STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235008	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLE LAWN MEDICAL CARE FACILI	50 SANDERSON LANE COLDWATER, MI 49036

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure updated and accurate Advance Directive information was in place for two residents (#25, #80) of six reviewed for Advance Directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time), resulting in the potential for a resident's preferences for medical care to not be followed by the facility or other healthcare providers. Findings include: Resident #25 (R25) Review of the medical record reflected that R25 was originally admitted to the facility on [DATE] and was readmitted on [DATE], with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/11/19, reflected that R25 scored three out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R25's Code Status document reflected notation to Ask when needed, regarding, TUBE FEEDING RESTRICTIONS - Indicates that the resident does NOT wish to be fed by artificial means (e.g., tube feeding for nutrition or water, intravenous nutrition, etc.) if he or she is not able to be nourished by oral means. The form was signed by R25's DPOA, Physician and two witnesses on 4/10/19. R25's medical record reflected a Progress Note for 5/8/19 at 11:52 AM that R25's DPOA was in agreement with placing her on comfort care. On 3/3/2020 at 11:17 AM, R25's medical record reflected that on 9/4/2019, she weighed 128.4 pounds. On 2/4/2020, R25 weighed 113 pounds, which was a 11.99 % weight loss. A weight for March 2020 was not recorded at the time of the review. Review of R25's medical record Task documentation for meal intake reflected 62 meal refusals documented from 2/5/2020 at 9:14 AM to 3/5/2020 at 8:44 AM. Review of R25's Progress Notes did not reflect that her DPOA had been notified of her meal refusals or weight loss. During an interview on 3/5/2020 at 11:23 AM, Licensed Practical Nurse (LPN) D reported that R25's son (DPOA) visited occasionally. LPN D reviewed R25's medical record and reported that R25 refused breakfast that morning. LPN D reported that R25 also refused her monthly weight for March 2020. When asked if R25's son/DPOA was aware of her weight loss and decreased intake, LPN D reported she would have had to ask Social Work if the DPOA was made aware at the care conference (in February 2020). During an interview on 3/5/2020 at 2:04 PM, Social Services Director (SSD) G reported that R25 had been on comfort care for quite some time. When asked what comfort care meant, SSD G reported they would give R25 medication to make sure she was pain free and anxiety free but would not give her certain medications or other things that would continue to sustain her. During the same interview, SSD G reported that R25's DPOA was very involved. When asked if she was aware if anyone had talked to R25's DPOA about her meal refusals, weight loss and nutritional status, SSD G reported that would usually be done by the Dietitian, as they were the one to follow up with nutrition and whether or not to approach family regarding tube feeding. According to SSD G, R25's code status in the computer reflected feeding restrictions, ask when needed. SSD G again stated the Dietitian was the one to discuss that with the family. During an interview on 3/5/2020 at 2:33 PM, Registered Dietitian (RD) H reported that some days R25 ate, some days she did not, and the family was ok with that because R25 was on comfort care. According to RD H, R25's DPOA was aware that she refused meals or supplements and beverages. RD H reported that she had not recently talked to R25's Physician regarding her weight loss due to R25 being on comfort care and family not wanting any specific measures. In regards to wishes for alternate methods of nutrition, such as a feeding tube, RD H stated she did not know what R25's wishes were. RD H reported she was sure SSD G would know. RD H stated she was not the person to talk to about tube feeding because she was not the person that did the code status forms. During an interview on 3/6/2020 at approximately 08:30 AM, Physician I reported that sometimes R25 ate, and sometimes she did not eat. Physician I reported that when R25 went on comfort care, the discussion was had with her DPOA regarding stopping everything. Resident #80 Review of the medical record revealed Resident #80 was an [AGE] year old female resident admitted to the facility on [DATE]. Further review of the medical record revealed that Resident #80's, son (Son Q) was documented in the profile section of the medical record as being the Durable Power of Attorney for Health Care. Further review of the chart revealed multiple notes indicating that (Son Q) was contacted for various updates and changes in treatment. A Nurse's Note dated [DATE] stated, Detailed message left for Son/DPOA, (Son Q), regarding res (resident) fall with no apparent injuries. Encouraged return call with further questions. Review of the Appointment of Patient Advocate documentation which was in Resident #80's medical chart, signed and dated 5/28/19 by Resident #80, revealed that Resident #80's second son, (Son R) was listed as the appointed patient advocate, not Son Q. During an interview on 3/04/20 at 1:22 PM when asked about Resident #80's Durable Power of Attorney for Health Care (DPOA-HC), Social Services Director (SSD G) stated that (Son Q) was listed as the number 1 emergency contact, and that Resident #80 wanted Son Q notified of all of her updates. When asked why Son Q was documented as Resident #80's DPOA-HC, and not Son R, as indicated by the Appointment of Patient Advocate Document, SSD G could not answer. During an interview on 3/05/20 at 9:43 AM when asked about who should be her DPOA-HC, Resident #80 stated, Son Q should be first, he lives here close .I always ask them to call (Son Q). This surveyor explained, that according to the legal documentation that was in her medical record, Son R was listed as the DPOA-HC. Resident #80 responded, (Son R) is my oldest son, we call him (Son R). He would be the second one they would call. This surveyor explained to her that currently the paper work in her chart indicates that (Son R) would be DPOA-HC if she was not able to make decisions, Resident #80 stated, No, it should be (Son Q), (Son R) is second. Resident #80 agreed that the DPOA paperwork should be changed.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to operationalize it's abuse policy and procedure for 3 of 3 (Resident #2, 80 and 84) reviewed for abuse, resulting in allegations of abuse that were not reported to the Nursing Home Administrator and the State Agency timely, and not thoroughly investigated and the potential for further allegations of abuse to go unreported, and not thoroughly investigated. Findings include: Review of the facility's Abuse Prevention and Investigation Program policy dated 12/2016 revealed, The Abuse Coordinator of the facility is the Administrator. The Administrator may appoint someone to act on their behalf if necessary. Allegations of abuse or suspected abuse, neglect or exploitation must be immediately reported to: Administrator, Other Officials in accordance with State Law, State Survey and Certification agency through established procedures .Definitions of Abuse .Abuse: means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical

