STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235182	A. BUILDING _____ B. WING _____	08/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LYNWOOD MANOR HEALTHCARE CENTER	730 KIMOLE LN ADRIAN, MI 49221

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to promote an environment that ensures dignity in 1 of 4 sampled residents (R43), from a total sample of 4 residents reviewed for dignity, resulting in the increased likelihood for R43 to feel embarrassment when facility staff failed to assist with urination needs timely. Findings Include: Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R43 was a [AGE] year old male admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected R43 had a BIM (assessment tool) score of 13 which indicated his ability to make daily decisions was cognitively intact, and he required two person physical assist with bed mobility, transfers and one person physical assist with dressing, eating, toileting, hygiene, and bathing. The MDS reflected R43 had frequent urinary incontinence. During an observation and interview on 8/26/20 at 12:25 p.m. R43 was observed in bed with only a brief on and no covers with meal tray on bedside table over bed. R43 asked Certified Nurse Aid (CNA) I for a urinal. CNA I responded, you usually do not use a urinal but I can get you one. CNA I left room the room and this surveyor remained outside R43 room. During an observation and interview on 8/26/20 at 12:41 p.m. this surveyor continued to observe outside R43's room with no urinal taken into room. This surveyor entered R43's room and R43 asked this surveyor a second time for a urinal and stated, if they do not bring one soon they are going to have to clean me up. This surveyor advised R43 to use the call light and observed functioning. CNA I walked past R43 room at 12:43 p.m. with call light on. CNA G, who had been working on another hall was observed entering R43's room at 12:48 p.m. after doning full personal protective equipment. CNA G exited R43 room at 12:55 p.m. and reported R43 had told CNA G he had asked for a urinal 45 minutes ago and no one brought one and he could not hold it. CNA G reported R43's brief was wet and needed to get assistance. CNA I had removed meal trays from both R43 and roommate within that time as well. Review of the facility urinary continence documentation, dated 8/23/20 through 8/27/20, reflected R43 was incontinent 8/23/20 through 8/26/20 and continent of urine on 8/27/20. During an interview on 8/28/20 at 1:07 p.m. Director of Nursing (DON) B reported they would expect staff to get a urinal immediately if a resident requested one. DON B reported R43 was confused at times, however even if resident had not used a urinal in past and asked staff for one, they would expect staff to provide one immediately to prevent incontinence.
F 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure resident rights were being honored for 2 of 3 sampled residents (R3 and R215), reviewed for resident rights, resulting in the facility staff refusing to allow alert and oriented residents access to outside courtyard. Findings include: Resident #3(R3) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R3 was a [AGE] year old male admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. and bathing and two person physical assist with transfers. The annual MDS, dated [DATE], reflected going outside for fresh air and taking care of personal belongings was very important to R3. During an observation and interview on 8/26/20 at 10:03 a.m. R3 was noted on observation(isolation) unit in room laying in bed. R3 had several personal items in bags around room and reported recently had to change rooms and staff have not assisted to him to take care of personal belongings after several requests. R3 stated, I feel like a prisoner here, trapped, they took my rights away. R3 reported since Covid restrictions staff do not allow residents out of rooms at all even to go outside and social distance. R3 reported greater than one hour call light wait in wheelchair after return from [MEDICAL TREATMENT] and stated, they do not understand how beat I am and say we have to pass trays. R3 became emotional with tears in eyes. During an observation on 8/26/20 at 11:15 a.m. closed signs were posted on doors to sun room as well as both enclosed outdoor patios. Review of the Care Plans, dated 7/2/19, reflected interventions that included, I enjoy being outdoors when the weather is nice. During an interview on 8/27/20 at 10:50 a.m. Director of Nursing (DON) B reported no smoking at this time and working on changes for current policy and plan to implement as soon as possible. DON B reported no reason why residents can not use outdoor patio. This surveyor asked if staff and residents were aware residents could use outdoor patios and DON B stated, No. Resident #215 (215) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R215 was a [AGE] year old male admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. dressing, hygiene and bathing. The MDS reflected going outside for fresh air was very important to R215. During an observation and interview on 8/25/20 at 2:45 p.m. R215 was noted on observation unit(isolation) in room in bed and appeared alert, oriented and pleasant. R215 appeared to have bilateral [MEDICAL CONDITION] with an electric power wheelchair noted in the room. R215 reported was upset that he was required to be isolated to room at all times including very upset not able to go outside to enclosed patio to smoke as he had done on prior admissions. R215 reported staff would not allow any residents to leave rooms. R215 stated, I has rights and they can not make me stay in my room. Review of the Care Plans, dated 8/18/20 through 8/28/20, reflected no mention of R215 going outside as indicated was important to R215 on the MDS assessment.