STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235320	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAHSER HILLS CARE CENTRE	25300 LAHSER RD SOUTHFIELD, MI 48034

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on interview and record review, the facility failed to ensure 10 of 10 residents who attended the anonymous resident council interview were assisted in exercising their right to vote, resulting in the residents not voting in the primary presidential election for the year 2020. Findings include: On 3/10/20 at 10:30 AM, a Resident Council Interview was conducted with ten residents who wished to remain anonymous. During the interview, residents were interviewed about their rights. When asked if any residents had voted (via absentee ballot) or were going to be voting in the primary presidential election held on 3/10/20, all 10 residents reported they were not assisted in obtaining an absentee ballot and nobody spoke with them regarding voting. When asked by a show of hands how many residents would have wanted to vote if given the opportunity, all ten residents raised their hands. On 3/11/20, Activity Manager (AM) O was interviewed. AM O reported the Resident Council met weekly and they invited AM O to attend the meetings. AM O reported resident rights were discussed during the meetings. When queried about how the facility ensured residents who wanted to vote in the primary presidential election on 3/10/20 received their absentee ballots in time, AM O reported when absentee ballots arrived in the mail, they were delivered to the residents. AM O did not have a list of residents who were registered to vote and/or assisted in getting an absentee ballot. AM O reported she took a roster of residents to the city clerk office to obtain a ballot on 3/10/20 (the day of the election) and they would not release the ballots. When queried about what was done prior to the day of the election to ensure everyone could vote, AM O reported being unaware of having to request an absentee ballot for each election. AM O provided photocopies of the sealed envelopes of absentee ballots received from residents, however, they were from 2018. There was no information provided about who received ballots for the 3/10/20 primary presidential election or how information was shared with the residents to ensure timely registration. A facility polity titled, Rights of Residents in (state name redacted) Nursing Facilities documented, .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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (R#620) of one resident reviewed for accommodation of needs had an appropriately sized bed for their height, resulting in resident complaints of discomfort. Findings include: On [DATE] at 9:03 A.M., R#620 was observed lying in bed. R#620's legs were bent and appeared contracted and approximately five inches were observed between the foot of the bed and R#620's feet. R#620 reported they were unable to stretch out their legs and were unable to move on their own. R#620 reported feeling uncomfortable and stated, This bed isn't big enough. My feet hurt, my neck hurts. I'm six foot seven. I need a different bed. A review of R#620's clinical record revealed R#620 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/11/20 at 12:30 PM, the Director of Nursing (DON) was interviewed. The DON reported residents were assessed for appropriate equipment, including appropriately sized beds and wheelchairs on admission. When queried about R#620 whether their bed was an optimal size for their height, the DON reported, Foot extenders could be placed to extend the bed. The DON was asked to provide any assessment of the resident upon admission regarding the bed size. No additional information was provided prior to the end of the survey. A policy regarding beds to accommodate individualized needs of residents was requested. The DON reported the facility did not have a policy.
F 0577 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.** Based on observation, interview, and record review, the facility failed to ensure residents and visitors had access to previous survey results without having to ask the facility, resulting in residents and visitors being uninformed of deficiencies identified in the facility. This had the potential to affect all residents who reside in the facility. Findings include: On [DATE] at 10:30 AM, a Resident Council Interview was conducted with ten residents who wished to remain anonymous. During the interview, residents were interviewed about their rights. When asked where residents could review results from the previous surveys conducted by the State Agency, no residents were aware of the location of the information. On [DATE] at 11:14 AM, observations of the 1st and 2nd floor was made. No survey information was located. On [DATE] at 2:45 PM, an interview with Receptionist U was conducted. When queried about where residents and visitors could access results from previous surveys, Receptionist U reported there was a binder located behind the desk and stated, They can just ask me for it. Receptionist U reported there were no other binders located throughout the facility because It's too big. On [DATE] at 2:52 PM, the Administrator was interviewed. When queried about where residents and visitors could access results from previous surveys, the Administrator reported a binder was kept behind the receptionist's desk and nowhere else in the facility. The Administrator reported there was a sign posted in the elevator that noted the survey results were at the receptionist desk. When queried about whether or not residents and visitors could obtain the binder without asking staff, the Administrator reported they would have to ask the receptionist. A facility policy titled, Rights of Resident in (state name redacted) Nursing Facilities documented, .You have the right to: a. Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** This citation pertains to intake #MI 626. Based on observation, interview and record review, the facility failed to maintain a clean, comfortable and homelike environment for two residents (R#26 and R#58) whose room environment was observed, resulting in an unsanitary environment and resident and/or family dissatisfaction with their living conditions. Findings include: On 3/11/20, review of a complaint reported to the State Agency included allegations that the facility smelled and was not clean. An onsite investigation was conducted from 3/9/20 to 3/12/20 to investigate the allegations. On 3/11/20 at 11:39 AM, the room occupied by R#26 and R#58 was observed to have a strong urine odor. Neither of the residents were present at this time, however there was a soiled brief placed directly into the trashcan without a liner located near

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

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) the entrance of the room. The soiled brief was not contained in a bag. On 3/11/20 at 2:00 PM, the room occupied by R#26 and R#58 was observed again and the strong urine odor as observed earlier remained. Neither of the residents were present at this time. The soiled brief was gone, but several used gloves remained in the bottom of the unlined trash can and on the floor surrounding the trash can. On 3/11/20 at 2:10 PM, an interview was conducted with Certified Nursing Assistant (CNA V) who reported was the staff assigned to the room occupied by R#26 and R#58. When asked about the observation of the soiled brief placed in the trash can and whether those items should be discarded into the trash can, and without a trash can liner, CNA V stated, No they're supposed to be in a bag and taken out. I might have put it in there earlier. I'll work on that. When asked who was responsible to ensure the trash cans had liners and used gloves were properly discarded, the CNA reported, The Housekeeper is suppose to put the liners in but I can do that now. On 3/11/20 at approximately 3:00 PM, the Director of Nursing (DON) was queried as to the facility's process for ensuring soiled briefs and gloves were stored adequately. The DON reported there was no policy, but that the facility's practice and expectation is to discard soiled items properly, in bag and taken to soiled utility room. The DON was informed of the above observations and reported she would follow up.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 511. Based on observation, interview, and record review, the facility failed to implement their resident concern policy to address resident/family grievances for one (R#35) of one resident reviewed for grievances, resulting in the potential for unresolved concerns regarding the care of the resident. Findings include: On 3/10/20 at 10:30 AM, during an interview with the facility's Resident Council members. One resident who wished to remain anonymous reported they shared a room with R#35. The resident reported R#35 sat in feces for several hours a week or so ago and stated, Nobody came to help him! The resident reported they notified the Administrator of the concern. On 3/10/20 at 3:15 PM, R#35 was interviewed. R#35 was observed lying in bed and answered questions mostly by nodding yes or shaking their head no. R#35 reported there were times when their call light was not answered timely and they had to lie in bed with soiled brief. R#35 did not elaborate or give any additional information. On 3/10/20 at 3:42 PM, R#35's family member was interviewed. R#35's family member reported they were concerned about R#35 sustaining multiple falls and felt the facility was understaffed. The family member reported R#35 had several falls in the past few months and the staff report the resident said he was getting up to use the bathroom. R#35's family member reported R#35 could not get themselves out of bed and could only shimmy in bed when they had a brief on that has not been changed. The family member reported speaking to the Director of Nursing (DON) about their concerns, as well as the Assistant Director of Nursing (ADON), and the Administrator. The family member reported the Administrator told them they did not have anything to do with clinical concerns and they would have to go to someone clinical. R#35's family member reported filling out multiple concern forms. On 3/11/20 at approximately 9:15 AM, 1:00 P.M., and 3:00 P.M., the Administrator and the DON were asked if there were any concern forms for R#35. At approximately 3:05 P.M., the Social Services Director reported there were no concern forms for R#35. On 3/11/20 at 3:55 PM, the Administrator was interviewed. When queried about the facility's grievance and concern process, the Administrator reported they were tracked on a concern form and explained the concern form could be completed by anyone. The Administrator reported the social services department maintained a binder with all of the resident concerns. The Administrator stated, If there are care concerns, like if a residents comes in with a care concern, I will go get the DON and ADON and they can express their concern to them. When queried about any concerns expressed by R#35, R#35's family members, or R#35's roommate, the Administrator reported the only thing he knew about was with headphone because the television was too loud and stated, If there was a clinical concern, I would have immediately got the clinical manager or DON. The Administrator reported he could not recall any clinical concerns brought to his attention and that they would not have been documented on a concern form. The Administrator denied talking to R#35's roommate about any concerns. At that time, the Administrator invited the DON and the Nurse Manager I to the interview. On 3/11/20 at 4:20 PM, the DON and Nurse Manager I were interviewed in the presence of the Administrator. Nurse Manager I did not recall any concerns brought forth by R#35's family or any other residents. The DON was queried about the facility's process for handling care concerns expressed by residents or family members. The DON reported they would be discussed in morning report and tracked. The DON reported not all concerns would be documented on a concern form and would rather be reflected in the clinical record in a progress note and care plan. When queried about any concerns expressed by R#35's family member or roommate, the DON reported family had concerns about all the falls. The DON reported it was not documented on a concern form because they included the family member in developing interventions and they were reflected in the care plan. The DON reported R#35's roommate expressed concerns that R#35 had their call light on and nobody answered it. The DON reported she conducted an investigation and it was in her office. When queried about how the resolution was monitored to ensure compliance was sustained, the DON reported, By the care plans and tasks. The DON reported there was no follow up with grievance. At that time, the Administrator reported a care concern regarding call lights would not be considered a grievance and stated, A grievance would mean it wasn't resolved. O 3/11/20 at 5:30 PM, the DON reported she was unable to locate the mentioned investigation into R#35's family's concerns. A review of R#35's clinical record and Incident and Accident (I&A) reports revealed R#35 had six falls since May 2019. R#35 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A MDS assessment dated [DATE] documented R#35 had moderately impaired cognition, and required extensive physical assistance by one to two people for bed mobility, transfers, and toilet use and did not walk. A facility policy titled, Resident Concern Policy (revision date: 2/26/19) documented, Instructions for requesting Assistance from Staff .In order for us to assist you, please follow the procedure identified below if you have any complaint/grievance about your care, treatment by staff or anything else related to your stay in our center .Step 1. Tell your grievance(s) to one of the individuals listed below: Director of Nursing .Administrator (Grievance Official) .Social Services Director .Charge Nurse (if after hours) .Step 2. If you are not satisfied with the staff person's response please complete our 'Resident's Assistance Form' .Step 3. Submit the form to our Administrator or Director of Nursing .Step 4. If you are not satisfied with the center's written response, complete a request for the administrator to review the investigation findings .Our time frames for investigating your grievance are: .As soon as possible but within 15 days - for any other grievance .We will give you a written response as soon as possible but not later than 30 days after we receive your request .We will follow-up to ensure your grievance has been addressed satisfactorily .
