STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235592	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HURON WOODS NURSING CENTER	1395 S HURON RD KAWKAWLIN, MI 48631

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 ensure that two residents (Resident #2 and Resident #15) were provided with the opportunity to vote, resulting in Resident #15 and Resident #2 not having the opportunity to exercise their right to vote in the Michigan Primary Election. Findings include: During the Resident Council meeting on 3/10/2020 at 1:15 PM, residents were queried if they were provided the opportunity to vote today or if they utilized absentee ballots for the Primary election. Two residents (#2 and #15) reported they wanted to vote but were never provided with the opportunity to do so. Interview was conducted with Activities Director M on 3/10/2020 at 2:30 PM, regarding the voting process at the facility. The director explained she would typically complete a sweep of the building to see who wants to vote. Once she knows, she ensures they have absentee ballots completed and turned into the clerk's office. If needed she will contact the resident families as well. Director M was asked if this process occurred for voting In the Primary Election today and she stated, no as she was not aware of the election today. On 3/10/2020 at approximately 3:00 PM, a review was completed of Resident #15 and #2's medical records. Resident #15 was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #2 was admitted to the facility 3/25/2019 with [DIAGNOSES REDACTED]. Both residents were deemed capable of making their own decisions. On 3/11/2020 at 11:18 AM, an interview was conducted with the DON (Director of Nursing) and Nurse Consultant D regarding voting in the Primary election. They both reported Resident #15 and #2 should have been provided with the option to vote. On 3/12/2020 at 2:00 PM, a review was completed of Rights of Residents in Michigan Nursing Facilities, dated 11/28/2016. The Rights booklet stated the following, .You have the right to exercise your rights as a resident of the facility and as a citizen or resident of the United States .
F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure Resident #23's capacity evaluation was completed upon admission for one resident reviewed for advanced directives, resulting in the facility allowing a severely cognitively impaired resident to sign their Do Not Resuscitate (DNR) form, when the resident did not possess the capacity to do so. Finding include: On 3/10/2020, a review was completed of Resident #23's medical record and it revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of Resident #23's medical records revealed the following: Resident Preferred Treatment Option Form - The form was signed on 10/11/19 by Resident #23 and two witnesses (facility staff) that indicated the resident was Status 3- The resident is to be hospitalized for [REDACTED]. Such treatments are not to include resuscitation . There is an option on the form that stated, .The resident is not capable of making decisions and has no legal representation . Do not Resuscitate Order Executed by Attending Physician DPOA or Guardian - On 10/11/19 Resident #23 signed this form indicating her code status as DNR (Do not Resuscitate). The form also witnessed by two facility staff and a physician. Review was completed of Resident 23's admission MDS (Minimum Data Set) Assessment and it indicated the resident was severely cognitively impaired. It was further found the facility had not completed a determination for capacity of decision making for the resident who was initially admitted on [DATE]. The facility was contacting Resident #23's DPOA (Durable Power of Attorney) for all medical decisions for the resident, although it had not been activated. On 3/9/2020 at 11:47 AM, an interview was conducted with Social Worker Q regarding Resident #23's DNR paperwork that she (the resident) signed. The Social Worker explained the resident had not been assessed for competency yet as she was missed during her admission, as this was recently discovered in their audits they complete quarterly. The Social Worker was asked if upon admission, the resident had the capacity to make her own medical decisions. Social Worker Q responded no. She added upon admission her BIMS (Brief Interview for Mental Status) was rated at a 2 (severe cognitive impairment). She was queried on how the resident was able to sign her DNR order and Resident Preferred Treatment Option. The Social Worker was not aware the resident signed her DNR and Preferred Treatment option form. On 3/11/2020 at 12:36 PM, an interview was conducted with Nurse N (Nurse who admitted Resident #23). Nurse N explained she does remember when Resident #23 was admitted to the facility. When assessing for cognition she asked the resident the date, time of day, where she is at, her date of birth and age. The Nurse reported the resident had some confusion and asked the nurse an unusual question but was able to answer the questions correctly. Nurse N stated if she felt the resident was incapable of making her medical decision at the time of admission, she would inform the physician and family. At the time of the admission the nurse felt Resident #23 was cognizant enough to choose and sign her code status as DNR. It was explained to the nurse the concerns of this writer and Nurse N further explained once all the admission paperwork is completed it is provided to the physician for review and signature. On admission the physician completes the capacity evaluation and must sign the code status document (that was initially completed on admission) indicating the president's ability to make that decision. Nurse N stated if the physician assessed and determined the resident was not capable, they overrule their initial assessment. On 3/11/2020 at 1:03 PM, an interview was conducted Admissions Coordinator R regarding admission code status and capacity evaluations. The Coordinator explained if the admission is during business hours, she will complete it and if its on off hours/weekends she will print out all the needed documents for the nurses to complete with the new resident. It was further explained the capacity, DNR and preferable treatment forms are printed out per resident by Admissions Coordinator R. Staff complete the forms (preferable treatment and DNR-if applicable) with the residents and place them in the physician box. Capacity evaluation are completed on admission and annually. On 3/12/2020 at 3:00 PM, a review was completed of the facility policy entitled, Advance Directives, revised November 2016. The policy stated, .Admitting personnel assess whether the resident is capable of making decisions or has a legal medical decision maker .The physician determination of decision-making capability will ultimately determine the residents capability to make health care decisions Unless the resident has been declared incapable of participating in medical decisions by the resident's attending and another physician .the resident shall be responsible for medical decisions .
