STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235541	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE LODGE AT TAYLOR	22950 NORTHLINE RD TAYLOR, MI 48180

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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** This citation pertains to Intake number MI 94. R #4 Based on observation, interview and record review the facility failed to provide a functioning call light, effecting two residents (R#4 and R#79) out of 29 reviewed for call lights, resulting in the potential for unmet care needs. Findings include: On 3/3/20 at 8:18 p.m., during interview with R#4 it was observed that resident did not have a call light. Inspection of call light plug revealed a single cord that went to roommate only. Resident was asked, do you have a call light. R#4 stated, I haven't had a call light since I came to this room. On 3/3/20 at 8:30 p.m., during interview with Director of Nursing (DON) when asked if all residents in the facility should have a call light. DON stated, Yes. On 3/4/20, record review revealed R#4 had been admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set ((MDS) dated [DATE], R#4 had intact cognition and was supervision with Activities of Daily Living (ADLS). Review of facility's census R#4 had been moved to current room on 2/3/20. Review of Fall Care plan documented the following: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. 7/24/18 On 03/04/20 at11:02a.m., during interview with Maintenance Director (MD), when asked how the facility ensures all residents have a call light., MD replied, We (maintenance staff) usually get report if there is damage. When asked to provide documentation to show evidence that call lights are monitored, MD replied, I don't have any documentation to prove that R#4 had a call light in room. They (maintenance staff) just picks a random room, but they don't document the room number. When asked if everyone should have a call light, MD stated, Everyone should have a call light. On 03/05/20 11:15 AM, during interview with Administrator (ADM), when asked if every resident should have a call light, ADM stated Yes. When asked how the facility ensures everyone has a call light, ADM replied nursing staff does audits so by the end of each month all call lights are checked. ADM was asked to provide documentation. Later in the day ADM stated, I do not have the audits for last month. On 3/5/20, review of policy Answering Call Lights had documented The purpose of this procedure is to respond to the resident's requests and needs. Residents who are unable to utilize call bells should be considered for an adaptive call bell or device for alerting staff to needs. If resident cannot utilize any device to alert staff to needs the facility will provide care per plan of care and revise as needed. Resident #79 On 3/3/20 at 6:45 PM, an interview with R#79 and her mother revealed We have been asking for a new blow call light (call light especially designed for the patient to puff air into to activate the call light), they (the facility) said that one has been ordered, but it's been 2 months. Observation revealed a blow call light attached to the side of the resident's bed with the arm extending toward the resident mouth. R#79 said the current blow call light was broken and that over time the call light arm begins to fall and ends up on my chest where I can't reach it. Record review revealed that R#79 was originally admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The 1/19/2020 Quarterly Minimum Data Set Assessment (MDS) indicated the resident's cognition was cognitively intact and was totally dependent on staff for all activities of daily living. Review of care plan dated 11/29/2018, titled, the resident is at risk for falls related to Incontinence, Pain, Paralysis. (Resident's name) uses an anti-anxiety, a muscle relaxant, and an [MEDICATION NAME]. She has MS and has had spasms in the past. Intervention: Be sure the resident's call light PUFF type is within reach and encourage the resident to use it for assistance as needed. 3/05/20 at 1:36 PM, Maintenance staff H was observed in R#79's room and was asked about the status of the puff call light replacement for the resident. Staff H said that a new puff call light had been express ordered for the resident and should be in later that day. At 2:26 PM, during an interview with the facility Administrator she said, Her mother (R#79's) had been asking for a new call light, and I told her it was on order. We ordered a breath call cord on 2/3/20, but when it arrived, it was put on anther resident's bed. I just found out today that it wasn't put on (R#79's) bed. Review of the facility's policy titled, Resident Right's dated 8/2016 documented, Residents are entitled to exercise their rights and privileges to the fullest extent possible .Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect kindness, and dignity.