F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 6 Based on interview, and record review, the facility failed to ensure freedom from abuse for one resident (R#70) of 12 residents reviewed for abuse, resulting in R#70 being physically abused by a staff member. Findings include: On 3/11/20 at 8:45 AM, the facility's Administrator was requested to provide all investigative material and documents for the Facility Reported Incident that was reported to the State Agency on 2/21/20 regarding R#70. At approximately 10:45 AM, the facility's Administrator provided a folder and confirmed all documentation regarding the investigation was contained in the folder. On 3/11/20 at 11:00 AM, a review of the investigation file provided by the facility's Administrator was reviewed. The file was noted to contain 6 individual documents: 1. R#70's face sheet, 2. A typed 24 hour summary report, 3. A typed, unsigned, undated statement from Certified Nursing Assistant (CNA) 'K', the alleged perpetrator, 4. A typed, unsigned, undated statement from the facility's Administrator, 5. A document regarding information for victims of domestic violence with the reporting police officer's name and incident number, and 6. A typed document titled 5 Day Investigative Findings. Review of the documents revealed: The 24 hour summary report read, .On February 21, 2020 at approximately 12:00PM, a staff member alleged that she saw another staff member hit resident (R#70) in the forehead while providing him care. The nurse manager immediately reported the allegation to the Executive Director (Administrator) and Director of Nursing. CNA 'K's statement read, I went to get the resident up for breakfast and he said no. He cursed at me. He hit me several times while trying to get him up that morning. At some point he punched me in the face. I grabbed both his hands and held him down. I told the resident that 'men don't hit woman <sic>'. After the incident

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) I continued providing care and making up his bed. The facility Administrator's statement read, On February 21, 2020, I was in the room when the resident was interviewed by the (City Name) Police Department.When I interviewed (R#70) in my office he stated that he was hit by a woman but was not able to identify the staff person. I also had the (City Name) Police Department talk to (R#70), (CNA 'K') and (CNA 'M') who were present in the room at the time of incident. The Police stated that because the resident was hitting the CENA (CNA) and the CENA reacted.that he would not be able to substantiate an abuse allegation. The 5 Day Investigative Findings Document read, On February 21, 2020 at approximately 12:00PM, a staff member alleged that she saw another staff member hit resident (R#70) in the forehead while providing him care. The nurse manager immediately reported the allegation to the Executive Director and Director of Nursing.Upon further investigation, it was reported that the resident was combative at the time that AM (morning) care was being rendered. The CNA that witnessed the incident (CNA 'M') and the alleged perpetrator (CNA 'K') both stated that the resident was striking and hitting the alleged perpetrator during care. Both CNAs stated the alleged perpetrator was struck in the face by the resident during care. The alleged perpetrator stated that at no time, did she strike the resident back. The alleged perpetrator did state that when she was hit in the face, her initial reaction was to close her eyes and put her hands out in front of her to stop any further blows from the resident. She did not, however, report that she made contact with the resident's face in an attempt to physically redirect the resident.In conclusion, the resident had no injury or harm resulting from the incident. The alleged perpetrator stated that she does not recall making contact with the resident's face but does state that her eyes were closed due to her being struck in the cheek by the resident.The alleged perpetrator, if contact was made, had no intent to harm the resident, but rather was physically redirecting the resident to protect herself from another strike.Education has been provided to staff to re-approach the resident if he becomes combative with care in the future. It was noted the Administrator/Abuse Coordinator's 5 day summary did not address the CNA's statement that read, . I grabbed both his hands and held him down. I told the resident that 'men don't hit woman <sic>'. On 3/11/20 at 4:10 PM, a telephone interview with CNA 'M' was conducted. During the interview, CNA 'M' was asked to recall the events surrounding the allegation of abuse she reported to the Unit Manager (Unit Manager 'I'). CNA 'M' explained that she was in orientation and she was working with CNA 'K'. She continued to explain that she and CNA 'K' were in R#70's room to assist him with morning care. CNA 'M' said that R#70 became combative during care and had hit CNA 'K' several times. CNA 'M' indicated that she told CNA 'K' they should leave, but CNA 'K' refused. CNA 'M' said R#70 kept saying Stop but CNA 'K' didn't. CNA 'M' stated, She kept grabbing him and telling him he had to get up, and that he was going to get up no matter what. CNA 'M' said R#70 then threatened to hit CNA 'K' and told her he was going to throw her into the wall. CNA 'M' continued to explain that R#70 did hit CNA 'M' again, and CNA 'M' stated, After he hit her that time, she hit him back straight in the middle of his forehead. CNA 'M' was asked who they reported the incident to and indicated they reported it to Unit Manager/Licensed Practical Nurse 'I'. CNA 'M' was then asked if they were interviewed or prepared any type of statement regarding the incident and indicated she signed and dated a statement regarding what she had witnessed. A review of CNA 'K's personnel file was conducted on 3/11/20 at approximately 3:30 PM. The file contained a document titled, EMPLOYEE CORRECTIVE ACTION that indicated CNA 'K' had been terminated from employment. The EMPLOYEE CORRECTIVE ACTION form read, .Describe situation and/or concerns:.CNA reported to ED (Executive Director) and DON (Director of Nursing) that on 2/20/2020 while providing care, resident was noted to be combative. CNA reported that the Kardex (care guide) says to reapproach <sic> for cares when combative but the CNA, by her own admission, did not follow this procedure leading to possible psychosocial harm by <sic>the resident during cares. CNA reported that she told the new CNA that she was going to provide care to the resident despite the combative behavior. A review of R#70's clinical record was conducted and revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. R#70's most recent Minimum Data Set assessment dated [DATE] indicated R#70 had moderate cognitive impairment, did not exhibit any physical, verbal, or rejection of care behaviors, was non-ambulatory, and required extensive assistance of one to two staff members for activities of daily living. On 3/11/20 at 4:20 PM, an interview with the facility's Administrator, DON, and Unit Manager 'I' was conducted regarding the allegation from CNA 'M' that CNA 'K' had hit R#70 in the head. It was explained that the police were called, responded, and since they couldn't substantiate abuse, the facility did not substantiate abuse. When asked about CNA 'K's statement that she had, .held him down., and told R#70, .men don't hit woman <sic>. and whether those could be considered abusive behaviors, no response was provided. During the interview, Unit Manager 'I' was queried about the incident. Unit Manager 'I' explained that CNA 'M' reported to her that she saw CNA 'K' hit R#70, and she (CNA 'M') heard CNA 'K' tell CNA 'L' that after he hit her, she hit him back. At that time, the Administrator was asked how CNA 'L' was involved in the incident and if it had been overheard that CNA 'K' told CNA 'L' she hit the resident, why wasn't there an interview or statement from CNA 'L'. The Administrator had no response to the questions. A review of a facility provided policy titled, ABUSE, NEGLECT, AND/OR MISAPPROPRIATION OF RESIDENT FUNDS OR PROPERTY with a revision date of 12/10/18 was conducted and read, .PURPOSE: To assure each resident in the center is free from abuse, neglect and exploitation. The facility was asked if they had any additional information to provide regarding the concern; none was provided by the end of the survey.
