STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235381	A. BUILDING _____ B. WING _____	08/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHIPPEWA COUNTY WAR MEM HOSP LTCU	500 OSBORN BLVD SAULT SAINTE MARIE, MI 49783

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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** Based on interview and record review, the facility failed to assess a resident's change in condition according to professional standards of practice and notify a physician of a change in condition for one Resident (#1) of three residents reviewed for quality of care. This deficient practice resulted in worsening of Resident #1's condition, subsequent hospitalization on the intensive care unit (ICU) and undergoing a life-altering surgical procedure. Findings include: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of a hospital Discharge Summary, dated and signed 7/17/20 at 12:13 p.m. by Physician A, revealed the following, in part: (Resident #1) admitted to the intensive care unit with critical care consultation and IV pressor therapy (medication to raise blood pressure) to maintain blood pressures which ultimately resulted from hypovolemic shock . secondary to profound diarrhea and fluid volume losses from her ileitis/[MEDICAL CONDITION] . she was placed on corticosteroid therapy [MEDICATION]), this was helpful . her diarrhea was improving and her symptoms were resolving and then as per our plan (corticosteroid) was withdrawn. This unfortunately resulted in a return of her abdominal symptoms of diarrhea, discomfort and distention along with [MEDICAL CONDITION] and weakness and her (corticosteroid) was resumed at a lower dose which resulted in improvement of her symptoms once again . to be admitted to long-term care unit for a period of strengthening and conditioning prior to return home. A review of the New Admission email sent to all nursing staff and certified nurse aides (CNAs) on 7/17/20 at 2:02 p.m., revealed the following, in part: (Resident #1) to LTC (long-term care) for short-term rehab . admitted to (hospital) on 7/1/20 with abdominal pain, vomiting and diarrhea . still has occasional loose stools . usually continent . appetite has been poor. A review of the, Bladder/Bowel Movement Assessment(s), for Resident #1 revealed the following, in part: Sat [DATE]:40 (CNA B) . Stool Size: Large, Stool Color: Brown Black, Stool Consistency: Liquid, Bowel Continence: Continent & Incontinent . Sun [DATE]:00 (CNA B) . Stool Size: Large, Stool Color: Black, Stool Consistency: Loose. Bowel Continence: Incontinent . Fri [DATE]:46 (CNA C) . Stool Size: Large, Stool Color: Brown, Blood Tinged, Stool Consistency: Loose, Mucous, Bowel Continence: Incontinent. Further review of the electronic health record (EHR) for Resident#1 revealed no nursing assessment to correspond with the Bladder/Bowel Movement Assessment(s), entered by CNA B and CNA C. The EHR for Resident #1 revealed no documentation that a licensed nurse or Resident #1's physician had been notified of the occurrences when Resident #1 had experienced black and blood-tinged stool. The EHR revealed Resident #1 had episodes of diarrhea recorded every day from admission on 7/17/20 to discharge on 8/4/20. On 7/24/20, the consistency of Resident #1's stool changed from, loose, to loose, watery. On 7/25/20, Resident #1 had, large, watery, loose, bowel movements recorded at 5:46 (a.m.) and 23:32 (11:32 p.m.). A review of the, Meals/Nourishment Record, revealed no recorded oral fluid intake for Resident #1 on 7/25/20. On 7/28/20, Resident #1's record revealed, large, loose, watery, bowel movements recorded at 8:00 a.m., 9:00 a.m. and 12:00 p.m. A review of the, Meals/Nourishment Record, revealed Resident #1 had no recorded oral intake for 7/28/20. On 7/31/20, large, watery, loose, bowel movements were recorded for Resident #1 at 1:12 a.m., and 9:45 a.m. Further review revealed Resident #1 had a recorded total oral, fluid intake of 60 milliliters (amount in two - standard, graduated, medicine cups). Resident #1's daily average of oral fluid intake, based on recorded intake, was 377 milliliters per day. Review of the Nurse Note, dated 7/20/20 at 4:03 a.m., signed by Licensed Practical Nurse (LPN) D revealed the following: Resident had greenish/black loose stools times 2 tonight. CNA stated she has had those since she came. Will monitor. An interview with LPN D, on 8/18/20 at 11:11 a.m., revealed LPN D did not call Resident #1's physician to report the black stool. When asked what black stool indicated, LPN D reported black stool indicated (Resident #1) was bleeding or taking an iron supplement. LPN D could not remember if Resident #1 had been taking an iron supplement at that time. When asked what the protocol was for reporting a suspected gastrointestinal (GI) bleed, LPN D reported she would pass on the information during shift report for the next shift nurse to monitor