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to update or modify the pressure ulcer/skin care plan for one resident (Resident #13), resulting in the potential for infection with the re-opening of a coccyx wound. Findings include; Record review of facility 'Person-Centered Care Planning Process: Admission, Comprehensive & Short term' policy dated 11/2016, revealed it is the policy of the facility to initiate the person centered care planning process was to provide effective person-centered care that meets professional standards of quality of care. To ensure prompt assessment and delivery of a high standard of care and communicate person-centered needs and to develop. review, and revise the resident's comprehensive plan of care. Short term care plans are to provide communication and documentation of specialized and limited term care planning needs. Resident #13: Record review of Resident #13's annual Minimum Data Set (MDS), dated [DATE], revealed an elderly female with a Brief Interview of Mental Status (BIMS) score of 7 out of 15, cognitive impairment noted with no behaviors. Medical [DIAGNOSES REDACTED]. Section H: Bladder and Bowel- frequently incontinent of bladder and bowel. Section M: Skin conditions- noted no pressure ulcers/injuries. Observation was made on 03/11/20 at 9:30 AM in Resident #13's room with Certified Nurse Assistant (CNA) W. CNA W assisted the resident from a recliner to a walker to go to the bathroom. There was a thin piece of red dysum anti-slip material noted in the seat of the chair. CNA W assisted Resident #13 with ambulation with oxygen hose to the restroom and removed the brief which was wet. Resident #13 had an old dressing that came off in the process. CNA W was able to show the state surveyor the open wound that was located at the top of the buttock creases/coccyx region. Observation of the coccyx region noted an open wound with depth. CNA W notified the Registered Nurse (RN) A. Observation was made on 3/11/20 at approximately 9:35 AM with Registered Nurse (RN) A. RN A gathered dressing supplies of skin prep, sterile saline wipe and a silicone 4 x 4 foam border dressing. RN A washed her hands and then came into the restroom to apply the dressing. The state surveyor had RN A complete measurements of the wound. The wound was 0.8 cm in length X 0.6 cm in width X 0.3 cm in depth. While in the restroom the hospice services Licensed Practical Nurse (LPN) X also observed the opened coccyx area. CNA W was observed to perform a wipe of the peri area twice and pull up the resident's brief. Resident #13 was assisted to back to the recliner. Record review of Resident #13's 'Short term Care Plan Wound & Skin' care plan, dated 1/9/20, revealed a Stage III coccyx, excoriation right inner buttock fold. Record review of a second 'Short term Care Plan Wound & Skin' Care Plan, dated 3/2/20, for the same location on the body revealed that there was no further documentation of the pressure ulcer reopening. Record review of Resident #13's 'Wound tracking' documentation in Point Click Care revealed that the Director of Nursing stopped monitoring the wound area on 3/3/2020. An interview on 03/11/20 at 10:55 AM with Registered Nurse (RN) A revealed that Resident #13's medical record did not have documentation of an open area to the coccyx noted after 3/3/20. RN A stated that the Director of Nursing (DON) is the wound care nurse and she does wound measurements once a week. There was no short-term care plan found for the re-opening of the coccyx wound, which was dated after 2/11/2020. In an interview on 03/11/20 at approximately 11:34 AM, Registered Nurse (RN) K Minimum Data Set (MDS) assessment nurse revealed that she was not aware of Resident #13 having an opened pressure ulcer. RN K stated that she had just told me about it before speaking to the state surveyor. in the last 10 minutes. RN K stated that the nurses are able to update care plans and Director of Nursing (DON) is the wound care nurse and she can also update care plans. RN K stated that she did review the wound tracker notes and there is nothing documented after the wound was documented as being resolved on 3/3/20. RN K stated that RN A had just told her that it (the wound) is open again. A record review of Resident #13's Care Plan, pages 1 through 17, revealed that the skin care plan stated that the pressure ulcers were unavoidable. Interventions addressed a cushion in the wheelchair, but there was no mention of a cushion or off loading/positional changes while in the recliner. Interventions were noted to perform skin inspections with AM/PM care and with showers. A record review of Resident #13's personal hygiene task report, dated 2/11/20 through 3/11/20, revealed that the resident received extensive assistance for the three days prior to the state surveyor's observations of the open wound area and there was no documentation of measurements or of notifying the physician of the re-occurrence of the pressure ulcer.