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 intakes MI 6. Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse for one resident, (R#70) of 12 residents reviewed for abuse, resulting in the potential for undetected and continued abuse. Findings include: On 3/11/20 at 8:45 AM, the facility's Administrator was requested to provide all investigative material and documents for the Facility Reported Incident that was reported to the State Agency regarding R#70. At approximately 10:45 AM, the facility's Administrator provided a folder and confirmed all documentation regarding the investigation was contained in the folder. On 3/11/20 at 11:00 AM, a review of the investigation file provided by the facility's Administrator was reviewed. The file was noted to contain 6 individual documents: 1. R#70's face sheet, 2. A typed 24 hour summary report, 3. A typed, unsigned, undated statement from Certified Nursing Assistant (CNA) 'K', the alleged perpetrator, 4. A typed, unsigned, undated statement from the facility's Administrator, 5. A document regarding information for victims of domestic violence with the reporting police officer's name and incident number, and 6. A typed document titled 5 Day Investigative Findings. Review of the documents revealed: The 24 hour summary report read, .On February 21, 2020 at approximately 12:00PM, a staff member alleged that she saw another staff member hit resident (R#70) in the forehead while providing him care. The nurse manager immediately reported the allegation to the Executive Director (Administrator) and Director of Nursing . CNA 'K's statement read, I went to get the resident up for breakfast and he said no. He cursed at me. He hit me several times while trying to get him up that morning. At some point he punched me in the face. I grabbed both his hands and held him down. I told the resident that 'men don't hit woman <sic>'. After the incident I continued providing care and making up his bed . The facility Administrator's statement read, On February 21, 2020, I was in the room when the resident was interviewed by the (City Name) Police Department .When I interviewed (R#70) in my office he stated that he was hit by a woman but was not able to identify the staff person. I also had the (City Name) Police Department talk to (R#70), (CNA 'K') and (CNA 'M') who were present in the room at the time of incident. The Police stated that because the resident was hitting the CENA (CNA) and the CENA reacted .that he would not be able to substantiate an abuse allegation . The 5 Day Investigative Findings Document that read, On February 21, 2020 at approximately 12:00PM, a staff member alleged that she saw another staff member hit resident (R#70) in the forehead while providing him care. The nurse manager immediately reported the allegation to the Executive Director and Director of Nursing .Upon further investigation, it was reported that the resident was combative at the time that AM (morning) care was being rendered. The CNA that witnessed the incident (CNA 'M') and the alleged perpetrator (CNA 'K') both stated that the resident was striking and hitting the alleged perpetrator during care. Both CNAs stated the alleged perpetrator was struck in the face by the resident during care. The alleged perpetrator stated that at no time, did she strike the resident back. The alleged perpetrator did state that when she was hit in the face, her initial reaction was to close her eyes and put her hands out in front of her to stop any further blows from the resident. She did not, however, report that she made contact with the resident's face in an attempt to physically redirect the resident .In conclusion, the resident had no injury or harm resulting from the incident. The alleged perpetrator stated that she does not recall making contact with the resident's face but does state that her eyes were closed due to her being struck in the cheek by the resident .The alleged perpetrator, if contact was made, had no intent to harm the resident, but rather was physically redirecting the resident to protect herself from another strike .Education has been provided to staff to re-approach the resident if he becomes combative with care in the future . It was noted the investigation file did not contain a statement from CNA 'M', who alleged they witnessed CNA 'K' hit R#70. It was further noted the investigation file did not contain a statement from Unit

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) Manager 'I', who CNA 'M' reported the allegation to. On 3/11/20 at 4:10 PM, a telephone interview with CNA 'M' was conducted. During the interview, CNA 'M' was asked to recall the events surrounding the allegation of abuse she reported to the Unit Manager (Unit Manager 'I'). CNA 'M' explained that she was in orientation and she was working with CNA 'K'. She continued to explain that she and CNA 'K' were in R#70's room to assist him with morning care. CNA 'M' said that R#70 became combative during care and had hit CNA 'K' several times. CNA 'M' indicated that she told CNA 'K' they should leave, but CNA 'K' refused. CNA 'M' said R#70 kept saying Stop but CNA 'K' didn't. CNA 'M' stated, She kept grabbing him and telling him he had to get up, and that he was going to get up no matter what. CNA 'M' said R#70 then threatened to hit CNA 'K' and told her he was going to throw her into the wall. CNA 'M' continued to explain that R#70 did hit CNA 'M' again, and CNA 'M' stated, After he hit her that time, she hit him back straight in the middle of his forehead. CNA 'M' was asked who they reported the incident to and indicated they reported it to Unit Manager/Licensed Practical Nurse 'I'. CNA 'M' was then asked if they were interviewed or prepared any type of statement regarding the incident and indicated she signed and dated a statement regarding what she had witnessed. A review of CNA 'K's personnel file was conducted on 3/11/20 at approximately 3:30 PM. The file contained a document titled, EMPLOYEE CORRECTIVE ACTION that indicated CNA 'K' had been terminated from employment. The EMPLOYEE CORRECTIVE ACTION form read, .Describe situation and/or concerns: .CNA reported to ED (Executive Director) and DON (Director of Nursing) that on 2/20/2020 while providing care, resident was noted to be combative. CNA reported that the Kardex (care guide) says to reapproach <sic> for cares when combative but the CNA, by her own admission, did not follow this procedure leading to possible psychosocial harm by <sic>the resident during cares. CNA reported that she told the new CNA that she was going to provide care to the resident despite the combative behavior . A review of R#70's clinical record was conducted and revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. R#70's most recent Minimum Data Set assessment dated [DATE] indicated R#70 had moderate cognitive impairment, did not exhibit and physical, verbal, or rejection of care behaviors, was non-ambulatory, and required extensive assistance of one to two staff members for activities of daily living. On 3/11/20 at 4:20 PM, an interview with the facility's Administrator, DON, and Unit Manager 'I' was conducted regarding the investigation. The facility's Administrator/Abuse Coordinator was queried if they had interviewed either CNA 'M' or Unit Manager 'I', and indicated they had. At that time, a copy of statements or interviews was requested, and it was queried why they were not in the original investigation folder that had been requested at 8:45 AM. The Administrator had no explanation why the statements weren't in the file and indicated the DON had them up in their office. During the interview, Unit Manager 'I' was queried about the incident. Unit Manager 'I' explained that CNA 'M' reported to her that she saw CNA 'K' hit R#70, and she heard CNA 'K' tell CNA 'L' that after he hit her, she hit him back. At that time, the Administrator was asked how CNA 'L' was involved in the incident and if it had been overheard that CNA 'K' told CNA 'L' she hit the resident, why wasn't there an interview or statement from CNA 'L'. The Administrator had no response to the questions. At the conclusion of the interview The DON was accompanied to obtain the missing interviews/statements. At that time, the DON was not able to locate the missing interviews/statements and at approximately 5:00 PM, the DON confirmed they did not have them. A review of a facility provided policy titled, ABUSE, NEGLECT, AND/OR MISAPPROPRIATION OF RESIDENT FUNDS OR PROPERTY with a revision date of 12/10/18 was conducted and read, .PURPOSE: To assure each resident in the center is free from abuse, neglect and exploitation . The facility was asked if they had any additional information to provide regarding the concern; none was provided by the end of the survey.
F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI 626. Based on interview and record review, the facility failed to ensure documented details regarding a resident's hospital transfer for one (R#94) of five residents reviewed for hospitalization , resulting in the potential for essential health information not being conveyed to the emergency room for evaluation and continued treatment. Findings include: On 3/11/20, review of a complaint reported to the State Agency included allegations that alleged a resident had multiple falls, and the facility had not adequately assessed and/or monitored the resident post fall. An onsite investigation was conducted from 3/9/20 to 3/12/20 to investigate the allegations. A review of the closed clinical record revealed R#94 was admitted into the facility on [DATE], readmitted on [DATE], and discharged to the hospital on [DATE]. [DIAGNOSES REDACTED]. According to the admission Minimum Data Set (MDS) assessment dated [DATE], R#94 had severely impaired cognition, had a history of [REDACTED]. A review of the interdisciplinary progress notes included: On 1/7/20 at 10:05 PM, .Son told writer that he wanted to pick up his father and take him to (name of local hospital), writer advised against that plan told son that is in best interest of the resident to go to the hospital (different hospital than the hospital the son preferred) and once he is stable, the son can transfer if need .Resident was transferred to hospital as determined by (name of local Emergency Response) approximately 8:30 pm . On 1/7/20 at 10:14 PM, .Writer was called to unit, upon arrival to floor observed resident in hallway near nursing station by (room number redacted) lying on his left side with face/head against the floor, upper body and lower extremity underneath. Noted blood has pooled near face . There was no documentation available for review (such as a facility transfer sheet) to ensure that the facility had provided the appropriate communication in regards to the resident's circumstances at the time of transfer to the receiving facility (hospital). On 3/12/20 at 10:00 AM, an interview and record review was conducted with the Director of Nursing (DON). When asked about the lack of documentation (such as a facility transfer sheet) of the reason for the transfer and any other pertinent documents from the electronic medical record (EMR) that would have been provided for the resident's hospitalization on [DATE], the DON confirmed there was no transfer documentation. When asked where that documentation would be located in the EMR, the DON reported it would be found under the forms section of the EMR. The DON was asked about the circumstances regarding the resident's hospitalization and lack of documentation and reported R#94 went to (name of local hospital) then was transferred to another hospital (per guardian's preference). The DON confirmed there was no documentation that indicated what hospital R#94 had been transferred to, other than the aforementioned progress notes. The DON was informed of the concern that there was no documentation of the circumstances of the transfer and where the resident was actually transported to upon discharge from the facility. The DON reported she would have to look further into that. There was no further documentation provided by the end of the survey. A review of the facility's policy Discharge or Transfer of Resident dated 11/21/17 documented, in part: .Emergency Transfer/Discharge: for medical reasons, or the immediate safety and welfare of a resident, initiated by the facility .To Provide safe departure from the Center, and provide sufficient information for after care of the resident .Initiate the (namebrand) Transfer Form and print when completed .Print completed (namebrand) Transfer Form, send the printed form and copied medical record with the resident .Charge Nurse to call and give report to hospital emergency room (ER) or admit nurse .