as staff did not phone physician's on the night shift, unless it is an emergency. A review of Resident #1's Medication Administration Record, [REDACTED]. An interview with Registered Nurse (RN) E, on 8/13/20 at 10:20 a.m., revealed the process for notifying the attending physician of concerns regarding a resident's condition was for the nurse caring for the resident to alert the, desk nurse, of the concern. RN E reported the desk nurse would then use an order request form to report the concern by fax to the physician, who would then respond by fax or phone call. RN E reported the faxed notifications were kept in a file for reference. RN E showed this Surveyor the file where the faxed notifications were kept at the nurses' station. The faxed notifications regarding Resident #1 were requested at this time. A review of the Order Request from (Hospital) - Long Term Care Unit, forms provided by the Director of Nursing (DON) , revealed no form had been faxed regarding a concern for blood in Resident #1's stool on 7/18/20, 7/19/20, 7/20/20 or 7/24/20. Further review revealed no notification had been faxed regarding a change in the consistency of Resident #1's stool from loose to watery on 7/24/20 or of Resident #1's continued incontinence. A review of a nurse note, dated 8/3/20 at 7:08 p.m., revealed the following, in part: Resident complaining of feeling nauseous after lunch . Resident stated . I just feel so weak. I wish I had an appetite. Is there a pill they can give me? Desk nurse sent note to doctor. Waiting response. Further review of the nurse note revealed, (Resident #1 family member) wanted to know what was going on . family was getting voicemails of (Resident #1) stating, I don't feel good. I want to go home. I can't breathe . Upon assessment . Resident stated I just feel so sick to my stomach . Resident had small emesis at supper complaining of feeling nauseous. Will continue to monitor. A review of the Medicare Nurse Assessment - LTC, dated 8/3/20 at 9:15 p.m., signed by RN F, revealed the following, in part: Gastrointestinal: Description: Round. Distended. Nausea. Diarrhea. Incontinence. Further review of all prior assessments revealed Resident #1's abdomen had not been distended prior to the assessment on 8/3/20. A review of the Order Request from (Hospital) - Long Term Care Unit, forms provided by the DON, revealed no form documenting the physician had been notified by fax of the Resident's change in condition on 8/3/20 at 9:15 p.m. A review of the EHR for Resident #1 revealed no documentation indicating the physician had been notified by any other means of communication. A review of a nurse note, dated 8/4/20 at 10:18 a.m., revealed the following, in part: Resident blood pressure low this morning. BP - 104/37 (normal range 120's/80's) on left arm, 81/45 on right arm . Resident continues to have poor fluid and food intake. Resident's (family) called this morning with concerns . requesting (Resident #1) be seen in ER (emergency room) . (Resident #1) agreed to be seen in ER. On 8/14/20 at 9:50 a.m., a review of Resident #1's EHR with the DON, revealed no documentation the physician had been notified, by any means of communication, regarding a concern of the frequency and consistency of Resident #1's stool or a concern of blood in the Resident's stool. There was no documentation the physician had been notified of Resident #1's condition on 8/3/20. In an interview at the time of the review, the DON confirmed staff had failed to recognize the concern for blood in the Resident's stool and the change in the consistency of the Resident's stool, along with limited oral fluid intake, as a change in Resident #1's condition, therefore did not notify the physician. The DON also confirmed the physician should have been notified on 8/3/20

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) when the nursing assessment revealed Resident #1's abdomen had become distended in addition to the Resident's nausea, vomiting and continued diarrhea. The DON reported Resident #1 did not complain to nursing staff which caused staff to make, assumptions, regarding the Resident's condition. The DON agreed that the Resident's lack of reporting how they felt, to nursing did not absolve nurses from conducting accurate nursing assessments and notifying the physician of concerns in order to allow the physician to change the course of treatment, if needed. A review of the Emergency Department Note, dated 8/4/20 at 9:43 a.m., revealed the following, in part: .presents to emergency department from long-term care with complaints of persistent diarrhea up to 3-4 times daily . replacing fluid losses with oral intake . nausea and occasional vomiting . will admit to ICU . plans to obtain a CT scan of the abdomen and pelvis while admitted . A review of the Internal Med History & Physical, dated 8/4/20 at 7:44 p.m., revealed the following, in part: Assessment and Plan. [MEDICAL CONDITION] . secondary to dehydration from diarrhea . Fecal occult blood test positive (positive for blood in stool). A review of the Diagnostic Imaging Report, CT Abdomen Pelvis wo con, dated 8/5/20 and signed 8/6/20 at 8:27 a.m., revealed the following, in part: Impression/Summary. 