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Number MI 817 Based on observation, interview and record review the facility failed to assess for the continued usage of 1:1 supervision for one resident (Resident #9) reviewed for supervision, resulting in Resident #9 continuing on 1:1 supervision when out of her room, while she was no longer displaying behaviors that jeopardized the welfare of staff and residents, with the potential for feelings of lonesomeness and unhappiness. Findings include: On 3/9/2020 during initial tour, Resident #9 was observed resting in her room and watching television. On 3/9/2020 at 1:30 PM, Nurse A was queried if Resident #9 is normally in her room. The nurse explained she does better in her room as there is less stimulation. The nurse further explained the resident historically has behaviors and yells at other residents and had prior resident to resident interactions. The nurse was not certain if Resident #9 displayed any of her prior behaviors in the past few months. The nurse stated the resident remains in her room for most of the day. On 3/9/2020 at 1:40 PM, an interview was conducted with Social Worker Q regarding Resident #9 and her activity level. The Social Worker reported the resident is on 1:1 when she is out of the room. She reported the resident becomes overstimulated if she sits out of her room too long and will bang on the table and swing at caregivers. The Social Worker reported she has been over stimulated for the past 6 months and had aggression with showers ad toileting. Resident #9 does attend music programs and in the past the resident was delightful and was the life of the party. Staff miss the resident's previous level of interaction. On 3/9/2020 at approximately 4:00 PM, a review was completed of Resident #9's medical records and it revealed the resident was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident is severely cognitively impaired and is dependent on staff for all ADL (Activities of Daily Living). Review of Resident #9's Kardex indicated the following: Safety: .Assure (Resident #9) is arm's length from other peers when she is visible upset/annoyed or angered. (Resident #9) resides in a private room to support her internal and external stimulation triggers. (12/9/19) (Resident #9) was relocated to private room for reduced stimulation risks with no room mate .1:1 care when out of her room. On 3/10/2020 at approximately 7:50 AM, a review was completed of the Resident #9's Activities Attended report from November 1, 2019 to February 1, 2020. Over that three-month period the facility completed the following activities with the resident: Sensory Stimulation- 12 times Television -26 times Music -9 times The resident was not available 30 times and 11 times the facility noted not applicable as a response. Activities Attended report from February 1, 2020 to March 9, 2020 revealed the following: Television- 16 times Sensory stimulation- 4 times The resident was not available 13 times and 7 times the facility noted not applicable as a response. On 3/10/2020 at approximately 8:00 AM, a review was completed of Resident #9's behavioral progress notes from September 2019 to November 2019: 9/30/2019 at 21:11: .She (Resident #9) was lashing out at several employees and was eventually calmed down . 10/18/2019 at 22:46: The resident was very agitated tonight starting after dinner and she was attempting to lash out at another resident. In the process, she clawed and kicked at me and several CNA's (Certified Nursing Assistants) .she sat by the nurse station until she was calm enough . 10/20/19 at 13:14: On 10/19/20 (Resident #9) was resting in bed .brought her to nurses station. (Resident #9) became immediately agitated yelling out, cry, reaching out, yelling at writer . 10/24/2019 at 21:03: At 18:30, Resident was agitated and witnessed hitting resident on forearm with a soft cover book . 10/25/2019 at 13:34: (Resident #9) was provided with one to one this shift in a quiet environment and did show aggression .calling staff names and trying to reach out and grab staff's arm . 10/30/2019 at 14:11: (Resident #9) had several prolonged episodes of agitation, and verbal aggression with hand shaking and yelling at other residents and staff today. She was relocated to the charge nurse station . 10/30/2019 at 15:47: Earlier today writer attempted to assist with (Resident #9) who was displaying signs of agitation outside the activities office . 10/30/2019 at 15:55: On 10/29/19 this writer walked by (Resident #9's) room and observed (Resident #9) shaking her hand in room mate's face as room mate was backed up to her own bed in her wheel chair . (Resident #9) screamed and attempted to hit this staff . 10/31/2019 at 16:57: (Resident #9) was observed interacting well with care giver but became upset after she left the area . (Resident #9) slammed hands on tray, became tearful and raised her voice and screamed . On 11/1/2019, Resident #9 was admitted to an inpatient psychiatric facility and returned to the facility on [DATE]. 11/19/2019 at 11:02: (Resident #9) became verbally aggressive (loud, accusatory tone and pointing at peer) . 11/20/2019 at 12:48: .She refused her morning medication but attempted several times .she refused to eat or drink anything.

