STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235544	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALLMARK LIVING BENTON HARBOR	1385 E EMPIRE AVE BENTON HARBOR, MI 49022

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number MI 559. Based on observation, interview, and record review the facility failed to implement the abuse policy by identifying, reporting and thoroughly investigating an injury of unknown origin for 1 of 3 residents (Resident #101), reviewed for abuse, resulting in delayed identification, reporting and investigation of an injury of unknown origin and the potential for further harm. Findings include: Review of the facility's Abuse Prevention and Reporting policy and procedure, revision date of 1/22/19, revealed .The resident has the right to be free from abuse .Training of Employees . During orientation of new employees, the facility will cover at least the following topics: .Staff obligations to prevent and report abuse .an employee's obligation under the law for reporting a suspected crime to the facility, the state survey agency and local law enforcement; the time frames for reporting .Employees are required to report any incident, allegation or suspicion of potential abuse .to administrator, or to an intermediate of the administrator .For resident injuries not involving an allegation of abuse .the administrator will appoint a person to gather further fact to make a determination as to whether the injury should be classified as an injury of unknown source .An injury should be classified as an injury of unknown source when both of the following conditions are met: . The injury was not observed by any person or the source of the injury could not be explained by the resident; and .The injury is suspicious because of the extent or injury or the location of the injury .All alleged violations involving abuse .including injuries of unknown source .are reported immediately, but not later than 2 hours after the allegation is made .or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury .to the administrator .and .the State Survey Agency . During an observation on 3/3/20 at 10:45 AM, Resident #101 was lying in her bed waiting for Certified Nursing Assistant J (CNA) to perform a bed bath. CNA J removed Resident #101's gown and revealed a silver dollar sized, scabbed wound, on the top of Resident #101's left shoulder. CNA J indicated the wound was unusual and does not know if it was new. CNA J indicated would ask Resident #101's nurse, Licensed Practical Nurse H (LPN), if the left shoulder wound had been noted. Review of the facility Admissions Record revealed Resident #101 was an [AGE] year-old female originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment, completed on 1/23/20, revealed Resident #101 required extensive assistance of 1-2 staff for transfers, dressing, hygiene and ambulation; and setup assistance for eating. Brief Interview for Mental Status (BIMS), on 1/23/20, revealed Resident #101 was severely cognitively impaired. Review of Resident #101's wound and skin assessments from 1/21/20 to 3/3/20 revealed a coccyx wound and no wounds noted to left shoulder. In an interview on 3/3/20 at 3:00 PM, LPN H indicated CNA J had not mentioned a wound on Resident #101's left shoulder and knows nothing about the wound. LPN H indicated the Director of Nursing B (DON) was in Resident #101's room now with the wound doctor, doing her weekly wound (on coccyx) and skin assessment. In an interview on 3/3/20 at 3:08 PM, DON B indicated had just left Resident #101's room with the wound doctor and observed a new wound on her left shoulder. DON B indicated Resident #101 did not know how the left shoulder wound occurred. DON B indicated the wound doctor assessed the wound and DON B would complete an risk management assessment. Review of Resident #101's Skin - Other Skin Condition Report V, dated 3/3/20 at 5:05 PM, revealed . Left shoulder (front) .Partial Thickness Abrasion, 2.5cm x 2cm , e-signed by DON B. In an interview on 3/4/20 at 11:45 AM, DON B indicated a if resident injury was found and it was unclear how it occurred, should complete a risk management assessment. DON B indicated Resident #101 could not tell me how the left shoulder wound occurred. DON B indicated asked if her nurse, LPN H, if knew anything about the wound and that LPN H indicated that Resident #101 would occasionally picked at herself and caused herself to bleed. DON B indicated Resident #101's wound was in an unusual location (head of shoulder) and was a large scab that did not look like it was caused by picking. DON B indicated reported Resident #101's left shoulder wound to Nursing Home Administrator in Training C (NHAT) and was told it did not need to be reported. In an interview on 3/4/20 at 12:00 PM, NHAT C indicated DON B reported Resident #101's left shoulder wound yesterday (3/3/20). NHAT C indicated was told Resident #101 had a scab on her left shoulder and the nursing staff thought it was cause by scratching or picking at her skin. NHAT C indicated she did not look at the wound on 3/3/20 or question any other staff members regarding the origin of the wound. In an interview on 3/4/20 at 2:20 PM, NHAT C indicated went to look at the wound on Resident #101's left shoulder. NHAT C indicated the wound was much bigger than reported. NHAT C indicated did not think it could be cause by scratching or picking. NHAT C indicated Resident #101 does not know how the wound occurred and suggested it could have happened after a fall. NHAT C indicated did find a recently reported fall. NHAT C indicated was going to report Resident #101's wound as an injury of unknown origin to State Agency (more than 24 hours after discovery by CNA J).