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain an Advanced Directive in a timely manner for one (#45) resident reviewed for advance directives, resulting in the potential for the resident's emergency care wishes to not be carried out. Findings include: On [DATE] at 11:00 PM, a review of the clinical record for Resident #45 (R45) revealed she was admitted into the facility on [DATE]. Her [DIAGNOSES REDACTED]. A Minimum (MDS) data set [DATE] documented intact cognition. However, the documentation that indicated if the resident would like CPR (cardiopulmonary resuscitation) and other life sustaining interventions to be performed was not seen in the Resident's clinical record. On [DATE] at 11:00 AM, the facility Administrator was asked to provide the Advanced Directive for R45. On [DATE] at 4:26 PM, the Administrator stated there was no advanced directive for the Resident. On [DATE] at 2:40 PM, when the facility Administrator was queried about her expectations for completion of an Advance Directive for residents, she said, That it be done. It is the standard that when a resident comes in, everyone is made a full code. Then during the first two weeks the advanced directive is discussed. The facility policy titled, Advance Directives, dated [DATE], was reviewed and documented the following: --Prior to or upon admission of a resident, the Social Services Director of designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives. --Should the resident indicate that he or she has issued advance directives about his or her care and treatment, documentation must be recorded in the medical record of such directive and a copy of such directive must be included in the resident's medical record. --The Nurse Supervisor will be required to inform emergency medical personnel of a resident's advance directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide privacy for residents during care, effecting three residents (R#28, R#29, R#64) out of 29 residents sampled for privacy and dignity, resulting in a lack of privacy during intimate care and feelings of embarrassment. Findings include: On 3/3/20 at 9:00p.m., upon knocking and entering room it was observed four Certified Nursing Assistants (CNAs) were at R#29's bedside, two CNAs were providing

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F 0583 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) care, two other CNAs were standing there, and privacy curtain was open. At that time all CNAs were made aware of the lack of privacy being given to R#29 and curtain was then pulled. Three of the four CNAs were interviewed individually as they exited the room. CNA A was asked, When providing care should the privacy curtain had been pulled, CNA A, stated, Yes. CNA B was asked, When providing care should the privacy curtain had been pulled, CNA B, stated, Yes. CNA C was asked, When providing care should the privacy curtain had been pulled, CNA C, stated, Yes. On 3/3/20, record review revealed R#29 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the minimum data set ((MDS) dated [DATE], R#29 had impaired cognition and was total dependent of Activities of Daily Living (ADLS). On 3/3/20 at 9:10 p.m., during interview with R#64 , when asked if staff provides privacy during care, R#64 stated, Sometimes when I am taking a shower other aides will come in shower and talk with the other aide with the door open when I am taking a shower. I don't like to have the door open when I am naked. It is embarrassing. On 3/3/20, record review revealed R#64 was readmitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the minimum data set ((MDS) dated [DATE], R#64 had intact cognition and was supervision with Activities of Daily Living (ADLS). On 03/04/20 at 10:15 a.m., after knocking and entering R#28's room, it was observed the resident was receiving care and changing clothes and privacy curtain was open. CNA A was again asked, while providing care should the privacy curtain always be pulled to provide privacy for the resident, CNA A stated, Yes. On 3/4/20, record review revealed R#28 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the minimum data set ((MDS) dated [DATE], R#28 had intact cognition and was extensive assist with Activities of Daily Living (ADLS). On 3/5/20 at 10:30 a.m., during interview with Director of Nursing (DON), when asked if all residents should be given privacy while care is given, DON stated, Yes. DON was made aware of observations made related to R#28 and R#29. DON was asked for policies related to privacy curtains in residents' rooms being drawn during care. DON was not able to provide a policy related to this situation.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a comprehensive splint application care plan for one (#51) resident reviewed for comprehensive care plans, resulting in the potential for missed opportunities for splint application and the potential for decline in range of motion and/or worsening of contractures. Findings include: On 3/3/2020 at 9:35 PM, Resident #51 (R51) was observed awake and lying in bed. The fingers on R51's left hand were noted to be flexed over, towards, and onto the top area of her palm. When R51 was queried if she has a hand brace, she said, Yes, it's blue. It's been a week since I had it on. When queried if staff were cleaning her hand, she said, They last cleaned it a week ago. On 3/3/2020 at 9:40 PM, when R51 granted CNA (Certified Nurse Aide) Q permission to