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 (Resident #21 and Resident #64) of two 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: Review of the MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT, Act 193 of 1996 (revised 2014), revealed that, An order executed under this section shall be on a form described in section 4. The order shall be dated and executed voluntarily and signed by each of the following persons: (a) The declarant, the declarant's patient advocate, or another person who, at the time of the signing, is in the presence of the declarant and acting pursuant to the directions of the declarant. (b) The declarant's attending physician. (c) Two witnesses [AGE] years of age or older, at least 1 of whom is not the declarant's spouse,

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235182	A. BUILDING _____ B. WING _____	08/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LYNWOOD MANOR HEALTHCARE CENTER	730 KIMOLE LN ADRIAN, MI 49221

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 -** Some	(continued... from page 1) parent, child, grandchild, sibling, or presumptive heir. (3) The names of all signatories shall be printed or typed below the corresponding signatures. A witness shall not sign an order unless the declarant or the declarant's patient advocate appears to the witness to be of sound mind and under no duress, fraud, or undue influence. Further review of this Act revealed, Sec. 4. A do-not-resuscitate order executed under section 3 or 3a shall include, but is not limited to, the following language, and shall be in substantially the following form: DO-NOT-RESUSCITATE ORDER This do-not-resuscitate order is issued by _____, attending physician for _____. (Type or print declarant's or ward's name) Use the appropriate consent section below: A. DECLARANT CONSENT I have discussed my health status with my physician named above. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. This order will remain in effect until it is revoked as provided by law. Being of sound mind, I voluntarily execute this order, and I understand its full import. _____ _____ (Declarant's signature) (Date) _____ _____ (Signature of person who signed for (Date) declarant, if applicable) _____ (Type or print full name) B. PATIENT ADVOCATE CONSENT I authorize that in the event the declarant's heart and breathing should stop, no person shall attempt to resuscitate the declarant. I understand the full import of this order and assume responsibility for its execution. This order will remain in effect until it is revoked as provided by law. _____ _____ (Patient advocate's signature) (Date) _____ (Type or print patient advocate's name) C. GUARDIAN CONSENT I authorize that in the event the ward's heart and breathing should stop, no person shall attempt to resuscitate the ward. I understand the full import of this order and assume responsibility for its execution. This order will remain in effect until it is revoked as provided by law. _____ _____ (Guardian's signature) (Date) _____ (Type or print guardian's name) _____ _____ (Physician's signature) (Date) _____ (Type or print physician's full name) ATTESTATION OF WITNESSES The individual who has executed this order appears to be of sound mind, and under no duress, fraud, or undue influence. Upon executing this order, the declarant has (has not) received an identification bracelet. _____ _____ (Witness signature) (Date) (Witness signature) (Date) _____ _____ (Type or print witness's name) (Type or print witness's name) THIS FORM WAS PREPARED PURSUANT TO, AND IS IN COMPLIANCE WITH, THE MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT. (http://www.legislature.mi.gov/(S([MEDICAL CONDITION]))/documents/mcl/pdf/mcl-Act-193-of-1996.pdf) Resident #21 (R21) Review of the Resident Profile revealed R21 admitted to the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] revealed R21 scored 3 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). Review of the Elder Code Status signed on 4/2/18, revealed R21 was a No Code (DNR). The form's language was not pursuant the Michigan Do Not Resuscitate Procedure Act, nor did the form have two witness signatures. Resident #64 (R64) Review of the Resident Profile revealed R64 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] revealed R64 scored 15 out of 15 (cognitively intact) on the Brief Interview Status (BIMS). The medical record revealed R64 was his own responsible party. Review of the Elder Code Status signed on 3/5/18, revealed R64 was a No Code (DNR). The form's language was not pursuant the Michigan Do Not Resuscitate Procedure Act, nor did the form have two witness signatures. In an interview on 08/26/20 at 03:06 PM, Social Worker (SW) C with Director of Nursing (DON) B present, reported advance directives and code status were obtained upon admission. SW C reported code status was reviewed quarterly and with changes. SW C reported before he arrived at the facility two years ago, the facility was cited for not having the correct DNR form and the form was updated. DON B obtained R21 and R64's Elder Code Status from the electronic medical record and DON B and SW C reported they were both old forms. In an interview, on 08/27/20 at 11:55 AM, Social Worker C reported After the Surveyor mentioned it, I did an audit last night and it showed 14 (residents' Advance Directive orders were) missing second signatures. I took it to QAPI (Quality Assurance/Performance Improvement meeting) last night and the plan is it will be completed by 9/09/20.