F 0656 **Level of harm -** 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** This citation pertains to intake number MI 559. Based interview and record review, the facility failed to ensure resident centered comprehensive care plans were developed, for 1 of 3 residents (Resident #100), reviewed for care plans, resulting in the worsening of pressure wounds and dehydration. Findings include: Review of the facility's Admission of Resident, policy and procedure (not dated), revealed Purpose: To facilitate smooth transition into a health care environment. To gather comprehensive information as a basis for planning individualized therapeutic care . In an interview on 3/5/20 at 9:30 AM, MDS nurse F indicated was unaware that Resident #100 admitted from the hospital on [DATE] with bilateral heel pressure injuries. MDS nurse F indicated should have been care planned and interventions and orders should have been developed. MDS nurse F indicated Resident #100 did not readmit with a [DIAGNOSES REDACTED]. MDS nurse F indicated Resident #100 did not have a baseline respiratory care plan and did not develop a respiratory care plan after his readmission on 2/18/20. MDS nurse F indicated Resident #100 should have had a baseline respiratory care plan developed at the time of his initial admission because he had a [DIAGNOSES REDACTED]. Addition interventions or revisions should have been added after his stay in the hospital for pneumonia. MDS nurse F indicated did not develop a hydration care plan either despite dehydrated in the hospital. In an interview on 3/4/20 at 12:08 PM, Director of Nursing B (DON) indicated after reviewing Resident #100's, 2/18/20 hospital wound consult, indicated did not know Resident #100 had been readmitted to the facility with bilateral heel pressure injuries. DON B indicated we should have called his physician to obtain treatment orders and started a care plan focus with interventions. DON B' indicated the unit manager or the DON should also be auditing the admission information. DON B indicated the facility currently has no unit managers, so the audits fall to the DON, and audits have not been done consistently. Review of the facility Admissions Record revealed Resident #100 was a [AGE] year-old male originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment, completed on 12/18/19, revealed Resident #100 required assistance of 1-2 staff for transfers, dressing, hygiene; and setup assistance for eating and ambulation. Brief Interview for Mental Status (BIMS), on 12/18/19, revealed

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.

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F 0656 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) Resident #100 was severely cognitively impaired. Review of Resident #100's hospital discharge records, with a hospital print date of 2/18/20, revealed .H&P (history and physical) .at 2/10/20 .ED (emergency department) Course: [MEDICATION NAME] started (antibiotic given for pneumonia), 2L (liters) of fluid given (for dehydration) .CXR (chest x-ray) showed density RLL (right lower lobe pneumonia) .Assessment/Plan .Acute [MEDICAL CONDITION] w/ acute respiratory (insufficiency) (cognitive decline due to respiratory distress or infection) . suspect aspiration pneumonia (pneumonia caused by inhaling food, liquid or vomit) .met [MEDICAL CONDITION] criteria on admit (serious condition that happens when infection causes injury to tissues and organs) . Review of Resident #100's wound consult, included in the 2/18/20 hospital discharge records, revealed . Consult . at 2/18/20 .consultation for pressure injury to bilateral heels .Right Heel: Skin with non-blanching (color does not return to skin when pressure was applied indicating skin impairment) maroon discoloration, raised intact fluid-filled blister. Area measured 3cm x 6cm .(picture of injury included) .Left Heel: Skin with reabsorbing blister, measures 4cm x 6.6cm. Center of reabsorbing blister has deep purple discoloration that measures 1.5cm x4cm, non blanchable .(picture of injury included). Resident #100 was discharged from the hospital and returned to the facility on [DATE]. Review of Resident #100's medical record revealed no care plan focuses or interventions developed for bilateral heel pressure injuries, respiratory issues, or hydration. Review of Resident #100's February 2020 Medication and Treatment Record (MAR/TAR), revealed no treatment or interventions for Resident #100's bilateral heel pressure injuries. In an interview on 3/3/20 at 9:15 AM, Hospital Registered Nurse U (HRN) indicated Resident #100 again entered the Emergency Department on 2/25/20 and was transferred to the Intensive Care Unit on 2/26/20. HRN U indicated took care of Resident #100 when he was admitted on [DATE]. HRN U indicated upon head to toe skin assessment Resident #100's bilateral heels had larger than golf ball sized wounds that were intact, non blanchable, and discolored brown to black. HRN U indicated requested a wound consult and the wound specialist staged Resident #100's bilateral heel wounds as unstageable deep tissue injuries (non blanchable, intact skin with dark discoloration of skin, depth of tissue necrosis unknown). Review of Resident #100's Physician's Discharge Summary from 2/25/20 to 3/4/20 hospital visit , revealed .(Resident #100) presented [MEDICAL CONDITION] due to pneumonia .Course was complicated by AKI (acute kidney injury), [MEDICAL CONDITION] (high sodium level due to dehydration) .it was decided to transition to hospice care .Chief complaint (2/25/20) .workup in ER showed the patient was febrile to 105 with leukocytosis of 16.7 (indicated infection). Chest x-ray showing persistent right lower lung opacities (pneumonia) .Patient also noted to have a lactic acid of 3.6 ([MEDICAL CONDITION]) and was given a total of 3 L of fluid in the ER (due to dehydration). Other notable labs were elevated sodium at 158 .Critical Care Progress Note .2/26/20 .Skin Pressure injuries to bilateral heels and in various spots on feet .wound care consulted .