look through her nightstand, a blue hand splint was observed buried in the bottom of her nightstand drawer. A review of R51's clinical record documented admission into the facility on [DATE]. R51's [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] documented intact cognition and impairment on one side of her upper extremity. The MDS also documented zero days of splint or brace assistance was performed during seven days prior to the assessment. A review of physician orders [REDACTED]. On at 11:00 AM off at 3:00 PM. On 3/4/2020 at 12:59 PM, Licensed Practical Nurse (LPN) J indicated she provided ADL (activity of daily living) care for R51 today because she was functioning as a CNA. When queried if she put R51's brace on today, LPN J said, The restorative (CNA) puts her brace on. When queried if CNAs are supposed to document when they put the brace on R51, LPN J said, Yes. LPN J identified CNA K as the restorative CNA. On 3/4/2020 at 1:04 PM, when Restorative CNA K was queried if she put the brace on R51 today, she said, Yes. When queried if she documented the brace application, CNA K said, Yes. CNA K added the kiosk (electronic medical record system) was used to document care provided to the residents. When the CNA documentation on the kiosk for R51's care was reviewed with CNA K, there was no plan of care related to the brace application as ordered by the physician. CNA K said, I'm looking to (document the) hand splint and it's not there. It's supposed to be there because she needs it. On 3/5/2020 at 11:05 AM, when the Director of Nursing (DON) was queried if R51 has a physician's orders [REDACTED]. When queried if R51 should have a care plan for the splint application, she said, Yes. When a review of R51's comprehensive care plans was conducted with the DON, the following focus was noted: Resident requires ROM (range of motion) related to weakness and mobility, initiated on 2/10/2020. An intervention included PROM (passive range of motion) to left hand 10x2 prior to splint application 5 times weekly, 15 minutes a day, for 8 weeks, initiated on 2/10/2020. A review of R51's care plans did not include a focus that referenced wearing the left-hand splint for a total of four hours five times weekly. When queried if R51 has a splint application care plan, the DON said, No. When queried why a splint application care plan was necessary, the DON said, To avoid contractures getting worse. When queried because R51 didn't have a splint application care plan, is that why it didn't show up as part of the CNA plan of care on the kiosk, the DON said, Yes. A review of the facility document titled, Care Plans-Comprehensive, dated 1/28/11, was reviewed and revealed the following: --An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. --Each resident's Comprehensive Care Plan has been designed to: incorporate identified problem areas; aid in preventing or reducing declines in the resident's functional status and/or functional levels; and, enhance the optimal functioning of the resident by focusing on a rehabilitative program.
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist one sampled resident (35) reviewed for activities of daily living. This deficient practice resulted in the resident (35) verbalizing feelings of shame and frustration. During an initial tour conducted on 3-3-20 at 8PM, resident (35) was observed lying in bed. The resident had a moderate amount of hair growth on her chin. When asked about it, the resident stated, I hate this hair on my chin; I haven't had it shaved because I have not had a shower. My shower days are Wednesdays and Saturdays during the day shift. When asked if she received any offers to shave her chin hair on days that are not shower days, the resident replied, no. According to a record review conducted on 3/4/20, resident (35) [DIAGNOSES REDACTED]. During a quarterly assessment dated [DATE] the resident was moderately cognitively (thought processes) impaired with a BIMS (Brief Interview of Mental Status) score of 12/15. Resident (35) required extensive 2-person physical assistance via a Hoyer Lift for transfers to the shower room; when receiving assistance with activities of daily living involving personal hygiene. A review of the resident's shower log dated 2/6/20/, 2/10.20, 2/13/20, 2/17/20, 2/24/20, 2/27/20, and 3/2/20, indicated the resident missed receiving showers on 2/6/20 and 2/10/20 due to refusal. The resident was observed on 3/4/20 at 10:16 AM, the resident appeared well-groomed to include shaved chin hair. The resident was asked if she received a shave recently, the resident stated, yes I received a shower and shave today. The resident was asked if she refuses showers, the resident stated, no, I think I am a lot of trouble for the staff because I have to be moved in the Hoyer lift. On 3/5/20 the DON provided no comments regarding the provision of ADL's with the facility when providing the surveyor with policy entitled, Shaving the Resident. The policy was revised on 1/16/11. The purpose of the procedure was to promote cleanliness and to provide skin care. There was no information contained in the shaving policy and procedure that addressed shaving female residents.