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

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful means the individual deliberately, not that the individual must have intended to, inflict harm or injury .Verbal Abuse: means the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability .Identification of Abuse, Neglect and Exploitation - The facility will consider factors indicating possible abuse, neglect, and/or exploitation of residents, including, but not limited to, the following possible indicators: .c. Physical injury of a resident, of unknown source .e. Verbal abuse of a resident overheard .9. Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect or exploitation is suspected, the Licensed Nurse should: .b. Notify the Director of Nursing and Administrator (document) .f. Contact the State Agency and the local Ombudsman office to report the alleged abuse .13. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must: a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation or resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours in the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency) in accordance with State Law. During an interview on 03/06/20 at 2:48 PM when asked who staff were supposed to report allegations of abuse to, Nursing Home Administrator (NHA A) stated that they should report to the house supervisor, and ultimately the NHA. When asked when the NHA A was supposed to be notified of allegations of abuse, NHA A stated, immediately. When asked when these allegations were to be reported to the State Agency, NHA A stated, It depends on the incident. Within two hours; if there is harm then immediately. When asked when an injury of unknown origin is supposed to be reported to the State Agency, NHA A stated that it depends on what the injury was. If it was significant then, less than 2 hours if not then within 24 hours; we would start investigation immediately. When asked what verbal abuse was, NHA A stated that it was derogatory statements between residents or staff to residents. Resident #2 Review of the medical record and Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was a [AGE] year old female resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS revealed Resident #2 had clear speech, was rarely/never understood, rarely/never understands, severely impaired cognitively, had inattentive and disorganized thinking behaviors and required extensive assistance of staff for Activities of Daily Living to include bed transfers and locomotion in her wheelchair. During an interview on 3/03/20 at 11:00 AM Resident #2's daughter stated that two weeks from today (2/18/20) the injury happened. I was helping her with her leg, and she screamed out don't touch me. I went to get a nurse to see if she had been having pain, the nurse came in to assess the resident. The nurse came in and felt around and my mom did not express anything. The nurse left, then later my mom started screaming about pain. Again, I went to the nurse to get Tylenol and blue gel (pain cream). I came back on that same Wednesday night and was asking staff if my mom was having pain, and they said that Tuesday night she was expressing pain, and that the nurse had to give her Tylenol. I came in on Thursday and she was in pain again, I asked the aide how she was when she put her socks on and the aide said she had some pain. I was grabbing her foot and she was having pain. The nurse came in and was touching her foot and leg and nothing was happening. I came back on Friday and I come in and her ankle looks swollen. I took her socks off and her foot was all bruised. I went and talked to the nurse, she called (Director of Nursing (DON) B) and they came down. That was Friday, they ordered an x-ray not sure if it was taken on Friday or Saturday. The x-ray came back as broken. During a family meeting, with my husband, (DON B) and (Assistant DON C), they said they talked to all the staff and they did not notice anything. When I push her (Resident #2) in the wheelchair her feet would fall off the wheelchair, so I requested a therapy assessment maybe three weeks ago with this concern. My mom does not like to stay in one place, they were letting her wheel herself in her wheelchair, she was using her left foot and her hands to ambulate. Resident #2's daughter stated that she does not know how the injury happened. Review of the medical chart revealed the following Nurse's notes: 2/19/2020 at 2:37 p.m., Resident stayed in bed for lunch due to c/o (complain of) left leg pain, routine [MEDICATION NAME] given, pillow under BLE (bilateral lower extremities). Daughter in to visit and aware of above. Resident is currently resting in bed. 2/21/2020 at 2:06 p.m., Res (resident) observed with bruising to Left lateral leg/foot. Greenish hematoma to leg measures approx. 15cm x 5cm, purple hematoma to foot measures approx. 15cm x5cm. Trace [MEDICAL CONDITION] note to foot. BIL (bilateral) padded leg protectors on per order. Foot box used per order, res occasionally removing feet from box, staff quickly assisting res with proper foot placement. No verbal c/o pain noted, facial grimacing noted x1 while assessing area. [MEDICATION NAME] given with benefit. Daughter .aware of above. House supervisor aware. Message left for rehab for eval of transfers. Note was written by Licensed Practical Nurse (LPN) S. Review of the physician note dated 2/22/20 revealed, The staff noted her left lateral ankle and left foot with a large ecchymosis, no reported history of injury .IMPRESSION: Soft tissue trauma to the left foot and ankle .PLAN: We will obtain an x-ray and evaluate after that. Review of the Radiology Report dated 2/22/20 revealed, Results: There is a fracture involving distal tibia and fibula (long bones of the lower leg) with no displacement . Review of the facility's General Incident Report dated 2/21/20 revealed, Res (Resident #2) noted with green/purple bruising to left lateral leg and left lateral foot .Person's statement of what happened: Nonverbal .List causes or potential causes: Poor weight distribution during transfers abnormal foot alignment per her norm. Order for Xray was written 2/22/20, results were the same day .resident was seen by the Doctor on 2/22/20 . Review of the facility's Determination of Reportable Incident/Investigation Guide revealed, Resident likely injured area during transfer r/t (related to) poor weight distribution with abnormal foot alignment per her normal .Incident reported to the state agency: No, there is no suspicion that abuse or neglect may have occurred. This document was completed by ADON C. During an interview on 3/05/20 at 1:53 PM when asked about Resident #2's injury ADON C stated that they had an incident note and we did do an investigation on that. She had a bruise on the calf to foot on the left side, it was found at 11am on Friday the 21st. ADON C stated that she investigated the incident, I went through and interviewed staff that was on that day. (Resident #2) is very fragile and we came to the conclusion that it was poor weight distribution during a transfer. When asked if she assessed the injury herself, ADON C stated, Yes, when I assessed it, I truly felt it was a pulled muscle. When asked if during her investigation, if there was a specific transfer that caused the injury, ADON C stated, I cannot pinpoint one scenario. The daughter had mentioned that (Resident #2's) ankle hurt starting on Monday (2/17/20) and the bruise came up on Friday (2/21/20). I cannot pinpoint a time of when this injury occurred. I don't have a fall for her. ADON C stated that it was on Friday (2/21/20) when they were first made aware of the injury to Resident #2's leg. ADON C continued that when we were in the family meeting, the daughter brought up the fact that she started complaining of the pain on that Tuesday. ADON was not able to provide an exact cause of the injury but did state that she believes it was from a transfer from either the bed to the wheelchair or the wheelchair to the bed. During this interview, ADON C confirmed that this injury was not reported to the State Agency. During an interview on 3/06/20 at 10:16 AM, when asked about Resident #2's injury to her leg, LPN S stated that she had Tuesday, Wednesday and Thursday off. It was on that Friday (2/21/20) Resident #2's daughter approached me and said she had a concern about (Resident #2's) foot. I saw the foot and then called the house supervisor; she brought the DON down there too. We measured her leg and completed a note. During this same interview LPN S stated, I touched her leg, she does not like to be fidgeted with and when I touched her leg, she had some facial grimacing, and this would be different for her. After the incident I watched her transfers, when we got her up for lunch, and then when rehab came. When asked why she was watching the resident being transferred, LPN S stated that they wanted to see how her transfers were or see if she bumped her bed when the girls got her up. When asked if she felt Resident #2's injury could have resulted from a transfer, LPN S stated No, I did not feel it was a transfer issue. When asked what she thought caused the injury, LPN S stated, I don't know. During an interview on 3/6/20 at 3:27 PM, when asked how the injury to Resident #2 occurred, Nursing Home Administrator A stated that they could not determine how it happened. NHA A further stated that it was not suspicious because of the location, because she transfers on that leg, We kind of expected that this would happen. Resident #80 and 84 Review of the medical record revealed Resident #80 was an [AGE] year old female resident admitted to the facility on [DATE]. Review of the MDS assessment dated [DATE] revealed Resident #80 had clear speech, was understood, understands and was cognitively intact. Review of the medical record and MDS assessment dated [DATE] revealed Resident #84 was a [AGE] year old male resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #84 had clear speech, sometimes understands, sometimes understood, was severely impaired cognitively and independently ambulated on the unit. During the resident council meeting interview on 3/4/20 at 11:00 a.m., Resident #80 reported that there was a resident that scared her a couple weeks ago. During an interview on 3/5/20 when asked about

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) her statement that she made during resident council, Resident #80 stated, it was the guy next door (Resident #84). He likes to wander the halls and we have been told that if he wanders into your room to call and get help. One day he came into my room and just stood there. I told him that his room was down the hall, and he said to me, You don't tell me what to do. He was screaming and cussing at me, we got really loud and the nurse had heard it and she came and got him, and then a couple of others came in. One of the girls that came in first asked me if he touched me. And I said no, but he sure did scare the heck out of me. Resident #80 stated that she was scared and that she was not sure what he was going to do but that she was ready because she had her crochet needle in her hand. Review of the medical record failed to reveal any documentation pertaining to this incident. During an interview on 3/5/20 at 11:27 AM when asked about this incident, Social Services Director (SSD G) stated that she was not in the facility when the incident took place but was told that Resident #84 went into Resident #80's room mistakenly and she yelled at him to get out, and told him this is not your room. SSD G stated that it was the House Supervisor T that she heard this information from. SSD G stated that the house supervisor called her, and then, I called the DON. When asked about there being no documentation in the chart about this incident, SSD G stated there would be documentation on the behavior log. SSD G provided this surveyor the behavior log for Resident #84 and stated that LPN S was the nurse that signed the behavior log note regarding this incident. Review of this log revealed a note dated 2/22/20 at 11:30 a.m., Res (Resident) entered females Room (Resident #80) yelling and cussing at her Don't tell me what to do [***] . Staff quickly assisting Res out of room. Res redirected much encouragement needed. [MEDICATION NAME] given. During an interview on 3/06/20 at 10:46 AM, when asked about this incident LPN S stated that she was in with another resident, I heard yelling I went out in the hallway and I saw Resident #84 just a step into Resident #80's room. They were yelling at each other, I put myself in between them and then I took Resident #84 for a walk. Then I called the house supervisor and told her that I need her down here. I went and talked to Resident #80 because she was upset. When asked if she heard what was actually said between to the two residents, LPN S stated No, I did hear the F word from Resident #84. When asked if she felt this was verbal abuse, LPN S stated that she didn't know, That is why I called house supervisor, that is our protocol. During an interview on 3/6/20 at 1:38 PM, when asked about this incident, House Supervisor T stated, that she was alerted about a situation between Resident #80 and #84 from LPN S and that she went and talked with Resident #80. House Supervisor T stated that when she went and talked to Resident #80, Resident #80 told her that Resident #84 came into her room and that she told him to get out. She said that he scared her. He told her she was a nasty old lady, and that she can't tell him what to do. House Supervisor T stated that she called Social Services Director (SSD G) and let her know what was going on. When asked if she had contacted the Nursing Home Administrator or the DON, House Supervisor T stated she personally called SSD G, and that SSD G was going to let DON B know. During an interview on 3/6/20 at 3:27 PM, when asked if she was notified about the incident between Resident #84 and Resident #80, Nursing Home Administrator A stated that DON B had notified her of the incident. When asked who notified DON B of the incident, NHA A stated that it was the House Supervisor. When asked how the House Supervisor was aware of the incident, NHA A stated that she was not sure but that she was probably called by the nurse. NHA A confirmed that this incident was not reported to the State Agency.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately report allegations of abuse for 3 (Resident #2, 80 and 84) of 3 total sampled residents reviewed for abuse, resulting in allegations of abuse that were not reported to the Nursing Home Administrator and the State Agency timely and the potential for further allegations of abuse to go unreported, and not thoroughly investigated. Findings include: Review of the facility's Abuse Prevention and Investigation Program policy dated 12/2016 revealed, The Abuse Coordinator of the facility is the Administrator. The Administrator may appoint someone to act on their behalf if necessary. Allegations of abuse or suspected abuse, neglect or exploitation must be immediately reported to: Administrator, Other Officials in accordance with State Law, State Survey and Certification agency through established procedures .Definitions of Abuse .Abuse: means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, in-cluding a caretaker, of goods or services necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physi-cal harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse in-cluding abuse facilitated or enabled through the use of technology. Willful means the individual deliberate-ly, not that the individual must have intended to, inflict harm or injury .Verbal Abuse: means the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability .Identification of Abuse, Neglect and Exploitation - The facility will consider factors indicating possible abuse, neglect, and/or exploitation of residents, including, but not limited to, the following possible indi-cators: .c. Physical injury of a resident, of unknown source .e. Verbal abuse of a resident overheard .9. Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect or exploitation is suspected, the Licensed Nurse should: .b. Notify the Director of Nursing and Administrator (document) .f. Contact the State Agency and the local Ombudsman office to report the alleged abuse .13. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must: a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, include-ing injuries of unknown origin and misappropriation or resident property, are reported immedi-ately, but not later than 2 hours after the allegation is made, if the events that cause the allega-tion involve abuse or result in serious bodily injury, or not later than 24 hours in the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the admin-istrator of the facility and to other officials (including the State Survey Agency) in accordance with State Law. Resident #2 Review of the medical record and Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was a [AGE] year old female resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS revealed Resident #2 had clear speech, was rarely/never understood, rarely/never understands, severely impaired cognitively, had inattentive and disorganized thinking behaviors and required extensive assistance of staff for Activities of Daily Living to include bed transfers and locomotion in her wheelchair. During an interview on 3/03/20 at 11:00 AM Resident #2's daughter stated that two weeks from today (2/18/20) the injury happened. I was helping her with her leg, and she screamed out don't touch me. I went to get a nurse to see if she had been having pain, the nurse came in to assess the resident. The nurse came in and felt around and my mom did not express anything. The nurse left, then later my mom started screaming about pain. Again, I went to the nurse to get Tylenol and blue gel (pain cream). I came back on that same Wednesday night and was asking staff if my mom was having pain, and they said that Tuesday night she was expressing pain, and that the nurse had to give her Tylenol. I came in on Thursday and she was in pain again, I asked the aide how she was when she put her socks on and the aide said she had some pain. I was grabbing her foot and she was having pain. The nurse came in and was touching her foot and leg and nothing was happening. I came back on Friday and I come in and her ankle looks swollen. I took her socks off and her foot was all bruised. I went and talked to the nurse, she called (Director of Nursing (DON) B) and they came down. That was Friday, they ordered an x-ray not sure if it was taken on Friday or Saturday. The x-ray came back as broken. During a family meeting, with my husband, (DON B) and (Assistant DON C), they said they talked to all the staff and they did not notice anything. When I push her (Resident #2) in the wheelchair her feet would fall off the wheelchair, so I requested a therapy assessment maybe three weeks ago with this concern. My mom does not like to stay in one place, they were letting her wheel herself in her wheelchair, she was using her left foot and her hands to ambulate. Resident #2's daughter stated that she does not know how the injury happened. Review of the medical chart revealed the following Nurse's notes: 2/19/2020 at 2:37 p.m., Resident stayed in bed for lunch due to c/o (complain of) left leg pain, routine [MEDICATION NAME] given, pillow under BLE (bilateral lower extremities). Daughter in to visit and aware of above. Resident is currently resting in bed. 2/21/2020 at 2:06 p.m., Res (resident) observed with bruising to Left lateral leg/foot. 