F 0658 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number MI 559. Based interview and record review the facility failed to provide professional standards of care, for 1 of 3 residents (Resident #100), reviewed for admissions, resulting an inaccurate and incomplete admission assessment and resident decline. Findings include: Review of the facility's Admission of Resident, policy and procedure (not dated), revealed Purpose: To facilitate smooth transition into a health care environment. To gather comprehensive information as a basis for planning individualized therapeutic care. Equipment: Transfer Documents .Procedure: .Conduct head to toe nursing assessment of body systems, parts .Be sure to measure any areas of redness or skin breakdown .Using information obtained, contact the physician .ensuring that admission orders [REDACTED]. Resident #100 Review of the facility Admissions Record revealed Resident #100 was a [AGE] year-old male originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment, completed on 12/18/19, revealed Resident #100 required assistance of 1-2 staff for transfers, dressing, hygiene; and setup assistance for eating and ambulation. Brief Interview for Mental Status (BIMS), on 12/18/19, revealed Resident #100 was severely cognitively impaired. Review of Resident #100's hospital discharge records, with a hospital print date of 2/18/20, revealed .H&P (history and physical) .at 2/10/20 .ED (emergency department) Course: [MEDICATION NAME] started (antibiotic given for pneumonia), 2L (liters) of fluid given (for dehydration) .CXR (chest x-ray) showed density RLL (right lower lobe pneumonia) .Assessment/Plan .Acute [MEDICAL CONDITION] w/ acute respiratory (insufficiency) (cognitive decline due to respiratory distress or infection) . suspect aspiration pneumonia (pneumonia caused by inhaling food, liquid or vomit) .met [MEDICAL CONDITION] criteria on admit (serious condition that happens when infection causes injury to tissues and organs) . Review of Resident #100's wound consult, included in the 2/18/20 hospital discharge records, revealed . Consult . at 2/18/20 .consultation for pressure injury to bilateral heels .Right Heel: Skin with non-blanching (color does not return to skin when pressure was applied indicating skin impairment) maroon discoloration, raised intact fluid-filled blister. Area measured 3cm x 6cm .(picture of injury included) .Left Heel: Skin with reabsorbing blister, measures 4cm x 6.6cm. Center of reabsorbing blister has deep purple discoloration that measures 1.5cm x4cm, non blanchable .(picture of injury included). Resident #100 was discharged from the hospital and returned to the facility on [DATE]. Review of Resident #100's medical record revealed no care plan focuses or interventions developed for bilateral heel pressure injuries, respiratory issues, or hydration. Review of Resident #100's February 2020 Medication and Treatment Record (MAR/TAR), revealed no treatment or interventions for Resident #100's bilateral heel pressure injuries. Review of Resident #100's admission Skin Assessment, dated 2/18/20, revealed .bruising .Clean skin. Old IV site present on both arms .Was there a new skin concern or change in skin condition that required physician notification .NO . e-signed by Licensed Practical Nurse (LPN) S. In an interview, on 3/4/20 at 12:50 PM, LPN S indicated worked 2nd shift and admitted Resident #100 to the facility from the hospital on [DATE]. LPN S indicated when admitting residents would first perform a head to toe skin assessment upon arrival. LPN S indicated did not see any skin injuries besides his old bruised IV sites. LPN S indicated was not aware that Resident #100 entered the facility with bilateral heel injuries. LPN S indicated used the paperwork that comes from the hospital with the resident to input medication and nursing orders. LPN S indicated reads over the hospital stay summary if has time but often has difficulty finding the time to do this. LPN S indicated does not know if someone else reviewed admission paperwork and orders as a double check and did not use a checklist to admit resident. LPNS indicated did not develop a care plan or interventions to monitor Resident #100's resolved dehydration and pneumonia. In an interview on 3/4/20 at 12:08 PM, Director of Nursing B (DON) indicated did not know Resident #100 had been readmitted to the facility with bilateral heel pressure injuries. DON B indicated the admitting nurse reviewed the discharge summary and found the bilateral heel pressure injuries or found these pressure injuries on initial assessment. Then the admitting nurse should have called the physician to obtain treatment orders and started a care plan focus with interventions. DON B indicated the nurse should also follow the admission checklist, that indicated to review transfer information. The checklist also has an area for a second nurse to verify admission orders [REDACTED]. DON B indicated the facility currently has no unit managers, so the audits fall to the DON, and audits have not been done consistently. DON B indicated Resident #100 slipped through the cracks. DON B indicated if there was not an admission checklist completed in the hard chart then it was not done. No admission checklist was found in Resident #100's chart. In an interview on 3/5/20 at 9:30 AM, MDS nurse F indicated was unaware that Resident #100 admitted from the hospital on [DATE] with bilateral heel pressure injuries. MDS nurse F indicated the nurse on duty starts the admission process. MDS F indicated the admission nurse was responsible for initiating care plans and clarifying unclear orders with the physician. MDS F indicated the next shift that works after a resident admitted should double check physician orders [REDACTED]. MDS F indicated the unit managers use to be responsible for reviewing admissions orders and hospital discharge summaries, after checklist was completed. MDS F indicated we no longer have unit managers, so the DON was ultimately responsible to ensure continuity of care. MDS F indicated we dropped the ball with Resident #100.