F 0685 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Assist a resident in gaining access to vision and hearing services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to respond timely to an ophthalmologist's recommendations for one (#45) resident reviewed for vision services, resulting in delay in assessment and potential delay in treatment. Findings include: On 3/3/2020 at 9:22 PM, Resident #45 (R45) was observed awake in her room. When R45 was queried if she had problems with her vision, she said, I have film on my eye. I've been waiting for an appointment, but the Social Worker keeps saying she didn't get to it. A review of the clinical record for Resident #45 (R45) documented an initial admission date of [DATE] and readmission date of [DATE]. R45's [DIAGNOSES REDACTED]. A Minimum (MDS) data set [DATE] documented intact cognition. On 3/4/2020 at 4:30 PM Social Worker, (SW N) was queried if she was aware of an eye appointment for R45. SW N said, I only know she was going to (an ophthalmology institute) years ago. (R45) had an eye doctor consult in February with (the facility's ophthalmologist). SW N added that after R45's eye doctor consult in

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F 0685 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) February, she requested to go back to the ophthalmology institute. The facility's eye doctor consult was reviewed with SW N and revealed the following: --Exam date: [DATE] --Assessment: after [MEDICAL CONDITION] --Plan: refer to ophthalmology When SW N was queried if she scheduled the follow up ophthalmology appointment for R45, she said, No. SW N added that she will make the (ophthalmology institute) appointment because that is where R45 wants to go. A review of R45's clinical record on 3/5/2020 documented in part a social service's note on 3/5/2020: SW meet with the resident regarding her eye appointment and her discharging from the facility. Resident states that she would like to go back to the (ophthalmology institute). SW will make an appointment for the resident to follow up for her eyes .SW express that she will continue to inform her about the eye appointment. On 3/5/2020 at 11:10 AM, when the Director of Nursing (DON) was queried about her expectations for scheduling resident's ophthalmology appointments, she said, That they would go to the ophthalmologist for follow up. When queried if a recommendation for a follow up appointment that was made on [DATE] should have been scheduled by now, the DON said, Yes. A facility policy titled, Transportation, dated 8/2014, was reviewed and documented the following: --Our facility shall help arrange transportation for residents as needed.
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** Based on observation, interview and record review the facility failed to provide adequate smoking supervision for two sampled residents (R#'s 56 and 216) from a total sample of 29, resulting in the potential for individual's safety precautions not being adhered to. Findings include: On 3/03/20 at 6:45 PM, observed three residents (R#'s 56, 216 and 104) smoking cigarettes with R#104's son in a designated area. There was no staff supervision present. R#104's son was queried and stated, I bring my mom her cigarettes and gave these other 2 residents one too. I think they're doctor said it was ok for them to smoke, I don't know. Upon completion of the cigarette, R#104's son took the resident from the smoke area and left the other 2 residents outside smoking. R#56 Record review revealed that R#56 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set Assessment ((MDS) dated [DATE] indicated the resident's cognition was intact and required limited assistance with all activities of daily living (ADL's). Review of a Safe Smoking Evaluation dated [DATE] documented: Does the resident currently smoke, use e-cigarettes, or tobacco products? yes. Resident may smoke independently or with set up. Review of a care plan titled, The resident is a smoker dated 9/28/19 had an intervention of Smoking paraphernalia will be kept secured at facility identified location .The resident requires supervision while smoking. R#216 Record review revealed that R#216 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The Nursing Admission assessment dated [DATE] indicated the resident's cognition was intact and required limited assistance with all activities of daily living (ADL's). Review of a Safe Smoking Evaluation dated 2/22/20 documented: Does the resident currently smoke? yes. Does the resident plan to smoke, use e-cigarettes, vapors, or any other tobacco related products while staying at the facility? no. Review of a care plan titled, The resident is a smoker dated 2/22/20 had an intervention of Smoking paraphernalia will be kept secured at facility identified location. On 3/4/20 at 10:42 AM, the Director of Nursing (DON) was queried regarding the facility's policy on allowing family members to supervise resident who smoke. The DON said that a family member could supervise their own loved one, but not other residents. Review of the facility's policy titled, Smoking Policy Campus-Residents dated 7/17 documented, Any resident with smoking privileges hall not be permitted to smoke without the direct supervision of a responsible staff member, family member, visitor or volunteer worker and direct supervision must be provided throughout the entire smoking period.