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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) Review of the physician note dated 2/22/20 revealed, The staff noted her left lateral ankle and left foot with a large ecchymosis, no reported history of injury .IMPRESSION: Soft tissue trauma to the left foot and ankle .PLAN: We will obtain an x-ray and evaluate after that. Review of the Radiology Report dated 2/22/20 revealed, Results: There is a fracture involving distal tibia and fibula (long bones of the lower leg) with no displacement . Review of the facility's General Incident Report dated 2/21/20 revealed, Res (Resident #2) noted with green/purple bruising to left lateral leg and left lateral foot .Person's statement of what happened: Nonverbal .List causes or potential causes: Poor weight distribution during transfers abnormal foot alignment per her norm. Order for Xray was written 2/22/20, results were the same day .resident was seen by the Doctor on 2/22/20 . Review of the facility's Determination of Reportable Incident/Investigation Guide revealed, Resident likely injured area during transfer r/t (related to) poor weight distribution with abnormal foot alignment per her normal .Incident reported to the state agency: No, there is no suspicion that abuse or neglect may have occurred. This document was completed by ADON C. During an interview on 3/05/20 at 1:53 PM when asked about Resident #2's injury ADON C stated that they had an incident note and we did do an investigation on that. She had a bruise on the calf to foot on the left side, it was found at 11am on Friday the 21st. ADON C stated that she investigated the incident, I went through and interviewed staff that was on that day. (Resident #2) is very fragile and we came to the conclusion that it was poor weight distribution during a transfer. When asked if she assessed the injury herself, ADON C stated, Yes, when I assessed it, I truly felt it was a pulled muscle. When asked if during her investigation, if there was a specific transfer that caused the injury, ADON C stated, I cannot pinpoint one scenario. The daughter had mentioned that (Resident #2's) ankle hurt starting on Monday (2/17/20) and the bruise came up on Friday (2/21/20). I cannot pinpoint a time of when this injury occurred. I don't have a fall for her. ADON C stated that it was on Friday (2/21/20) when they were first made aware of the injury to Resident #2's leg. ADON C continued that when we were in the family meeting, the daughter brought up the fact that she started complaining of the pain on that Tuesday. ADON was not able to provide an exact cause of the injury but did state that she believes it was from a transfer from either the bed to the wheelchair or the wheelchair to the bed. During this interview, ADON C confirmed that this injury was not reported to the State Agency. During an interview on 3/06/20 at 10:16 AM, when asked about Resident #2's injury to her leg, LPN S stated that she had Tuesday, Wednesday and Thursday off. It was on that Friday (2/21/20) Resident #2's daughter approached me and said she had a concern about (Resident #2's) foot. I saw the foot and then called the house supervisor; she brought the DON down there too. We measured her leg and completed a note. During this same interview LPN S stated, I touched her leg, she does not like to be fidgeted with and when I touched her leg, she had some facial grimacing, and this would be different for her. After the incident I watched her transfers, when we got her up for lunch, and then when rehab came. When asked why she was watching the resident being transferred, LPN S stated that they wanted to see how her transfers were or see if she bumped her bed when the girls got her up. When asked if she felt Resident #2's injury could have resulted from a transfer, LPN S stated No, I did not feel it was a transfer issue. When asked what she thought caused the injury, LPN S stated, I don't know. During an interview on 3/6/20 at 3:27 PM, when asked how the injury to Resident #2 occurred, Nursing Home Administrator A stated that they could not determine how it happened. NHA A further stated that it was not suspicious because of the location, because she transfers on that leg, We kind of expected that this would happen. Resident #80 and 84 Review of the medical record revealed Resident #80 was an [AGE] year old female resident admitted to the facility on [DATE]. Review of the MDS assessment dated [DATE] revealed Resident #80 had clear speech, was understood, understands and was cognitively intact. Review of the medical record and MDS assessment dated [DATE] revealed Resident #84 was a [AGE] year old male resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #84 had clear speech, sometimes understands, sometimes understood, was severely impaired cognitively and independently ambulated on the unit. During the resident council meeting interview on 3/4/20 at 11:00 a.m., Resident #80 reported that there was a resident that scared her a couple weeks ago. During an interview on 3/5/20 when asked about her statement that she made during resident council, Resident #80 stated, it was the guy next door (Resident #84). He likes to wander the halls and we have been told that if he wanders into your room to call and get help. One day he came into my room and just stood there. I told him that his room was down the hall, and he said to me, You don't tell me what to do. He was screaming and cussing at me, we got really loud and the nurse had heard it and she came and got him, and then a couple of others came in. One of the girls that came in first asked me if he touched me. And I said no, but he sure did scare the heck out of me. Resident #80 continued stating that she was scared, she was not sure what he was going to do but that she was ready because she had her crochet needle in her hand. Review of the medical record failed to reveal any documentation pertaining to this incident. During an interview on 3/5/20 at 11:27 AM when asked about this incident, Social Services Director (SSD G) stated that she was not in the facility when the