F 0658 **Level of harm** - Minimal harm or potential for 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** Based on observation, interview, and record review the facility failed to administer medications and/or treatments per accepted standards of practice for two (R#30, R#66, R#107) of six residents reviewed for accepted standards of practice, resulting in administration of another resident's ordered treatment to a resident other than prescribed, and narcotic medications not being documented and/or signed out when administered. Findings include: R#30: On 3/10/20 at approximately 9:10AM a wound care observation was conducted for R#30, and Licensed Practical Nurse (LPN) 'G' was observed to prepare to perform wound care for the resident. Included in the supplies was a bottle of H Clor 12 0.125% solution, which was noted to have been prescribed to R#66 (not for the resident observed) per review of the label on the bottle of solution. LPN 'G' explained that the resident's (R#30) solution had run out. LPN 'G' was observed to remove the seal from the bottle of solution prescribed to R#66. LPN 'G' was queried as to what treatment was being applied to the resident's wound, and explained it was the solution and gauze covered by border gauze. The clinical record for R#30 was reviewed and revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/11/20 at 9:10 AM the facility's Director of Nursing (DON) was queried about the situation described above, and explained that usually staff would use use assigned treatment for [REDACTED]. R#107: On 3/10/20 at approximately 8:23AM, Licensed Practical Nurse (LPN) 'D' was observed to administer morning medications, which included one tablet of [MEDICATION NAME] 10-325 milligram (mg), a controlled substance pain medication to R#107. Review of a physician order [REDACTED]. Review of the clinical record for R#107

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a facility job description for a License Practical Nurse (LPN) dated 8/2/15 revealed, in part, 1. Provide care to residents by performing a variety of treatments, including changing dressing 3. Administer medications to residents according to the Nurse Practice Act, Nursing Department Policies, and standards and procedures and as prescribed by the physician .
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 has three deficient practices. Deficient Practice #1 Based on observation, interview, and record review, the facility failed to assess skin blisters and [MEDICAL CONDITION] for one (R#620) of two residents reviewed for [MEDICAL CONDITION] and skin conditions, resulting in the potential for unidentified health conditions and decline in health status. Findings include: On 3/10/20 at 9:56 AM, a wound care observation was conducted with Nurse G (the facility's wound care nurse). During the observation, R#620's lower left arm appeared [MEDICAL CONDITION]. R#620's inner part of the upper arm just above the elbow crease was observed with a dressing applied. Underneath the dressing there were two round pink areas, approximately the size of a nickel and a dark colored area of approximately the same size. Nurse G reported the areas were fluid filled blisters when they were first assessed by him. When queried about how R#620 got the fluid filled blisters, Nurse G reported they were because of his arm swelling. On 3/10/20 at 2:30 PM, R#620 was visiting with a family member. R#620 reported they did not have a history of blisters and they were not sure what caused them. R#620 reported having a history of swelling in the arms. On 3/11/20 at 12:27 PM an interview with the Director of Nursing (DON) was conducted. When queried about how and when R#620 got the blisters to their left arm, the DON reported Nurse G said they talked to the attending physician who reported there was a history of swelling and that was what caused the blisters. When queried about where swelling to the arm would be documented, the DON reported in the progress notes. When queried about who assessed R#620's arm, the DON stated, The physician probably saw it and the wound doctor. At that time, any documented assessment of R#620's arm was requested, as well as any documentation to show when the blisters were first identified, assessed, and treated. On 3/11/20 at 2:55 PM, the DON reported R#620 would be seen by the attending physician on that day. No documentation was provided that R#620's swelling and blisters were assessed by the physician prior. On 3/12/20 at 8:55 AM, and interview was conducted with Nurse G. When queried about when they first became aware of the blisters to R#620's left arm, Nurse G reported a nurse mentioned it to me and they called the physician and wound care team. Nurse G reported the attending physician said he was (R#620's) doctor before and they had chronic [MEDICAL CONDITION] which caused the blister and so we elevated R#620's arm for 2 days. A review of R#620's clinical record revealed the following: R#620 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Wound care note dated 3/11/2020 documented, .Left upper arm 2 blister epithelized . A Wound rounds note dated 3/11/2020 documented, .3 fluid filled blisters to left upper arm 2 inferior blisters now open and epithelized. No drainage. Superior one scabbed over . A Nurses Note dated 3/10/2020 documented, I assessed the patient after the Wound Nurse alerted me to possible swelling in the left arm. The pt had less definition in the arm and it was warm to touch. The Pt. has a temperature of 99.7, HR of 56, O2 (oxygen) of 95% RA . A Wound care note dated 3/10/2020 documented, .Left upper arm blister epitomized . A Nurses Note dated 3/9/2020 documented, .Left upper arm blister improving . Wound care notes dated 3/7/2020 and 3/6/2020 did not document the blisters to R#620's left upper arm. A Wound Rounds note dated 3/4/2020 documented, .Developed 3 fluid filled blisters to left upper arm 3 of which is open with clearing slough (non-viable tissue) and (positive for) drainage .Rx (Prescription) open blister with (medicated gauze dressing) + border gauze and change daily or prn. Rx intact blister with (foam dressing) change q (every) 3 days or prn (as needed) . There were no Nursing Notes, Wound Notes, Wound Round Notes, or Physician Notes that documented [MEDICAL CONDITION] or skin changes to R#620's left arm prior to 3/4/20 when evaluated by the wound team (at which time there were 3 fluid filled blisters, open with slough and drainage). There was no documentation that the attending physician assessed R#620's arm for [MEDICAL CONDITION] and/or the blisters as of 3/11/20 at 2:55 P.M. There were no skin assessments that identified the blisters on R#620's arm until 3/11/20. A facility policy titled, Wound Management Program documented, .To assure that resident who are admitted with, or acquire, wounds receive treatment and services to promote healing, prevent complications and prevent new skin conditions from developing . Deficient Practice Statement #2: This citation pertains to intake #MI 378. Based on interview and record review, the facility failed to consistently perform neurochecks following falls for two (R#51 and R#94) of nine residents reviewed for accidents, resulting in the potential for lack of identification of changes in resident neurological conditions and delayed intervention. Findings include: On 3/11/20, review of a complaint reported to the State Agency included allegations that alleged a resident had multiple falls and the facility had not adequately assessed and/or monitored the resident for neurological changes post fall. An onsite investigation was conducted from 3/9/20 to 3/12/20 to investigate the allegations. Resident #51: A review of the closed clinical record revealed R#51 was admitted into the facility on [DATE] and discharged against medical advice on 2/28/20. [DIAGNOSES REDACTED]. According to the admission Minimum Data Set (MDS) assessment dated [DATE], R#51 had severely impaired cognition, required extensive assistance of two plus persons physical assist with bed mobility, extensive assistance of one person physical assist with transfers, walked in room and corridor limited assistance with one person physical assist, locomotion on and off unit required extensive assistance of one person physical assist, was frequently incontinent of bowel and bladder with no toileting program, and had no falls. On 3/11/20 at approximately 9:00 AM, the Director of Nursing (DON) was requested to provide any documentation of R#51's incident/accident reports, including investigations since admission. A review of R#51's incident report provided by the facility dated 2/20/20 at 11:40 PM documented, in part: .Called by CNA (Certified Nursing Assistant), resident observed on floor in hallway, appears to have tripped over floor cleaning tubing while walking with his daughter. daughter stated he was walking to <sic> fast and I was holding his arm but I couldn't hold on as he began to fall, I couldn't stop him.Resident gave no response when asked what happened. daughter gave statement as above .Resident was lying on his right side, in hallway outside of (room number redacted) .resident noted with abrasion to right eye and nose and when asked if he had pain he said yes and pointed to the face .Skin assessment complete, noted small abrasion to right knee . A review of R#51's available neurocheck documentation following the fall on 2/20/20 at 11:40 PM revealed there were only five completed neurocheck assessments: one on 2/21/20, two on 2/22/20, and two on 2/23/20. On 3/11/20 at 1:55 PM, an interview was conducted with the DON to review the resident's post fall monitoring for neurochecks. The DON was asked to explain what the facility's process was for neurological monitoring post fall such as performing neurochecks and reported The system (electronic clinical record) is set up for q (every) shift x 24 (hours) but we do q shift x 72 (hours). When asked who was responsible for completing the neurochecks, the DON reported, The Nurses. When asked whether the nurses worked eight or 12 hours shifts, the DON reported Eight. Upon review of R#51's available neurochecks, the DON confirmed they were not completed as required. When asked if the neurocheck documentation would be kept anywhere else, the DON reported, No. Resident #94: A review of the closed clinical record revealed R#94 was admitted into the facility on [DATE], readmitted on [DATE], and discharged to the hospital on [DATE]. [DIAGNOSES REDACTED]. According to the admission MDS assessment dated [DATE], R#94 had severely impaired cognition, had a history of [REDACTED]. On 3/11/20 at approximately 9:00 AM, the Director of Nursing (DON) was requested to provide any documentation of R#94's incident/accident reports, including investigations since admission. On 3/11/20 at 2:48 PM, review of R#94's incident/accident reports included 12 falls between 7/16/19 and 3/6/20 which occurred on: 7/16/19 at 8:49 PM, 7/26/19 at 6:55 AM, 8/3/19 at 6:15 AM, 8/14/19 at 2:40 PM, 11/10/19 at 2:23 PM, 11/20/19 at 2:41 PM, 11/23/19 at 11:40 PM, 12/1/19 at 6:50 AM, 12/11/19 at 9:13 AM, 1/7/20 at 4:00 AM, 1/7/20 at 8:48 AM, and 3/6/20 at 10:10 AM. A review of R#94's available neurocheck documentation following these 12 falls revealed there were only seven neurocheck assessments completed on: 7/17/19 at 12:00 PM, 8/3/19 at 2:00 PM, 8/4/19 at 1:30 PM, 11/24/19 at 8:00 AM, 12/1/19 at 12:00 AM, 12/11/19 at 6:00 AM, and 1/7/20 at 10:55 PM. On 3/11/20 at 4:17 PM, an interview was conducted with the DON. When asked about the lack of neurological monitoring following R#94's falls, the DON acknowledged the lack of documentation and offered no further response. A review of the facility policy Falls Reduction Program dated 9/25/2016 documented, in part: .If a fall occurs Charge Nurse to complete the following .Neurological Assessment, as applicable with any known or suspected head trauma .Charge Nurse to monitor for delayed consequences of incident utilizing the following .Neurological Assessment per directions, as applicable .

