the PEG tube). A progress note authored by Dietitian Z dated 4/30/20 titled Weight Loss Evaluation documented in part, This resident has lost 9.72 % within the past 30 days .the weight history indicates A. .5% weight discrepancy since last months weight .The following orders and approaches already in place .1. Diet: reg.(regular) Supplements in place: Plus 2 120 cc TID .Weigh resident weekly x4 then monthly .Dietitians Comments: Consuming 50% most meals, 75% some .Stage 3 coccyx wound present per wound care .Suggestions: Plus 2 120 cc QID, weekly weights . A review of R#909's Hospital Records dated 5/6/20 was reviewed and documented, in part, ED (emergency department) notes .Chief Complaint .Patient presents with Tailbone Pain .pt to ER from nursing home .Patient has a history of possible stage III Stage IV ulcer buttocks .Nutritional Diagnosis: [REDACTED].patient is not eating .5/12/20 . PEG tube placement today. On 7/27/20 at approximately 11:05 AM, an interview was conducted with Dietician Z concerning R#909's weight loss. Dietician Z was queried as to why R#909 was not weighed weekly and monitored once it was discovered that they had had a significant weight loss on 4/8/20. Dietitian Z reported that they were fairly new to the Facility and had started in October. They further reported that they usually did assessments one time per month and thus waited until the end of the month to add additional interventions. When further asked why the resident was not weighed following the reporting of a significant weight loss and whether the food acceptance was being monitored, Dietitian Z indicated that she needed to go review the resident's documents. Dietitian Z returned along with a corporate representative and indicated that R#909's food acceptance forms from 1/3/2020-6/1/2020 could not be provided, no further documentation as to acceptance forms was provided by the end of the Survey. With respect to 3x weekly weights as initiated by NP A, it was reported that due to COVID-19 pandemic in April 2020, obtaining residents weights were not always completed due to infection concerns. A review of the Facility Policy titled, QAPI (quality assurance performance improvement) Weight Monitor Policy (Issue Date 6/1/2020) documented, in part, the following: Policy: It is the policy of our facility to be both proactive in preventing weight loss as well as reactive when weight loss occur in one of our residents . Procedure: All residents will be weighed on the day of admission and the day after admission .As per current standards of practice, after admission, the resident will be weighed weekly for four weeks .Residents will be weighed monthly as a routine after the first 30 days .Nursing .will be responsible for obtaining monthly weights. All residents with a 5# (pound) weight change .weight reports will be run by the dietitian to determine who has had significant weight change .Weight reports will be reviewed by the dietitian. Significant weight change will be defined as: A. a 5% weight discrepancy (increase or decrease) from previous month's weight .the dietitian will assess each resident to determine why the weight change occurred .He or she will document findings and recommendations in a progress note. The dietitian will document on the weight loss .in the progress notes in the resident's chart .A. reasons for weight change, B. future risk factors; C. Interventions .D. Changes in plan of care .