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 and implement a complete plan of care to prevent pressure ulcers for one of one reviewed for pressure ulcers (Resident #36), resulting in/or contributing to facility acquired pressure ulcers. Findings include: According to the Minimum Data Set (MDS), dated [DATE], Resident #36 (R36) was admitted to the facility on [DATE], was severely cognitively impaired, needed assistance of two or more staff for bed mobility, did not walk, was totally dependent on staff for locomotion in a wheelchair, had one stage 1, one stage 2, and one unstageable pressure ulcer, and had [DIAGNOSES REDACTED]. R36's Admission MDS, dated [DATE] revealed she received [MEDICAL TREATMENT] treatments. According to R36's [DIAGNOSES REDACTED]. Pressure ulcer of right heel, Stage 2, date 7/15/2020 - [DIAGNOSES REDACTED]. On 08/25/20 at 2:51 PM, R36 was observed lying in bed on her left side and did not respond when spoken to even though her eyes were open. R36 had a blue pressure relieving (Prevalon) boot on her right lower extremity but none on her left lower extremity. On 8/27/20 (Thursday) at 10:17 AM, R36 was not in her room, but a pair of Prevalon boots were lying on her bed. In an interview, on 08/27/20 at 11:09 AM, CNA G said, (R36) is at [MEDICAL TREATMENT] today . She gets sores easily. Her boots should be on her. They got her up early this morning, the shift before me . (R36) doesn't talk. Very sweet lady. In an interview, on 08/27/20 at 12:07 PM, Wound Nurse LPN (Licensed Practical Nurse) D stated she was not sure why R36's pressure relieving boots were on her bed and not on R36's feet and said, (R36) leaves so early for [MEDICAL TREATMENT]. Review of R36's Physician order [REDACTED]. - Reposition and offload buttocks from side to side while in bed every 2 hours. Active 4/12/2020 23:00 (11:00 PM). - Float heels on pillow to prevent breakdown every morning and at bedtime for preventative measures. Active 7/15/2020 21:00 (9:00 PM). - Resident to wear Prevalon boots AAT (at all times) excluding ADL's (activities of daily living) and shower. Active 8/18/2020 21:00 (9:00 PM). In an interview, on 08/28/20 at 10:19 AM, Wound Nurse D said she would look for any physician progress notes [REDACTED]. Wound Nurse D said she asked the night shift nurse that morning and was told, They never put the boots on (R36) when she goes to [MEDICAL TREATMENT] . I will have to follow up on why they don't. Wound Nurse D had spread sheets for the pressure ulcers that she said she did not load into R36's medical record, stating they were her records. Wound Nurse D said the Pressure Ulcer Tracking Records were not supposed to be scanned into the medical record, but she didn't know why. The Pressure Ulcer Tracking records for R36 revealed: Three pressure ulcers present upon admission that were healed: 4/08/20 - left inner ankle Stage II 1 x 1 (no depth documented) resolved on 6/02/20. 4/08/20 - midline inner buttocks unstageable 4.5 x 2.0 (no depth documented) resolved (date unknown). 4/08/20 - right outer ankle unstageable 1 x 1.5 (no depth documented) wound bed intact. Resolved 5/26/20. One pressure ulcer present upon admission that was still present: 4/08/20 - left inner buttock unstageable 1 x 0.5 (no depth documented) wound bed eschar. On 8/25/20 - left buttock: Stage II (see below) 4.0 x 1.0 (no depth documented), wound bed moist. Because lost muscle and other structures aren't restored during healing, a Stage IV pressure ulcer can't become a Stage III, II, or I ulcer; it remains a Stage IV ulcer throughout healing. After healing is complete, it should be classified as a healed Stage IV ulcer, not a Stage 0 ulcer. <journals.lww.com/nursing/fulltext/2004/ /why_you_should_avoid_reverse_pressure ulcer_staging .> Four facility acquired pressure ulcers: 7/15/20 - right inner heel, Stage II pressure ulcer 3.0 x 4.0 (no depth documented), wound bed pink/moist. 7/15/20 - bottom right foot unstageable 2.5 x 1.5 (no depth documented), wound bed scab. 8/11/20 - right foot ball joint deep tissue injury 2 x 1.9 (no depth documented), wound bed intact. 