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) Deficient Practice Statement #3: Based on observation, interview, and record review the facility failed to apply a prescribed topical cream per physician order for [REDACTED].#52 was observed in their room and was queried in regard to their stay at the facility. The resident explained, in part, that they had itching in their arms and neck, and explained they took a medication for this. The resident also explained they were supposed to get a cream applied. R#52 said the nurse present applied the cream and said that the other shift did not apply the resident's cream. Per the resident, it was supposed to be applied twice daily. Review of a physician order for [REDACTED].> topically every 8 hours for Itching and rash . The clinical record for R#52 was reviewed and revealed the resident was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's annual minimum data set assessment dated [DATE] documented the resident scored twelve out of fifteen on a brief interview for mental status exam, which indicated the resident was moderately cogntively impaired. Review of R#52's Medication Administration Record [REDACTED]. Holes were observed on the resident's MAR indicated [REDACTED]. On 3/11/20 at 1:42 PM the facility's Director of Nursing (DON) was queried about the holes observed on the resident's MAR, and said they would follow up. An explanation was not received by the end of survey to explain why the resident's MAR indicated [REDACTED].
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform accurate and timely skin assessments (including wound measurements), ensure timely interventions to reduce the risk of pressure ulcer development, and ensure ordered interventions were being implemented for one residents, (R#'s 106) of five residents reviewed for pressure ulcers, resulting in the development of a stage three pressure ulcer (full thickness loss of the skin and may extend into the subcutaneous tissue layer, there may be undermining and/or tunneling that makes the wound much larger than it may seem on the surface) and the potential for the additional development and or worsening of pressure ulcers. Findings include: Resident #106 On [DATE] at approximately 10:00 AM, R#106 was observed in their bed. R#106 was observed to have a [MEDICAL CONDITION] and tube feeding being delivered through a pump for nutrition. Attempts at verbal communication with R#106 were not successful. A review of R#106's clinical record was conducted and revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. It was noted R#106 did not have a [DIAGNOSES REDACTED]. A review of R#106's Nursing admission assessment was conducted and SECTION C. Skin Integrity did not indicate R#106 admitted to the facility with any wounds. R#106's Braden Score (a score calculated to determine risk for pressure ulcer development) upon admission was 11, and indicted R#106 was at a high risk for pressure ulcer development. A review of R#106's admission orders [REDACTED]. Continued review of R#106's record was conducted and a Skin & Wound Evaluation dated 2/17/20 (6 days after admission) indicated R#106 had a stage three pressure ulcer to their coccyx that was Present On Admission and measured 11.7 cm (centimeters) by 7.2 cm. The sections for Depth of wound, Undermining or Tunneling were noted to have Not Applicable documented. Continued review of Skin & Wound Evaluation forms revealed the following: [DATE] A stage three pressure ulcer on the coccyx that measured 10.4 cm x 3.9 cm. Not Applicable was noted to be documented in the sections for depth, undermining, or tunneling. 3/3/20 A stage three pressure ulcer on the coccyx that measured 1.8 cm x 1.0 cm. Not Applicable was noted to be documented in the sections for depth, undermining, or tunneling. A review of R#106's care plans was conducted and the first care plans and interventions to address skin integrity or pressure ulcers for R#106 were also noted to have begun on 2/17/20, upon first evidence of R#106's stage three pressure ulcer. On [DATE] at 11:30 AM, a wound care observation for R#106 was conducted with Licensed Practical Nurse (LPN) 'G' (facility wound care nurse) and Wound Care Nurse Practitioner (NP) 'J'. The wound was observed to be approximately 4-5 cm in length, 3-4 cm in width with with a pink base, scant drainage, and small areas of necrotic tissue and fragile skin surrounding the wound. At that time, staff were not observed to measure the wound. Upon completion of the wound care, an interview was conducted with NP 'J' and LPN 'G'. They were asked about their procedure for measuring wounds and LPN 'G' indicated they used a camera to photograph the wound and the camera calculated the size. When queried about the measurement changes and if they compared them from week to week, especially the change from [DATE] (10.4 cm x 3.9 cm) to 3/3/20 (1.8 cm x 1.0 cm) NP 'J' explained that because the facility staff don't do manual measurements, there would be discrepancies. Continued interview with LPN 'G' was conducted and LPN 'G' was asked about the order on 2/13/20 for the cream to the skin tear. LPN 'G' stated, She must have had something there if the (brand name cream) was ordered. LPN 'G' was then asked how he determined the wound was present upon admission based on his assessment on 2/17/20 when the admission skin assessment did not address any skin concerns and the first documentation of the wound occurred on 2/17/20, 6 days after admission to the facility. LPN 'G' had no explanation. On 3/11/20 at approximately 2:00 PM, an interview with the facility's Director of Nursing (DON) was conducted regarding R#106's stage three pressure ulcer. The DON was asked how it was determined that R#106 admitted with the wound. The DON did not offer any explanation and indicated it was a concern that the identification came six days after admission. A review of a facility provided policy titled, WOUND MANAGEMENT PROGRAM revised 8/17/17 was conducted and read, .POLICY: To assure that residents who are admitted with, or acquire, wounds receive treatment and services to promote healing, prevent complications and prevent new skin conditions from developing.PROCESS (PREVENTION):.2. Complete Skin Assessment as a portion of the admission assessment. 3. Place initial interventions for residents at risk for development of skin breakdown in Care Plan. The facility was asked if they had any additional information to provide regarding the concern; none was provided by the end of the survey.