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Numbers: MI 275, MI 443, and MI 901. Based on observation, interview and record review, the facility failed to provide sufficient staffing to meet resident needs for six residents (R#'s 901, 905, 908, 909, 912 and 913) of six residents reviewed for staffing, resulting in complaints of short staffing and staff not being able to provide all aspects of care including bathing/showers. Findings include: On 7/21/20 at approximately 12:40 p.m., during a phone conversation with former employee CNA (certified nursing assistant) M, CNA M indicated that the facility was understaffed on weekends and midnight shifts. CNA M indicated that there were not enough staff to answer call lights or to get showers completed. Resident #901 A review of the clinical record revealed R#901 was originally admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the 5 Day Minimum Data Set ((MDS) dated [DATE] revealed R#901 had a BIMS (Brief Interview of Mental Status) score of 3 out of 15 which indicated severe cognitive impairment and required extensive assistance with two-person physical assist for bathing. The MDS revealed (0) behavior for rejection of care. A review of the facility's ADL care plan dated 3/27/20 revealed R#901 had a Self-care deficit R/T (related to) Decreased functional independence. Resident has multiple medical conditions that impacts abilities, good days, and bad days with abilities. Bathing: Shower 2x per week. Staff to supervise and/or assist as needed for completion and safety . The Shower Schedule was reviewed and revealed R#901's scheduled shower days were Tuesday and Friday (7:00a - 3:00p). A 30-day review of the facility's Resident CNA (Certified Nursing Assistant) Documentation Record for April 2020 revealed the following: 4 /14/20 - (Not Documented) 4/17/20 NP (Not Performed) 4/21/20 - (Not Documented) 4/24/20 NP (Not Performed) Further review of the Resident CNA Documentation Record revealed the following explanation for care not provided: 4/14/2020 - No documentation 4/21/2020 - No documentation 4/17/2020 - 8:00a-2:45p Transfer Not Performed 4/24/2020 - 7:00a-3:00p Bathing Not Performed A review of the facility's Progress Notes did not reveal R#901 refused their shower/bathing on 4/14, 4/17, 4/21, and 4/24/20. On 7/27/20 at approximately 3:15 p.m., a call was placed to CNAs 'D' and CNA 'E' and a message was left on the voice mail with no return call by the end the of the survey. During an interview on 7/27/20 at 3:26 p.m., when queried about R#901's missed showers/documentation, CNA 'F' stated, Usually if the documentation is blank, the service is not done . CNA 'F' further explained there was a lot going on, and they had a lot of people to take care of . R#905 A review of an allegation involving R#905 indicated the facility did not have enough staff to provide care. On 7/21/20 the medical record for R#905 was reviewed and revealed the following: R#905 was admitted to the facility on [DATE] and had

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) [DIAGNOSES REDACTED]. R#905's MDS with an ARD (Assessment Reference Date) of 3/8/20 revealed R#905 needed extensive assistance from facility staff with most of their activities of daily living. R#905's BIMS score was 15 indicating intact cognition. A review of R#905's care plan revealed the following: Admission#1-Self-Care deficit .Etiology-Self Care deficit R/T (related to): Decreased functional independence .Interventions: Bathing-Shower 2x (times) per week . A review of R#905's documented scheduled showers for March 2020 revealed the following: R#905 did not receive their showers on 3/14 and on 3/25. CNA documentation indicated R#905's showers were not performed R#908 A Complaint was filed with the State Agency that alleged R#908 was not receiving consistent ADL care, including showers, and was observed looking not groomed. A review of R#908's medical record documented that the resident was originally admitted to the facility on [DATE] for therapy following a fall that resulted in a fractured femur (right hip). R#908 also had [DIAGNOSES REDACTED]. A review of R#908's MDS dated [DATE] documented that the resident had a BIMS score of three (severely cognitively impaired) and required extensive one person assist for most ADL care. R#908's care plan for ADL care documented, in part, the following: Self Care Deficit (Effective 4/27/20) . Interventions: Bathing Shower 2x per week . A review of R#908's shower records for the Month of May 2020 documented as follows: 5/16/20: Not Performed 5/20/20: Not Performed 5/27/20: Not Performed 5/30/20: Not Performed There was no documentation that indicated the resident had refused showers on the above dates. R#909 A Complaint was filled with the State Agency that alleged R#909 was not receiving consistent ADL care and when observed in the Hospital the resident's hair was unkempt and toes, heals and nails were not cared for and the resident has developed a pressure ulcer to the coccyx. Review of R#909's medical record revealed that the