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) She became agitated when I attempted to give her anything . 11/21/2019 at 12:38: (Resident #9) was sleeping at the nurses station in her WC (wheelchair) .Lunch was served and she refused to accept any food or fluids . 11/22/2019 at 13:04: .This morning (Resident #9) was yelling at staff and other residents and reaching out to touch people passing her by . 11/25/2019 at 10:00: (Resident #9) was sitting at the nurse's station prior to breakfast in her WC .She would reach out to passersby trying to grab them .She would reach over and pull my clothing. She would grab my arm hand and squeeze it not wanting to let go . On 12/9/2019, Resident #9 was moved to a private room, prior to the room change the resident had consistent behaviors. Once the room change was completed the amount of behaviors the resident exhibited were minimal, if any. Progress note on 2/7/2020 stated, .Overall (Resident #9) has had decreased behaviors noted since her room change. She had 18 documented behaviors in October 2019 .December review reveals 0 . Further review of January and February 2020 revealed no documented behaviors. Yet, there is no assessment noted of continued need for the resident to be a 1:1 when out of her room. Interview were conducted with facility staff who will remain confidential due to the fear of retaliation. Staff reported it has been difficult to take Resident #9 out of her room due to staffing concerns on 2nd shift. They reported when she is out of her room, she must be a 1:1 and because of that she is never out of her room. On one occasion Resident #9's tray was left in her room and all food items were covered and she had not been fed. The staff stated they feel bad for Resident #9 as she has not had any recent resident to resident interactions but is still on a 1:1. They reported prior the resident's psychiatric admission she was continuously out of her room and since her return they feel she is being isolated. They reported the resident was very interactive with them and now is a shell of the person the used to know. On 3/11/2020 at 11:45 AM, an interview was conducted with Staffing Coordinator Y regarding current staffing concerns. The Coordinator reported they are having issues hiring and maintaining staff. Once they hire someone, another aide will resign. She continued the last few months have been more difficult in maintaining staffing for aides on 2nd shift. She stated ideally on 2nd shift they would have 6 aides and 2 nurses and recently they reimplemented mandating. It was explained there are two rotations and on the 1st rotation, there is one spot open for an aide. On the 2nd rotation, there are 5 spots open for aides. Coordinator Y reported she mandates daily but also some staff do pick up the shifts. She reported due to the shortage the aides are stressed and burned out. There have been days when they worked with 4 aides and that was after mandating. This upcoming weekend Coordinator Y reported they have to mandate the majority of the shift to ensure coverage. On 3/11/2020 at 12:05 PM, Nurse Consultant D was queried about Resident #9 and the amount of time spent in her room at the facility. It was explained the resident does well in low stimulation settings and has displayed aggressive behaviors when in high traffic areas. The nurse was queried if there has been any recent resident to resident interactions, other behaviors and if the resident had been trialed on discontinuing her 1:1 when out of her room. Consultant D stated they have not trialed her on discontinuing the 1:1 or assessed the continued need for 1:1 when not in her room. It was explained there have not been any recent resident to resident interactions. It was provided that throughout the course of the survey the resident has been in her room for most of time and was rarely observed outside of her room.
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, assess and document the re-occurrence of a Stage III pressure ulcer for one resident (Resident #13). Findings include: Record review of the facility 'Skin at Risk Assessment, Documentation, Staging & Treatment' policy dated 1/2020, revealed it is the policy of the facility to assess resident risk factors for the development of impaired skin integrity and intervene as indicated utilizing the admission assessment, plan of care, and Minimum Data Set as formal assessment tools. It was the policy of the facility to assess skin on a regular basis to determine whether changes in the patient's skin condition have occurred. Weekly measurements are conducted on existing pressure injuries. The purpose is to provide prompt identification and intervention for residents at risk of impaired skin integrity corresponding to risk factors and to limit the development of avoidable pressure ulcers and provide evidence-based guidance on effective strategies to promote pressure ulcer healing. A pressure injury (ulcer) is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or as an open ulcer and may be painful. The injury occurs as a result of intense/prolonged pressure or pressure in combination of shear. Stage III: Full-thickness loss of skin, subcutaneous fat maybe visible but bone, tendon or muscle is not exposed. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Record review of the facility Center of Medicare Service (CMS) form 672, dated 3/9/2020, revealed that there were no residents with pressure ulcers residing within the facility. Record review of the facility Matrix, printed on 3/9/2020, revealed that there were no residents identified as having any pressure ulcers. Resident #13: Record review of Resident #13's Minimum Data Set (MDS), dated [DATE], revealed an elderly female with Brief Interview of Mental Status (BIMS) score of 7 out of 15, cognitive impairment noted with no behaviors. Medical [DIAGNOSES REDACTED]. Section H: Bladder and Bowel- frequently incontinent of bladder and bowel. Section M: Skin conditions- noted no pressure ulcers/injuries. In an observation on 3/9/20 at approximately 9:13 AM, Resident #13 was lying in bed at a 45-degree angle with the bedside tray table with breakfast tray. Resident #13 was flat on her bottom and complained that it was uncomfortable to sit. In an observation on 3/10/20 at approximately 10:00 AM, Resident #13 was seated up in a brown cloth