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 #s: MI 511, MI 378, MI 626, and MI 599. Based on observation, interview and record review, the facility failed to provide adequate supervision and implement interventions to prevent falls, and ensure adequate assessment and investigation following multiple falls for one (R# 35) of nine residents reviewed for accidents, resulting in repeated falls with injuries, including a hematoma and a lump to R#35's head, and reinjury to an existing wound on R#35's leg, and the potential for continued falls and injuries. Findings include: On 3/11/20, review of a complaints reported to the State Agency included allegations that alleged residents had multiple falls without adequate intervention, assessment, and/or monitoring. An onsite investigation was conducted from 3/9/20 to 3/12/20 to investigate the allegations. R#35 An observation of R#35 was conducted on 3/10/20 at 3:15 PM. R#35 was lying on their back in bed. R#35 reported falling because I was trying to go to the bathroom. R#35 reported they hurt their leg. No further details were expressed by R#35. On 3/10/20 at 3:42 PM a family member of R#35 reported that R#35 fell six times in the past year and they were concerned it happened because they were not changing his brief timely. The family member reported R#35 could shift around in the bed, but could not walk, transfer themselves, or turn around completely in bed. On 3/12/20 at 1:41 PM, the Assistant Director of Nursing (ADON) was interviewed. When queried about any concerns expressed by R#35's family member, the ADON reported a family member had concerns regarding a fall from 12/13/19. The ADON reported R#35 fell during the midnight shift, could not stand or walk, and could not transfer or turn in bed without assistance. The ADON reported R#35 had been at risk for falls since they were admitted into the facility and had fallen multiple times. A review of R#35's incident and accident (I&A) reports since 1/2019 was conducted with the ADON in addition to a review of R#35's clinical record. The following was revealed: An I&A documented on 5/15/19 at 1:13 PM, R#35 was discovered on the floor with a pillow underneath their head at the bedside. It was documented R#35 reported they wanted to lay down. The I&A documented R#35 was encouraged to use their call light when in need of transfer. A Falls assessment dated [DATE] documented R#35 unlocked their wheelchair and attempted to get themselves back into bed. The documented intervention was to place the resident in high traffic areas when he is up in his wheelchair. The ADON confirmed R#35 had a care planned intervention initiated on 1/13/18 to assist to high traffic area when up in the wheelchair. The ADON reported R#35 should not have been left at the bedside in a wheelchair on 5/15/19. An I&A documented on 8/21/19 at 4:10 PM,during the nurse's round, R#35 was up in a wheelchair next to the bed. At approximately 4:05 PM, a Certified Nursing Assistant (CNA) found the resident on the floor on their right side. It was documented R#35 was sent to the hospital for a CT scan. The resident reported they were trying to get into bed. A Falls Assessment documented it was determined the resident had poor safety awareness and the intervention implemented was to Place resident in common areas when he is up in his wheelchair. Physical therapy to evaluate. The ADON reported on 8/21/19, if the nurse who did rounds observed R#35 in a wheelchair at the bedside, they should have redirected the resident to a common area for monitoring and observations. The ADON confirmed that the same intervention was initiated at that time along

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) with an evaluation from physical therapy. An I&A dated 12/13/19 at 9:43 AM documented, R#35 reported to an oncoming nurse at 7:05 AM that they fell and hit their head and was picked up off the floor by two girls. It was documented R#35 had a hematoma on top of scalp. R#35 reported, per the I&A, the they were trying to get up to use the bathroom and fell and hit their head. A Falls Assessment documented the root cause of the fall as bladder urgency. The intervention implemented by documented as assist with toileting and check and change upon awaking in the morning. Written and signed statements were attached to the I&A. The first statement dated 12/19/29 (six days after R#35's documented fall) was by CNA S and it documented, (R#35) was yelling while I was going to do vitals I went to see why (R#35) was yelling and (R#35) said (R#35) tried to get up. (R#35) was seating on the floor, I laid (R#35) on the floor and I ask for help to get (R#35) off the floor then I left because it was time to go. Another hand written and signed statement by CNA T documented, they assisted with transferring R#35 and then went home. In regards to the fall that occurred on 12/13/19, the ADON reported they came in that morning and a nurse approached them stating R#35 told the nurse they fell . The ADON stated, (R#35) told me they fell as well. The ADON reported R#35 told them two girls assisted them back to bed. The two girls were identified as CNA S and CNA T. When queried about whether or not the CNAs reported the fall to a nurse, the ADON reported they didn't tell anyone and R#35 was not assessed by a nurse prior to being transferred back into bed and the assigned CNA left after obtaining the assistance from the other CNA. The ADON reported R#35 sustained a hematoma to the top of their head and that the resident reported they wanted to get up and use the bathroom. The intervention added after that fall was to assist with toileting and check and change in the morning. When queried about why R#35 continued to fall out of bed, the ADON reported, I think (R#35) is trying to get off the wetness because he was wet. On 1/23/20 at 6:55 AM, an I&A documented R#35 was observed on the floor by their bed with their shoulder only on the safety mat. R#35 reported they were trying to go to the bathroom, hit their head and it was painful. A lump to the right side of R#35's head was documented and wound care on left leg from previous injury which has been damaged more by the fall today. It was documented the resident was educated on using the call light and the body pillow is not effective. In regards to the fall sustained by R#35 on 1/23/20, the ADON stated the fall happened again on the night shift and the resident's brief was went and with fresh BM (bowel movement). The ADON was unable to find a physicians order for a body pillow. Further review of R#35's clinical record revealed R#35 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A MDS (Minimum Data Set) assessment dated [DATE] documented R#35 had moderately impaired cognition, and required extensive physical assistance by one to two people for bed mobility, transfers, and toilet use and did not walk. A facility policy titled, Falls Reduction Program documented, .To provide a safe environment for residents, modify risk factors, and reduce risk of fall related injury .Implement and indicate individualized interventions on Care Plan/Kardex .If fall occurs Charge Nurse to complete the following: Physical assessment of resident and observation of environment .Immediate interventions as identified by physical assessment and environmental observation .Incident Report .Initiate safety interventions and update care plan as applicable .Determine the need for ongoing assessments/interventions based on MDS reviews, fall risk history, and IDT (Interdisciplinary Team) member recommendation. Trends/patterns will be evaluated by the QAPI (Quality Assurance Performance Improvement) committee to establish new facility strategies towards improvement in the Falls Reduction Program .
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation has two deficient practice statements. Deficient Practice #1 Based on observation, interview and record review, the facility failed to confirm the use of laxatives and stool softeners with a physician for a resident with [MEDICAL CONDITION] (C. diff - infection of the large intestine) for one (R#570) of four residents reviewed for bowel and bladder resulting in the continued use of laxatives and stool softeners while experiencing loose stool. Findings include: On 3/9/20 at 9:05 AM, a receptacle containing Personal Protection Equipment (PPE) was hung on the outside of the door to R#570's room. Licensed Practical Nurse (LPN) 'X' explained R#570 was in isolation for [DIAGNOSES REDACTED]. R#570 was observed lying in bed. R#570 was questioned about the care at the facility, however R#570 did not answer. Review of R#570's clinical record revealed R#570 was originally admitted into the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. According to the admission Minimum Data Set (MDS) assessment dated [DATE], R#570 scored 4/15 on the Brief Interview for Mental Status (BIMS) exam indicating severe cognitive impairment. The MDS assessment also indicated R#570 was incontinent of bowel and bladder and required the extensive to total assistance of staff for all Activities of Daily Living (ADL's). Review of R#570's physician orders [REDACTED]. Another order dated 3/3/20 read, [MEDICATION NAME] (a laxative) Solution 20 GM/30ML (gram/milliliter) Give 30 ml via PE[DEVICE] two times a day for Constipation. An additional order dated 3/3/20 read, Senna (a laxative) Tablet 8.6 MG (Sennosides) Give 2 tablet via PE[DEVICE] two times a day for Constipation. Review of R#570's March Medication Administration Record [REDACTED]. The March MAR indicated [REDACTED]. Review of R#570's clinical record revealed documentation for Consistency of BM, the options for Loose/Diarrhea and Loose (Ostomy) were marked on: 3/5/20 one time, 3/6/20 two times, 3/8/20 three times, and 3/9/20 two times. On 3/10/20 at 1:57 PM, LPN 'X' was interviewed and asked about R#570's stool and being given three bowel medications. LPN 'X' explained R#570 was having very loose stools and she had noticed R#570 was getting three bowel medications, but since she did not work at the time the medications were ordered she had not called the doctor to clarify the orders. On 3/10/20 at 2:41 PM, Certified Nursing Assistant (CNA) 'W' was interviewed and asked if R#570 was having loose stools. CNA 'W' explained R#570 had a very large loose watery BM. On 3/11/20 at 9:25 AM, ADON 'A' was interviewed and asked about R#570 receiving three bowel medications while having loose watery stool. ADON 'A' explained the nurses should have held the medications and called the doctor before giving three bowel medications to a resident having loose stool. On 3/11/20 at 9:32 AM, Nurse Practitioner (NP) 'Y' was interviewed by phone and asked about R#570 receiving three bowel medications and having [DIAGNOSES REDACTED]. NP 'Y' explained the medications should have been held, the medications would just make the loose stool worse. On 3/11/20 at 2:39 PM, an interview with the DON and RN 'Z', who served as the Staff Development/Infection Control nurse, was conducted concurrently. During that interview RN 'Z' explained when R#570 was admitted on [DATE], the hospital paperwork was almost two hundred pages and the [DIAGNOSES REDACTED] [DIAGNOSES REDACTED].#570 had [DIAGNOSES REDACTED]. RN 'Z' was asked if the three bowel medications should have been given when it was known R#570 had [DIAGNOSES REDACTED]. RN 'Z' explained the nurses should have held the medications and called the doctor to clarify the orders. The DON was asked if giving three bowel medications while having [DIAGNOSES REDACTED] could increase R#570's distress. The DON indicated it could cause distress. Review of R#570's admission paperwork from the hospital dated 3/2/20 revealed on page 13 of 116 pages, .Assessment: .3. [DIAGNOSES REDACTED]icile [MEDICAL CONDITION]. Contact isolation plus Oral [MEDICATION NAME] (an antibiotic). We will discontinue [MEDICATION NAME] ([MEDICATION NAME] Sodium) and senna . Review of a facility policy titled CHANGE OF CONDITION - RESIDENT PHYSICIAN/NP NOTIFICATION revised 10/29/14 read in part, Attending physician/physician extender or on call physician extender is to be notified of residents change in condition/health status . 1. Seven (7) days a week, attending physicians or physician/NP on call is to be notified of all condition or health status changes . Deficient Practice Statement #2: This citation pertains to intake #MI 378. Based on interview and record review, the facility failed to implement recommended urinary monitoring following a resident's hospitalization for one (R#94) of four residents reviewed for bowel and bladder, resulting in the increased potential for unidentified [MEDICAL CONDITION], and continued and/or worsening infection. Findings include: On 3/11/20, review of a complaint reported to the State Agency included allegations that alleged concerns regarding the lack of urinary monitoring. An onsite investigation was conducted from 3/9/20 to 3/12/20 to investigate the allegations. A review of the closed clinical record revealed R#94 was admitted into the facility on [DATE], readmitted on [DATE], and discharged to the hospital on [DATE]. [DIAGNOSES REDACTED]. According to the admission Minimum Data Set (MDS) assessment dated [DATE], R#94 had severely impaired cognition, required extensive assistance of one person for toilet use, had no catheter, was always incontinent of bowel and bladder with no toileting program and had no infections during this assessment period of seven days. A review of R#94's hospital discharge instructions dated 2/10/20 documented, in part: .Special Instructions .Bladder can <sic> every 8 hours and straight cath > (greater than) 400 cc (cubic centimeters) of urine . A review of the physician orders [REDACTED]. A review of the nursing admission assessment dated [DATE] documented, in part: SECTION J. Bladder/Bowel asked a. How long has the resident been incontinent or had a catheter? which had a response next to 6. Don't know; b. How often is the resident wet? which had a

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	235320	A. BUILDING _____ B. WING _____	03/12/2020

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F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 7) response next to 1. Once or more per shift; c. Resident is wet during: which had a response next to 3. Day and Night time; d. Amount of Urine: which had prompted a response for either 1. Small spots clothes or bed) or 2. Large (puddles/soaks, clothes, bed, floor) which was left blank for either choice. The section for catheter type/size was marked N/A (not applicable). A review of the facility's physician history and physical dated 2/12/20 did not address the recommendation for urinary monitoring via bladder scan and straight catheterization as identified under the special instructions on the resident's hospital discharge paperwork. A review of the resident's care plans including discontinued interventions revealed a care plan regarding the resident's use of an indwelling catheter that was discontinued on 10/17/19. There was no current care plan to address the hospital instruction to bladder scan and straight catheterize the resident. On 3/12/20 at 10:00 AM, an interview and record review was conducted with the Director of Nursing (DON). When asked about the lack of urinary monitoring for R#94's readmission, the DON confirmed there was no mention within the physician evaluation on 2/12/20 and reported she would have to investigate and follow up. On 3/12/20 at 11:35 AM, the DON reported she had reviewed the hospital orders regarding the bladder scan and straight catheterization and the DON confirmed there was no order upon readmission. A facility policy regarding urinary monitoring and following recommendations was requested at that time. On 3/12/20 at approximately 2:00 PM, the DON reported there was no policy for following recommendations and that it was a standard of practice. A review of the facility's policy Incontinence Management dated 9/23/2019 documented, in part: .Initiate interventions to address bowel and bladder function by documenting on the Care Plan/Kardex .Monitoring the Residents success to the toileting plan, and any needed revisions will be the responsibility of the CCC (Clinical Care Coordinator) or nurse manager .