1. There has been interval development of a ventral wall hernia . The appearance suggests incarceration/strangulation. Bowel ischemia (inadequate blood supply causing tissue death) is suspected. A review of the General Surgery Consult Note, dated 8/5/20 at 7:08 p.m., revealed the following, in part: Location: ICU. Assessment and Plan . recommend urgent exploration . A review of the Operative Report, dated 8/5/20 and signed 8/6/20 at 6:13 a.m., revealed the following, in part: Post-procedure Diagnosis: [REDACTED]. Procedure: Exploratory laparotomy, resection of contaminate mesh, [MEDICATION NAME] colectomy (removal of a portion of the colon) with end-[MEDICAL CONDITION] formation (diversion of the colon through the abdominal wall for elimination of stool). A review of the General Surgery Progress Note, dated 8/6/20 at 6:38 a.m., revealed the following, in part: Location: ICU . Assessment and Plan: s/p (following) lap [MEDICATION NAME] colon resection for ischemic [MEDICAL CONDITION] with multiple areas of necrosis/perf (holes). A review of the General Surgery Progress Note, dated 8/14/20 at 6:38 a.m., revealed the following, in part: Location: ICU. Assessment and Plan: pt (patient/Resident #1) developing atelectasis (collapse) rt base (right lung), pt (patient/Resident #1) depressed. The progress note revealed Resident #1 remained hospitalized in the ICU as of 8/14/20.
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing staff were competent to identify signs and symptoms of [MEDICAL CONDITION], the potential for dehydration, conduct appropriate nursing assessment and communicate concerns to the resident's attending physician for one Resident (#1) of three residents reviewed for competent nursing care. This deficient practice resulted in delayed treatment for [REDACTED]. Findings include: A review of the electronic health record (EHR) for Resident #1 revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #1 was discharged to the emergency department (ED) on 8/4/20 for evaluation of dizziness and [MEDICAL CONDITION] (low blood pressure). The EHR for Resident #1 revealed Resident #1 had had episodes of diarrhea recorded every day from admission on 7/17/20 to discharge on 8/4/20. On 7/24/20, the consistency of Resident #1's stool changed from, loose, to loose, watery. On 7/25/20, Resident #1 had, large, watery, loose, bowel movements recorded at 5:46 a.m. and 23:32 (11:32 p.m.). A review of the Meals/Nourishment Record, revealed no recorded oral fluid intake for Resident #1 on 7/25/20. On 7/28/20, Resident #1's record revealed, large, loose, watery, bowel movements recorded at 8:00 a.m., 9:00 a.m. and 12:00 p.m. A review of the, Meals/Nourishment Record, revealed Resident #1 had no recorded oral intake for 7/28/20. On 7/31/20, large, watery, loose, bowel movements were recorded for Resident #1 at 1:12 a.m., and 9:45 a.m. Further review revealed Resident #1 had a recorded total oral, fluid intake of 60 milliliters (amount in two - standard, graduated, medicine cups). Resident #1's daily average of oral fluid intake, based on recorded intake, was 377 milliliters per day. A review of the Bladder/Bowel Movement Assessment(s), for Resident #1 revealed the Resident had the following, in part: Sat [DATE]:40 (entry by CNA B) . Stool Size: Large, Stool Color: Brown Black, Stool Consistency: Liquid, Bowel Continence: Continent & Incontinent . Sun [DATE]:00 (10 p.m.) (entry by CNA B) . Stool Size: Large, Stool Color: Black, Stool Consistency: Loose. Bowel Continence: Incontinent . Fri [DATE]:46 (2:46 p.m.) (entry by CNA C) . Stool Size: Large, Stool Color: Brown, Blood Tinged, Stool Consistency: Loose, Mucous, Bowel Continence: Incontinent. Further review of the EHR for Resident#1 revealed no nursing assessment to correspond with the Bladder/Bowel Movement Assessment(s) entered by CNA B and CNA C. The EHR for Resident #1 revealed no documentation that a licensed nurse or Resident #1's physician had been notified of the occurrences when Resident #1 had experienced black and blood-tinged stool. An interview with the DON on 8/13/20 at 12:55 p.m., revealed CNAs were expected to relay signs and symptoms of illness to a licensed nurse. The DON agreed black stool or blood in stool should have been communicated to a licensed nurse to allow the nurse to assess the resident and pass along the information in shift report. The DON reported each shift nurse should pass the information on to be shared in the morning Interdisciplinary Team (IDT) meetings. Review of the IDT meeting notes with the DON, revealed no report of Resident #1's loose black stools on 7/18/20, 7/19/20, 7/20/20 or the