8/25/20 - left out foot unstageable, 1.0 x 1.5 (no depth documented), wound bed intact. In a telephone interview, on 08/28/20 at 11:01 AM, the [MEDICAL TREATMENT] center's RN (Registered Nurse) E stated, We have a bed that we put (R36) in, on her side, and we switch sides midway, but we don't do anything else. She is here for a total 4 hours. I know she has wounds on her bottom. I think there are some on her feet. I don't get a report on them but I wish I would. I can't recall any boots. There has been nothing said about boots - not at all. There is no reason she can't wear them here. If she needs them, I prefer she has them on. No, I did not speak with Wound Care (D) nurse there. I would personally prefer to know where (R36) has wounds and how to position her and prevent any new wounds. In an interview, on 08/28/20 at 11:08 AM, Nurse Aide (CNA) F stated she worked full- time and said, I always work with (R36) every time I work. She . a regular cushion in her wheelchair . she is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235182	A. BUILDING _____ B. WING _____	08/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LYNWOOD MANOR HEALTHCARE CENTER	730 KIMOLE LN ADRIAN, MI 49221

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) up (in her wheelchair) when she goes to [MEDICAL TREATMENT]. She is supposed to have the boots on all the time. There was a standard wheelchair cushion in R36's wheelchair and CNA F reported that was the only cushion R36 had for her wheelchair and it was just a regular cushion. In an interview, on 08/28/20 at 11:41 AM, DON (Director of Nursing) B said, I just heard (R36) . didn't have a Roho cushion (see below). (R36) should have a Roho cushion (see below) in her wheelchair so (now) I just ordered one. DON B agreed that the facility should have worked with [MEDICAL TREATMENT] on coordinating a plan of care and that R36 that included R36 wearing her Prevalon boots on while attending [MEDICAL TREATMENT]. Roho cushions are adjustable air seat cushion which usually prevents a person from pressure injuries, sores or skin rashes and ensures long-term comfort and safety. <www.wheelchair-experts.in/types-of-roho-cushions/ Review of R36's Care Plans revealed, turn/reposition at least every 2 hours - side to side, avoiding pressure to buttock/coccyx - Date Initiated: 04/08/2020 (on admission) . PR (pressure relieving) cushion to WC (wheelchair) - Date Initiated: 4/17/20 . to wear Prevalon Boots AAT excluding showers. - Date Initiated: 8/18/20. There was no intervention to coordinate care with the [MEDICAL TREATMENT] center to assure R36 was receiving correct pressure relieving care for the prevention of and treatment of [REDACTED].
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** Based on observation, interview and record review, the facility failed to prevent pressure ulcers for one of one reviewed for pressure ulcers (Resident #36), resulting in facility acquired pressure ulcers. Findings include: According to the Minimum Data Set (MDS), dated [DATE], Resident #36 (R36) was admitted to the facility on [DATE], was severely cognitively impaired, needed assistance of two or more staff for bed mobility, did not walk, was totally dependent on staff for locomotion in a wheelchair, had one stage 1, one stage 2, and one unstageable pressure ulcer, and had [DIAGNOSES REDACTED]. R36's Admission MDS, dated [DATE] revealed she received [MEDICAL TREATMENT] treatments. According to R36's [DIAGNOSES REDACTED]. Pressure ulcer of right heel, Stage 2, date 7/15/2020 - [DIAGNOSES REDACTED]. According to R36's vital signs records, on 8/7/2020 at 11:35, R36 weighed 131.1 pounds and (4/14/2020 at 2:54 PM) was 62.0 inches tall. On 08/25/20 at 2:51 PM, R36 was observed lying in bed on her left side and did not respond when spoken to even though her eyes were open. R36 had a blue pressure relieving (Prevalon) boot on her right lower extremity but none on her left lower extremity. On 8/27/20 (Thursday) at 10:17 AM, R36 was not in her room, but a pair of Prevalon boots were lying on her bed. In an interview, on 08/27/20 at 11:09 AM, CNA G said, (R36) is at [MEDICAL TREATMENT] today . She gets sores easily. Her boots should be on her. They got her up early this morning, the shift before me . (R36) doesn't talk. Very sweet lady. In an interview, on 08/27/20 at 12:07 PM, Wound Nurse LPN (Licensed Practical Nurse) D stated she was not sure why R36's pressure relieving boots were on her bed and not on R36's feet and said, (R36) leaves so early for [MEDICAL TREATMENT]. Review of R36's Care Plans revealed they included, turn/reposition at least every 2 hours - side to side, avoiding pressure to