F 0740 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure facility staff consistently respond to a resident's distressed behavior for one (R#30) of two residents reviewed for mood and behavior, resulting in the resident crying out and yelling for a prolonged period of time, and exhibited feelings of frustration. Findings include: On [DATE] at 9:33 AM R#30 was observed in a specialized wheelchair with adaptive head rest and built up arms in the television area on the second floor. The resident was observed to be yelling and crying out, and four other residents and a staff member were observed to be in the television room as well. A staff member was observed to be passing by the television area towards the secured unit at the facility, and R#30 was observed to be yelling out in a louder tone. The staff member who was passing by approached the resident, and asked R#30 they were ok. Unit Manager (UM) 'H' passed by the television area, and was not observed to interact with R#30. R#30 was observed to be crying out and yelling. On [DATE] at 9:36 AM, a staff member came into the television room and interacted with another resident in the area. The staff member gave the other resident breakfast, and was speaking with the other resident about which breakfast foods the resident would like. On [DATE] at 9:37 AM, R#30 was observed to be crying out and yelling. On [DATE] at 9:38 AM, R#30 was observed to be crying out and yelling and staff were not observed to be in the television room or interacting with the resident. A staff member who had assisted another resident in the room with breakfast returned to deliver breakfast items to the other resident, and told the other resident (not R#30) they would be back to check on them. This staff member was not observed to interact with R#30. Then Licensed Practical Nurse (LPN) 'D' approached R#30 and attempted to administer medications and a supplement to R#30. R#30 was not receptive to taking their medications and the nurse was observed to leave. R#30 was observed to continue to cry and yell. On [DATE] at 9:41 AM, the staff member who had brought another resident their breakfast approached the other resident (not R#30) with cereal, and then left the area, not interacting with R#30. At 9:43 AM, R#30 was observed to be yelling out in a loud tone. A staff member was heard to say, She'll calm down in a little while. R#30 continued to yell out, and the staff member asked the resident why they did not want to eat. The breakfast tray was set by the resident. 0[DATE] at 9:44 AM, Certified Nursing Assistant (CNA) 'E' said, She's in a bad mood today Ms. (Staff member name).she in a little bad mood today, she'll be singing in a couple hours. CNA 'E' was then observed to say to R#30, You're going to hurt your throat. The resident was observed to be yelling. On [DATE] at 9:46 AM, CNA 'E' was observed to walk out with the resident's tray, and the resident continue to yell out from their specialized wheelchair. On [DATE] at 9:53 AM, R#30 was observed in the second floor television area yelling out. LPN 'D' approached R#30 and was observed to tell R#30, If I can't talk to you I can't help you, what do you want? LPN 'D' was observed to say the resident wanted to be back in bed. At 9:55 AM, R#30 was observed to continue to yell and scream. At 9:57 AM, CNA 'E' and another staff member were observed in the television area, and both staff members were observed to leave out of the room. R#30 remained in the television area and was yelling out. At 9:58 AM, Unit Manager (UM) 'H' entered the television area, looked into the television area while the resident was yelling, and walked back towards the nursing station. On [DATE] at approximately 9:59 AM, CNA 'E' approached R#30 and said, Do you want to go back to your room for awhile? (LPN 'D') going to give you your medicine. R#30 was observed to be taken out of the activity room at that time. The clinical record for R#30 was reviewed and revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per review of the resident's quarterly minimum data set (MDS) assessment dated [DATE], R#30 had moderately impaired cognition, and it was documented the resident had no hallucinations, no delusions, no physical behavioral symptoms, no verbal behavioral symptoms, and no other behavioral symptoms. Review of a plan of care for R#30 dated 2/5/20 documented the following: I may present with verbal outbursts at times not directed towards others. I am noted with speaking out loud in my room, seemingly having a conversation with myself. I do not engage often with others during interactions unless I choose to. I can verbalize however at times it is unrelated to subject matter. I can be resistant to care at times. I have dx (diagnosis) of Mild Intellectual Disability, MDD (major [MEDICAL CONDITION]), and GAD (generalized anxiety disorder) which contributes to my behavioral s/s (signs/symptoms). At times I will refuse to eat my meals if I do not like what is offered even with multiple choices/options provided as I do not understand the consequences of refusing nutrition and hydration. Interventions per the plan of care included, in part, the following: -Observe for Combative/Verbal/Rejection of Care/Other. Report and document observations, -Provide diversional activities of choice, -Approach resident in a calm and friendly manner, inform resident of care tasks prior to starting are and speak with resident throughout care task to promote compliance, -Do not confront, or argue: respond calmly and set boundaries. Re-approach as needed. On 3/11/20 at approximately 1:45 PM, the facility's Director of Nursing (DON) was queried in regard to the observation of R#30 yelling out. The DON explained the resident should be assessed to see the underlying factor and to determine what kind of interventions could take place (examples: pain, anxiety). The DON explained that a behavior note would be completed so that it could be discussed the next morning in morning report, and could be reviewed by the interdisciplinary team (IDT). Review of a nurses note dated [DATE] at 11:41 (AM) documented, in part, Received in bed awake and alert.Treatment done by Wound Nurse. The resident became restless after treatment was done. Had initially refused all medication including her scheduled pain medication, however, after several attempts,the resident took all of her meds. Assisted OOB (out of bed) into w/c (wheelchair) by two persons. Pillows used for positioning. The resident has a poor tolerance for sitting up in her w/c. Yelling and crying. Asking to be put back in bed less than 20 minutes after the CNA assisted her up in her w/c. Calmed down and sat up in w/c without further complaints after her meds were given. On 3/11/20 at 4:25PM Social Work Director (SWD) 'B' was queried in regards to R#30. SWD 'B' explained that the resident talked out loud to herself when in her room, and explained the resident would come out at times. SWD 'B' explained the resident sometimes had outbursts, and per SWD 'B' the resident liked to be alone or in their room. SWD 'B' explained the resident's family would come to visit the resident and would take the resident out of the facility. Per SWD 'B' the resident had intellectual disability. The interactions documented above were shared with SWD 'B', and SWD 'B' explained the resident could be approached to see if the resident was in pain, the resident could be provided privacy to go back to their room, and it could be ruled out if the resident was having pain or had been incontinent. SWD 'B' explained that she was going to add an intervention to the resident's plan of care. Review of a facility policy titled, ASSESSMENT AND INTERVENTION FOR MOOD AND BEHAVIOR SYMPTO[CONDITION] dated 2/24/09 documented, in part, the following: III. MONITORING BEHAVIOR SYMPTO[CONDITION] A. Document symptom. Use concrete description including an action verb instead of a label for behavioral symptom.B. Record occurrence on shift when it happened. C. Document individual interventions as identified on care plan and as care givers try, EXAMPLES: 'Toileted', 'Hot chocolate/cookie', 'Distracted with family album' D. Record effectiveness of interventions. E. Review monitoring and document patterns and effectiveness of interventions F. Discuss monitoring information with resident, family and care givers to determine effectiveness of care plan. G. Include discussion in IDT

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F 0740 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 8) meeting to determine appropriateness of current care plan, document progress toward goals, and make changes to treatment plan as appropriate. H. Define and set treatment goals resulting from discussions with the resident and Interdisciplinary team to maintain the highest practicable quality of life.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure appropriate documentation for the use of controlled substances for one (R#107) of six residents reviewed for controlled substance records, resulting in the potential for drug diversion. Findings include: Review of a physician order [REDACTED].#107's March 2020 Medication Administration Record [REDACTED]. The resident's controlled substance record documented one tablet was signed out on 3/3/20 at 9:00 PM. 3/4/20: The resident's MAR indicated [REDACTED].The resident's controlled substance record documented one tablet was signed out on 3/4/20 at 10:30AM and an additional tablet was signed out at 9:00PM. 3/5/20: The resident's MAR indicated [REDACTED]. Review of the resident's controlled substance record documented a dose was signed out on 3/5/20 (no time documented) and 11:00 PM. 3/7/20: The resident's MAR indicated [REDACTED]. Review of the resident's controlled substance log documented an entry for a removal of one tablet of medication between the dates of 3/6/20 and 3/7/20. This entry appeared to be dated 3/8/20, and did not indicate which time the medication had been removed. Documentation dated 3/7/20 on the controlled substance record revealed a tablet of medication was removed on 3/7/20 at 11:00AM and 5:00AM. 3/8/20: The resident's MAR indicated [REDACTED]. Review of the resident's controlled substance record documented one tablet was signed out on 3/8/20 at 9:00 PM. [DATE]: The resident's MAR indicated [REDACTED]. The resident's controlled substance record documented one tablet was signed out on [DATE] at 2:56PM and 10:30 (not documented AM or PM). Review of the clinical record for R#107 revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/12/20 at 2:20PM, the facility's Director of Nursing explained that on the narcotic record documentation for 3/7/20 at 5:00am should have been for 3/8/20. Additional discrepencies were not explained. Review of a facility policy titled, Medication Storage Controlled Medication Storage dated 11/2017 documented, in part, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations. Review of a facility policy titled, Medication Administration General Guidelines dated 9/2018 documented, in part, Documentation 1. The individual who administers the medication dose, records the administration on the resident's MAR indicated [REDACTED].