incident took place but was told that Resident #84 went into Resident #80's room mistakenly and she yelled at him to get out, and told him this is not your room. SSD G stated that it was the House Supervisor T that she heard this information from. SSD G stated that the house supervisor called her, and then, I called the DON. When asked about there being no documentation in the chart about this incident, SSD G stated there would be documentation on the behavior log. SSD G provided this surveyor the behavior log for Resident #84 and stated that LPN S was the nurse that signed the behavior log note regarding this incident. Review of this log revealed a note dated 2/22/20 at 11:30 a.m., Res (Resident) entered females Room (Resident #80) yelling and cussing at her Don't tell me what to do [***] . Staff quickly assisting Res out of room. Res redirected much encouragement needed. [MEDICATION NAME] given. During an interview on 3/06/20 at 10:46 AM, when asked about this incident LPN S stated that she was in with another resident, I heard yelling I went out in the hallway and I saw Resident #84 just a step into Resident #80's room. They were yelling at each other, I put myself in between them and then I took Resident #84 for a walk. Then I called the house supervisor and told her that I need her down here. I went and talked to Resident #80 because she was upset. When asked if she heard what was actually said between to the two residents, LPN S stated No, I did hear the F word from Resident #84. When asked if she felt this was verbal abuse, LPN S stated that she didn't know, That is why I called house supervisor, that is our protocol. During an interview on 3/6/20 at 1:38 PM, when asked about this incident, House Supervisor T stated, that she was alerted about a situation between Resident #80 and #84 from LPN S and that she went and talked with Resident #80. House Supervisor T stated that when she went and talked to Resident #80, Resident #80 told her that Resident #84 came into her room and that she told him to get out. She said that he scared her. He told her she was a nasty old lady, and that she can't tell her what to do. House Supervisor T stated that she called Social Services Director (SSD G) and let her know what was going on. When asked if she had contacted the Nursing Home Administrator or the DON, House Supervisor T stated she personally called SSD G, and that SSD G was going to let DON B know. During an interview on 3/6/20 at 3:27 PM, when asked if she was notified about the incident between Resident #84 and Resident #80, Nursing Home Administrator A stated that DON B had notified her of the incident. When asked who notified DON B of the incident, NHA A stated that it was the House Supervisor. When asked how the House Supervisor was aware of the incident, NHA A stated that she was not sure but that she was probably called by the nurse. NHA A confirmed that this incident was not reported to the State Agency.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop a comprehensive care plan for one out of 42 residents (Resident #70) resulting in the potential for care needs not being met. Findings Included: Resident #70 (R70): Per the facility face sheet R70 was admitted to the facility on [DATE]. In an interview and observation on 3/03/2020, at 09:22 AM, Resident # 70 stated about three months ago her skin had became red and itchy, and stated the facility staff had put cream on it twice a day, but said that was about two months ago and the cream had not helped. Observation R70's back, stomach, chest, and arms revealed her skin was covered in large areas of red raised welts. R70 also said she had blister on her shin that was open and being treated with a gauze wrap. Review of R70's [DIAGNOSES REDACTED]. Record review of progress notes, dated 2/4/2020, revealed R70 had Psoriasis to her torso, trunk, abdomen, back, peri-area, and upper thighs, and complained of itchiness to all areas affected. The note revealed [MEDICATION NAME] Ointment 0.005% (medication) was to be applied to all affected areas. Review of another progress note, dated 2/11/2020, revealed R70 continued to have psoriasis spots to her torso, trunk, abdomen, back, breasts, peri-area, and upper thighs and some small areas to both arms, and R70 continued to have itchiness to all areas. Review of a progress note, dated 2/25/2020, revealed R70 continued to psoriasis to her back, abdomen, peri-area, thighs, neck, arm pits and arms. Review of a progress note, dated 2/28/2020, revealed R70

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	235008	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLE LAWN MEDICAL CARE FACILI	50 SANDERSON LANE COLDWATER, MI 49036

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) was noted to have an long linear open area to her coccyx (tailbone). The note revealed the open area measured 1cm x 0.1cm, to be cleansed with normal saline, patted dry, then a [MEDICATION NAME] (medication) was to be applied with [MEDICATION NAME] (an adhesive dressing). Review of a progress note, dated [DATE], revealed R70 had a blister to her right shin that measured at 1.5cm x 1.5cm. The note also revealed R70 continued to have Psoriasis on her back, abdomen, peri-area, both thighs, neck, both armpits, and both arms. The note revealed R70 was educated on the benefits of not itching her skin. Review of R70's physician's orders [REDACTED]. Record review of R70's care plan's that were in place revealed no current plan of care related to her coccyx open area, skin psoriasis, or the blister on her right lower leg. The only care plan noted in R70's medical record revealed that she was at risk for an alteration in her skin integrity because she was admitted on [DATE] with bruising, scratches on her buttocks, and a red area underneath her left breast. The care plan was last revised on 4/17/2018. No interventions were noted on the care plan to measure and document the open area on her coccyx, document and treatment for [REDACTED]. One intervention was noted that revealed, Provide me (R70) with wound care as ordered by my physician., although the intervention was initiated on 4/16/2018, and revised on 4/27/2018, it was also canceled as an intervention on the date of 4/27/2018. In an interview on 3/04/20, at 01:59 PM, Director of Nursing (DON) B stated that when the nurses received a new order then the nurse was to update the resident's care plan. DON B said her expectation for the nurses regarding R70's blister on her skin, open area to her coccyx, and skin rash was that they update her care plan when the changes were discovered, or physician's orders [REDACTED].