occurrence of blood-tinged stool on 7/24/20. The DON agreed Resident #1's condition should have been communicated to nursing by the CNAs. The DON also reported the expectation was for nursing to then assess the resident and notify the physician of the resident's condition. An interview with the Director of Nursing (DON) on 8/14/20 at 9:50 a.m. revealed the facility procedure upon admission was as follows: desk nurse reviews the resident information, including hospital discharge summaries, and passes along the information via email to all licensed nurses and CNAs. A review of the New Admission Info email, dated 7/17/20 at 2:02 p.m., revealed the email had been sent to the groups LTC CENA, and LTC Nurses. Further review of the email notification revealed the following, in part: (Resident #1) was admitted to (hospital) on 7/1/20 with abdominal pain, vomiting and diarrhea . still has occasional loose stools . usually continent . appetite has been poor. A review of Resident #1's EHR with the DON, on 8/14/20 at 10:00 a.m., lacked any documentation to show the physician had been notified, by any means of communication, regarding a concern of the frequency and consistency of Resident #1's stool or a concern of blood in the Resident's stool. There was no documentation the physician had been notified of Resident #1's condition on 8/3/20. During the interview at the time of the review, the DON confirmed staff had failed to recognize the concern for blood in the Resident's stool and the change in the consistency of the Resident's stool, along with limited oral fluid intake, as a change in Resident #1's condition, therefore did not notify the physician. The DON also confirmed the physician should have been notified on 8/3/20 when the nursing assessment revealed Resident #1's abdomen had become distended in addition to the Resident's nausea, vomiting and continued diarrhea. The DON reported Resident #1 did not complain to nursing staff which caused staff to make assumptions, regarding the Resident's condition. The DON agreed the Resident's lack of reporting how they felt to nursing staff did not absolve nurses from conducting accurate nursing assessments and notifying the physician of concerns in order to allow the physician to change the course of treatment, if needed. On 8/18/20 at 12:07 p.m., the Nursing Home Administrator (NHA) reported nursing staff utilized nationally recognized standards to identify signs and symptoms of illness and changes in resident's conditions. A review of the Change in status, identifying and communicating, long-term care, provided by the NHA and dated 5/15/20, revealed the following, in part: .identifying and addressing any change in a resident's status from baseline is important . upon recognition of a potentially life-threatening condition or significant change in a resident' status, the nurse must communicate with other health care providers to meet the resident's needs . reviews of the resident's medical record . are essential parts of the assessment when a change occurs . every health care team member is responsible for communicating a resident's change in status . nursing assistants are usually the first to notice a change in a resident's condition and should immediately report this finding to a nurse . nurses are responsible for communicating a resident's change in status, including the assessment finding, to the practitioner. Competency evaluations for LPN B, CNA C, and CNA D, was requested from the NHA on 8/18/20 at 7:24 a.m. and again at 9:11 a.m. A review of the documentation provided by the NHA, on 8/18/20 at 12:01 p.m., revealed a, Long-Term Care CNA Competency Based Checklist, for CNA B. Further review of the competency checklist revealed the following, in part: Competencies: 6. Communicates to RN/LPN any unusual observations (signs and symptoms) . Evaluation: Date Met: 2/1/20. The review of the documentation provided by the NHA revealed no competency check for LPN B or CNA D had been completed. A review of the facility assessment, titled, (Hospital) Long-Term Care Facility Assessment- July 2019 Review, revealed the following, in part: Competency: (Hospital) identified in November 2019, that a program of competency requires further development. The team started with a baseline of knowledge and skill of all staff. Currently LTC staff do an annual skills fair with all hospital staff. We need to continue building a competency education and annual program for all long term care staff that includes per: Knowledge, assessment, pharmacological,

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F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) treatment, care considerations and technical /hands on skill . Policies and Procedures: Staff are trained on policies and procedures consistent with their roles . Nursing staff utilize Lippincott Procedures, Lippincott Advisor and Lippincott Professional. Last reviewed 5/6/20.