F 0770 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician ordered laboratory specimens were obtained and sent out per physician's orders [REDACTED].#94) of one resident reviewed for laboratory services, resulting in a lack of coordination of care and delay in treatment. Findings include: On 3/11/20, a review of the closed clinical record revealed R#94 was admitted into the facility on [DATE], readmitted on [DATE], and discharged to the hospital on [DATE]. [DIAGNOSES REDACTED]. A review of the physician orders [REDACTED]. Review of the resident's clinical record, including the laboratory/results section from 12/1/19 to 3/12/20 revealed no findings. On 3/12/20 at 11:00 AM, the Director of Nursing (DON) was asked to review the clinical record and when asked where the lab results were maintained, the DON reported under the lab results tab. The DON was requested to access any results for R#94 and upon review via the facility's computer was unable to locate. The DON reported she would follow up. At that time, the DON was requested to provide a facility policy regarding laboratory services and/or following physician orders. On 3/12/20 at 1:15 PM, the DON reported there was no documentation that the labs had been completed as ordered. When asked about the facility's policy, the DON reported, There is no policy. It's a standard of care. The Doctor writes it and we do it.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation has two deficient practices. Deficient practice #1 Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices as it regards to hand hygiene and glove use for four residents, (R#'s 42, 20, 81, and 673) of nine residents reviewed for infection control, resulting in the potential for the spread of infection. Findings include: R#42 On 3/10/20, Certified Nursing Assistant (CNA) 'R' was observed assisting with wound care for R#42. During the observation, R#42 had both a bowel movement and urinated during the wound care treatment. CNA 'R' was observed to remove and change their soiled gloves twice while providing incontinence care. CNA 'R' was not observed to perform hand hygiene in between changing from soiled gloves to clean gloves. R#'s 20 and 81 On 3/10/20 at 8:48 AM, Licensed Practical Nurse (LPN) 'Q' was observed preparing and administering medications. LPN 'Q' was observed to don gloves, open a capsule and mix the contents with applesauce for administration. Upon preparing the medication, LPN 'Q' removed their gloves and discarded them. LPN 'Q' was not observed to perform hand hygiene after removing the gloves. LPN 'Q' then entered R#20's room, had physical contact to wake R#20 and administered the previously prepared medications. Upon entering the room, LPN 'Q' was not observed to perform hand hygiene. Upon completion of the medication pass, LPN 'Q' exited the room without performing hand hygiene. LPN 'Q' then proceeded out to the hallway and signed the medications out as given to R#20 in the electronic medical record. After signing the medications out as given, LPN 'Q' retrieved the blood pressure monitor from the medication cart drawer and obtained R#81's blood pressure. LPN 'Q' then prepared medications for R#81 and administered them in the hallway. LPN 'Q' was not observed to perform hand hygiene after administering medications to R#20 or prior to obtaining R#81's blood pressure and preparing and administering their medications. R#673 On 3/11/20 at 8:45 AM, LPN 'P' was observed preparing and administering medications to R#673. Among the medications for administration was a subcutaneous injection of [MED]. LPN 'P' prepared the medications, entered R#673's room and gave the subcutaneous injection without donning gloves. On 3/11/20 at approximately 10:45 AM, an interview was conducted with the facility's Director of Nursing (DON) regarding hand washing, glove use, and [MED] injections. The DON indicated that hands should be washed in between glove use and patient contact, and gloves should be worn when giving [MED] injections. A review of a facility provided policy titled, HANDWASHING AND HAND HYGIENE with a revision date of 6/25/19 was conducted and read, .Conditions which may require hand hygiene include but not limited to: Before and After applying gloves, before and after eating, after using the restroom, after contact/potential contact with blood or body fluids . A review of a second facility provided policy titled, Medication Administration Subcutaneous dated 9/2010 was reviewed and read, .d. Prepare syringe and needle .7. Put on gloves .16. Inject medication slowly . The facility was asked if they had any additional information to provide regarding the concern; none was provided by the end of the survey. Deficient Practice Statement #2 Based on observation, interview and record review the facility failed to immediately implement infection control practices for one (R#570) of one resident reviewed for isolation precautions resulting in R#570 sharing a room with R#57 when positive for [MEDICAL CONDITION] (C. diff) and the potential for other residents contracting [DIAGNOSES REDACTED]. Findings include: On [DATE] at 9:05 AM, a receptacle containing Personal Protection Equipment (PPE) was hung on the door to R#570's room. Licensed Practical Nurse (LPN) 'X' explained R#570 was in isolation for [DIAGNOSES REDACTED]. R#570 was observed lying in bed. R#570 was questioned about the care at the facility, however R#570 did not answer. Review of R#570's clinical record revealed R#570 was originally admitted into the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. According to the admission Minimum Data Set (MDS) assessment dated [DATE], R#570 scored 4/15 on the Brief Interview for Mental Status (BIMS) exam indicating severe cognitive impairment. The MDS assessment also indicated R#570 was incontinent of bowel and bladder and required the extensive to total assistance of staff for all Activities of Daily Living (ADL's). On 3/10/20 at 1:57 PM, an interview with LPN 'X' was conducted. LPN 'X' explained R#570 was still having very loose stools, and they were cleaning R#570 up and the stool was everywhere. On 3/11/20 at 9:25 PM, an interview with the Assistant Director of Nursing (ADON) 'A' was conducted. ADON 'A' explained when R#570 was admitted on [DATE] from the hospital, the [DIAGNOSES REDACTED]. It wasn't until R#570 started having fevers on 3/7/20 that the Infection Control nurse, Registered Nurse (RN) 'Z' noticed in the hospital paperwork that R#570 had [DIAGNOSES REDACTED]. ADON 'A' was asked who was responsible for reading the hospital paperwork. ADON 'A' explained the admitting nurse read the paperwork and called the doctor for orders, then it was reviewed by herself. On 3/11/20 at 2:39 PM, an interview with the Director of Nursing (DON) and RN 'Z', who served as the Infection Control Nurse, was conducted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235320	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAHSER HILLS CARE CENTRE	**25300 LAHSER RD SOUTHFIELD, MI 48034**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 9) concurrently. RN 'Z' was asked about R#570 being admitted on [DATE] but not put into isolation until 3/7/20. RN 'Z' explained when R#570 was admitted on [DATE], the hospital paperwork was almost 200 pages and the [DIAGNOSES REDACTED] was not mentioned until page 45 or 50. R#570 was admitted on [MEDICATION NAME] (an antibiotic), but they thought it was for [MEDICAL CONDITION]. When it was discovered R#570 was positive for [DIAGNOSES REDACTED], they implemented isolation precautions for R#570. The DON was asked if R#570 had a roommate before the isolation precautions were put into place. The DON explained R#570 did have a roommate, R#57. Both residents were incontinent, but R#57 showed no signs or symptoms of [DIAGNOSES REDACTED]. Review of R#570's admission paperwork from the hospital dated 3/2/20 revealed on page 13 of 116 pages, .Assessment: .3. [DIAGNOSES REDACTED]icile [MEDICAL CONDITION]. Contact isolation plus Oral [MEDICATION NAME] (an antibiotic). We will discontinue [MEDICATION NAME] ([MEDICATION NAME] Sodium) and senna . Review of R#57's clinical record revealed R#57 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the most recent MDS assessment dated [DATE], R#57 scored 14/15 on the BIMS exam, indicating intace cognition. The MDS assessment also indicated R#57 required the assistance of staff for all ADL's and was frequently incontinent of bowel and bladder. Review of a facility policy titled, ADMISSION OF RESIDENT revised 10/23/14 read in part, 1. To provide an opportunity to obtain all required information when a resident is admitted . 5. To establish lines of communication between the facility staff and the resident, the resident's representatives and the resident's attending physician. 6. To establish baseline data .