resident was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of R#909's MDS, dated [DATE] documented that the resident had a BIMS score of four (severely cognitive impaired) and required extensive one to two person assist for transfers, bed mobility and showering. R#909's record documented that they were to receive showers on Monday and Wednesdays. A review of R#909's shower record for April 2020 and May 2020 documented the following: 4/14/20: Bed Bath Performed - No shower 4/17/20: Not Performed 4/21/20: Not Performed 4/24/20: Not Performed 4/28/20: Not Performed 5/01/20: Not Performed R#912 On 7/23/20 at approximately 12:12 p.m., R#912 was observed in their room up in their wheelchair. R#912 was queried if they had any concerns regarding their care in the facility and they indicated they had not received many of their showers. R#912 further indicated that they believed the facility did not have enough staff. On 7/23/20 the medical record for R#912 was reviewed and revealed the following: R#912 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#912's MDS with an ARD of 5/19/20 revealed R#912 needed extensive assistance with most of their activities of daily living. R#912's BIMS score was 15 indicating intact cognition. A review of R#912's documented scheduled showers for April and May 2020 revealed the following: R#912 did not receive their showers on 4/23, 5/4, 5/7, 5/11, 5/18 and 5/25. CNA documentation indicated R#912's showers were either not performed or were not documented as being completed. A review of R#912's care plan during April and May 2020 revealed the following: Focus-Admission #1 Self-Care deficit .Goals-Resident will demonstrate doing ADLs to the best of his/her ability. Staff will assist as needed .Interventions-Bathing: Shower 2x per week . R#913 On 7/23/20 at approximately 2:00 p.m., R#913 was observed in their room up in their wheelchair. R#913 was queried if they had any concerns regarding their care in the facility and they indicated that they were not receiving their showers. R#913 indicated their scheduled showers were to be completed by the midnight shift staff and they could never give them showers. R#913 stated it was bad. R#913 further stated staffing in the building was sh****. On 7/23/20 the medical record for R#913 was reviewed and revealed the following: R#913 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#913's MDS with an ARD of 6/6/20 revealed R#913 needed extensive assistance with most of their activities of daily living. R#913's BIMS score was 15 indicating intact cognition. A review of R#913's documented scheduled showers for March and May of 2020 revealed the following: R#913 did not receive their showers on 3/28, 5/2, 5/27 and 5/30. CNA documentation indicated R#913's showers were either not performed or were not documented as being completed. A review of R#913's care plan during March and May of 2020 revealed the following: Focus-Admission #1 Self-Care deficit R/T decreased functional independence .Goals-Resident will demonstrate doing ADLs to the best of his/her ability. Staff will assist as needed .Interventions-Bathing: Shower 2x per week . On 7/22/20 at approximately 2:20 p.m., during a conversation with the Director of Nursing (DON), the DON was queried how often residents in the facility should be provided showers and they indicated they should be given two showers a week and also as needed. On 7/23/20 at approximately 1:50 p.m., during a conversation with CNA D, CNA D was queried regarding the staffing levels in the facility. CNA D indicated that sometimes the facility is short when it came to staffing. CNA D indicated that at times, due to the staffing, the residents had to wait longer for call lights to be answered and to get them to the restroom and as a result became wet. On 7/27/20 at approximately 10:30 a.m., a phone interview was conducted with CNA W. CNA W reported that they had worked in the Facility for over five years and reported that the facility could not keep staff in the building and they were always understaffed, especially over the past few months. On 7/27/20 at approximately 11:37 a.m., CNA N was queried regarding the staffing levels in the facility. CNA N indicated that at times they do not have enough staff and that staff comes and goes. CNA N indicated that during the height of the pandemic in March 2020 staffing was down. On 7/27/20 at approximately 1:53 p.m., during a conversation with the DON, the DON was queried regarding staffing in the facility. The DON indicated that they had some staffing challenges during the height of the COVID-19 pandemic and that the challenges were related to staff being out sick. A facility document titled Staffing during an Emergency with an issue date of 4/1/20 revealed the following: POLICY: During normal operations, the facility complies with state and federal regulations for staffing. During an emergency, including a pandemic, the facility may experience staffing challenges and, under specific emergency conditions, has staffing strategies to meet resident needs .