buttock/coccyx - Date Initiated: 04/08/2020 (on admission). Review of R36's Physician order [REDACTED]. - Reposition and offload buttocks from side to side while in bed every 2 hours. Active 4/12/2020 23:00 (11:00 PM). - Float heels on pillow to prevent breakdown every morning and at bedtime for preventative measures. Active 7/15/2020 21:00 (9:00 PM). - Renal diet . Needs to be sitting up in wheelchair for all meals. Active 7/15/2020 00:00 (midnight). - Resident to wear Prevalon boots AAT (at-all-times) excluding ADL's (activities of daily living) and shower. Active 8/18/2020 21:00 (9:00 PM). In an interview, on 08/28/20 at 10:19 AM, Wound Nurse D said, A physician saw (R36) on 4/10/20 (two days after her admission) and wrote she had chronic wounds. However, there was no documentation to clarify what chronic wounds meant. Wound Nurse D said she would look for any physician progress notes [REDACTED]. Wound Nurse D stated, (R36's) left buttocks and coccyx has gotten better and worse and continues to go back and forth. Wound Nurse D stated she thought R36 acquired the facility acquired pressure ulcers because she was on [MEDICAL TREATMENT], had diabetes, and the wounds present on admission makes her more susceptible for them reoccurring. Wound Nurse D said she asked the night shift nurse that morning and was told, They never put the boots on (R36) when she goes to [MEDICAL TREATMENT] . I will have to follow up on why they don't. Wound Nurse D had spread sheets for the pressure ulcers that she said she did not load into R36's medical record, stating they were her records. Wound Nurse D said the Pressure Ulcer Tracking Records were not supposed to be scanned into the medical record, but she didn't know why. The Pressure Ulcer Tracking records for R36 revealed: Three pressure ulcers present upon admission that were healed: 4/08/20 - left inner ankle Stage II 1 x 1 (no depth documented) resolved on 6/02/20. 4/08/20 - midline inner buttocks unstageable 4.5 x 2.0 (no depth documented) resolved (date unknown). 4/08/20 - right outer ankle unstageable 1 x 1.5 (no depth documented) wound bed intact. Resolved 5/26/20. One pressure ulcer present upon admission that was still present: 4/08/20 - left inner buttock unstageable 1 x 0.5 (no depth documented) wound bed eschar. On 8/25/20 - left buttock: Stage II (see below) 4.0 x 1.0 (no depth documented), wound bed moist. Because lost muscle and other structures aren't restored during healing, a Stage IV pressure ulcer can't become a Stage III, II, or I ulcer; it remains a Stage IV ulcer throughout healing. After healing is complete, it should be classified as a healed Stage IV ulcer, not a Stage 0 ulcer. <journals.lww.com/nursing/fulltext/2004/ /why_you_should_avoid_reverse_pressure ulcer_staging .> Four facility acquired pressure ulcers: 7/15/20 - right inner heel, Stage II pressure ulcer 3.0 x 4.0 (no depth documented), wound bed pink/moist. 7/15/20 - bottom right foot unstageable 2.5 x 1.5 (no depth documented), wound bed scab. 8/11/20 - right foot ball joint deep tissue injury 2 x 1.9 (no depth documented), wound bed intact. 8/25/20 - left out foot unstageable, 1.0 x 1.5 (no depth documented), wound bed intact. In a telephone interview, on 08/28/20 at 11:01 AM, the [MEDICAL TREATMENT] center's RN (Registered Nurse) E stated, We have a bed that we put (R36) in, on her side, and we switch sides midway, but we don't do anything else. She is her for a total 4 hours. I know she has wounds on her bottom. I think there are some on her feet. I don't get a report on them but I wish I would. I can't recall any boots. There has been nothing said about boots - not at all. There is no reason she can't wear them here. If she needs them, I prefer she has them on. No, I did not speak with Wound Care (D) nurse there. I would personally prefer to know where (R36) has wounds and how to position her and prevent any new wounds. In an interview, on 08/28/20 at 11:08 AM, Nurse Aide (CNA) F stated she worked full- time and said, I always work with (R36) every time I work. She has an air mattress and a regular cushion in her wheelchair . she is up (in her wheelchair) when she goes to [MEDICAL TREATMENT]. She is supposed to have the boots on all the time. This Surveyor went to R36's room with CNA F and it was observed R36 was lying in bed with an air mattress but the air mattress flow switch was in the off position. CNA