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the faciity failed to ensure care plan revision for two out of 42 residents (Resident #'s 48 and 67), resulting in the potential for unmet care needs. Findings Included: Resident #67 (R67): Review of a facility admission assessment revealed R67 was admitted to the facility on [DATE]. Review of physician's orders [REDACTED]. Review of R67's list of [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS), dated [DATE], revealed R67 was assessed to have no mood disorder. Review of a Psychopharmacological/Behavioral Management Form/Risk vs. Benefit document, dated 12/4/2019, revealed R67 did not attend group activities, was tearful at times, made sad statements, had periodic refusal of care, preferred to remain in bed, and had no interaction with grandchildren as he had before. The document revealed R67 was order to start receiving [MEDICATION NAME] for a [DIAGNOSES REDACTED]. Benefit that he was tearful and sad because that was what was reported to her by the Certified Nurse Aids (CNA's) who had verbally told her that R67 had been crying and tearful. Review of a Mulitdisciplinary Care Conference, revealed the care conference was conducted on 12/4/2019. The care conference notes revealed under section G, Social Work Summary R67's mood had fluctuated and he was started on [MEDICATION NAME]. Record review of R67's care plans revealed a care plan, initiated on the date of 10/14/2019, that R67 was at risk for a psychosocial well-being problem and mood alteration related to his recent hospitalization and admission to the facility, and a [DIAGNOSES REDACTED]. The care plan was not revised until the date of 1/21/2020, and an intervention to administer R67 his antidepressant medication as ordered was not initiated until 1/21/2020. Resident #48 (R48) On 03/03/20 at 12:02 PM R48 was observed and interviewed in his room. R48 revealed he was on fluid restrictions, recently had [MEDICAL CONDITION], and had spinal cord damage which kept him from moving his left leg much. If I have [MEDICAL CONDITION] it's usually in the left lower leg. R48 was cleanly dressed and groomed, sitting in his electric wheelchair with shorts on. R48's bilateral lower legs appeared swollen with 2-3 + dema, and dark pink in color. R48's left lower leg was observed to have 2 circular shaped necrotic looking areas. Area #1 visually appeared to be approximately 1 inch in diameter and circumference. Area #2 visually appeared to be approximately 1/4 inch diameter and circumference. No drainage or odor was noted. On 03/04/20 at 04:59 PM the Electronic Medical Record (EMR) reflected R48 was admitted to the facility on [DATE] and readmitted on [DATE]. [DIAGNOSES REDACTED]. The annual Minimum Data Set (MDS: resident assessment tool) dated 12/23/20 reflected yes for Moisture Acquired Skin Damage (MASD: MOISTURE ASSOCIATED SKIN DAMAGE Is superficial skin damage caused by sustained exposure to moisture such as incontinence, wound exudate, or perspiration). On 03/04/20 at 03:13 PM R48 was observed in his room sitting in his wheelchair. R48 had a Band-Aid dressing noted at his left knee dated 03/03/2020. He had gripper socks on each feet, pulled up over the opened areas, leaving a deep indentation ring about both calves. Licensed Practical Nurse (LPN L) entered the room during interview with R48, and was asked about the opened areas viewed on 03/03/2020. LPN L revealed, she was not aware of the current opened areas. R48's gripper sock to the left lower leg was lowered, and 3 opened areas were now observed. Area #3 was not noted and may have been missed yesterday, based on R48's positioning. R48's left calf had 3 areas: Larger area #1 had a dried gold colored center, with black eschar colored tissue surrounding it, and was circular in shape. Area #2 was the same as yesterday. Area #3 appeared to be a pinpoint circular area with a black eschar center. R48's left leg appeared to have greater swelling and/or girth than his right lower leg. All 3 areas were observed to be flushed to the skin, and not on top (raised) above the skin. The Centers for Medicare & Medicaid Services MDS 3.0 section M section reflected: Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar On 03/04/20 at 03:42 PM Registered Nurse (RN M) was asked about R48's 3 opened areas to his left lower leg. RN M revealed, R48 was treated for [REDACTED]. Review of the EMR progress notes were negative for any skin/wound notes related to the opened areas of the left lower leg. R48's last skin wound note, was dated 02/21/2020 and referred to his buttocks. No documentation was noted in the EMR or R48's hard chart reflecting his doctor had been notified of the opened areas for possible treatment. No skin sheets or skin integrity documentation was noted completed, or addressed the 3 opened areas to R48's left lower leg calf area. R48's alteration in my skin care plan revised on 09/25/2019 intervention reflected: Report [MEDICAL CONDITION], redness, bruising, Non-intact skin to my Charge nurse. Date Initiated: 12/17/2018 Treatment as ordered to my LLE (Left Lower Extremity). Date Initiated: 09/25/2019 On 03/04/20 at 05:37 PM a meeting took place with the Director of Nursing (DON B). She was informed of the 3 open areas observed with no documentation or treatment provided. DON B revealed she would see what she could find. The DON was interviewed again on 03/06/20 at 10:25 AM. She revealed there was no monitoring of the areas, the areas were scabs, generally they did not monitor scabs and it would be hard to check. DON B was informed no documentation was available reflecting the areas were scabs. DON B revealed, R48's scabs came an went, were always in different areas, Certified Nursing Assistants (CNA's) checked skin and reported anything abnormal, and the staff were usually good for reporting it. When informed no documentation of monitoring the areas to R48's left lower leg/calf could be found DON B replied, Right. Later the same day at approximately 10:35 AM, the EMR reflected the following progress notes for R48: Skin eval to Lt knee: Area noted with three individual intact scabs, most distal scab measuring 0.7cm x 0.3cm, middle scab measuring 0.8cm x 0.4cm, proximal open area measuring 1cm x 0.4cm, scant amount of drainage noted on previous dressing. Area cleansed, patted dry and CDD applied. Area to lower gluteal crease near anus noted with fragile skin, intact and blanchable. Licensed Practical Nurse (LPN O) Created Date : 3/4/2020 22:41:16 Res noted with two scabbed area to L posterior calf of LLE; 1)flakey scab approx. 1.1 x 1.0 cm, 2) 3.6x 3.0cm, res denies tenderness to areas, 0 drainage warmth or odor, 0 s/s of infection. RN N Created Date : 3/5/2020 10:45:31 Also, an order dated 03/05/2020 at 03:00 PM reflected: skin monitoring scabbed areas to BLE (Bilateral Lower Extremity) every evening shift.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to monitor alteration in skin integrity for 1 sampled residents (Resident #48), resulting in undocumented opened areas with the potential for worsening and/or infection. Findings Include: Resident #48 (R48) On 03/03/20 at 12:02 PM R48 was observed and interviewed in his room. R48 revealed he