F 0684 **Level of harm** - 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** This citation pertains to intake number MI 559. Based interview and record review the facility failed to ensure a resident received quality care, for 1 of 3 residents (Resident #100), reviewed for comprehensive care, resulting in the worsening of pressure wounds, dehydration, and a lack of a comprehensive plan of care. Findings include: Review of the facility Admissions Record revealed Resident #100 was a [AGE] year-old male originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment, completed on 12/18/19, revealed Resident #100 required assistance of 1-2 staff for transfers, dressing, hygiene; and setup assistance for eating and ambulation. Brief Interview

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) for Mental Status (BIMS), on 12/18/19, revealed Resident #100 was severely cognitively impaired. Review of Resident #100's hospital discharge records, with a hospital printed date of 2/18/20, revealed .H&P (history and physical) .at 2/10/20 .ED (emergency department) Course: [MEDICATION NAME] started (antibiotic given for pneumonia), 2L (liters) of fluid given (for dehydration) .CXR (chest x-ray) showed density RLL (right lower lobe pneumonia) .Assessment/Plan .Acute [MEDICAL CONDITION] (cognitive decline due to respiratory distress or infection) w/ acute respiratory (insufficiency) . suspect aspiration pneumonia (pneumonia caused by inhaling food, liquid or vomit) .met [MEDICAL CONDITION] criteria on admit (serious condition that happens when infection causes injury to tissues and organs) . Review of Resident #100's wound consult, included in the 2/18/20 hospital discharge records, revealed . Consult . at 2/18/20 .consultation for pressure injury to bilateral heels .Right Heel: Skin with non-blanching (color does not return to skin when pressure was applied, indicating skin impairment) maroon discoloration, raised intact fluid-filled blister. Area measured 3 cm x 6 cm .(picture of injury included) .Left Heel: Skin with reabsorbing blister, measures 4 cm x 6.6 cm. Center of reabsorbing blister has deep purple discoloration that measures 1.5 cm x 4 cm, non blanchable .(picture of injury included). Resident #100 was discharged from the hospital and returned to the facility on [DATE]. Review of Resident #100's medical record revealed no care plan focuses or interventions developed for bilateral heel pressure injuries, respiratory issues, or hydration. Review of Resident #100's February 2020 Medication and Treatment Record (MAR/TAR), revealed no treatment or interventions for Resident #100's bilateral heel pressure injuries. Review of Resident #100's admission Skin Assessment, dated 2/18/20, revealed .bruising .Clean skin. Old IV site present on both arms .Was there a new skin concern or change in skin condition that required physician notification .NO . e-signed by Licensed Practical Nurse (LPN) S. In an interview, on 3/4/20 at 12:50 PM, LPN S indicated worked 2nd shift and admitted Resident #100 to the facility from the hospital on [DATE]. LPNS indicated when admitting residents would first perform a head to toe skin assessment upon arrival. LPN S indicated did not see any skin injuries besides his old IV sites on his bilateral arms, that were bruised. LPN S indicated was not aware that Resident #100 entered the facility with bilateral pressure injuries. LPN S indicated used the discharge paperwork from the hospital (came with the resident) to input the resident's medication and nursing orders. LPN S indicated would read over the hospital stay summary if has time but often has difficulty finding the time to do this. LPN S indicated does not remember if read all of Resident #100's discharge paperwork. LPN S indicated does not know if a manager or other nurse should review a resident's admission paperwork as a double check. LPN S indicated it would be nice if someone else verified admission orders [REDACTED]. The admission process has changed multiple times in the last 6 months, cannot keep it all straight. Review of the New Admission Checklist, revealed .Review of Transfer Information .Have 2nd nurse verify admission orders [REDACTED].Nurse Initials .Nurse Mgr Initials .