turned it on and said, It's supposed to be on. There was a standard wheelchair cushion in R36's wheelchair and CNA F reported that was the only cushion R36 had for her wheelchair and it was just a regular cushion. In an interview, on 08/28/20 at 11:41 AM, DON (Director of Nursing) B said, I just heard (R36's) air mattress was not on - it should be on. And, she didn't have a Roho cushion. (Name of R36), should have a Roho cushion in her wheelchair so I just ordered one. DON B agreed that the facility should have worked with [MEDICAL TREATMENT] on coordinating a plan of care and that R36 that included R36 wearing her Prevalon boots on while attending [MEDICAL TREATMENT]. DON B said, I don't know if the doctor has seen her pressure ulcers. (Wound Nurse D) does the dressing changes. I'm not sure what the doctor's involvement has been with (R36's) pressure ulcers. DON B said she would look to see if there are any physician progress notes [REDACTED]. Roho cushions are adjustable air seat cushion which usually prevents a person from pressure injuries, sores or skin rashes and ensures long-term comfort and safety. <www.wheelchair-experts.in/types-of-roho-cushions/
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** Based on observation, interview, and record review, the facility failed to ensure adequate staff to meet the resident needs in 3 of 17 sampled residents (Resident #3, Resident #20 and Resident #215) and 2 residents from the confidential group interview reviewed for staffing, resulting in resident care and needs not being consistently met and the potential for all residents to be affected. Findings include: During an observation and record review on 8/25/20 at 1:00 p.m. staffing was posted, dated 8/25/20, located in the lobby on entrance with census of 65. It reflected: 6 Certified Nurse Aids(CNA) on day shift, 7 CNA on night shift, and no Registered Nurse(RN) staff today on duty. Resident #3(R3) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R3 was a [AGE] year old male admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. and bathing and two person physical assist with transfers. The annual MDS, dated [DATE], reflected going outside for fresh air and taking care of personal belongings was very important to R3. During an observation and interview on 8/26/20 at 10:03 a.m. R3's room was located on the observation(isolation) unit in room laying in bed. R3 reported long call light response times between one and three hours depending on staffing. R3 reported often he needed to request sheets get changed after showers that are now two times weekly but for months only received one shower weekly. R3 reported greater than one hour long wait in wheelchair after return from [MEDICAL TREATMENT] and stated, they do not understand how beat I am and say we have to pass trays. R3 became emotional and began to cry while talking. Resident #215 (215) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R215 was a [AGE] year old male admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. dressing, hygiene and bathing. The MDS reflected going outside for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235182	A. BUILDING _____ B. WING _____	08/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LYNWOOD MANOR HEALTHCARE CENTER	730 KIMOLE LN ADRIAN, MI 49221

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) fresh air was very important to R215. During an observation and interview on 8/25/20 at 2:45 p.m. R215 was noted on observation unit(isolation) in room in bed and appeared alert, oriented and pleasant. R215 appeared to have bilateral [MEDICAL CONDITION] with an electric power wheelchair noted in the room. R215 reported long call light response times on second and third shift up to one hour. R215 reported needed two person assist and reported some small staff are not able to assist him because he is large man. During an interview on 8/28/20 at 11:13 a.m. Staffing Coordinator(SC) J reported working at the facility for 6 months. SC J reported not aware of any requirement when scheduling nurses. SC J reported schedules 3 nurses from 7am-7pm, 3 nurses from 7pm-11pm, and 2 nurse from 11pm-7am. SC J reported CNA staff are scheduled 7 CNA staff from 7am-7pm, 6 CNA staff from 7pm-11pm, and 5 CNA staff from 11pm-7am. SC J reported today census was 66 so divide by 3(3%)=hours and 5 aids until 3pm, but should have 6 but had