textured recliner with her legs elevated and the chair reclined. There was a slip of red dycem (anti-slip material) noted to the bottom of the chair. There was no further cushion other than the recliner seat. In an observation on 3/11/20 at approximately 8:30 AM, Resident #13 was seated up in the brown recliner with her legs elevated on the chair footrest. The state surveyor notified the Certified Nurse Assistant (CNA) W that observations of transfers and skin check needed to be reviewed. An observation was made on 03/11/20 at 9:30 AM in Resident #13's room with Certified Nurse Assistant (CNA) W. CNA W assisted the resident from recliner to use a walker to go to the bathroom. There was a thin piece of red dycem anti-slip material noted in the seat of the chair. CNA W assisted Resident #13 with ambulation with oxygen hose to the restroom and removed the brief which was wet. Resident #13 had an old dressing that came off in the process. CNA W was able to show the state surveyor the open wound that was located at the top of the buttock creases/coccyx region. Observation of the coccyx region noted an open wound with depth. CNA W notified the Registered Nurse (RN) A. An observation was made on 3/11/20 at approximately 9:35 AM with registered Nurse (RN) A. RN A gathered dressing supplies of skin prep, sterile saline wipe and a silicone 4 x 4 foam border dressing. RN A washed her hands and then came into the restroom to apply the dressing. The state surveyor had measurements taken of the wound. The wound measured 0.8 cm in length X 0.6 cm in width X 0.3 cm in depth. While in the restroom the hospice services Licensed Practical Nurse (LPN) X also observed the opened coccyx area. CNA W performed a wipe of the peri area twice and pulled up the brief. Resident #13 was assisted to back to the recliner. A record review of Resident #13's 'Short term Care Plan Wound & Skin' care plan, dated 1/9/20, revealed Stage III coccyx, excoriation right inner buttock fold. A record review of a second 'Short term Care Plan Wound & Skin' care plan, dated 3/2/20, for the same location on the body revealed that there was no further documentation of the pressure ulcer reopening. A record review of Resident #13's 'Wound tracking' documentation in Point Click Care revealed that the Director of Nursing stopped monitoring the wound area on 3/3/2020. In an interview on 03/11/20 at 10:55 AM, Registered Nurse (RN) A revealed that, in the resident's medical record, there was no documentation of an open area to coccyx after 3/3/20. RN A stated that the Director of Nursing is the wound care nurse and she does wound measurements once a week. There was not a short-term care plan found for the re-opening of the coccyx wound, which was dated after 2/11/2020. In an interview on 03/11/20 at approximately 11:34 AM, Registered Nurse (RN) K (Minimum Data Set (MDS) assessment nurse) stated that she was not aware of Resident #13 having an opened pressure ulcer. RN K stated that she had just been told about it 10 minutes ago, before speaking to the state surveyor. RN K stated that the nurses are able to update care plans and the Director of Nursing (DON) is the wound care nurse and she can also update care plans. RN K stated that she did review the wound tracker notes and there is nothing documented after 3/3/20. A record review of Resident #13's care plans, pages 1 through 17, revealed that the skin care plan stated that the pressure ulcers were unavoidable. Interventions addressed a cushion in the wheelchair, but there was no mention of a cushion or off loading/positional changes while in the recliner. Interventions were noted to perform skin inspections with AM/PM care and with showers. A record review of Resident #13's personal hygiene task report, dated 2/11/20 through 3/11/20, revealed that the resident received extensive assistance for the three days prior to the state surveyor's observation of the open wound area and there was no documentation of measurements or of notifying the physician of the re-occurrence of the Stage III pressure ulcer.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to intake number MI 752. Based on observation, interview and record review, the facility failed to 1) ensure that one resident (Resident #8) was free of scratches and digs on her hand and face, 2) ensure that one feeding assist resident (Resident #52) was safe while eating hot cereal from a cup without a lid, and 3) ensure that one resident (Resident #23) was free of a fall with injury, with the potential to affect eight feeding assist residents in the assist dining room, resulting in the likelihood of injury from a burn (from hot thicken cereal), pain, discomfort and pain medication usage with possible hospitalization . Findings include: Resident #8: Review of The Face Sheet, Minimum Data Set (MDS) dated ,[DATE], physician orders [REDACTED].#8 was [AGE] years-old, admitted to the facility on [DATE], required extensive staff assistance with all Activities of Daily Living. The residents [DIAGNOSES REDACTED]. Review of the Altered Functional mobility and ADL care plan dated 9/12/19, revealed the resident required extensive assist with all ADL's related to [MEDICAL CONDITION]'s Disease and stated Inspect skin with bathing and care; report impaired skin integrity to charge nurse. Encourage soft gloves to be worn to reduce the risk of inadvertent, self-inflicted scratches and assess that her fingernails are trimmed, filed and have rounded shape to avoid jagged edges, Observation was made on 3/9/20 at 11:40 a.m., the resident was sitting in her high-back wheelchair in the hallway near the nurses station. The resident was observed to have a total of 14 scratches (some with dried blood on them between the fingers) on her top left hand. She also had a scratch on her forehead, approximately 1 to 1.5 inches in length. The residents pointer finger on her right had had a broken, jagged edge nail and the resident was noted to have small jerky movements (related to Houghton's Disease). No dressing, Band-Aid or covering at all was on the residents left hand at the time. Due to cognitive impairment and decreased communication, the resident was not able to tell this surveyor how she got the scratches. During an interview done on 3/9/20 at 11:42 a.m., Nursing Assistant/CNA C stated I work with her (the resident) last Thursday (on 