*New admissions include brand new admissions and any prior residents who are readmitted to the facility following a discharge to another setting . In an interview, on 3/5 /20 at 12:40 PM, Medical Records Manager E (MRM) indicated when notified a new admission or readmission was arriving, would place a New Admission Checklist on the outside of the resident's hard chart. MRM E indicated this has been the procedure for years and once the checklist was completed it should be placed inside the chart. No New Admission Checklist was found in Resident #100's chart. In an interview, on 3/4/20 at 12:08 PM, Director of Nursing B (DON) indicated does not know Resident #100 that well; he lived on the dementia unit and the former unit manager oversaw the dementia unit (unit managers last day was 2/18, the day Resident #100 readmitted to the facility). DON B indicated after reviewing Resident #100's, 2/18/20 hospital wound consult, indicated did not know Resident #100 had been readmitted from the hospital with bilateral heel pressure injuries. DON B indicated we should have called his physician to obtain treatment orders and started a care plan focus with interventions. DON B indicated when residents admit to the facility from the hospital the nurse on duty should review the available documentation such as, discharge summary and orders. DON B indicated the nurse should be following the admission checklist and, on the checklist, there is area for a second nurse to verify admission orders [REDACTED]. DON B indicated the facility currently has no unit managers, so the audits fall to the DON, and the audits have not been done consistently. DON B indicated if there was not a admission checklist completed in the hard chart then it was not done. In an interview, on 3/5/20 at 9:30 AM, MDS nurse F indicated was unaware that Resident #100 admitted from the hospital on [DATE] with bilateral heel pressure injuries. MDS nurse F indicated Resident #100 did not readmit with a [DIAGNOSES REDACTED]. MDS nurse F indicated Resident #100 did not have a baseline respiratory care plan and did not develop a respiratory care plan after his readmission on 2/18/20. MDS nurse F indicated Resident #100 should have had a baseline respiratory care plan developed at the time of his initial admission because he had a [DIAGNOSES REDACTED]. Additional interventions or revisions to a baseline respiratory care plan should have been added after his stay in the hospital for pneumonia. MDS nurse F indicated did not develop a hydration care plan either. MDS nurse F indicated if a resident was at risk for dehydration a CNA task would be initiated and Resident #100 had this task triggered. MDS nurse F indicated the CNAs should document how much fluids were consumed for breakfast, lunch, and dinner. MDS nurse F indicated Resident #100 was on the locked dementia unit and cups of fluid were not left in the resident rooms. Fluids were given at meals, at snack time (after breakfast and lunch), and by request. MDS F indicated Resident #100 was not cognitively intact enough to request fluids when thirsty. In an interview on 3/4/20 at 2:40 PM, CNA O indicated care for Resident #100 frequently before his admission to the hospital on [DATE] and after he returned from the hospital on [DATE]. CNA O indicated before Resident #100's illness, that lead him to admit to the hospital, Resident #100 was able to walk independently and would verbally respond to questions (incoherently at times). Resident #100 could also feed himself independently. CNA O indicated once he had fallen ill, he could no longer walk, talk, or feed himself and his abilities did not return after his readmission to the facility on [DATE]. CNA O indicated Resident #100 really liked to drink water prior to his illness and would seek out drinks. CNA O indicated after his illness and hospitalization Resident #100 could not tell us if he was thirsty. Review of Resident #100's CNA task, fluid intake, that revealed the approximate amount of fluids in milliliters (ml) consumed in 24 hours: .2/19 .(2:59 AM) 120 (ml) .(7:01 AM) .240 (ml) .(360 ml of fluid in 24 hours) .2/20 .(12:47 AM) .120 (ml) .(7:01 AM) .240 (ml) .(360 ml of fluid in 24 hours) .2/21 .(12:53 AM) .25 (ml) .(11:01 AM) .240 (ml) .(265 ml of fluid in 24 hours) .2/22 .(2:04 AM) .120 .(1:49 PM) .480 (ml) .(600 ml of fluid in 24 hours) .2/23 .(1:59 PM) .580 (ml) .(580 ml of fluid in 24 hours) .2/24 .(12:39 PM) .480 (ml) .(480 ml of fluid in 24 hours) .2/25 .(12:32 PM) .120 (ml) .(120 ml of fluid before discharged back to hospital approximately 9:30 AM) . In an interview on 3/6/20 at 9:30 AM, Registered Dietician R (RD) indicated assessed Resident #100 on 2/3/20 and found his intake adequately met his needs at that time. RD R indicated came to the facility on [DATE] (10 days after readmission) to perform Resident #100's readmission dietary assessment but could not complete the task because he had been discharged back to the hospital. RD R indicated was notified or consult regarding Resident #100's hydration status after he returned from the hospital on [DATE]. RD R indicated used the formula 30 ml x weight in kilograms (kg) to estimate the amount of fluids a resident required daily to stay hydrated. Resident #100 weighted approximately 86.8 kg, multiplied by 30 mls, which equals 2,600 ml of fluid required daily. RD R reviewed Resident #100's fluid intake documentation from 2/19 to 2/25. RD R indicated the amount of fluid documented was definitely concerning and not adequate. It would be a red flag to further investigate why so little fluid was consumed or recorded. RD R indicated if his fluid intake was a triggered task for the CNA's to document on, then at some point dehydration was a concern. RD R indicated someone at the facility should have been reviewing his fluid intake documentation. RD R indicated Resident #100's intake should have triggered an investigation and interventions should have been put in place such as: assessment of hydration, scheduled fluids at medication pass, a discussion of why not drinking (fluid availability, refusals, sickness, cognitive decline), or considering the need for IV hydration or an hospital evaluation. Review of Nurse Practitioner Q (NP) 2/19/20 readmission assessment, revealed .