call in so she worked until 11am. During an interview on 8/28/20 at 1:07 p.m. DON B reported ratio of 8:1 resident to CNA on first shift, 12:1 resident to CNA on second shift, and 15:1 resident to CNA on third shift. DON B reported if acuity increases staff keep DON B informed. DON B agreed facility does not have enough RN staff to meet 8 hour every 24 hour. During a confidential, individual resident council interview on 08/28/20 at 09:55 AM, when asked about call lights, one resident stated Oh that's a big issue. That's a big issue. The confidential resident reported that some nightshifts worked with two aides and one nurse for the whole hall. The confidential resident stated That's what we go through a lot. Sometimes we have to wait a half an hour to an hour before they can wait on us .It irritates me. The confidential resident reported call light response time was often 30 to 60 minutes. On 08/28/20 at 10:17 AM, a second confidential resident reported he often waited over an hour for his call light to be answered. Resident #20 (R20) Review of the Resident Profile revealed R20 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE] revealed R20 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS) and required extensive assistance of two staff members for activities of daily living (ADLs). In an interview on 8/26/20 at 10:15 AM, R20 reported the facility was understaffed. R20 reported he was unable to get up and use the bathroom without assistance and therefore uses the bed pan. R20 stated When you hit the button, I will sit for one hour and 10 minutes before someone comes in the room. When I press that button, I look at the clock on the wall. When the state was in here a couple weeks ago, there were so many people in here, they were tripping over themselves. That doesn't happen when the state isn't here. They bring all these people in when you guys show up, but as soon as you left, it went back to normal. R20 reported there have been many times were call light response times were 30 to 45 minutes. R20 stated One time someone answered my call light. She said she had to go get someone. I asked if she could just hand me my urinal from the bathroom. She said she had to go get someone else.
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on observation, interview, and record review, the facility failed to provide Registered Nurse services for at least eight consecutive hours a day, seven days a week, resulting in increased likelihood of resident care and needs not being consistently met and the potential for all 65 current residents to be affected. Findings include: During an observation and record review on 8/25/20 at 1:00 p.m. staffing was posted, dated 8/25/20, in the lobby on entrance with census of 65, 6 CNA days, 7 nights, and no Registered Nurse(RN) staff today on duty. Review of staffing posted on 8/27/20 reflected no RN staff working. During an interview on 8/28/20 at 11:13 a.m. Staffing Coordinator(SC) J reported working at the facility for 6 months. SC J reported not aware of any requirements when scheduling nurses. SC J reported schedules 3 nurses from 7am-7pm, 3 nurses from 7pm-11pm, and 2 nurse from 11pm-7am. SC J reported CNA staff are scheduled 7 CNA staff from 7am-7pm, 6 CNA staff from 7pm-11pm, and 5 CNA staff from 11pm-7am. SC J reported today census was 66 so divide by 3(3%)=hours and 5 aids till 3pm, but should have 6 but had call in so she worked until 11am. During an interview on 8/28/20 at 11:47 a.m. Human Recourses Director (HR) K reported assisting with nursing staff schedules within past six months and reported there may be times on weekends when we do not have Registered Nurses for at least 8 hour every 24 hours. Review of the facility posted staffing sheets, dated 8/10/20 through 8/28/20, reflected three of the thirteen days had an RN on duty for at least 8 hours. Review of the Nursing Staffing Report completed by HR K, dated 8/10/20 through 8/16/20, reflected no RN staff in house for at least 60 hours between 8/14/20 night shift through 8/17/20 day shift. During an interview on 8/28/20 at 1:07 p.m. DON B reported ratio of 8:1 resident to CNA on first shift, 12:1 resident to CNA on second shift, and 15:1 resident to CNA on third shift. DON B reported if acuity increases staff keep DON B informed. DON B agreed facility does not have enough RN staff to meet 8 hour every 24 hour requirement.