3/5/20) and she did not have that (scratches), they were not there before today (3/9/20). CNA C informed this surveyor that she had observed the scratches on the residents left hand on the early morning of 3/9/20, however did not inform the Nurse of them. During an interview done on 3/9/20 at 11:45 a.m., Nurse, RN B said she was not told of the scratches prior to this surveyor showing them to her (on 3/9/20) and stated I did not see them there, I worked last Thursday (on 3/5/20). It (a facility Incident Report) should have been done when it was noticed. During an interview done on 3/9/20 at 11:55 a.m., the Director of Nursing/DON stated It's definitely new, it should be reported to the charge nurse, she is going to write it up (write out an Incident Report). Review of the facility Incident report dated 3/9/20 (after this surveyor requested information regarding the residents scratches on her hand and forehead), stated Observed 14 small scratch-like areas to top of left hand; filed jagged right pointer fingernail. Root cause most likely related to jagged edge on fingernail. Review of the facility Accident/Incident Reports policy dated 2/15/20, stated It is the policy of this facility to complete an accident/incident report for unexplained bruises or abrasions; accidents or incidents where there is injury or the potential to result in injury. Resident #52: Review of the Face Sheet, Minimum Data Set ((MDS) dated [DATE], physician orders [REDACTED].#52 was [AGE] years-old, admitted to the facility on [DATE], alert with confusion, required staff assistance with all Activities of Daily Living (ADL's) and was an assist with feeding as needed with decreased safety awareness. The residents [DIAGNOSES REDACTED]. The resident was placed by the facility in the assist dining room due to feeding difficulties requiring staff assistance as needed. Review of the Altered Nutritional Status care plan dated 8/29/14 (up-dated 10/17/19) and physician order [REDACTED]. Review of the Altered Mobility care plan dated 1/18/12 (up-dated 2/28/20), revealed the resident received a pureed diet and staff were to provide physical assistance with acceptance of meals as needed. Also this care plan stated prefers her oatmeal in a coffee mug. Observation was made on 3/10/20 at 8:01 a.m., in the back assist dining room of Resident #52 having breakfast. There were several staff members in this dining room at the time searing food and assisting with feeding other residents. The resident had received a coffee cup of hot cereal. CNA H had added some of the residents milk to the hot cereal (no temperature was taken of the hot cereal after the milk was added). The residents cereal in the cup was observed to be almost up to the rim of the cup. When the resident was holding onto the cup without a lid on it, she almost spilled the hot cereal several times onto her chest, neck and abdomen area. The resident had a non-lined cloth clothing protector on at the time (which would of held in the hot cereal fluid if spilled directly on the chest area). The cup was observed tipping toward the resident and back away from the resident several times as she tried to drink the cereal. The resident was unable to drink the hot cereal by herself and almost spilled it several times. The resident had a small cup of milk with a lid on it and small straw sitting next to her coffee cup of hot cereal without a lid on it. The residents right hand was noted to be continuously shacking; she was very unsteady with the hot cup of cereal. This surveyor requested Cook J take a temperature of the hot cereal on the serving table at this time, which was reported as being 70.2 degrees. During an interview done on 3/10/20 at 8:20 a.m., CNA H said she had put a lid with straw on the residents milk cup but not on the cup of hot cereal and stated she (Resident #52) should have a top on it (a lid on her coffee cup of hot cereal). Review of the facility Temperature Production Log dated 3/10/20, revealed the Hot Cereal was cooked at 197 degrees, started (started on serving line) at 189 degrees and sat a a temperature (end) of 172 degrees. Review of the Altered Mobility care plan dated 1/18/12 (up-dated 2/28/20), revealed the resident had altered mobility, decreased physical mobility, spastic limbs and generalized weakness. This made self feeding difficult at times, with hand shaking and having a hard time holding onto a cup filled with hot cereal. During an interview done on 3/10/20 at 11:55 a.m., the Dietary Manager E stated I have to change the care plan (add put a lid on the coffee cup with hot cereal in it). I try to make it in the dining rooms at least one time a day; staff did not inform me of this, they should have. During an interview done on 3/10/20 at 12:00 p.m., Registered Dietitian F stated If she (Resident #52) was having trouble she should of had a lid (on the coffee cup with the hot cereal in it). Review of the Nutritional Services review dated 3/11/20, stated She (the resident) has meals in the Back Dining Room. She has a [MEDICAL CONDITION] dx (diagnosis) with feeding difficulties. She prefers her hot cereal in a mug (coffee cup), however she is now trying cup with lid for hot cereal. This note was written the day after the observation of the resident in the dining room on 3/10/20. Resident #23: On 3/10/2020 at approximately 8:10 AM, a review was completed of Resident #23's medical record and it revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review was completed of the resident's medical records and it revealed the resident was severely cognitively impaired and requires the assistance of one person assist for toileting. Review of the progress notes yielded the following: 11/20/19 at 10:29: .She (Resident #23) continued to self transfer to bedside commode. 11/30/2019 at 13:12: .(Resident 23) transfers herself to the bedside commode for toileting . 12/4/19 at 14:57: .She (Resident #23) transfers to the commode for toileting in her room . 12/6/2019 at 12:44: .Does attempt to transfer to commode in room . 