(Resident #100) was sent to the hospital for evaluation of his behavior and was found to have [MEDICAL CONDITION], probably due to medications. He was admitted to (hospital) 02/10-02/18 for medication adjustments. He improved with this and returned back to the facility on new dosing .Dermatologic (skin) .without signs of unexplained trauma or skin breakdown .reviewed hospital records and medication list . No plan found to address bilateral heel pressure injuries or resolved pneumonia,[MEDICAL CONDITION], and dehydration. In an interview on 3/5/20 at 1:25 PM, NP Q' indicated performed Resident #100's readmission assessment on 2/19/20. NP Q indicated often there was no discharge summary to review and it was difficult to know how the resident was treated in the hospital if the hospital discharge paperwork was not accessible (discharge packet was available in hard chart and on the computer under referral packet on 2/18). NP Q indicated when paperwork was missing had to rely on a good nurse's report. NP Q indicated if a resident admitted to the facility with a resolved respiratory issue like pneumonia [MEDICAL CONDITION] the nurses should be pushing oral fluids. NP Q indicated told the nurses frequently to encourage residents to drink every time they interact with them. NP Q indicated it was also important to push fluids with residents with dementia, like Resident #100, due to the dementia process the residents forget to regulate thirst. Elderly residents and residents with

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F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 3) dementia could become dehydrated again within 12 hours, if their fluid intake was not monitored and encouraged. NP Q indicated was not aware Resident #100 was admitted to hospital with dehydration, pneumonia, or pressure injuries to his bilateral heels. Resident #100 was admitted to the hospital again on 2/25/20 (7 days after his last hospital admission). Review of Resident #100's Physician's Discharge Summary from 2/25/20 to 3/4/20 hospital visit , revealed .(Resident #100) presented [MEDICAL CONDITION] due to pneumonia .Course was complicated by AKI (acute kidney injury), [MEDICAL CONDITION] (high sodium level due to dehydration) .it was decided to transition to hospice care .Chief complaint (2/25/20) .workup in ER showed the patient was febrile to 105 with leukocytosis of 16.7 (indicated infection). Chest x-ray showing persistent right lower lung opacities (pneumonia) .Patient also noted to have a lactic acid of 3.6 ([MEDICAL CONDITION]) and was given a total of 3 L of fluid in the ER (due to dehydration). Other notable labs were elevated sodium at 158 .Critical Care Progress Note .2/26/20 .Skin Pressure injuries to bilateral heels and in various spots on feet .wound care consulted . In an interview on 3/3/20 at 9:15 AM, Hospital Registered Nurse U (HRN) indicated Resident #100 entered the ED on 2/25/20 and was transferred to the Intensive Care Unit on 2/26/20. HRN U indicated took care of Resident #100 when he was admitted on [DATE]. HRN U indicated upon head to toe skin assessment of Resident #100, found his bilateral heels had larger than golf ball sized skin impairments that were intact, non blanchable, and discolored brown to black. HRN U indicated requested a wound consult and the wound specialist indicated the wounds had worsened and staged Resident #100's bilateral heel wounds as unstageable deep tissue injuries (non blanchable, intact skin with dark discoloration of skin, depth of tissue necrosis unknown). In an interview on 3/5/20 at 9:30 AM, Family Member T (FM) indicated visited several days before Resident #100 entered the hospital on [DATE]. FM T indicated Resident #100 was walking and feeding himself. FM T indicated Resident #100 had dementia but would respond to you when spoken to, although it often did not make sense. FM T indicated Resident #100 was admitted to the hospital on [DATE] and was unable to walk, talk or feed himself. FM T indicated no one notified the family that Resident #100 had pressure injuries until his 2/25/20 after admission to the hospital. FM T indicated was released from the hospital yesterday (3/4/20), unable to walk, with huge open sores on both heels, and on hospice. FM T indicated hospice predicated Resident #100 only days to a week to live.