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure coordination of care between the facility and the contracted [MEDICAL TREATMENT] center for one (#45) resident reviewed for [MEDICAL TREATMENT] services, resulting in the potential for fluid overload and overall health problems. Findings include: On 3/3/2020 at 9:22 PM, Resident #45 (R45) was observed awake in her room. Signage was observed on R45's wall that stipulated she was on a 1500 ml (milliliter) fluid restriction. A review of the clinical record for R45 documented an initial admission date of [DATE] and readmission date of [DATE]. R45's [DIAGNOSES REDACTED]. A Minimum (MDS) data set [DATE] documented intact cognition. A review of the referenced [MEDICAL TREATMENT] Communication Records for R45 revealed the following: --1/9/2020: keep her off the pop! she has too much fluid on! --1/21/2020: fluid overload; limit her fluids! 40 oz. per day --1/30/2020: patient is fluid overloaded. She needs to be restricted to 40 oz fluids/24 hours. --2/1/2020: fluid restriction please! --2/15/2020: please encourage fluid restriction! (The emphases were from the [MEDICAL TREATMENT] center.) A review of R45's care plans related to [MEDICAL CONDITION] documented in part the following: Focus: --The resident needs [MEDICAL TREATMENT] related to [MEDICAL CONDITION]. Revision date: 1/30/2020. --[MEDICAL CONDITION] on [MEDICAL TREATMENT] (HD), and diabetes mellitus-type 2 (DM-2). I have a therapeutic diet in place related to DM-2, [MEDICAL CONDITION], and [MEDICAL CONDITIONS]. I have excellent appetite/intake. I enjoy some high phosphorus and potassium foods and am aware that they affect my HD lab values. I have a fluid restriction in place related to [MEDICAL CONDITION] on HD. I have been observed with pop from vending machines and extra liquids on multiple occasions. I have been educated and understand that extra fluids may affect my weight, labs, and overall health status. Interventions included: --1500 ml/day fluid restriction - 840 ml/dietary, 660 ml/nursing. Date initiated: 01/30/2020. On 3/4/2020 at 4:50 PM, the facility's Registered Dietitian (RD L) was queried about R45's [MEDICAL TREATMENT] Communication Records. When queried if she reviews R45's [MEDICAL TREATMENT] communication sheets, RD L said, I will review some, but not each one that comes here. I only use them to track pre and post weights. When queried what should happen if the [MEDICAL TREATMENT] communication sheets indicated a fluid restriction, RD L said, I would educate the resident, alert nursing that the order should go in, and determine the amount of fluid for nursing and dietary. When queried about R45's current fluid restriction, RD L said, She's currently on 1500 (ml); 840 for dietary and 660 for nursing. When queried about the importance of a fluid restriction for a R45, RD L said, She has a history of being fluid overloaded. When RD L was queried if she was aware of the [MEDICAL TREATMENT] center's recommendation for R45 to be on a daily 40-ounce (1200 ml) fluid restriction, she said, No. A review of the facility RD's progress note of 2/27/2020 did not reveal a reference to a conversation with [MEDICAL TREATMENT] center's RD related to fluid recommendations as stipulated on the 1/30/2020 [MEDICAL TREATMENT] Communication Record. On 3/5/2020 at 10:30 AM, when the [MEDICAL TREATMENT] center's Registered Dietitian (RD M) was queried about R45's fluid restrictions, she said, (R45) should be on a fluid restriction. I tell them at a minimum 1200 to 1500 ml. (R45) has been hospitalized many times for fluid overload. We really have to watch her. When RD M was queried about the 40-ounce fluid restriction indicated on the [MEDICAL TREATMENT] communication sheet, she said, That's about 1200 ml. When queried if she was okay with that recommendation, RD M said, Yes. I would expect the facility to have discussed it with their RD and decide on what to do. It is the RD there that makes a call to the physician about any changes. On 3/5/2020 at 11:14 AM, when the Director of Nursing (DON) was queried about the purpose of [MEDICAL TREATMENT] communication sheets, she said, They're for the nursing facility to document the resident's vital signs, meds given, and any changes in condition. When the sheet comes back, it should have vital signs, weights, any changes, any orders for labs, and fluid status. When the DON was queried about what should happen with recommendations that come from the [MEDICAL TREATMENT] center, she said, We are to notify the physician and dietitian. The facility policy titled, Care of the [MEDICAL TREATMENT] Resident, dated 1/2012, was reviewed and revealed the following: --The purpose is so that [MEDICAL TREATMENT] residents will be provided care and services in a manner that promotes the resident's quality of life, and to attain or maintain the resident's highest possible physical, mental, and psychosocial well being. --[MEDICAL TREATMENT] residents are given fluid based on the fluid restrictions as ordered by the physician. --Send the [MEDICAL TREATMENT] Communication Record with the resident to be completed and returned as needed.