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure signs and symptoms of depression were documented in the clinical record for one of five residents (Resident #67 (R67)) prior to beginning administration of [MEDICATION NAME] (an antidepressant medication), resulting in the potential for unnecessary medications. Findings Included: Review of a facility admission assessment revealed R67 was admitted to the facility on [DATE]. Review of Physician's orders, dated 12/4/2019, revealed R67 was ordered to start receiving [MEDICATION NAME] (an antidepressant) 5mg one time a day for a [DIAGNOSES REDACTED]. Review of R67's list of [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS), dated [DATE], revealed R67 was assessed to have no mood disorder. On 3/03/2020, at 1:21 PM, an attempt was made to interview R67. R67 began to answer questions appropriately, although kept falling asleep, and the interview was not able to be completed. Review of an Admission Psychosocial Assessment, dated 10/12/2019, revealed R67's family member had provided the information for the assessment. The assessment revealed R67 liked to spend his day watching television and taking naps. Under, Section G, Check all behaviors exhibited by resident. Anxious was checked as a behavior R67 exhibited, but Depression was not checked for a behavior R67 exhibited. Review of a Psychopharmacological/Behavioral Management Form/Risk vs. Benefit document, dated 12/4/2019, revealed under, [DIAGNOSES REDACTED]. The document revealed R67 was checked marked to have had [DIAGNOSES REDACTED]. The document revealed R67 did not attend group activities, was tearful at times, made sad statements, had periodic refusal of care, preferred to remain in bed, and had no interaction with grandchildren as he had before. The document revealed R67 was order to start receiving [MEDICATION NAME] for a [DIAGNOSES REDACTED]., remained in bed, and did not interact with family members. No behavioral documentation related to depression or otherwise was found in R67's EMR or paper medical record prior to the date of 12/4/2019 when the [MEDICATION NAME] was ordered. In an interview on 3/06/2020, at 9:25 AM, Social Services Director (SSD) G stated that she documented on R67's Psychopharmacological/Behavioral Management Form/Risk vs. Benefit that he was tearful and sad because that was what was reported to her by the Certified Nurse Aids (CNA's) who had verbally told her that R67 had been crying and tearful. SSD G stated that the CNA's did not document that, and said the only documentation of R67 being sad and/or sad was just what she documented on R67's Psychopharmacological/Behavioral Management Form/Risk vs. Benefit document. In an interview on 3/06/2020, at 10:27 AM, Director of Nursing (DON) B stated that she expected SSD G to complete an evaluation of R67 for depression, and expected a report by staff that R67 was showing signs and symptoms of depression, that included R67 was refusing care, not coming out of his room, and stated the documentation should have been in a progress notes, or documented on the Psychopharmacological/Behavioral Management Form/Risk vs. Benefit document prior to R67's [MEDICATION NAME] being ordered. In another interview on 3/06/2020, at 11:48 AM, DON B stated that she was not able to find any behavioral documentation in R67's EMR or paper medical record prior to starting him on the [MEDICATION NAME]. Review of the facility policy and procedure titled, Behavioral Management and Psychoactive Drug Use Protocol, dated 11/2019, revealed under, Policy Statement: Residents are not given [MEDICAL CONDITION] drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record . Further review of the policy revealed under #11. Use of [MEDICAL CONDITION] medication in specific circumstances: b. Enduring conditions (i.e., non-acute, chronic, prolonged): i. The resident's symptoms and therapeutic goals shall be clearly and specifically identified and documented.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on interview and record review the facility failed to document, monitor and implement departmental infection control practices for the beauty salon department that serviced no less than 48 residents weekly, resulting in the potential for the spread of infection. Findings Include: During review of the facility's infection control program with the infection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235008	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLE LAWN MEDICAL CARE FACILI	**50 SANDERSON LANE COLDWATER, MI 49036**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) control Registered Nurse (RN K) on 03/06/20 at 11:15 AM, it was revealed that all departments were monitored for infection control monthly. When reviewing the departmental infection control monthly sheets all departments were noted monitored except for the beauty shop. RN K reviewed departmental records back to October 2019, and was unable to locate such records. RN K revealed she would continue to look for them. The facility's Hair Stylist (HS P) was interviewed by phone on 03/06/20 at 12:19 PM. HS P revealed she did an average of 12 residents hair daily. When questioned if she was aware that the facility monitored the beauty shop for infection control , HS P denied. Although per RN K monthly infection control meetings were held at the facility with the Medical Director, Administrator, Director of Nursing, and Housekeeping; upon exit of the facility on 03/16/2020 no documentation was provided to validate infection control monitoring practices had been instituted for the beauty shop department. The facility's Infection Control Policy revised 08/2019 reflected: Policy Statement- .The facility Infection Preventionist or designee conducts routine surveillance and monitoring of the workplace to minimize the spread of infection and determine compliance with infection control practices .