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number MI 559. Based on interview and record review, the facility failed to identify and treat pressure ulcers for 1 of 3 residents (Resident #100), reviewed for pressure ulcers, resulting in the worsening of the pressure ulcer. Findings include: Review of the facility Admissions Record revealed Resident #100 was a [AGE] year-old male originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment, completed on 12/18/19, revealed Resident #100 required assistance of 1-2 staff for transfers, dressing, hygiene; and setup assistance for eating and ambulation. Brief Interview for Mental Status (BIMS), on 12/18/19, revealed Resident #100 was severely cognitively impaired. Review of Resident #100's wound consult, included in the 2/18/20 hospital discharge records, revealed . Consult . at 2/18/20 .consultation for pressure injury to bilateral heels .Right Heel: Skin with non-blanching (color does not return to skin when pressure was applied indicating skin impairment) maroon discoloration, raised intact fluid-filled blister. Area measured 3cm x 6cm .(picture of injury included) .Left Heel: Skin with reabsorbing blister, measures 4cm x 6.6cm. Center of reabsorbing blister has deep purple discoloration that measures 1.5cm x4cm, non blanchable .(picture of injury included). Resident #100 was discharged from the hospital and returned to the facility on [DATE]. Review of Resident #100's medical record revealed no care plan focuses or interventions developed for bilateral heel pressure injuries, respiratory issues, or hydration. Review of Resident #100's February 2020 Medication and Treatment Record (MAR/TAR), revealed no treatment or interventions for Resident #100's bilateral heel pressure injuries. Review of Resident #100's admission Skin Assessment, dated 2/18/20, revealed .bruising .Clean skin. Old IV site present on both arms .Was there a new skin concern or change in skin condition that required physician notification .NO . e-signed by Licensed Practical Nurse (LPN) S. In an interview, on 3/4/20 at 12:50 PM, LPN S indicated worked 2nd shift and admitted Resident #100 to the facility from the hospital on [DATE]. LPN S indicated when admitting residents would first perform a head to toe skin assessment upon arrival. LPN S indicated did not see any skin injuries besides his old bruised IV sites. LPN S indicated used the paperwork that comes from the hospital with the resident to input medication and nursing orders. LPN S indicated reads over the hospital stay summary if has time but often has difficulty finding the time to do this. LPN S indicated does not know if someone else reviewed admission paperwork and orders as a double check. LPN S indicated was not aware that Resident #100 entered the facility with bilateral pressure injuries. Review of Resident #100's Certified Nursing Assistant (CNA) shower documentation, revealed Resident #100 received a shower or complete bed bath on 2/20/20 by CNA O and on 2/24/20 by CNA M. In an interview on 3/4/20 at 2:40 PM, CNA O indicated gave Resident #100 a shower or bed bath after returning from his hospital stay. CNA O indicated checked his skin over on that day and did not see any skin impairments. In an interview on 3/4/20 at 3:00 PM, CNA M indicated most likely gave Resident #100 a bed bath after returning from his hospital stay. CNA O indicated does not recall any skin impairments. In an interview on 3/4/20 at 12:08 PM, Director of Nursing B (DON) after reviewing Resident #100's, 2/18/20 hospital wound consult, indicated did not know Resident #100 had been readmitted to the facility with bilateral heel pressure injuries. DON B indicated we should have called his physician to obtain treatment orders and started a care plan focus with interventions. DON B' indicated the unit manager or the DON should also be auditing the admission information. DON B indicated the facility currently has no unit managers, so the audits fall to the DON, and audits have not been done consistently. Review of Nurse Practitioner Q (NP) 2/19/20 readmission assessment, revealed .(Resident #100) was sent to the hospital for evaluation of his behavior and was found to have [MEDICAL CONDITION], probably due to medications. He was admitted to (hospital) 02/10-02/18 for medication adjustments. He improved with this and returned back to the facility on new dosing .Dermatologic (skin) .without signs of unexplained trauma or skin breakdown .reviewed hospital records and medication list . No plan found to address bilateral heel pressure injuries In an interview on 3/5/20 at 1:26 PM, NP Q' indicated performed Resident #100's readmission assessment on 2/19/20. NP Q indicated often there was no discharge summary to review and it was difficult to know how the resident was treated in the hospital if the hospital discharge paperwork was not accessible (discharge packet was available in hard chart and on the computer under referral packet on 2/18/20). NP Q indicated when paperwork was missing had to rely on a good nurse's report. NP Q indicated was not aware Resident #100 had pressure injuries to his bilateral heels. Review of Resident #100's Physician's Discharge Summary from 2/25/20 to 3/4/20 hospital visit , revealed .(Resident #100) presented [MEDICAL CONDITION] due to pneumonia . Critical Care Progress Note .2/26/20 .Skin Pressure injuries to bilateral heels and in various spots on feet .wound care consulted . In an interview on 3/3/20 at 9:15 AM, Hospital Registered Nurse U (HRN) indicated Resident entered the ED on 2/25/20 and was transferred to the Intensive Care Unit on 2/26/20. HRN U indicated took care of Resident #100 when he was admitted on [DATE]. HRN U indicated upon head to toe skin assessment Resident #100's bilateral heels had larger than golf ball sized skin impairments that were intact, non blanchable, and discolored brown to black. HRN U indicated there were two additional scabbed areas on top of one of Resident #100's feet. HRN U indicated requested a wound consult and the wound specialist indicated heels had worsened and staged Resident #100's bilateral heel wounds as unstageable deep tissue injuries (non blanchable, intact skin with dark discoloration of skin, depth of tissue necrosis unknown). In an interview on 3/5/20 at 930 AM, Family Member T (FM) indicated was not notified that Resident #100 had pressure injuries until 2/26/20 by HRN U from the hospital. FM T indicated was released from the hospital yesterday (3/4/20), and his bilateral heel pressure injuries progressed to large open sores.