12/9/2019 at 08:54: .She (Resident #23) transfers herself to the bedside commode . On 3/10/2020 at 3:50 PM, an interview was conducted with CNA T regarding Resident #23's fall on 2/29/2020 that resulted in a femur fracture. CNA T stated she was working the back hall and came to the nurse station to inform the nurse of something. The nurse was not there, and she and CNA S heard what sounded like a walker being moved. They went to investigate and found Resident #21 on the floor and it appeared she was trying to self-transfer to the commode (that was kept at bedside). Resident #23 was laying on her left hip, holding herself up with arm and her knee was bent the wrong way. The aides immediately went to alert the nurse and made the resident comfortable as they waited on the ambulance to arrive. CNA T reported Resident #23 stated to her I fell , lets go back to bed. CNA T reported there was one other time (that CNA T can recall) the resident had fallen from trying to self-transfer to the commode as Resident #23 is impulsive. On 3/10/2020 at 4:03 PM, an interview was conducted with CNA S regarding Resident #23's fall. The CNA explained while at the front desk, she heard what sounded like a commode had tipped and then went back to the ground. They went to investigate the noise and found Resident #23 sitting on the floor, and the resident stated, my leg is broken. The resident was sitting against the commode when they walked into the room. The aide explained the resident was known to self-transfer to the commode and previously self-transferred and fell when she was attempting to toilet herself. On 03/11/2020 at approximately 10:05 AM, a review was completed of Resident #23's five falls with the DON (Director of Nursing) and Nurse Consultant D. With her most recent fall resulting in a femur fracture. Four of the five falls were related to the resident's need to use the restroom. The falls are as follows: 11/19/2019 at 09:05: . (Resident #23) sitting on floor facing bed. W/C (wheelchair) behind her. Resident stated, I had to take a pooper. Interventions: Remove foot pedals 11/21/2019 at 15:30: Resident was attempting to self-transfer and was on the floor at 15:30. She was facing the door of her room on her bottom and her legs were in front of her. Her wheelchair was facing the window behind her but was within arm's reach. She was alert and checked for injuries at time of incident. Interventions: Anti-roll back brakes were applied.

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	235592	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HURON WOODS NURSING CENTER	1395 S HURON RD KAWKAWLIN, MI 48631

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 -** Some	(continued... from page 4) 11/25/2019 at 0150: .staff heard loud noise and seen bedroom door . start to swing shut. (Resident #23) was observed lying on the floor with her lower extremities in the bedroom and her upper body out into the hall .she stated I hit my head. I'm surprised I didn't knock myself out . Resident was evaluated at acute care hospital and complained of pain in her buttock/hip area. The conclusion was the resident attempted to get up from bed as she had to use the restroom. Intervention: A soft touch call light was initiated. 1/23/2020 at 15:30: Resident was attempting to self-transfer .she was facing the door of her room on her bottom and her legs were in front of her . Resident stated, I have to go pee. Intervention: Night gowns for sleep at HS (night) 2/29/2020 at 01:30: .heard what sounded like bedside commode tipped and then legs of commode return to the floor .She (Resident #23) stated she was trying to pee and fell .internal rotation noted to right lower extremity with shortening . Resident suffered a right femur fracture. Following review of the falls an interview was conducted with the DON and Consultant D. They reported the resident's bedside commode had been there since her admission and they discontinued the commode at bedside (after the femur fracture) as the risk outweighed the benefits. They were queried if the usage of commode was reevaluated as 4 of 5 falls were related to the resident having to use the restroom. They reported the commode was not reevaluated until after Resident #23's last fall which caused a femur fracture. They were further queried if the resident can utilize the call light and they reported she is not. They have it to alert staff if she is getting out the bed. The DON and Consultant D were asked if they educated staff on best placement of the call light or tried different positions with the light to see what is best for the resident. The DON and Consultant reported they had not. On 3/11/2020 at 2:06 PM, an interview was conducted with Nurse O regarding Resident #23's fall. The nurse reported the aides came to get her as she was on break and when she entered Resident #23's room she observed that her knee was internally rotated. She reported the resident attempts to self-transfer frequently as she is impulsive and does not recognize her need for assistance. Review was completed of the facility policy entitled, Accident/Incident Reports, revised 2/15. The policy does not address continued evaluation of interventions.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to 1) ensure that three medication carts were clean and sanitary, 2) ensure that three medication cart's open and partly used medications were dated with an open date and 3) ensure that opened and partly used treatment medications were dated with an open date of three medications carts and one medication room observed, resulting in the likelihood for cross contamination and out dated mediations given to residents with decreased stability, sterility and efficacy. Findings Include: Observation was done on 3/9/20 at 9:25 a.m., of Medication cart #3, accompanied by Nurse, RN A. The following concerns were observed: -A medication cup was found in the second drawer with crushed medications mixed with applesauce (se-up of medication). During an interview done on 3/9/20 at 9:25 a.m., Nurse, RN A stated It (the med cup with crushed medications) should not be in there. -Resident #14 had Nasal Spray (Oxymetazoleus) open, partly used with no dates on the container at all; no open date was written on the bottle or medication box. -Resident #39 had Saline Nasal Spray 65% open, partly used with no dates on the container at all. -Resident #52 had Ear Drops ([MEDICATION NAME]) open, partly used with no dates on the container at all. -Resident #3 had Nasal Spray open, partly used with no dates on the container at all. -Observation of the top and second drawers of the medication cart (cart #3), revealed several pieces