F 0740 **Level of harm** - Minimal harm or potential for 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 interview and record review, the facility failed to obtain clinical assessment/rationale from the physician or psychologist related to adding an additional antidepressant and obtain timely psych services for one (#19) resident reviewed for psych medications, resulting in the potential for negative psychosocial outcomes. Findings include: A review

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F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) of the clinical record for Resident #19, (R19) documented an initial admission into the facility on [DATE] and readmission on 9/16/19. R19's [DIAGNOSES REDACTED]. A Minimum (MDS) data set [DATE] documented severe cognitive impairment. A review of current physician orders [REDACTED]. [MEDICATION NAME] (an antidepressant) was also administered to R19 daily between [DATE] to 3/4/2020. The start date for [MEDICATION NAME] was 9/17/19. On 3/5/2020 at 11:17 AM, when the Director of Nursing (DON) was queried why R19 was prescribed [MEDICATION NAME], she said, I will have to investigate. The DON added that this was a verbal order from a medical doctor (Physician O). When the DON was queried about who normally orders antidepressants for the residents in the facility, she said, They're normally ordered by psych services or the psychologist. On 3/5/2020 at 11:27 AM, the Physician O and the Nurse Practitioner for Physician O were called to inquire about the reason for the [MEDICATION NAME] order. A return call was not received from the Physician or Nurse Practitioner by the end of the survey. When the DON was queried if there should be a clinical assessment regarding the purpose/need for the order for an additional anti-depressant, she said, Yes. When queried if the clinical record provided an assessment for the purpose/need for [MEDICATION NAME], the DON said, No, I do not see any. When the DON was queried if R19 was being monitored by psych services, she said, No. We can call them and ask that they see her right away. On 3/5/2020 at 11:52 AM, the Social Worker (SW O) was interviewed about R19's psych medications. When SW O was queried if R19 was on other psych medications, she said, (R19) is on [MEDICATION NAME] (an antidepressant). On 3/5/2020 at 2:50 PM, when the facility Administrator was queried about why R19 was prescribed [MEDICATION NAME], she said, Per my experience her meds may have been used for sleep. If psych didn't provide it, it's probably for sleep or appetite. When the Administrator was queried if [MEDICATION NAME] was used for appetite or sleep, she said, No. When queried if R19 should have received behavioral services for [MEDICATION NAME], the Administrator said, Not necessarily. When the Administrator was queried if behavioral services were indicated for someone diagnosed with [REDACTED]. When R19's March 2020 MAR indicated [REDACTED]. When the Administrator was queried about why R19 was prescribed [MEDICATION NAME] when she was already receiving a medication for depression ([MEDICATION NAME]), the Administrator said, (R19) should have been referred to psych. The Administrator was asked to provide documentation for the rationale for [MEDICATION NAME] administration. A policy that directs behavior health care services in the facility was also requested. On 3/5/2020 at 3:32 PM, the Administrator said, We couldn't find any information about the ([MEDICATION NAME] order). The Administrator also stated the facility does not have a policy that governs behavioral health services. On 3/5/2020 at 4:15 PM, the facility provided a psych evaluation signed by psych services Physician Assistant (PA R) on 3/5/2020 at 3:26 PM. The document revealed the following: --Plan: start ([MEDICATION NAME]) for depression with decreased appetite and poor sleep, continue ([MEDICATION NAME]). These two medications work well together to improve depression and each treat target symptoms. --Indication for visit: New Patient.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to prevent a potential significant medication error for one sampled resident (R#217) of a total number of seven residents reviewed during medication pass; putting resident #217 at risk for not receiving the prescribed dose of [MED]. Findings include: On 3/4/20 at 9:24 AM, an observation was made of Nurse D administering [MED] via an [MED] pen into the left upper arm of resident #217. Review of the current medical record indicated R#217 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The Admission Nursing Assessment and required supervision with all activities of daily living. Review of the March 2020 Medication Administration Record [REDACTED]. Nurse D attached a needle to the pen and dialed up from 0 to the prescribed 12 units of [MED], without first performing a manufactures recommenced safety test (priming test ensuring the pen and needle work properly as well as, removing air bubbles by turning dosage selector to 2 unit and pressing the injection button to check if [MED] come out of the needle tip). Nurse D, cleaned the resident's skin with an alcohol swap, and injected the contents into the left upper of resident #217. Following the [MED] administration Nurse E stated, I hold it (the [MED] pen injection button) down for a few seconds so the [MED] goes into site. I didn't realize I had to prime the needle first. But that does make sense. An interview was conducted with the facility's Director of Nursing (DON) on 3/4/20 at 10:42 AM regarding [MED] pens, and Nurse D not priming the [MED] pen prior to administering the [MED] to resident #217. The DON stated, The nurse was supposed to prime the [MED] pen prior to [MED] administration. Review of the policy titled, Subcutaneous [MED] 2007 documented, Always perform the safety test before each injection.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, record review and interview, the facility failed to inspect and test annually in accordance with NFPA 101, 19.7.6, 8.3.3.1 and NFPA 80, Standard for Fire Doors and Other Opening Protectives 5.2, 5.2.3. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review.This deficient practice could affect 20 occupants in the event of a fire. Findings Include: On March 5, 2020 at approximately 1:23 PM, observation revealed the north side Storage exit door would not open without excessive force. On March 5, 2020 at approximately 3:10 PM, record review revealed the facility failed to have a record of inspection for the 1 hour rated Cornell kitchen fire door assembly. This will potentially allow the door to fail to function when needed in the event of a fire. An annual inspection and testing according to NFPA 80 2010 edition, section 5.2.1 is required. These findings were confirmed by the Maintenance Director at the time of discovery through interview.