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number MI 559. Based on observation, interview, and record review the facility failed to investigate a fall for 1 of 3 residents (Resident #101), reviewed for accidents, resulting in not identifying the root cause of an accident, and implementing inventions to prevent further accidents. Findings include: Review of the facility's Fall Prevention Program, last reviewed 4/7/19, revealed .Purpose: To assure the safety of all residents in the facility .The Fall Prevention Program includes the following components: Documentation requirements .Identification of all risk/issue .Addresses each fall .Interventions are changed with each fall .Preventative measures .Standards .Accidents/Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determined possible safety interventions . Review of the facility Admissions Record revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235544	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALLMARK LIVING BENTON HARBOR	**1385 E EMPIRE AVE BENTON HARBOR, MI 49022**

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) Resident #101 was an [AGE] year-old female originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment, completed on 1/23/20, revealed Resident #101 required extensive assistance of 1-2 staff for transfers, dressing, hygiene and ambulation; and setup assistance for eating. Brief Interview for Mental Status (BIMS), on 1/23/20, revealed Resident #101 was severely cognitively impaired. During an observation on 3/3/20 at 10:45 AM, Resident #101 was lying in her bed waiting for Certified Nursing Assistant J (CNA) to perform a bed bath. CNA J removed Resident #101's gown and revealed a silver dollar sized scab, on the top of Resident #101's left shoulder. CNA J indicated does not know if Resident #101's shoulder wound was new. Resident #101 indicated it might be from the time she fell through the mechanical lift sling. Resident #101 indicated it happened awhile ago, approximately a month ago. Reviewed Resident #101's skin and wound assessments for the last two months and no report of an impaired skin area to the left shoulder was found. On 3/3/20 at 3:40 PM, requested all incident/accident reports for Resident #101 for the last three months. Nursing Home Administrator in Training C (NHAT) indicated there were none. Review of Resident #101's General Progress Notes, dated 1/17/20 at 2:42 PM, revealed, .Resident transferred to bed with staff via hoyer lift (mechanical lift) and started slipping from sling. Resident lowered to floor via lift and transferred into bed by 3 staff. No injuries but resident states I hate that d*** thing referring to lift. Call light in reach ., e-signed by Licensed Practical Nurse H (LPN). (sic) In an interview on 3/5/20 at 10:30 AM, LPN H indicated on 1/17/19 worked as Resident #101's day nurse. LPN H indicated Resident #101 was being transferred by CNA K and another staff member via mechanical lift and Resident #101 started slipping through the sling. LPN H indicated the staff lowered her to the floor. LPN H indicated did not fill out a incident/accident report because did not consider this a fall. In an interview on 3/5/20 at 11:45 AM, CNA K indicated on 1/17/19 transferred Resident #101 via mechanical lift from wheelchair to her bed with the assistance of LPN H. CNA K indicated Resident #101 had a sling with an open bottom already placed beneath her in the wheelchair. CNA K indicated attached the sling to the hoyer arms correctly, crisscrossing the sling between her legs. CNA K indicated raised Resident #101 up in the air and she began waving her arms and legs, and her bottom started slipping through the opening in the sling. CNA K indicated lowered Resident #101 to the ground, called another aide into the room, and the 3 staff members transferred her to the bed. CNA K indicated does not like the open bottom slings, because if the wrong size (too big) sling was placed under the resident, they could fall through the sling. CNA K indicated once Resident #101 was comfortable, asked LPN H if needed a statement for the incident/accident report. LPN H indicated did not need a statement, and would not fill out a report because Resident #101 did not fall. CNA K indicated policy stated if a resident was lowered to the floor, consider it a fall, and fill out a report. CNA K indicated this was not the first time Resident #101 has had a fall using the hoyer lift. Resident #101 panicked and flailed her arms and legs in the sling because she was very fearful of falling from the lift. Review of Resident #101's Care Plan, revealed the focus, .I am at risk for falls r/t (related to) Incontinence, w/c (wheelchair) transfers and incontinent care. I have limited safety awareness. I also receive antidepressant medication . Revision on: 07/17/2019 . Interventions for this focus, included: .Follow facility fall protocol .Revision on: 01/31/2018 .Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate Resident/family/caregivers/IDT as to causes. Date Initiated: 03/01/2017 . No fall care plan updates since 11/2019 and no care plan interventions referencing Resident #101's fear of the mechanical lift or how to ensure safety when using the mechanical lift. In an interview on 3/4/20 at 2:20 PM, Nursing Home Administrator in Training (NHAT) C indicated just went to look at Resident #101's wound on her left shoulder. NHAT C indicated that Resident #101 reported the wound could have happened when she fell a few weeks ago. NHAT C indicated there was no incident/accident report for a fall, only a progress note on 1/17/20 referencing a fall. NHAT C indicated there should have been an incident/accident report completed, an investigation into the 1/17/20 fall should have been done, and interventions should have been put in place to prevent further falls.