of paper and crushed white pill-like material on the back bottom of the drawers. -Observation was done on 3/9/20 at 9:54 a.m., of Medication cart #2, accompanied by Nurse, RN G. The following concerns were observed: -Observation of the second an third drawers of Medication cart #2, revealed several pieces of paper and crushed white pill-like material on the back bottom of both drawers. -Resident #46 had Dry Eye Relief open, partly used with no dates on the container at all; no open date was written on the bottle or medication box. During an interview done on 3/9/20 at 10:00 a.m., Nurse, RN G stated There should be the date it's (medications) open on the bottle and the box. During an interview done on 3/9/20 at 12:40 p.m., the Director of Nursing (DON) said nursing staff should be cleaning the med carts and no set-up's should be done. Observation was done on 3/11/20 at 8:55 a.m., of the facility Med room and resident treatments (stored in the med room), accompanied by Nurse, RN I. The following concerns were observed: -Stock medications that were found to be open and partly used with no dates on the containers or box's at all. Minerin Cream Antifungal Cream Two tubes of [MEDICATION NAME] Ointment Derma Sgn Hydrogel Wound Dressing -Resident #42 had Nyatatin powder open, partly used with no dates on the container at all. -Resident #6 had Nyatatin powder open, partly used with no dates on the container at all. -Resident #22 had two containers of Nyatatin powder open, partly used with no dates on the container at all. -Resident #43 had DermaPhor open, partly used with no dates on the container at all. -Resident #9 had Minerin Cream open, partly used with no dates on the container at all. -Resident #44 had Mat-Freez Gel open, partly used with no dates on the container at all. -Resident #31 had Muscle Rub open, partly used with no dates on the container at all. During an interview done on 3/11/20 at 8:55 a.m., Nurse, RN I stated When they (resident medications) are open, they need a date on them (an open date). During an interview done on 3/11/20 at 8:43 a.m., the DON stated We date the med when it's open and then we go by the expiration date. Review of the facility Medication Storage & Stability policy dated 8/2019, stated Once these products (medications) are opened, they must be used within a specific timeframe to avoid reduced stability and sterility and potentially, reduced efficacy.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent facility-acquired Urinary Tract Infections and re-educate staff on peri care for all residents within the facility, resulting in urinary tract infections or recurrent urinary tract infections for dependent residents. Findings include: Record review of the facility 'Infection Control Program' policy dated 10/2009, revealed that infection control coordinator shall provide educational programs to increase the staff awareness of infectious disease and the importance of prompt reporting and treatment, as well as proper infection control practices. it is the responsibility of the infection control team and education department to establish and initial and periodic training. The facility shall implement, comply with and review at least annually, written policies and procedures regarding infection prevention and control which are consistent with the most up-to-date Centers for Disease Controls and Prevention (CDC) publications. Record review of the facility 'Urinary Tract Infection: Catheter Associated UTI's, Prevention & Surveillance Guidelines' policy dated 10/2011, revealed it is the policy of the facility to apply evidence-based guidelines to alterable risk factors in the development of nosocomial (Facility acquired) Urinary Tract Infections. Interview and record review on 03/10/20 at 03:00 PM during the Infection Control task with Registered Nurse (RN) L was asked to provide the annual review of the infection control policies documentation. RN L was not able to locate an annual policy review or if there had been any infection control updates or revision to policies. RN L and the state surveyor reviewed the December 2019 Resident infection line listing noted a total of 13 infections with 8 facility acquired Urinary Tract Infections for the month. Record review of the December 2019 'Infection Control Resident Surveillance' log revealed that Resident #36 sustained a facility acquired urinary tract infection [MEDICAL CONDITION] on 12/4/19 that required antibiotic of Keflex. On 12/27/19 Resident #36 again sustained a facility acquired urinary tract infection [MEDICAL CONDITION] and was placed on antibiotic. In an interview on 03/10/20 at 03:00 PM during the Infection Control task with Registered Nurse (RN) L was asked about staff re-education in peri-care and RN L pulled a blue folder from a binder and presented 9 CNA 'Return Demonstration Incontinence Care/Principles of Bed bath' check off sheets. Further education material was presented that 8 nurses signed a sheet about education undated with no topic. Record review of a staff list presented to surveyors at the beginning of the survey revealed a total of 47 Certified Nurse Aides and 15 nurses were identified. Record review of the January 2020 Resident infection control log Resident #21 was noted to have a Urinary Tract Infection [MEDICAL CONDITION] on 1/24/20 with the organism Escherichia Coli (E. coli) and received antibiotic [MEDICATION NAME]. Record review of the February 2020 Resident Infection Control log revealed that Resident #36 on 2/14/2020 was noted to have urinary tract infection with organism Escherichia coli (E. coli) and received [MEDICATION NAME] antibiotic. On 2/25/20 Resident #21 was noted to have urinary tract infection with organism Escherichia coli (E. coli) and received [MEDICATION NAME] antibiotic. Both were re-current Urinary tract infections that occurred after the facility staff were educated and both Resident #21 and #36 are dependent on staff for personal care. A second request was made for the annual

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 5) infection control policies review documentation in the morning on 3/11/2020 from the corporate representative and the Nursing Home Administrator. At the time of the annual survey exit conference there were no documents of the annually reviewed infection control policies presented to surveyors.