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Dispose of garbage and refuse properly.** Based on observation, interview, and record review the facility failed to properly maintain the exterior garbage disposal area in a clean and sanitary manner, resulting in the potential for the attraction of pests and rodents. This deficient practice has the potential to affect all 115 residents in the facility. Findings include: On 03/03/20 at 07:35 PM observed a white ice cart, tray table with a broken rotted out wooden tabletop, used gloves, and trash debris surrounding the dumpsters. When queried, Dietary Aide I advised maintenance is responsible for cleaning the exterior dumpster area. During an interview with the Maintenance Director H on 03/03/20 at 09:50 PM, he advised the outside grounds area is checked daily now since the weather is better. Maintenance Director H advised the ice cart and tray table is used for parts, because the wheels are expensive. When asked for a policy on cleaning the exterior dumpster area, Maintenance Director H advised there isn't a policy for cleaning the exterior dumpster area. According to the 2013 FDA Food Code, 5-501.15 Outside Receptacles. (A) Receptacles and waste handling units for REFUSE, recyclables, and returnable used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers. (B) Receptacles and waste handling units for REFUSE and recyclables such as an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around and, if the unit is not installed flush with the base pad, under the unit.
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** Based on interview and record review, the facility failed to ensure the Medical Director attended the QAPI (Quality Assurance and Performance Improvement) meetings on a quarterly basis, resulting in the potential for lack of coordination of medical care and policies that could impact all residents who resided in the facility. Findings include: On 3/5/2020 at 2:00 PM, an interview and record review of the QAPI process including attendance records was conducted with the facility Administrator. The Administrator reported that she started in September 2019 and the QAPI meetings occurred at least quarterly. A review of the QAPI meeting attendance records/signature sheets from March 2019 to February 2020 was conducted and revealed the following: March 2019: Medical Director was in attendance April 2019: Medical Director did not attend May

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235541	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE LODGE AT TAYLOR	**22950 NORTHLINE RD TAYLOR, MI 48180**

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F 0868 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) 2019: Medical Director was in attendance June 2019: Attendance record not available July 2019: Attendance record not available August 2019: Medical Director did not attend September 2019: Medical Director did not attend October 2019: Attendance record not available November 2019: Attendance record not available December 2019: Medical Director did not attend January 2020: Medical Director did not attend February 2020: Medical Director did not attend When queried about the missing QAPI meeting attendance records/signature sheets, the Administrator said, I cannot find the signature sheets. The Administrator was unable to provide other documentation to verify the Medical Director's attendance and/or participation. A review of the facility policy titled, Quality Assessment and Process Improvement Committee (QAPI), dated 11/28/16, was reviewed and documented the following: --The facility shall establish and maintain a Quality Assessment and Process Improvement Committee that oversees the identification and improvement of Quality deficiencies through a systematic approach utilizing PDSA (Plan-Do-Study-Act). --Goals of the committee included: to focus on systems of care, outcomes, and services for residents and staff; to monitor and evaluate performance of all services and programs of the facility, including services provided under contract or arrangement; to help identify negative outcomes relative to resident care and resolve them appropriately.