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain a functioning call light system affecting five of five residents (Resident #'s 22, 37, 39, 40, and 42), resulting in the potential for resident needs to be unmet. Findings Included: Resident #37 (R37): Per R37's list of diagnoses, R37 had difficulty in walking, lack of coordination, and muscle weakness. Review of a Minimum Data Set (MDS), dated [DATE], revealed R37 was wheelchair bound and did not walk. In an observation and interview on 8/25/2020, at 2:15 PM it was observed that there was no call light system in the wall. R37 stated that about three weeks ago the call light box that went into the wall was taken out. R37 said his roommate (R22) also used the call light. R37 stated that he had to use his phone in his room to call the nursing station for assistance. Resident 22 (R22): Review of R22's [DIAGNOSES REDACTED]. The care plan also revealed R22 was to be encouraged to use bell to call for assistance. Resident #40 (R40): Record review of a care plan for ADLs, dated 1/27/2014, and revised on 7/29/202, revealed R40 required extensive assistance for grooming, transferring, toileting, dressing, and bathing. In an observation and interview on 8/26/2020, at 9:00 AM, it was observed that the call light system in the wall for R40 to use did not function. R40 was observed to be in Bed-C the third bed in the room. R40 stated that her roommate (R42 who was in Bed-B) called staff for her. It was also observed that the call light cord for R40 was not within her reach. Resident # 40 stated that she had no way to get staff in her room, and had to depend on R42 to use the only functioning call light in the room, that was attached to Bed-A, to get her staff assistance when needed. The call light for Bed-A was observed attached to the wall box system, but the call light box was hanging down out of the wall. Resident #42 (R42): Record review of a care plan for ADLs, dated 7/23/2020, revealed R40 required extensive assistance by two staff members for toileting, transfers, grooming, dressing, and bathing. In an interview on 8/26/20, at 9:02 AM, R42 stated she did not have a call light, because her call light was broken. R42 stated she had to use the call light for Bed-A. Resident #39 (R39): Review of R39's [DIAGNOSES REDACTED]. Review of R39's care plans for ADLs, dated 5/13/2017, and revised on 7/28/2020, revealed R39 required extensive assistance for all of her ADL's. In an observation on 8/25/2020, at 2:00 PM, it was observed that there was no call light box in the wall, and no call light accessible to R39. In an interview on 8/26/2020, at 10:25 AM, R39 stated that she did not have a call light, because it did not work, R39 also stated that she did not have a bell to use. It was observed that a bell (like a cow bell) was on top of a tall dresser next to R39's bed, which was out of R39's reach. In an interview on 8/27/2020, at 10:29 AM, Certified Nurse Aid (CNA) H stated that some of the resident's call lights did not work, and it was because the resident's beds would hit the call light box in the wall and break them. CNA H said it was different for all the resident rooms on how long the call lights had been broken. In an interview on 8/27/2020, at 11:17 AM, Administrator A stated that his maintenance staff member had recently left his position at the facility and said he had not been able to fix the call lights yet. Administrator A said the resident's beds were hitting and breaking the call lights. Administrator A said the call lights would get fixed but then break again from the resident's beds. In an interview on 8/27/2020, at 2:39 PM, Licensed Practical Nurse (LPN) D, who was a Unit Manager, stated that on the 200 hall a lot of the call lights had been tugged too hard, and said staff would put them back into the wall, but they come back out. LPN D said there were a lot of work orders in for about a week or two to get them fixed, and said it was taking a lot of time to get them fixed. In an observation on 8/27/2020, at 2:44 PM, with LPN D of R22 and R37's call light system revealed the call light was not working, and the call light box for Bed-A was not in the wall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235182	A. BUILDING _____ B. WING _____	**08/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LYNWOOD MANOR HEALTHCARE CENTER	**730 KIMOLE LN ADRIAN, MI 49221**

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 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) Observation of R39's call light revealed there was no call light unit in the wall. Resident # 39's bell (cow bell) was not within her reach and observed to be on the bedside table. LPN D stated that R39 would not be able to reach her bell. Record review of several, Building Services Work Order Request, revealed that on 3/30/2020 R40's call light box was on the floor, on 4/17/2020 the call light needed to be fixed, on 4/20/2020 the call light was out of the wall, and on 7/21/2020 the call light was out of the wall. The section on the work order request that indicated the work had been completed was blank. Review of a, Building Services Work Order Request, revealed that on 6/18/2020 R39's call light was out of the wall. The section on the work order request that indicated the work had been completed was blank. Review of a, Building Services Work Order Request, revealed that on 7/2/2020 R37 and 22's call light was out of the wall. The section on the work order request that indicated the work had been completed was blank. In an interview on, 8/28/2020, at 9:48 AM, Administrator A stated that he did not have documentation that the call lights had been fixed.